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SEX EX LIBRIS: ABSTINENCE MESSAGES IN HIGH SCHOOL HEALTH TEXTBOOKS CULTIVATE SEX NEGATIVITY AMONG TEENS

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF SOCIOLOGY

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To
My family, friends, mentors, and loved ones

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Abstract

The vast majority of high schools require some form of sex education. Despite numerous concerns about the efficacy of abstinence-only education programs and their failure to demonstrate a reduction in the onset of teenage sexual activity, such curricula remains widespread in U.S. public schools. One resource in formal sex education is health textbooks. Six widely used high school health textbooks were investigated. Through qualitative content analysis of the written material, a shared emphasis on abstinence was identified, specifically in relation to premarital relationships, decision-making, and risk prevention. Textbooks emphasize that marriage is the only appropriate place for people to have sex, aim to instruct teens on how to make responsible decisions and how to refuse engaging in deviant behavior, and stress that sex is a high-risk activity that teens should avoid in favor of abstinence. Using the data from these high school health textbooks, I develop a theory of patronizing exclusivism to explain the implicit and explicit messages about abstinence and identify six primary features: perpetuation of the stereotypical ideal family, denial of demographic realities, assumption that teens are impulsive, conflation of sex with morality, encouragement of stigma of the sexually active, and promotion of sex negativity. Promotion of sex negativity is the root strategy and facilitates the implicit and explicit messages about abstinence in high school health textbooks. The theory of patronizing exclusivism has implications relevant to dialogue about how sex education should be taught and what should be included.

Chapter 1: Introduction

According to the Centers for Disease Control and Prevention, 46.8 percent of U.S. high school students surveyed in 2013 reported ever having had sexual intercourse. Furthermore, 34 percent reported having had sexual intercourse during the previous three months and of those, 40.9 percent did not use a condom and 81 percent did not use birth control pills (Kann, et al. 2014). At the same time, the National Center for Health Statistics reported that U.S. teen birth rates have reached historic lows for all age and race-ethnic groups, declining 44 percent from 1991 through 2010 (Hamilton and Ventura 2012). However, teen birth rates remain high in comparison to other developed countries (Kirby 2007). Additionally, young people aged 15 to 24 acquire nearly half of the estimated 19 million sexually transmitted infections annually (Centers for Disease Control 2013).[1]

As a result of these trends, as well as the HIV/AIDS epidemic, the vast majority of high schools now require some form of sex education (Kendall 2008). This "education" has been influenced at both the national and local levels by religious conservative movements that mobilized to guarantee that the sex education presented in schools would emphasize an abstinence-only approach and limit information about condoms and contraception to discussions about their failure rates. Despite numerous concerns about the efficacy of abstinence-only education programs and their failure to demonstrate a reduction in the onset of teenage sexual activity, such curricula remains widespread in U.S. public schools. Public schools are often the single source of formal sex education, thus the credibility and appropriateness of information that schools

[1] The phrases "sexually transmitted infection" (STI) and "sexually transmitted disease" (STD) are often used interchangeably. Medically speaking, infections are referred to as diseases when they cause

provide can significantly impact students throughout their lives (Isley, et al. 2010). One resource in formal sex education is health textbooks. Yet, rather than being objective sources of information, textbooks offer subjective representations of the formal knowledge that educational institutions feel is most appropriate for students. Given society's current emphasis on sexual purity and conflation of sexuality with morality, sex is often portrayed as an activity fraught with risk unless conducted within the confines of marriage (Irvine 2006). In other words, remaining abstinent until marriage is highly encouraged in the textbooks assigned to students in their high school health classes.

Defining Sex Education

The content of school-based sex education programs varies widely. The Sexuality Information and Education Council of the United States (SIECUS) defines sexuality education, or sex education, as "a lifelong process of acquiring information and forming attitudes, beliefs, and values about such important topics as identity, relationships, and intimacy" (2004: 13). The goal of sex education, according to SIECUS, is to promote adult sexual health through assisting young people in developing a positive view of sexuality, providing them with information they need to take care of their sexual health, and helping them acquire skills to make decisions now and in the future. The different approaches to sex education – abstinence-only until marriage and comprehensive sex education – are defined in Table 1.

A Brief History of Abstinence-Only Education

Debates about sex education are not new. An "abstinence agenda" that promotes heterosexual standards, such as chastity before monogamous marriage, marital sex

chiefly for procreation, and stable parenthood thereafter, dates to the late 1800s and early 1900s (Sethna 2010).[2] Sex education for youth was seen as a solution to the societal ills of prostitution and venereal diseases. Social purists, most of whom were white, middle-class Christian evangelicals, believed that children had been kept ignorant about sex to the detriment of society and public health. To that end, they produced age-graded and gender-appropriate texts for children on "purity education" to forestall children's non-reproductive sexual activities (i.e., masturbation) and demonstrate the significance of the monogamous heterosexual couple. These guides, such as Sylvanus Stall's *What A Young Boy Ought to Know* (1897) and Mary Wood-Allen's *What A Young Girl Ought to Know* (1897), encouraged children to adopt the abstinence agenda through their diet, dress, exercise, studying of the reproduction of flora and fauna, and having the right kinds of friends (Sethna). However, the authors of the purity guides were afraid that the knowledge of the details of human reproduction would stir children's sexual desire. Language about the act of sexual intercourse was unclear and, most often, omitted.

The physician-dominated social hygiene movement supplanted the social purity movement by the end of the Second World War, but the abstinence agenda remains. Irvine (2006) points out that sex panics, or hostilities that break out in communities debating a particular sex education program, have regularly occurred since the 1960s. Such sex panics are part of a political initiative by social and religious conservatives to control sexual knowledge and, in doing so, protect young people and preserve sexual

[2] As of October 19, 2014, 32 states and D.C. supported same-sex couples with marriage equality; however, as same-sex marriage has only very recently become legal in a majority of states, when marriage is addressed in the textbooks and throughout this dissertation, the implied meaning is heterosexual marriage.

morality. They believe that all sex should be confined to marriage and discussion of sex should be controlled so as to not entice youth to immoral thoughts or behaviors. Irvine explains that, in the view of conservatives, discussion of contraceptives has led to high levels of adolescent sexual activity, teenage pregnancy, and sexually transmitted infections (STI). The best approach to sexual health, in their opinion, is to teach youth to abstain from all sexual behavior until they are married. Thus, the abstinence agenda that promotes chastity until one is in a heterosexual, monogamous marriage and that children should be born within wedlock echoes from the past to the present.

Irvine (2002) argues that sex education panics are a powerful form of affective politics that work to the advantage of national conservative religious advocacy organizations by paralyzing dialogue and associating comprehensive sex education with disease and danger. By the mid-1990s, local battles over sex education led many states to change legislation and policies to require teaching abstinence (Kantor, et al. 2008). At the same time, social conservatives at the national level pressured policymakers to increase support for abstinence-only education.

In 1995, Senator Rick Santorum (R-PA) and Senator Lauch Faircloth (R-NC), introduced a provision to the Personal Responsibility and Work Opportunity Reconciliation Act (Haskins and Bevan 1997). Their provision's unambiguous message was that sex outside of marriage is wrong. Furthermore, afraid that advocates of comprehensive sex education might dilute their legislation, Santorum and Faircloth outlined specific characteristics in remarkable detail. Former Congressional staffers Haskins and Bevan (1997) report that, in their discussions with people involved with writing the initial legislation, they found that several family groups, led by Robert

Rector of the conservative think tank Heritage Foundation, had approached Senator Faircloth about the importance of abstinence-only education. No formal attempt was made by Democrats to change the language of the provision, and President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 with Santorum and Faircloth's provision intact. Every program that receives federal funding under this provision must adhere to an eight-point definition of abstinence education (Table 2). Haskins and Bevan write:

> "Regardless of how one feels about the standard of no sex outside marriage, we believe both the statutory language and…the intent of Congress are clear. This standard was intended to align Congress with the social tradition – never mind that some observers now think the tradition outdated – that sex should be confined to married couples. That both the practices and standards in many communities across the country clash with the standard required by the law is precisely the point. As in the cases of civil rights and smoking, the explicit goal of the abstinence education programs is to change both behavior and community standards for the good of the country. It follows that no program that in any way endorses, supports, or encourages sex outside marriage can receive support from the abstinence education money" (1997: 475).[3]

Furthermore, Haskins and Bevan acknowledge that the perceived Congressional attack on births to unmarried parents under the Personal Responsibility and Work Opportunity Reconciliation Act is based more on the idea that sex outside of marriage is wrong and is bad for mothers, children, and society than on empirical evidence that links abstinence-only policies with reduced non-marital births.

Abstinence-only programs came to prominence with the enactment of Title V, Section 510 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Since fiscal year 1998, the Title V program had annually allocated $50 million of federal funds to the teaching of abstinence from sexual activity outside of marriage to

[3] In the mid-1990s, only men and women could be legally married.

school-age children (Trenholm, et al. 2007).[4] Other sources of federal funding for abstinence-only education included the Adolescent Family Act that was developed in 1981 to prevent teen pregnancy, and Community-Based Abstinence Education that gave grants to programs that only promote abstinence and do not discuss or demonstrate contraceptives (Weiser and Miller 2010). However, fiscal year 2010 marked a significant shift in the federal government's funding for abstinence-only programs (SIECUS 2011). By that time, nearly half of the states had refused federal funding for abstinence-only education because evaluations of the abstinence-only programs showed they were ineffective. The Obama administration and Congress eliminated the funding of the Community-Based Abstinence Education grant program and the abstinence-only portion of the Adolescent Family Life Act. However, Congress earmarked $4.7 million in discretionary funding for a Competitive Abstinence Education grant program that provides funds to community and faith-based organizations (SIECUS 2013). Two new federal funding streams have been created: the Teen Pregnancy Prevention Initiative and the Personal Responsibility Education Program. Both programs, according to SIECUS (2011), can be comprehensive and are medically accurate. Funding for the comprehensive sex education programs is consistently challenged and cuts are often made to these programs in an attempt to increase funding for abstinence-only federal programs.

[4] This funding, while initially allowed to expire in 2009, was resurrected in 2010 as a result of the Healthcare Reform Package and has been extended to 2014. States must match the federal funding at 75 percent, resulting in $87.5 million annually funding programs promoting abstinence until marriage.

Still, there continues to be a concentration of Title V abstinence-only funding in southern states.[5] This is important for two reasons. First, compared to their counterparts in the rest of the country, more youth in the South engage in risky sexual behaviors such as having four or more sexual partners and not using contraceptives if they are currently sexually active (SIECUS 2011; Kann, Kinchen, and Shanklin 2014). Yet, Texas strongly supports abstinence-only education, although school districts in Austin, Corpus Christi, Harris, Midland, San Antonio, and Plano are slowly adopting curriculum that includes some information on contraception (SIECUS 2011). Second, textbook publishers orient their coverage toward large states, like Texas, that have large markets, statewide adoption, and active adoption boards that effectively function as censors (Loewen 1995). Schools and districts that are in smaller markets must choose among books made for the larger markets. In short, this means that the topics and treatments of subjects in textbooks published for the abstinent-only-supporting Texas are not just read by Texan students.[6]

Despite the debate regarding the quality, morality, and effectiveness of various types of sex education programs, the general U.S. population has expressed strong and stable support for state-provided comprehensive sexuality education, as long as abstinence was emphasized. In a nationally representative phone survey (National Public Radio, et al. 2003), 99 percent of parents considered sexually transmitted infections to be an appropriate topic for sex education classes. Fourteen percent of

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[5] These southern states include: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, North Carolina, South Carolina, Tennessee, Kentucky, Virginia, and West Virginia.

[6] Texas Education Code specific to sex education curriculum in Table 3. Note that districts are required to have local school education advisory councils to oversee the curriculum. A 2002 Human Rights Watch report states that an estimated 50 percent of school districts do not have school education advisory councils, nor are they penalized for noncompliance.

parents considered abortion and condom instruction inappropriate topics. Twenty-five percent of parents considered homosexuality and sexual orientation inappropriate, 27 percent considered oral sex inappropriate, and 28 percent considered students being told that they can obtain contraception at health clinics without their parents' knowledge inappropriate in sex education classes. In a study of factors predicting preferences for types of sex education by Bleakley et al. (2010), support for various approaches was largely related to beliefs about which programs were most effective for preventing unplanned teen pregnancy. Those who believe abstinence-only education is effective in preventing unplanned pregnancy tend to attend religious services more frequently, are less liberal and more conservative, are of African-American or other non-white race-ethnicity, are male, are not college educated, and report low-income. In contrast, 82 percent of respondents in Bleakley et al.'s study supported comprehensive sex education and believe it is an effective means to prevent pregnancy. As Kendall (2008) points out, fundamental differences in beliefs about the purposes of sex education and the morality of sex itself underlie the continuing struggles over sex education.

In regard to actual effectiveness of different approaches, there is no strong evidence that abstinence-only programs delay the initiation of sex, increase the return to abstinence, reduce the number of sexual problems, or have a negative impact on the use of condoms or other contraceptives (Kirby 2007). A study by Haglund and Fehring (2010) utilizing data from the 2002 National Survey of Family Growth found no significant differences between those who received abstinence-only and those who received abstinence-plus education in terms of ever having had sex.[7] Teens whose sex

[7] Haglund and Fehring (2010) define "abstinence-plus" as abstinence education combined with information about condoms and contraceptives. Only learning how to say no was indicative of

education included abstinence were 17 percent less likely to ever have had sex than those who had not formally learned how to say no. However, the estimated mean age of sexual debut for those who learned to say no in their formal sex education was 17.6 compared to 17.1 for those who did not learn to say no. In contrast to a dearth of evidence supporting abstinence-only programs, comprehensive sex education programs have demonstrated positive behavioral effects. Kirby (2007) studied comprehensive sex education programs and found that over 40 percent of students delayed the initiation of sex, reduced the number of sexual partners, and increased condom or contraceptive use. Additionally, almost 30 percent reduced the frequency of sex and more than 60 percent reduced unprotected sex. Kirby found that comprehensive sex education programs worked for both males and females, for all major race-ethnic groups, for those experienced and those inexperienced with sex, and in different settings and different communities.

In sum, although an abstinence agenda has had a lingering effect on modern-day approaches to sex education, both funding and practical concerns about effectiveness have led to a slow turn toward comprehensive sex education programs. Parents seem to support such programs, as long as they emphasize abstinence first. Nevertheless, Texas's promotion of abstinence-only sex education, when combined with its hold on the textbook market, may mean that abstinence-only messages continue in textbooks for years to come.

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abstinence-only education, whereas learning how to say no and learning about birth control methods was indicative of abstinence-plus education. Not learning how to say no meant respondents reported no sex education or only learned about birth control in their sex education.

Research Question

Through qualitative content analysis of the written material, a shared emphasis on abstinence was identified, specifically in relation to marital relationships, decision-making, and risk prevention. This study was designed to provide insight into messages about abstinence. Thus, the research question directing this inquiry was: "What are the implicit and explicit messages about abstinence in high school health textbooks?"

Significance of the Study

Sex education curriculum has been examined by a wide array of scholars from a variety of backgrounds, including education, health, medicine, and sex researchers (Kendall 2009, Lin and Santelli 2008, Wilson and Wiley 2009, Casemore 2010, Gilbert 2010, Lesko 2010, Ott et al. 2011). None of these studies focus on high school health textbooks; rather, they utilize such methods as surveys, focus groups, and case studies to form the basis for their conclusions. Sociologists have not conducted an examination of the ways in which abstinence is addressed in high school health textbooks, nor, to my knowledge, has such a study been published in another field. Thus, my study and the theory created within it are valuable contributions to dialogue about how sex education should be taught and what should and should not be included.

Outline of the Study

My primary goal in this chapter has been to introduce my study and lay out the relevant context for it. Chapter two reviews relevant literature related to the three main themes in my study: emphasis on marriage, distrust of teens' decision-making skills, and risk prevention. In chapter three, I elaborate on the data used in this study as well as how the data were collected and analyzed. I also include a discussion of the

methodological assumptions that informed me as a researcher and guided my study, specifically a contextual constructionist-oriented paradigm and feminist standpoint theory.

Chapter four of the study focuses on how the textbooks emphasize that marriage is the only appropriate place for people to have sex. In the chapter, I define what the textbooks mean by "marriage" and how to find a good marriage partner. Next, I examine the textbooks' reasons why a person should get married and how to make a marriage successful. Then I assess the arguments made in the textbooks for staying abstinent until marriage. I conclude the chapter by analyzing the issues ignored by the textbooks, such as the period of emerging adulthood, the increasing prevalence of single adults, the reality of cohabitation as a legitimate option for couples, the lives of lesbian, gay, bisexual, and transgender individuals, the context of divorce and remarriage as an adult, and differences of race-ethncity and class.

In chapter five, I examine how the health textbooks exhibit a distrust of teens' decision-making skills. The chapter opens with an explanation of what the textbooks mean by "family" and what constitutes healthy family relationships. Next, I explain how the role of parent or guardian is constructed in the textbooks, including how they are responsible for teaching their children how to make decisions, setting dating guidelines and limits, and instructing their teens on how to refuse pressure to engage in deviant behaviors, such as sexual intercourse. Then I examine how textbooks address teens who have had sexual intercourse and how this affects their relationship with their parents. I conclude chapter five by addressing ignored issues, such as the prevalence of

teens who have experienced sexual assault or violence, that parents and families can be dysfunctional, and differences of class and race-ethnicity.

The purpose of chapter six is to show how textbooks emphasize that sex is a high-risk activity that teens should avoid in favor of abstinence. Chapter six starts with defining what the textbooks mean by "sex" and how the definitions are associated with procreation. Next, I examine the risk factors that could make a teen more likely to engage in sex. Then, I address each of the harmful consequences associated with sex, including sexually transmitted infections, HIV/AIDS, teen pregnancy, rape and sexual violence, and negative emotional effects. This is followed by an analysis of how contraceptives are discussed in my sample, and an evaluation of the suggested alternatives to sex offered by the textbooks. Chapter six concludes by looking at issues textbooks ignore, such as the need to control fertility, sexual pleasure, and race-ethnicity and class differences.

The main objective of the concluding chapter is to summarize the study and formulate a theory that accounts for the implicit and explicit messages high school health textbooks have about abstinence. I also discuss the limitations of my study and offer suggestions for ways in which scholars might conduct further research about abstinence and sex education.

Chapter 2: Literature Review

As textbooks are cultural artifacts, they are a reflection of not only the authors, but also the era and society in which they were created. Health textbooks aim to describe society as well as prescribe activities and behaviors that readers should follow if they wish to lead healthy lives. For example, one of the prescriptions made in the textbooks is for people to abstain from sexual activity until they are married. The issue with the textbooks' descriptions and prescriptions is that they are not always accurate reflections of society.

In this chapter, I review literature related to the three main themes in my study: emphasis on marriage, distrust of teens' decision-making skills, and risk prevention. Through a review of the literature, I discovered that the reality of society, from demographics to parent-teen relations, did not always match the reflection of society portrayed in the textbooks.

Emphasis on Marriage

Over the past sixty years, the age at first marriage has been increasing substantially in the United States and other developed countries. In 1960, the median age at first marriage was approximately age 20 for women and age 23 for men (Kantor et al. 2008). According to data from the 2006-2010 National Survey of Family Growth, the median ages among women and men had risen to 25.8 and 28.3 years, respectively (Copen et al. 2012). Meanwhile, the age at first sexual intercourse has been declining. In 1960, the median age at first sexual intercourse among women was around age 20 and slightly lower among men (Kantor et al. 2008). The age at first sexual intercourse is now around age 17 for both women and men. Kantor et al. argue that it is unrealistic to

expect the 7- to 10-year gap between age at first sexual intercourse and age at first marriage to be entirely reversed or eliminated. Furthermore, the protections inherent with abstinence until marriage, such as being free of STIs, are only applicable if both partners have abstained from sexual activity. It is questionable whether both partners will have waited until marriage to have any sort of sexual intercourse.

Despite evidence of these demographic trends both in the U.S. and other developed countries, abstinence-only advocates presume that people will marry young and into male-female partnerships. Virginity is considered a special gift a young person, especially a young woman, can give to a spouse (Luker 2006, Valenti 2010).[8] To that end, proponents of abstinence-only programs promote virginity pledges. Millions of adolescents in the United States have taken virginity pledges (Kantor, et al. 2008). However, pledging is associated with a delay in first sexual intercourse only for those between the ages of 15 to 17, but only if the adolescents who pledge are in a minority within their school (Bearman and Bruckner 2001). Pledging has no effect on transition to first sex in schools where more than 30 percent of students are pledgers (Bearman and Bruckner). Overall, Bruckner and Bearman (2005) found that 88 percent of all those who take virginity pledges do not wait until marriage to have intercourse. Pledgers are different from non-pledgers in that they initiated sex at older ages, tended to get married earlier, had fewer sexual partners, were significantly less likely to have used a condom at first intercourse, and were more likely to report having had only oral or anal sex (Bruckner and Bearman). Yet these differences have not demonstrated a decrease in risk for sexually transmitted infections. Pledgers and non-pledgers have

[8] Virginity here means penile-vaginal penetration in the context of male-female couples.

similar rates of sexually transmitted infections, which is not surprising given pledgers' lower rates of condom use and the substitution of oral and anal sex for vaginal sex (Bruckner and Bearman). Some adolescents who have oral heterosexual sex prior to first vaginal intercourse may do so in order to maintain their virginity and because they perceive fewer health risks for oral sex (Copen, Chandra, and Martinez 2012). Data from the National Survey of Family Growth between 2007 and 2010 shows that about two-thirds of women and men between the age of 15 to 24 had ever had oral sex (Copen et al 2012). Twenty-six percent of women and 24 percent of men aged 15 to 24 had oral sex prior to first vaginal intercourse. Luker (2006) points out that teenagers do not think that oral sex is sex, thus it could be considered a loophole for virginity pledgers to preserve their purity.

As abstinence-only advocates mark heterosexual marriage as the only legitimate place to have sex, it is also considered the only legitimate place to have and raise children. Again, this position is in contrast to demographic trends in the United States and other developed countries (Casper and Bianchi 2002). In the United States in 2011, 40.7 percent of births were to unmarried women (Hamilton, Martin, and Ventura 2012). Although research has indicated that family structure affects psychological, behavioral, and academic outcomes (Cherlin 2010), there is no evidence that marriage is only socially productive when other forms of relationships are stigmatized (Luker 2006). In *The Marriage-Go-Round* (2009), Cherlin describes family life in the United States as being marked by radically contradictory attitudes toward marriage. The cultural model of marriage, as put forth by Cherlin, says that marriage is the best way to live one's life, marriage should be a loving, permanent relationship, marriage should be a sexually

exclusive partnership, and divorce should be a last resort. The cultural model of marriage is in contrast to the cultural model of individualism. The cultural model of individualism states: one's primary responsibility is to one's self, individuals must make choices over the life course about the kinds of intimate lives they wish to lead, a variety of living arrangements are acceptable, and people who are personally dissatisfied with marriage and other intimate partnerships are justified in ending them. These cultural models are comparable to the life trajectory presumptions that underlie abstinence-only and comprehensive sex education. As previously stated, abstinence-only education presumes that people will remain chaste until they are in a heterosexual, monogamous marriage and that children should be born within wedlock. This is similar to the cultural model of marriage in its assertion that the only safe and moral sex is married sex. On the other hand, comprehensive sex education presumes that marriage will happen later in life, after people have prepared for a career. Marriage is one of many acceptable options because people take different life paths. This is similar to the cultural model of individualism in that people must make decisions about the type of intimate lives they want to lead and marriage is not the only path that can lead to intimacy.

In addition to the cultural model of individualism, the life course phase of emerging adulthood reflects how people no longer follow a linear path from marriage to childrearing. Jeffrey Jensen Arnett (2000) argues that from the ages of 18 to 25, people enter a stage called "emerging adulthood," a period that is neither adolescence nor young adulthood. During this time, emerging adults may explore many different life directions because their future is so uncertain and they are relatively free from social roles and normative expectations. Emerging adults can seek a variety of experiences

because they are less likely to be monitored by parents or constrained by responsibilities of, for example, the marriage role or parenting role. One of these experiences is dating. Arnett points out that adolescent dating activity is primarily recreational, although it does provide adolescents with their first experiences with romantic love and sexual experimentation. However, in emerging adulthood, dating focuses less on recreation and more on the potential for emotional and physical intimacy. Relationships in emerging adulthood last longer than those in adolescence, are more likely to include sexual intercourse, and may include cohabitation. Emerging adults are trying to find out what kind of person they wish to have as a life partner. Another experience emerging adults might seek out is engaging in high-risk behaviors, such as unprotected sex, using drugs, and driving while intoxicated. Arnett posits that emerging adults engage in these behaviors in order to obtain a wide range of life experiences before settling down. After marriage, the responsibilities of the marriage role constrain adults from engaging in high-risk behaviors. However, marriage is not a signal of adulthood. Arnett states that the characteristics that signal to emerging adults that they have reached adulthood are not the demographic transitions of finishing education, establishing a career, or marriage. Instead, those characteristics are accepting responsibility for one's self and making independent decisions. Marriage does not play as much of an integral role in people's lives as abstinence-only advocates believe.

Furthermore, men and women have formed different conclusions about how to prepare for their future. Kathleen Gerson examined the family-life experiences and future family aspirations of the "children of the gender revolution" in her book *The Unfinished Revolution* (2010). Gerson interviewed 120 young men and women, many

of whom were in the stage of emerging adulthood. She found that family forms are fluid, not static and that the "children of the gender revolution" have converging desires – satisfying, lifelong partnerships with flexible and egalitarian caring patterns – yet diverging fallback plans should their plans for egalitarianism fail. Most young women report self-reliant back-up strategies that will protect them from dependency on and vulnerability in traditional marriages. In contrast, most young men report neo-traditional fallback strategies that emphasize their status as the family's main breadwinner while still permitting their spouse to work. The unfinished revolution points to the inflexibility of social institutions that have yet to catch-up to the "children of the gender revolution's" new ideas.

By placing so much value on heterosexual, monogamous marriage, abstinence-only programs end up denying other realities. First, they deny the existence of other types of sexuality, specifically homosexuality. In abstinence-only programs, homosexuality is either omitted altogether or only mentioned as a risk factor for HIV/AIDS (Moran 2000). In a Human Rights Watch (2002) report on the state of sex education, a curriculum director for a Texas school district explained that there was no mention of homosexuality or how homosexuals might protect themselves from sexually transmitted infections, HIV or AIDS, because the "traditional" family is the only acceptable place to have sex.[9] The Medical Institute for Sexual Health publishes guidelines and advice for abstinence educators faced with tough questions about homosexuality. These guidelines, replicated in the Human Rights Watch (2002) report, characterize homosexual relationships as wrong and unhealthy and suggest that

[9] By "traditional," I mean a heterosexual married couple.

individuals who desire same-sex relationships should refrain from sex forever for health, moral, and religious reasons. However, advocates of abstinence-only education rationalize their denial of non-heterosexual sexualities because they claim to treat all youth equally by giving them all the same message: abstinence. Ignoring issues surrounding homosexuality and stigmatizing homosexuality as deviant and unnatural may have profoundly negative impacts on the well-being on gay, lesbian, bisexual, transgender, and questioning youth (Santelli et al. 2006).[10]

The second reality denied in abstinence-only programs is the increase in cohabitation. Smock (2000) points to cultural and economic changes, as well as the sexual revolution, feedback loops, and intragenerational processes that have led cohabitation to become more common in the U.S.. Cohabitation has become the prevailing way in which adult women enter unions and is becoming a common context in which to bear and parent children (Kennedy and Bumpass 2008). In fact, the majority of women, across all ages, education levels, race-ethnicities, have some cohabiting experience. Data from the 2012 Current Population Survey show that, of cohabiters, 51 percent of men and 57 percent of women were under the age of 34 (Vespa, Lewis, and Krieder 2013). In contrast, only 15 percent of married men and 19 percent of married women were under the age of 34. Furthermore, until 2014, most same-sex couples could only cohabitate because they were not legally allowed to marry in the majority of states. The idea that people will wait to live together until they are married is also quite a middle-class cultural norm. Often, members of the middle-class will wait to marry, perhaps using cohabitation as a stepping-stone toward marriage, and they frequently

[10] Further work is necessary to determine how lesbian, gay, bisexual, transgender, and questioning youth feel about their exclusion from sex education, specifically from abstinence-only education. Such work is beyond the scope of the current project.

separate or divorce when their relationships do not match their expectations. In contrast, the poor have developed a different cultural norm about marriage. Edin and Kefalas (2005) found that poor women insist on having some level of economic security before marriage though they will live with their boyfriends. They wish to achieve a "white picket fence dream" (202). Both the poor and affluent no longer see sex, co-residence, or childrearing as inextricably tied with marriage. But the poor have an extremely high bar for marriage, as it is the equivalent of a dream for a better future and a key to upward mobility. Poor women consider marriage a luxury, or as a want rather than a need. Rather than waiting to have children until after they are married, it makes the most sense to them to have children, establish economic security, and then get married. As Edin and Kefalas (2005) point out, "If the poor shared both the middle class's marriage standards and their childbearing behaviors, few Americans would question their behavior" (204). In other words, the poor's strong belief in the symbolic significance of marriage is in line with abstinence-only programs; however, their childbearing outside of wedlock, often as teens, make the poor incompatible with the lessons of abstinence and traditional values.[11]

The third reality denied in abstinence-only programs is the increasing number of adults who are single and/or living alone. About 50 percent of American adults are single (Klienenberg 2012, Yardeni 2014). Data from the 2012 Current Population Survey show that people who live alone make up 27 percent of all U.S. households (Vespa, Lewis, and Kreider 2013). Of Current Population Survey respondents between the ages of 18 to 34, 8.4 percent of men and 6.9 percent of women reported living alone

[11] Traditional family values hold that marriages must be permanent and that a home-centered mother and a breadwinning father are the best way to ensure children's healthy development (Gerson 2010).

in 2012. Kleinenberg (2012) points out that living alone is a fairly stable living arrangement; people who live alone are likely to stay that way over a five-year period. These figures are notable because they speak to how individuals are choosing not to get married or cohabitate. Although most Americans will get married at some point in their lives and many couples choose to cohabitate before or instead of getting married, there is a significant number of people who live alone. These adult life paths – being single, living alone - are rarely discussed despite their substantial numbers.

Last, abstinence-only advocates promote marriage as a lifelong institution. If partners abstain from sex until marriage, they are not only preserving their virginity, but they are protecting themselves from unwanted pregnancy, STIs, and HIV infection. Most adults – 52 percent of men and 58 percent of women – marry only once (Krieder and Ellis 2011). In 2009, 83 percent of married couples had reached at least their fifth wedding anniversary and 55 percent had reached at least their fifteenth wedding anniversary. However, not all marriages last. People separate, divorce, and get remarried; some do this multiple times. Krieder and Ellis (2011) report that 22 percent of men and women have ever been divorced. The median length of first marriages that ended in divorce was eight years for both men and women. In addition, most men and women remarry within five years of a divorce. The median duration to remarriage following divorce was four years and the median length of second marriages that ended in divorce was eight years. Abstinence-only programs do not address divorce or remarriage. This is important because it underscores how the messages about abstinence only apply to first marriages, specifically when both partners have waited until marriage to have sex. The assumption is that the spouses will remain married; therefore,

abstinence-only advocates do not push an abstinence-between-marriages agenda, nor do they offer input for people who were previously married.

The practices and standards of abstinence-only programs clash with the reality of U.S. society and there is no evidence that abstinence-only programs and their explicit emphasis on marriage have changed societal behavior. Regardless, abstinence-only programs emphasize heterosexual marriage.

Distrust of Teens' Decision-Making Skills

Although there is agreement among the general U.S. population that adolescents need to know about certain topics related to sex, there is disagreement over who should teach them (National Public Radio, et al. 2003). Abstinence-only education is, in part, based on the idea that schools should teach children to abstain and parents should fill in the blanks (Elliot 2010a). Studies with both male and female adolescents indicate that their preferred source of sex education is their parents, specifically their mothers (Jordan, Price and Fitzgerald 2000; Somers and Surmann 2004). Parents also believe that their role in sex education is crucial. Parents in rural Ohio perceived themselves as the leading source of sex education for their teens and believe that outside organizations, such as schools, should be supplementary (Jordan, Price, and Fitzgerald 2000). However, while 94 percent of these parents reported having talked to their teen about sex, only 9 percent of them believed that most parents talked to their children adequately about sexual matters. The topics discussed most often by rural Ohio parents were related to reasons for not having sex: the possibility of getting a sexually transmitted infection, the possibility of getting pregnant, and how sex is wrong and against the parents' values. Parents' effectiveness in conveying sex education is another

matter. In a study of mothers' and adolescents' communication about sex and HIV/AIDS, researchers found that safer sex and abstinence were rarely discussed (Lefkowitz et al. 2003). When abstinence was discussed, it was more likely to be in tandem with a discussion of safer sex.

Part of the issue is that parents are not sure what to discuss in their conversations with teens about sex. The parents in Elliot's (2012) book, *Not My Kid*, want their children to be informed about sex, but worry that too much knowledge would rob sex of its mystery. Fields (2008: 48) terms the sense of urge in the need to protect children from sexual harm "the seductive rhetoric of childhood sexual innocence." As children become teens, adults begin to see them as highly sexual beings that must be protected from their own sexuality. This belief is based on the idea that sex is an uncontrollable urge to which teens with raging hormones are especially susceptible (Elliot 2010a).

Another problem is that parents of teens, uncomfortable with their own anxieties about sexuality, parenting, and their teens' opportunities, end up constructing their children as asexual. As parents are expected to explain sex to their teens, their feelings of embarrassment and discomfort mean that conversations tend to be infrequent. Elliot (2010a) interviewed the mothers of teens to find out the challenges they perceive when trying to talk with their teen children about sex and sexuality. Mothers believed their children, especially sons, were reluctant to learn about sex from them. They had difficulty seeing their children as sexual beings and were ambivalent about what to teach their children about sex and when to initiate such a conversation. Elliot (2012) argues that parents accomplish the "desexualization" of their teenagers through the "othering" of their teen children's peers. Put another way, other teenagers are sexual

and engage in risky behaviors, but their own children are not that type of kid. Elliot concludes that the concerns about the teens' friends are influenced by sexual stereotypes associated with race-ethnicity, class and gender. As a result, conversations between parents and their teen children about sex and sexuality often preserve and legitimate sexual hierarchies, stereotypes, and inequalities.

Parents' concern about the sexualization of adolescents is intensified by the way that teen sexual activity is covered in the media. Teens are thought to be sexual threats to themselves as tales about sex bracelets, rainbow parties, and sexting are spread across news outlets.[12] Best and Bogle (2014) argue that the concerns about these acts say more about what adults fear than what teens are actually doing. Messages from the media and images from popular culture reinforce the idea that kids are having sex at increasingly younger ages and they are participating in incredibly dangerous, promiscuous, and reckless sexual behaviors. Best and Bogle refute such claims with empirical data and demonstrate that the claims about teens and sex are grossly exaggerated in their book *Kids Gone Wild*. However, they also point out that one reason such misleading tales of teen behavior gain traction is because parents can use such stories to reassure themselves that their children are good and pure.

Many social problems and ills in modern America are traced back to parental failure. Parents are bombarded with messages about how every act as a mother or father has implications for whether they are raising good kids or bad kids or, even worse, putting their children at risk (Coontz 1992). There is a societal pre-occupation about

[12] As Best and Bogle (2014) explain in their book, sex bracelets are colored bracelets that teen girls wear to indicate what sexual activities they have done or will do; rainbow parties are events in which teen girls each wear a different shade of lipstick and, as they take turns fellating teen boys, create a rainbow on boys' penises; sexting is sending sexually explicit photos over text messages.

parental responsibility for every aspect of a child's life. Parents are portrayed as having exclusive control over their child's outcome. As parenting plays such a pivotal role in the life of a child, various experts tell parents what they should and should not do in order to raise healthy children. However, as Coontz points out, there are many factors that affect children's outcomes that have nothing to do with the choices made by families. Children are resilient enough to survive, and may even benefit from, parents' mistakes. Furthermore, some of the forces affecting children are out of the parents' control. For example, there are limits to what parents can do to counter the effects of socioeconomic status on their children. Ultimately, there is no family arrangement that consistently produces well-adjusted children. Thus, Coontz argues that parenting needs to be reconceived and parents' exclusive responsibility for their own child's material wellbeing and emotional health needs to be de-emphasized. In other words, childrearing should not be left entirely to parents; rather it should be also be the prerogative of support networks outside of the family.

Parents can, however, influence whether their teens postpone having sex. Coontz claims that most sexually active teens are "startlingly unaware of their own sexual responses and biological processes" (203). Teens deny to themselves that they are sexually active. For instance, girls are likely to feel that it is acceptable to be "swept away" in the moment, but that "nice girls" do not plan for sex (203). By having frank discussions with their teens about bodies and sex drives, parents are acknowledging that teens can be, and often are, sexually active. Such parental discussions also make teens more likely to postpone having sex for the first time until they are sixteen or older (Coontz). Both teens' and parents' denial that teens are sexually active has been, Coontz

argues, has been one of the major contributors to the high teen-pregnancy rate in the United States.

Bay-Cheng (2005) posits that the core of macro-level policy and micro-level practice decisions to intervene in the relationships of peers is a fundamental distrust of teens' intentions and decision-making capacity. Friends of teens are viewed as symbols of danger, vulnerability, risk, and misinformation. Yet, in Bay-Cheng's study of sex education internet forums, she found that such fears were unfounded. Forum members endorsed a wide range of sexual choices that ranged from abstinence to protected, consensual sex. Teens did not make fun of those who selected abstinence nor did they shame those who chose to engage in sex. Forum members were given the opportunity to correct misinformation in popular sex-related urban legends, as well as point out the classism, racism, misogyny, and homophobia linked with such legends. The peers did not pressure one another into conformity by asserting that "everybody's doing it." Bay-Cheng links her evidence to Ungar's (2000) myth of peer pressure. The myth of peer pressure, according to Ungar, is part of an adult-authored social construction of adolescence that serves to reify age-based power and control.

On the other hand, there is evidence that teens do feel pressure to have sex. In a 2003 national survey of adolescents and young adults, the Kaiser Family Foundation found that twenty-nine percent of 15 to 17 year olds reported feeling pressure to have sex, which was comparable to the pressure to use drugs (29%) or smoke cigarettes (27%). Notably, sexually active teens were twice as likely to report feeling pressure to have sex (41%) than their peers who had not had sex (20%). Perception of peer sexual experiences also has an influence on teens' intent to have sex. Miranda-Diaz and

Corcoran (2012) found a positive association between perceiving that one's classmates have had sex and one's intent to have sex within three months. Furthermore, they found that half of the youth in their study that intended to have oral sex also intended to have vaginal or anal sex. It is important to note, however, that intent to have sex is not the same as actually having sex. Ali and Dwyer (2011) found a 10 percent increase in the proportion of close friends initiating sex increases the probability of a teen initiating sex by 4.7 percent. In both studies, there is no indication that the positive association or increase in probability is due to shaming or pressure from the sexually active teens themselves toward the teens who are not sexually active. In other words, teens might have sex to feel like they fit in among their sexually active peers; however, the extent to which they are pressured from others to do so is unclear.

One of the aims of abstinence-only education is to teach teens how to say no to sexual behaviors. Thus, teens are taught that "true sexual freedom" means being able to say "no" to premarital sex (Lesko 2010). Abstinence-only curricula emphasizes feeling sure and not confused, feeling safe by not engaging in sexual behaviors or interacting with sexually-active teenagers, and feeling self-controlled and free by knowing the consequences of premarital sex and what constitutes a good partner (Lesko). Comprehensive sex education, on the other hand, emphasizes feeling scientific through provision of the facts with which to make one's own decision, feeling positive and critical of sexist portrayals of women and/or negative stereotypes of homosexuality, and feeling free in the triumph of reason over tradition and of personal decision-making over mandates (Lesko). In the comprehensive sex education curriculum Lesko studied,

teens were taught both the positive aspects and negative aspects of sexuality and then were trusted to make their own decisions.

Yet some parents do not trust teens to make their own decisions regarding sex. These parents advocated abstinence because they asserted that teens lacked the judgment and decision-making capacity to, for example, use contraception at all or consistently (Elliot 2010b). The knowledge shared by parents with their teens emphasized consequences of premarital sex. Thus, the parents stress that the only safe sex is no sex at all and try to instill in their children a sense of personal responsibility so that the teens will want to avoid the risks of pregnancy, disease, and victimization. To illustrate this point, Elliot shares the example of a mom named Sylvia who said she believes teens will be more responsible about sex when they are older because, at this time, teenagers are irresponsible. Abstinence, according to its advocates, can help teens develop values such as respect, responsibility, and self-control (Gresle-Favier 2010).

Stressing abstinence until marriage can also have unforeseen consequences. Men who took virginity pledges and developed avoidance skills to maintain self-control and sexual purity experienced sexual confusion after they got married. Diefendorf (2014) studied 15 young evangelical Christian men who were in a support group for those who had pledged to remain abstinent until marriage. The men discussed their struggles with pornography, masturbation, and other perceived threats to their abstinence. Diefendorf followed up with the men three to four years after the meetings. Fourteen of the men were married, but they still continued to think of sex in terms of control. The taboo of having sexual activity before marriage because it was disrespectful to God transformed into a taboo to talk about sex with their spouses because it was disrespectful to their

wives. Diefendorf argues that men have become accustomed to associating sex with something negative and those issues were carried with them into their marriage beds. If individuals make commitments to abstinence in their teens, the years of negative messages about sex and the need for control may be difficult to undo.

In sum, the second reason behind abstinence-only education efforts is a distrust of teens' decision-making skills. While there is general agreement that teens need to know about something about sex, there is disagreement as to what topics should be covered as well as who should teach them. Both parents and adolescents think that parents should teach their kids about sex, but this can be problematic due to parental embarrassment and discomfort, as well as a lack of parental knowledge about these issues. Some parents would like to believe that their teen children are asexual and that the teen's peers are the ones not only engaging in risky sexual behaviors, but pressuring their son or daughter to engage in those behaviors, too. Furthermore, because teens' decision-making skills are distrusted, this affects the knowledge shared with teens. Parents who advocate abstinence tend to emphasize the consequences of premarital sex because they do not trust their teen children to be responsible. Teens must demonstrate personal responsibility in the eyes of their parents as they age in order to be considered responsible enough to have sex.

Risk Prevention

Several factors played a crucial role in the promulgation of a conservative stance focused on the health, social, and moral risks for adolescents and sexuality. Gresle-Favier (2010) lists these factors: the teen pregnancy "epidemic" of the late 1970s and 1980s, the pedophilia panic of the 1980s and 1990s, the public awareness that sexual

abuse was present inside and outside of the family, and the discovery of HIV and AIDS. The AIDS crisis restored the fear of disease to a prominent position in sex education (Moran 2000). Conservatives could argue that sex outside of the frame of lifelong marital monogamy was literally deadly. In an attempt to make sexuality less desirable for the teens' own sake, many abstinence-only programs have emphasized infection and disease. Indeed, sexuality is understood as a site of risk and schools with abstinence-only programs are sites of protection from risk (Fields and Tolman 2006).

Yet some topics are considered off-limits for sex education despite being effective in diminishing risk of STIs. School-based condom education – specifically being taught how to use a condom – is associated with fewer reports of sexually transmitted infections, as well as a greater likelihood of STI testing (Dodge et al. 2009). In contrast to information on how to use condoms properly, abstinence-only education has been shown to explicitly and implicitly send the message that condoms fail to provide 100 percent protection against sexually transmitted infections including HIV (Lin and Santelli 2008). One lesson in an abstinence-only program falsely claims that the HIV virus is smaller than sperm and can penetrate through latex condoms and fails to clarify that is only true of lambskin condoms (Lin and Santelli). Thus, while abstinence-only programs may address condoms, they neither explain how to use them nor provide accurate information about their efficacy.

Abstinence-only sex education also implies that getting a sexually transmitted infection or disease is a horrible, life-altering experience. In her book *Damaged Goods? Women Living with Incurable Sexually Transmitted Diseases*, Adina Nack interviewed women who, like herself, are living with incurable sexually transmitted diseases to find

out how they processed their diagnoses.[13] Nack (2008) states, "many Americans with STDs are left wondering if they are, in fact, damaged goods – their bodies and reputations so spoiled that they may never again feel healthy, whole, and valuable" (2). The individuals are blamed for their illnesses. Prior to infection, however, Nack notes that many of the women with incurable STDs felt like their sexual health was invincible. Their invincibility meant that the women saw themselves as "good" girls who, despite being sexually active, should not worry about the shameful health risks of "bad" girls. After their diagnoses, their conception of themselves as sexual beings was radically altered and they had to employ strategies to manage their stigma. Abstinence-only education stresses the incidence rate of STD infection as a way to persuade people to wait until marriage to have sex. Despite acknowledging that millions of people live with STDs, sex education does little to help those living with an STD come to terms with their diagnosis. Instead, those with STDs become part of the population to be feared and are used as examples of what can happen if a person has premarital sex.

Discussion of sexual pleasure is also left out of abstinence-only programs. After all, according to abstinence-only advocates, acknowledging teen sexual activity is often seen as encouraging it. However, Gresle-Favier (2010) argues that solely focusing on negative discourses regarding sexuality and leaving out desire and more positive aspects of sex does not necessarily benefit adolescents. As adolescent sexuality is portrayed as illegitimate and premarital sex as immoral, feelings of guilt perpetuated by abstinence-only education might not be very conducive to empowering teens' decision-making in sexual situations. Fields and Tolman (2006) argue that real risk lies not in sexuality, but

[13] The women in Nack's book show symptoms, thus their sexually transmitted infection is technically a sexually transmitted disease. This is reflected throughout the paragraph.

in failing to equip young people to navigate their sexual lives. Educators meet significant obstacles in their efforts to address young people's sexuality without recognizing that they live and learn in actual bodies with emotions and urges. Recognition of bodies as sites of desire and pleasure is prevented in abstinence-only education and sex is reduced to a matter of danger and risk. Fields (2008) suggests that sex education needs to have a more encompassing, positive focus on the pleasures of reaching sexual subjectivity, knowing oneself, and resisting intellectual and sexual alienation. Such sex education is aligned with the tenets of sex positivity.

Sex positivity combines sexual health promotion and sexual violence prevention. It encourages discussion of sex and exploration of the emotional, intellectual, spiritual, social, and physical domains of sexuality (Perry 2008). Active, enthusiastic consent is the sole requirement of sexual encounters. Thus, consent is the act of articulating and receiving a "Yes," or "Yes means yes." It stands in contrast to the dominant models of prevention education in which people are to say or listen for "No" and push back. Messages about rape and sexual violence under an enthusiastic-consent model change from "sex when someone says no and fights back is wrong" to "sex when someone does not openly and enthusiastically want it is wrong" (Kulwicki 2009). Sex positivity involves sexual partners talking with one another so that both may experience pleasure. Furthermore, sex positivity does not promote one type of encounter as more appropriate than another. Sex negativity, on the other hand, provides limited scripts for appropriate sexual activity (Jacobs Riggs 2008). Sex negativity also treats sex as risky and sexual pleasure as sinful.

By emphasizing that sex is a risky rather than pleasurable act, abstinence-only education does not necessarily equip teens to navigate their sexual lives. Teens are deprived of basic information about their bodies, the bodies of their sexual partners, sexual relationships, and sexual behaviors. They also lack information about how their bodies, sexual relationships, and sexual behaviors will change as they age. As a result, this engenders sexual illiteracy among youth and adults (di Mauro and Joffe 2007). Most people will engage in premarital sex rather than waiting until they are married for first intercourse; indeed, premarital sex has become a social norm (Fields 2008). Teens that have had sex before receiving formal abstinence-only education are systematically ignored in these programs that are mostly geared to adolescents who have not yet had sex (Santelli, et al. 2006). In other words, their specific reproductive health needs require more than abstinence-only education. Although abstinence from sexual intercourse is theoretically fully protective against pregnancy and disease, abstinence-only programs often fail to prevent these risks.

The majority of the preceding literature review was based on the themes I found in my analysis of the textbooks: emphasis on marriage, distrust of teens' decision-making skills, and risk prevention. As evident in the literature, the reality of society does not always match the textbooks' portrayal of society.

Chapter 3: Methods

In this chapter, I first address the data used in this study, followed by explanations of the data collection procedures and the data analysis method. I also include a discussion of the methodological assumptions that informed me as a researcher and guided my study, specifically a contextual constructionist-oriented paradigm and feminist standpoint theory.

Data

This project investigates the ways in which abstinence is addressed in high school health textbooks. There is a precedent for sociological examination of textbooks. The most well-known study of textbooks by a sociologist is James W. Loewen's *Lies My Teacher Told Me* (1995). Loewen surveyed twelve high school history textbooks to determine what messages and (mis)information students are given in their American history classes. Other sociologists have conducted studies of sociology textbooks, looking for their inclusion of gender issues (Hall 1988), treatment of poverty (Pritchard 1993), presentation of disability (Taub and Fanflick 2000) and organization of core concepts (Keith and Ender 2004). Marriage and family textbooks have been analyzed by sociologists as well, specifically the presentation of abortion and adoption (Stoley and Hall 1994) and the elderly (Stoley and Hall 1996). Overall, studies of textbooks show us the knowledge that ideologically aligns with the dominant groups in society. Authors and publishers of textbooks do not want to upset conservative groups that may oppose inclusion of abortion, oral contraceptive use, and homosexuality in the curriculum. Thus, textbook writers and publishers adopt a protective stance that allows

them to minimize controversy through purportedly neutral facts and research (Low and Sherrard 1999).

For the current study, I found a list of publishers of high school textbooks through an Internet search and determined which of the publishers produced health textbooks by visiting each publisher's website. The publishers that produce health textbooks are: McGraw-Hill, Pearson, Holt Education, Cengage Learning, and their respective imprints. I solicited textbooks from these publishers. Upon receipt of the textbooks, it was evident that some were written for an undergraduate audience and others were supplemental material explicitly focused on sex education.[14] The undergraduate-level textbooks and sex education supplements were removed from this study so as not to skew the results.

There are six books in this study: *Essentials of Health and Wellness* (2005), *Health and Wellness* (2008), *Lifetime Health* (2009), *Health: Making Life Choices* (2010), *Prentice Hall Health* (2010), and *Glencoe Health* (2011) (Table 4). First, I went through the table of contents of each textbook and made a list of the chapters and sections related to sex, family, and reproductive health to look for common themes (see Appendix A). Next, I found that these textbooks shared an emphasis on abstinence, specifically in relation to marital relationships, decision-making, and risk prevention. As a result, the current study focuses on abstinence-only themes.

One question raised about this data set is whether these textbooks are actually being used in classrooms. In other words, to what extent are these textbooks being put

[14] The high school textbooks have a graphic on the inside for school districts to fill out to indicate that the district owns the textbook, as well as slots for students' names to indicate to whom the book was issued, for what period of time, and the condition of the book (Figure 1). The collegiate-level textbooks did not have such a graphic. Furthermore, the collegiate-level textbooks tended to have "higher ed" somewhere on their copyright page.

into students' hands and, presumably, read? Unfortunately, textbook publishers do not supply sales data or adoption rates, as they consider them to be trade secrets (Loewen 1995). Twenty-one states adopt health textbooks for schools within the state to use (Table 5). School districts within these states must use one of the textbooks that has been adopted, and thus approved, by the state. For example, school districts in Louisiana must choose either *Prentice Hall Health* or *Lifetime Health*. Each textbook in this study has been adopted by at least one state. *Glencoe Health* is adopted in eighteen of the twenty-one states. *Health: Making Life Choices* is adopted in one state. In states that do not have statewide adoption, the school district selects the textbook it wants to use on its own. I contacted at least ten of the largest school districts in states that do not have statewide adoption.[15] None of the respondents from states without statewide adoption reported *Essentials of Health and Wellness* as being adopted for their school(s). The largest number of school districts reported *Glencoe Health* as their assigned textbook. Although most school districts did not indicate the edition year of the textbook in use, Toledo City Public Schools reported using the 1994 edition of *Lifetime Health*. Schools in Nome, Alaska, Kansas City, Missouri, and Cleveland, Ohio, assign the 1999 edition of *Lifetime Health*. South Berwick schools in Maine have adopted the 1999 edition of *Glencoe Health*. It is unclear why such outdated editions are adopted for use in these schools; however, one can surmise that budgetary issues play a significant role. For example, due to budgetary restrictions in California, schools are not allowed to purchase new textbooks until after the 2015-2016 school year (California Department of

[15] Locating contact information for some of the school districts was difficult. I sent two rounds of email to ask which health textbook was assigned. Of the 378 individuals or districts contacted, I received information from 165 respondents about the textbook they use or that they do not use a textbook.

Education 2014). In summary, all of the textbooks in my study have been adopted by school districts across the United States for student use.

Data Collection and Analysis

To analyze the high school health textbooks, content analysis was used. Content analysis is a method that enables researchers to study human behavior in an indirect way, through an analysis of their communication. Silverman (2010) defines content analysis as the establishment of categories and systematic links between them and then finding how often those categories are used in a particular text. Content analysis has been primarily used as a quantitative research method until recent decades (Neuendorf 2002, Zhang and Wildemuth 2009). Qualitative content analysis goes beyond merely counting words and extracting objective content from texts to examine themes and patterns that appear or are latent in the manifest content. Put another way, while quantitative analysis deals with duration and frequency of form, qualitative analysis deals with the forms and their patterns. The process of qualitative content analysis involves condensing raw data into categories or themes based on valid inference and interpretation. The process uses inductive reasoning, by which themes and categories emerge from the data through the researcher's careful examination and constant comparison (Charmaz 2006). I used a conventional qualitative content analysis approach, as outlined by Hsieh and Shannon (2005). In conventional qualitative content analysis, coding categories are derived directly and inductively from the raw data, in this case the actual text in the textbooks.

In addition to a qualitative content analysis, this study relies on Glaser and Strauss's (1967) constant comparative method of qualitative analysis and theoretical

sampling as outlined in their grounded theory approach. Use of the constant comparative method in conjunction with a conventional qualitative content analysis meant that successively more abstract concepts and theories were generated through inductive processes that compared data with data, data with category, category with category, and category with concept. Although the constant comparative approach cannot make general statements of empirical regularity about large populations – such as all high school health curricula – it was designed to allow for the generation of theory. Charmaz (2006) diagrammed the grounded theory process and I have adapted her diagram in Figure 2. Theoretical sampling is a form of data collection controlled by the emerging theory rather than a preconceived theoretical framework. In other words, the analyst "jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser and Strauss 1967: 45).

Before I could engage in qualitative content analysis, I scanned the relevant text from the high school health textbooks into Portable Data Files (PDFs).[16] I converted the Portable Data Files (PDFs) into an Optical Character Recognition (OCR) format using Adobe Acrobat so that I could highlight portions of text. I then imported the files into Atlas.ti, qualitative data analysis software, to assist in the organizing, managing, and coding of data in an efficient manner.

I then defined the unit of analysis. The unit of analysis refers to the basic unit of text to be classified during content analysis. Qualitative content analysis usually uses individual themes – a single word, a phrase, a sentence, a paragraph, or an entire

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[16] By "relevant text," I mean portions of the textbook that related to abstinence, sex, family, refusal skills, etc. In other words, I did not scan parts of the textbooks that were about topics like proper nutrition and dieting, anatomy, first aid, etc.

document - as the unit of analysis. I assigned a code to a text portion of any size, as long as that portion represented a single theme, issue, or idea of relevance to my research question: In what ways is abstinence addressed in high school health textbooks?

The next step in data collection involved the development of categories and a coding scheme. As I sought to develop theory, I generated categories inductively from the data using Glaser and Straus's (1967) constant comparative method. The constant comparative method involves the systematic comparison of each text assigned to a category with other texts already assigned to that category and integrating categories and their properties through the development of analytical memos. Thus, my data analysis and data collection took place sequentially with preliminary data analysis informing further data collection. Using constant comparative method, I was able to assign a unit of text to more than one category simultaneously; however, the categories in my coding scheme were defined in such a way that they were internally homogenous and externally heterogeneous (Zhang and Wildemuth 2009). Early in the data collection process, in addition to coding text, I began to write theoretical notes in which I examined the data, related examples to one another, and developed new concepts. Gradually, I integrated these theoretical notes into larger analytical memos that helped further focus my study.

In addition to the use of analytical memos, I found the ongoing process of coding text as central to the data analysis. Coding is an iterative process. I coded sample text, checked code consistency, and revised coding rules until I achieved sufficient coding consistency. Coding rules were applied to the entire body of text after sufficient coding consistency has been achieved. This required reading and re-reading the data to

highlight and label important, descriptive, or informative issues that emerged for later sorting and categorization. I looked at the data with an eye for identifying and discovering classes of things, persons, and events and the properties that characterized them. Ultimately, I developed theory that accounts for the implicit and explicit messages that high school health textbooks have about abstinence and why. I knew that development was complete when no new ideas or concepts emerged, and when no negative cases could be found that invalidated the framework of analysis. Assured that my coding was consistent, I made sense of the themes and categories identified and their properties. I made inferences, identified relationships between categories, uncovered patterns, and tested categories against the full range of data (Bradley 1993). This data analysis process continued during and after data collection until I developed an overall pattern for data analysis that accounted for all the abstinence-related phenomena observed in the high school health textbooks. In reporting my findings, I strove for a balance between description and interpretation. I have also tried to report my analytical procedures and processes, especially in relation to the coding practices and the methods used to establish trustworthiness, as completely and truthfully as possible.

Criteria used to evaluate the quality of conventional positivist research designs – validity, reliability, and objectivity – are unsuitable for judging the quality of qualitative content analysis. Charmaz (2006) notes that, while expectations for grounded theory studies vary, she recommends four main criteria for evaluating grounded theory – credibility, originality, resonance, and usefulness. For each criterion, Charmaz lists a series of questions for the researcher to ask herself (Table 6). In evaluating my research,

I have asked myself the questions posed by Charmaz. I chose Charmaz's criteria, as opposed to those suggested by other qualitative researchers, because her criteria not only accounted for the empirical study and theory development, but the aesthetics of writing as well. Furthermore, her book, *Constructing Grounded Theory*, was very accessible and practical. The criteria Charmaz recommends helped me address the implicit and explicit messages about abstinence in high school health textbooks and analyze how those messages are constructed. Overall, the grounded theory I produced adheres to these criteria; therefore, my theory conceptualizes and conveys what is meaningful about the messages regarding abstinence in high school health textbooks.

Assumptions

I used a construct-oriented approach in my qualitative research. Guba (1990) describes the constructionist paradigm as being relativist, subjectivist, hermeneutic and dialectic. Constructionism involves a relativist ontology in that it acknowledges that realities exist in the form of multiple constructions that are shaped by a person's own experiences. The subjectivist epistemology of constructionism holds that findings are the result of an interaction between the inquirer and the inquired. The hermeneutic aspect of the constructionist methodology consists in depicting constructions as accurately and as close to reality as possible. The dialectic aspect of the methodology entails comparing and contrasting multiple constructions with the aim of refining them to a few constructions that have as much consensus as possible.

There are many assumptions that underlie the constructionism paradigm. The nature of knowledge that underlies constructionism consists of constructions about which there is relative consensus among those trusted to interpret texts. A formal

literature review conducted using a construction-oriented approach will take advantage of multiple interpreters from a wide range of settings. In other words, my formal literature review reflects sources from within and outside of sociology. My major task as a researcher within this construction-oriented approach has been to act as "orchestrator and facilitator" of understanding (Guba and Lincoln 1994).

A construction-oriented approach is aligned with my position as a sociologist. Berger and Luckmann (1966) argue that reality is socially constructed. The job of the sociologist is to ask whether a difference between two realities could actually be a difference between two cultures. This conflict between realities is at the heart of my study: one reality emphasizes abstinence in sex education as a way to curb teenage pregnancy and the spread of sexually transmitted infections; the other reality sees an emphasis on abstinence-only sex education as problematic and causing more problems than it has solved. I am conscious of social constructionism's potential flaws, namely that relativism can turn into a dead end. However, I believe that it was the best paradigm for this study because it provided a way to analyze the connection between the organization of knowledge and societal structure, raised issues for me to address about my embeddedness in a culture, and was a useful method for revealing complex and contradictory meanings in "facts" (Sprague 2005).

My position as a feminist researcher is also aligned with a constructionist approach. Social constructionism requires that scholars be conscious of their embeddedness in culture as well as their complicity in institutions that produce and disseminate official knowledge (Sprague). As a feminist woman, I have strong feelings about reproductive health and a woman's right to make decisions about her own body.

My knowledge is located within a specific matrix of physical location, history, culture, and interests (Sprague). Thus, I have incorporated feminist standpoint theory within social constructionism's requirement regarding scholars' consciousness and embeddedness. Overall, it is important to address my value set and recognize that it plays a role in shaping and creating inquiry outcomes.

My incorporation of feminist standpoint theory means that I am not using a strict constructionist paradigm, rather a "contextual constructionism" (Best 1993). According to Joel Best, contextual constructionists assume that researchers "will understand the empirical world better if [they] pay attention to the manner in which social problems emerge" (139). This paradigm is inspired by the sociological imagination. Among the scholars who have defined and refined the field of constructionism are Joel Best (1993, 1995), Gusfield (1985), Holstein and Miller (1993), Holstein and Gubrium (2003), Ibarra and Kitsuse (1993, 2003), and Weinberg (2008). I consulted their works as necessary to guide my study.

Two main criteria are appropriate for judging the quality of a construction-oriented inquiry: trustworthiness and authenticity (Guba and Lincoln 1994). The trustworthiness criteria include credibility, transferability, dependability, and confirmability. The trustworthiness criteria parallel internal validity, external validity, reliability, and objectivity. The authenticity criteria include fairness, ontological authenticity through enlarging personal constructions, educative authenticity through improving understanding of others' constructions, catalytic authenticity through spurring to action, and tactical authenticity through empowering action. Researchers can help ensure the quality of their work – that it is not impressionistic, anecdotal, or

atheoretical - by applying certain criteria that meet the core values of the craft. Tracy (2010) outlines eight “big-tent” criteria for excellent qualitative research. Using quantitative criteria like generalizability, objectivity, and reliability with qualitative data will not work well. The eight criteria Tracy lists are: having a worthy topic, utilizing rich-rigor, sincerity, credibility, resonating findings, significant contribution, ethical considerations, and meaningful coherence. I have sought to meet these “big-tent” criteria in my study.

Chapter 4: Emphasis on Marriage

In this chapter, I focus on how the textbooks emphasize that marriage is the only appropriate place for people to have sex. Given that the average age at first marriage in the United States is in one's late twenties and nearly half of individuals have had sexual intercourse by age 17, it is likely that people are not going to wait until marriage to have sex. Despite these demographic realities, sex is still constructed in the textbooks as an important, special act that should be exclusive to married couples. This chapter begins by defining what the textbooks mean by "marriage" and how to find a good marriage partner. Next, I examine the textbooks' reasons why a person should get married and how to make a marriage successful. Then I assess the arguments made in the textbooks for staying abstinent until marriage. I conclude this chapter by analyzing the issues ignored by the textbooks, such as the period of emerging adulthood, the increasing prevalence of single adults, the reality of cohabitation as a legitimate option for couples, the lives of lesbian, gay, bisexual, and transgender individuals, the context of divorce and remarriage as an adult, and differences of class and race-ethnicity.

Defining Marriage

Most of the textbooks stressed commitment, intimacy, and the importance of the decision in their definitions of marriage. *Health: Making Life Choices* states, "the highest form of commitment between two people in our society is marriage" (508). It is meant to be permanent, lifelong, and above all other relationships. Marriage is the cornerstone of the family unit and requires work to be sustained. Readers of *Health & Wellness* are cautioned to make sure that their relationship is commitment-motivated rather than feelings-motivated (188). Feelings-motivated relationships are risky because

a partner might not feel like being supportive or feel like being sexually faithful. Commitment-motivated relationships are stronger because the partners honor the promises made in their wedding vows rather than their feelings.

In regard to intimacy, emotional intimacy was stressed over physical intimacy. Partners should share their values and beliefs, their needs, wants, and disappointments, and their efforts in completing tasks. However, the textbooks emphasize that only married partners should share physical intimacy in the form of sex. "Having sex before marriage does not provide the security and intimacy that comes with the commitment of marriage," state the authors of *Health and Wellness* (187). Those who are just dating can have the warmth and closeness of physical intimacy in some ways, but sex before marriage is irresponsible. Readers of *Health and Wellness* are told, "Fact: Sex before marriage does not predict sexual satisfaction during marriage" (187). Thus, there is no need to have premarital sex to determine marital sexual compatibility.

Given that marriage is a significant commitment that will impact one's sex life, textbook readers are encouraged to take the decision to marry very seriously. *Prentice Hall Health* states, "If you choose to marry, it will probably be one of the most important decisions you will make. It will affect you, your spouse, your family, your friends, and future generations" (531). You have to be certain that you are in it for the long haul. One of the ways that *Health: Making Life Choices* underscores the gravity of the decision to marry is by comparing it with the story of Cinderella:

> Marriage is the highest form of commitment in our society. Did you ever wonder what happened to Cinderella and the Prince after they married? Did they really live happily ever after? At times, every couple has disagreements. A mature couple learns how to resolve problems without harming the relationship before entering into a lifetime commitment. Marriage is the institution that legally joins two people. The idea that marriage will magically make people

> happy is probably the most destructive idea that partners can have. Marriage requires good communication, emotional maturity, and sharing a life with someone who has similar values and interests. (506)

In other words, marriage is a huge decision. One should not get married only to have sex or in hopes that it will lead to happiness. Marriage is not a fairy tale.

Why Get Married

Provided that marriage is a significant commitment, partner selection is important. Textbooks recommend that you find someone who is similar to yourself. Although there are no guarantees or secret formula to a couple's success, characteristics that help determine compatibility include level of education, values, social class, geographic location, age, race-ethnicity, and religion. *Prentice Hall Health*, however, admits that people who are quite different can have successful marriages, but they will have to work to overcome those differences (531). You can find your special someone by dating – something that, as *Essentials of Health and Wellness* points out "almost all married people went through… even people who have decided to remain single have probably dated at some time" (351). Readers are also encouraged to consult their parents about their partner choices. "A marriage is more likely to succeed when a person's parents approve of the future husband or wife," *Health & Wellness* tells its readers. The decision to marry will not only affect the partners; it affects their families as well.

After a couple has dated for some time, they may contemplate getting married. Textbooks offer a variety of reasons why a couple would want to get married. Both *Health & Wellness* and *Essentials of Health & Wellness* argue that couples who marry to love, nurture, commit to one another and share intimacy are likely to succeed (192; 526). On the other hand, *Health: Making Life Choices* points out that "simply loving

each other, the wish to do so, or stating that such a bond exists" is not enough for marital success (505). *Prentice Hall Health* is surprisingly candid in its explanation for why people marry:

> People marry for a variety of reasons. Some people marry because they desire another person's love and companionship. Others marry for financial, social, or cultural reasons. Some couples marry in order to start a family of their own" (531).

Ultimately, each partner should know himself or herself well, including what is important to him or her. Goals and long-term plans should be considered and any questions resolved before a marriage takes place. However, some couples marry for what the writers of *Essentials of Health and Wellness* term the wrong reasons such as financial gain, sex, escape from an unhappy home situation, poor self-esteem, or thoughts that they have no other options available (526). Teens are told that they should not get married because they are not finished developing. In other words, they have not experienced the changes in thinking and behavior, or the developmental tasks, of adolescence.

Overall, textbooks emphasize that marriage – while it brings with it the benefits of love, intimacy, the commitment of someone, and sexual relations – also requires work to make it a success. The textbooks do not portray marriage as a solution to problems, nor do they provide a sort of checklist teens could possibly see and decide that they are ready to get married.

All of the textbooks provide information on challenges that married couples may face, as well as qualities of healthy, successful marriages. Challenges that couples may face are usually listed and include: finances, changes in living arrangements, changes in work situations, family illness, abuse, infidelity, poor communication, alcohol or drug

dependency, problems with in-laws, decisions about having children and arranging childcare, conflicting loyalties involving family and friends, and poor sexual relations. Likewise, qualities for successful marriages are usually listed and include: love, commitment, compromise, emotional intimacy, compatibility, communication, friendship, mutual respect, and physical attraction. In order to develop a healthy intimate relationship, *Health: Making Life Choices* lists nine tasks, including "Let sexual involvement wait for commitment. Marriage is the highest form of commitment" (505). Thus, discussions of intimacy in the textbooks seemingly require a reminder that sex needs to wait until marriage.

Abstinence Until Marriage

Now we turn to the claims given in the textbooks for why it is important to stay abstinent until marriage. First, delaying gratification, especially sexual gratification, is part of having healthy family values. In *Health & Wellness*, students are taught that in healthful families, parents or guardians should teach children the importance of delayed gratification:

> Being able to delay gratification is especially important in relationships. During your teen years, you may experience sexual feelings and desires, but it is not appropriate for you to be sexually active. Waiting until marriage to express intimate sexual feeling protects your emotional and physical health and follows healthful family values. (138)

Parents and guardians also teach their children that sex and love are part of a marriage commitment. Practicing delayed gratification of sexual feelings is acknowledging that sex belongs only in marriage.

Next, staying abstinent until marriage is a way to demonstrate good character. *Health & Wellness* defines character as "a person's use of self-control to act on responsible values" (169). One way to have good character is to practice abstinence

from sex, thus upholding your family's values. The implicit message here is that you have failed to show good character and uphold your family's values if you engage in premarital sex, thus stigmatizing the students who have not been abstinent until marriage. There is no discussion or exception made for victims of sexual assault who, by being forced to have sex, were involuntarily not abstinent. By construing all premarital sex as bad and not distinguishing between voluntary and involuntary sex, sexual assault victims may believe that they have let their families down and have bad character.

The third reason why it is important to stay abstinent until marriage is that it protects against sexually transmitted infections including HIV. In *Lifetime Health*, abstinence is part of having a responsible relationship:

> Remaining abstinent until you are in a stable, committed relationship, such as marriage, will help you avoid feeling regretful later. Married individuals who were not sexually active before their marriage do not have to worry about STDs. Remaining abstinent until you are married will also help you avoid becoming a single parent. (461)

However, *Lifetime Health* also acknowledges that even those who have been abstinent are still subject to other risk factors for HIV, as it can be transmitted in ways other than sexual activity (506). The protective factor of sexual abstinence is strongly advocated in *Health & Wellness*, *Lifetime Health*, and *Glencoe Health*, with each emphasizing that it is the "only method," "most effective method," "only way," and "best way" to avoid sexually transmitted infections. What is missing from most of these decrees is that both partners will have had to be abstinent in order for the protective factor to be valid. *Lifetime Health* stands out in its mentioning the need to "marry someone who has also been abstinent and is uninfected" in order for protection against sexually transmitted

infections to be most effective (482). As most people wait until their late-twenties to marry, the expectation of both partners' abstinence is questionable.

The fourth reason for remaining abstinent until marriage is that sex within marriage is special. Furthermore, textbooks advocate for sexual fidelity and monogamy within the marital relationship. *Health & Wellness* addresses these reasons by emphasizing how sex within a marriage is exceptional:

> Sexual fidelity helps protect the health of marriage partners. When marriage partners are faithful to one another, they do not need to worry about the sexual transmission of diseases. When teens practice abstinence from sex in their dating relationship, they reserve sex for the marriage relationship. This helps keep sex within marriage very special. (169).

Lifetime Health gives suggestions to teens that are being pressured to engage in sex. They advise if the student hears "Come on, just this once," that the student replies with, "That's exactly what I'm afraid of. I'd rather save myself for someone who will love me for life" (466). This reinforces the idea that marriage is a lifelong commitment and sex should be saved for such a relationship. However, the idea that sex is something to be saved for the person you intend on being with for the rest of your life can be harmful, as *Health: Making Life Choices* points out:

> A particularly destructive idea is that once a person has had sexual intercourse, that person is committed to having intercourse again with that person or with other partners in the future. Anyone who is no longer a virgin, a term applied to people before their first occasion of sexual intercourse, may choose abstinence at any time in their lives. The person may change moral or religious beliefs, or may simply decide to wait for the right person or may wish to take a break from worry about pregnancy or spread of infection. For many different reasons, saying no is always an option (584).

Given the emphasis placed on how special sex is with the right person within a marital relationship, teens may get the idea that, if they lose their virginity, they have to commit to spend the rest of their lives with that person. By associating the first time a person

has sex with lifelong commitment, some textbooks are sending a mixed message about obligations to relationships.

Prentice Hall Health is an exception in its discussion of fidelity and monogamy in that it does not mention marriage.

> For people in a long-term sexual relationship it is important to practice sexual fidelity. Sexual fidelity is practiced when both partners agree to have sexual contact only with one another – to be monogamous. If both partners are uninfected, sexual fidelity eliminates the risk of getting HIV or another STI. If either partner has practiced risky behaviors in the past, he or she should be tested for HIV and other STIs. People in long-term relationships may not be sure that their partners are faithful and uninfected. They can reduce the risk of HIV infection by using a condom during every sexual encounter (593).

Thus, *Prentice Hall Health* acknowledges that even sex within a committed relationship is not without risk. The suggestion that condoms be used during every sexual encounter within a long-term sexual relationship, however, does not align with statistics about condom use. Data from the National Survey of Family Growth's 2006-2010 wave indicate that only 15.3 percent of currently married couples used condoms as their method of contraception (Jones, Mosher, and Daniels 2012).

Overall, *Prentice Hall Health* and *Essentials of Health and Wellness* do not stress abstinence until marriage and standout from the other textbooks in this study. These textbooks both promote abstinence, they do not exclusively tie abstinence to marriage. Although in other parts of *Health: Making Life Choices* abstinence and marriage are linked, in its discussion of sexual activity, it mentions marriage as one type of commitment. Healthy intimate relationships can lead to commitments and one way to add fulfillment to such commitments is through sexual activity:

> Touching, hugging, and kissing are intimate, pleasurable activities. These activities may also satisfy emotional needs, and therefore can be emotionally fulfilling. It is normal and natural in a committed relationship for these activities to sometimes lead to sexual intercourse, the reproductive act between the sexes.

> When a couple delays sexual activity for a significant period of time, they give themselves time to develop a committed, loving relationship. Forming an intimate relationship in which the couple have trust and mutual respect for each other takes time. When this occurs, the intimacy that a couple shares can be more fulfilling. (579)

In sum, the data gathered from the textbooks appear to suggest that marriage is a very important life event that should be taken very seriously. Marriage is meant to be a lifelong commitment and sex should be saved for such a relationship in order to demonstrate healthful family values, show good character, protect against STIs including HIV, and reserve it as a special act.

Ignored Issues

Now I will analyze the issues ignored by the textbooks, such as the period of emerging adulthood, the increasing prevalence of single adults, the reality of cohabitation as a legitimate option for couples, the lives of lesbian, gay, bisexual, and transgender individuals, the context of divorce and remarriage as an adult, and differences of class and race-ethnicity. As a result of this lack of inclusion, the textbooks may be doing an inadequate job of meeting their proposed duty: preparing teenagers for life outside of high school. *Health & Wellness* explicitly states this duty in relation to its teen readers and marriage:

> You are not ready for marriage right now. However, your high school education is helping you prepare for your future. You are gaining information and skills to use as an adult. You have already learned something about marriage by observing your parents or guardian and other adults who are married or have been married. From them, you may have learned something about intimacy. (187)

Textbook readers are informed of what marriage is and what it entails, given reasons why people marry, and told the qualities of healthy marriages as well as the challenges married couples face. Marriage is a normative, enduring responsibility of adulthood.

The health textbooks in this study ignore the realities of emerging adulthood. Arnett (2000) posits that people in the United States between the ages of 18 to 25 are in a period known as "emerging adulthood." During this time, emerging adults can explore a variety of life experiences before entering adult responsibilities such as the commitments of marriage or parenthood. Emerging adulthood is a time for adults to have a broad range of dating, romantic, and sexual experiences because parental oversight has lessened and there is little pressure to get married. Given the amount of relative freedom during the time of emerging adulthood, textbooks' insistence on abstinence until marriage for both partners seems to be a case of wishful thinking.

The next issue textbooks ignore is the increasing number of single adults and how to handle prolonged periods of being single. Half of the United States population over the age of 16 was currently single as of August 2014 (Yardeni 2014). *Essentials of Health and Wellness* is the only textbook to discuss being single along with its lesson on marriage:

> Relationships can cause stress, but not having relationships can cause stress, too. The lack of a romantic relationship is not necessarily a problem (unless the person wants to be in a relationship), but everyone needs friends and acquaintances with whom they feel comfortable. (512)

Being single well into adulthood is more socially acceptable in modern U.S. society. The textbooks' discussions of adulthood tend to focus on marriage and parenting. These are life events that individuals are not only waiting longer to do, but may not do at all. As age at first marriage has steadily increased, the proportion of people's adult lives spent in marriage has declined. This period of adulthood between adolescence and marriage is not addressed in the textbooks.

The third issue textbooks ignore is the rise in cohabitation. Cohabitation has become the prevailing way in which adult women enter unions and is becoming a normal context in which to bear and parent children (Kennedy and Bumpass 2008). *Essentials of Health and Wellness* is the only textbook in this sample that addresses cohabitation. Introduced as a "trend that started in the 1970s," cohabitation is not exactly described as a good option for couples. A textbox states:

> New research indicates that men are less interested in marriage than they were years ago. Why? Because couples are more willing to live together, and men are comfortable with this living together and the sexual relationships that go with it without the legal entanglements. (525).

This information seems to be similar to the idiom against buying cows when milk can be obtained for free. Indeed, the authors of *Essentials of Health and Wellness* dismiss cohabitation as a testing ground for marriage in subsequent pages:

> On the surface, cohabitation may seem like a good idea. It allows a couple to get to know one another and test their relationship in a setting like marriage and its legal entanglements. If things go badly during cohabitation, they can leave the relationship and move on. Evidence shows, however, that this strategy does not ensure a successful marriage. In fact, people who live together before marriage are more likely to divorce than people who enter into marriage without those conditions. It may be that these marriages start out with weaker commitments. (528)

Although the evidence the authors mention is accurate, they fail to mention other factors that may lead to couples that married after cohabitating to divorce.

Textbooks also ignore the lives of lesbian, gay, bisexual and transgender people. Surprisingly, there was only one definition of marriage in the sample that was specifically heterosexual. *Lifetime Health* defined marriage as "a lifelong union between a husband and wife, who develop an intimate relationship" (410). However, the fact that only one textbook explicitly referenced a husband and wife in its definition does not mean that the textbooks addressed the lives of lesbian, gay, bisexual, or

transgender individuals. The pictures in and around discussion of marriage and relationships were of male-female couples. *Health: Making Life Choices* includes a lesson on sexuality and sexual orientation, though the lesson focuses on defining homosexual, gay, lesbian, and bisexual. It does not discuss what it is like to be a gay or lesbian or how individuals in those relationships might confront unique issues such as discrimination or barriers to marriage and adoption. In addition, *Health: Making Life Choices* defines sexual intercourse as "the reproductive act between the sexes," thus implying that lesbians and gays do not have sexual intercourse because no reproduction can take place (579). There is no mention of transgender experiences in any textbook.

The fifth issue that textbooks fail to address is how to handle divorce and remarriage from the point of view of those divorcing or remarrying. In other words, the lessons on divorce and remarriage focus on how teens should handle the divorce and/or remarriage of their parents. The exception to this is a paragraph in *Essentials of Health and Wellness*:

> Deciding to seek a divorce is usually very difficult for both spouses. In fact, it is common for the decision to be postponed repeatedly. It does not usually result from one incident but from a long chain of events. Adjusting to a divorce can be difficult for both spouses and for the children involved. It often causes frustration, conflict, pressure, and changes in the living situation. Most people who divorce eventually remarry. Unfortunately, divorce rates are even higher for second marriages than for first marriages. Some positive things about remarriages, however, are that partners often demonstrate better skills in conflict resolution and communication, and they share more of the housework and childrearing duties. (514)

Neglecting the context of divorce and remarriage as an adult is a significant oversight on the part of most of the textbooks, although it may be difficult for high school students to think that far ahead. In addition to discussing marital challenges that may lead to divorce, issues like the financial cost of divorce and the risks associated with

being a stay-at-home spouse with little to no employment history need to be addressed to best prepare teens for such life experiences.

The last issues ignored in the textbooks are race-ethnicity and class differences in regard to marriage rates. People from different education levels and different racial backgrounds do not have the same probability of first marriage.[17] For example, the National Survey of Family Growth 2006-2010 data show that the probability of first marriage by age 25 is highest for foreign-born Hispanic (56%) and white (48%) women, while black (24%) women's probability was lowest (Copen et al. 2012). Women with a bachelor's degree had a lower probability (37%) of first marriage by age 25 compared to women with a high school diploma (53%). By age 35, Asian (85%), white (84%) and foreign-born Hispanic women (80%) had much higher rates of probability of first marriage than black women (58%). Furthermore, women with bachelor's degrees have a higher probability (84%) of first marriage by age 35 than women with high school diplomas (78%).[18] Textbooks do not address these probability disparities; instead, all readers are treated the same, as if they have the same chance of getting married. Chances of marriage also vary in accordance with the national economy. Payne (2014) examined data from the 2008-2012 American Community Surveys, covering the time during and immediately following the Great Recession. Payne found that the marriage rate declined from 2008 to 2011 for whites and Hispanics, but by 2012, the rate increased slightly for both groups. A similar pattern occurred for those with the highest

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[17] Here, education level is a proxy for class, as the National Survey of Family Growth 2006-2010 report (Copen et al. 2012) does not include income data.

[18] As men marry at an older age than women, NSFG data looks at first marriage by age 35 for men. Asian (80%) and white (74%) men had the highest probability of first marriage by age 35. Black (61%) and U.S.-born Hispanic (60%) had the lowest probability. There was no difference on the basis of education with the probabilities for bachelor's degree (73%) and high school diploma (71%) being very similar.

level of education (a college degree). In other words, the marriage rate declined for those with college degrees until 2012, when it slightly increased. Those with less than high school, high school/GED, and some college continued to decline. Payne's findings are consistent with other research that has shown that increases in unemployment reduce the odds of marriage (Schaller 2012). In a study on fragile families, Fein (2004) found that disadvantaged married couples tend to be young and disproportionately Latino. This disproportionate representation is due to Latinos' likelihood to marry, stay married, and be poor; thus, Fein claims Latinos deserve special attention in research on marriage. Although people with economic disadvantage are likely to marry, the difficulty of staying married increases with levels of economic disadvantage. There is a higher probability of marital dissolution for married women who come from less affluent neighborhoods and who have lower levels of education. Black women, across all levels of education, have the highest risk of marital disruption over the first 15 years of a marriage (Fein). Given these differences in marital rates across classes and race-ethnicities, the emphasis on marriage may be assuming that people have the same likelihood of getting and staying married. As whites and those with higher levels of education are more likely to get married, I argue that the textbooks are catering mostly to white, middle-class students. Such implicit tailoring is problematic for the significant population of non-white, working class and poor students.

Summary of Emphasis On Marriage

In this chapter, I have detailed how the health textbooks emphasize that marriage is the only appropriate place for people to have sex. According to the textbooks in my sample, people should abstain from sex until they make the life-long

commitment of marriage. As marriage is a serious decision, textbooks provide reasons why someone might get married as well as suggestions on how to find a suitable marriage partner. Readers are also given arguments for staying abstinent until marriage, including the value of delayed gratification, demonstration of good character, protection against sexually transmitted infections including HIV, and the special nature of sex within marriage.

Placing such importance on abstinence until marriage may be unrealistic given the current family behaviors of the United States, such as later age at first marriage. As such, textbooks ignore the period of emerging adulthood, the increasing prevalence of single adults, the reality of cohabitation as a legitimate option for couples, the lives of lesbian, gay, bisexual, and transgender individuals, the context of divorce and remarriage as an adult, and class and racial differences. Explicitly tying sex to marriage and stigmatizing sex before marriage, as most of the textbooks do, are not conducive to helping adolescents develop the skills needed to navigate their sexual health or develop positive views of sexuality.

Overall, the textbooks aim to instruct teens to wait until they have made a marital commitment to engage in sexual relations. Teens are prompted to consider the reasons why people get married, the type of person they might marry, and arguments for remaining sexually abstinent. While marriage may be the path for many of the teens who read these textbooks, those who will be single well into their late twenties, those who choose to cohabit, those who are not heterosexual, those who may get divorced and remarry in the future, and those who have lower probability of marriage are not adequately addressed in the texts.

Chapter 5: Distrust of Teens' Decision-Making Skills

In this chapter, I focus on how the health textbooks exhibit a distrust of teens' decision-making skills. The stereotypical teen is ruled by their hormones and emotions and incapable of making mature, rational, responsible decisions, such as the decision to not have sex. Families, specifically parents, are meant to socialize their children into being functioning members of society, including staying abstinent until marriage. This chapter begins by defining what the textbooks mean by "family" and what constitutes healthy family relationships. Next, I explain how the role of parent or guardian is constructed in the textbooks, including how they are responsible for teaching their children how to make decisions, setting dating guidelines and limits, and instructing their teens on how to refuse pressure to engage in deviant behaviors, such as sexual intercourse. Then I examine how a textbook addresses teens that have had sexual intercourse and how this affects their relationship with their parents. I conclude this section by addressing the issues textbooks ignore, namely the prevalence of teens that have experienced sexual assault or violence, that parents and families can be dysfunctional, and differences of class and race-ethnicity.

Defining Family

First we need to define what textbooks mean by "family." *Prentice Hall Health* states, "the family is often called the 'basic unit of society.' It is the structure within which children are raised, and values and customs are passed from generation to generation" (112). *Health: Making Life Choices* describes the family in a more traditional way: "a group of people who are related by adoption, blood, or marriage and are committed to each other," later adding that "families come in all shapes and sizes.

Wherever people live together, they form some type of family" (516). All of the textbooks describe what the purpose of families is as well as describe healthy families. Healthy families are those that demonstrate such characteristics as caring, commitment, respect, appreciation, empathy, communication, cooperation, trust, support, love, acceptance, and loyalty.

Families are meant to be the setting in which people learn the skills that will help them in their relationships throughout their lives. *Essentials of Health and Wellness* describes one of the purposes of families, that is, providing a model for later relationships:

> It is within the family that you learn what works and what doesn't in respect to relationships. You have opportunities to observe the qualities that make family relationships satisfying and enjoyable – and those that don't. Family life also provides your earliest opportunities for learning and practicing skills in communication, problem solving, and conflict resolution. Teens who are fortunate enough to have good relationship role models for these skills as they are growing up have a head start in developing their own skills for healthy relationships later in life. (308)

As such, teenage readers are told in each of the textbooks that it is important to spend time with their families. Healthy family relationships require work and the involvement of each family member. In spending time with their families, teens can help keep their families strong, maintain their family's identity and rituals, and practice having to balance external obligations with family life. *Lifetime Health* acknowledges that this idea might be unappealing to teens:

> As a teen, you may find yourself wanting to spend more time with friends than with family. Your changing relationships with your friends can be stressful for your parents, too. Parents may feel hurt that their teen prefers spending more time with their friends than with them. Or parents may worry that their teenager is engaging in friendships that are unhealthy. (416)

Teens are reassured that their desire to be more independent and spend more time with their friends is normal. However, while teens are expected to establish their own sense of selves and test the developing relationship skills they have learned from their family, they are still expected to choose their family over their friends.

The Parental Role

Teens desire to be independent and make their own decisions. A recurring theme in the lessons on decision-making was how teenage independence is challenging for parents. *Essentials of Health and Wellness* explains why this is challenging for parents:

> Most teens today are dependent members of the family structure. Because they have their role within the family, parents and other family members often view teenagers as being incapable of making healthy independent decisions. (305)

The relationship between parents and children change as these children become teens. This change is challenging for both the teen and the parents. The textbook readers are encouraged to try to see this relationship from both sides, or at least try to understand their parents' point of view and the weight of parental responsibilities.

One of the responsibilities of parents is to demonstrate the decision-making process for their teens. Parents or guardians serve as role models for decision making in healthful families. *Health and Wellness* says to its teen readers, "You observe your parents or guardians using the decision-making process. They carefully evaluate options before deciding what to do. They weigh the consequences of possible actions. They make responsible decisions and teach you to do the same" (137). According to *Glencoe Health*, it is a very satisfying experience for parents when they can see their children learning to get along with others and solve their own problems (506).

Yet, some parents have a problem with trusting their teens. This lack of trust of parents toward their teens serves as a source of great frustration and conflict in families. *Health: Making Life Choices* tries to explain to teens why parents have this struggle:

> There may have been a time when you thought, 'How can I get my parents to trust me? They're always checking up on me!' This question may seem unanswerable. In truth, most parents *want* to trust teens. Parents want to think of their children as honest and trustworthy. Those interested in gaining trust must learn this principle: trust grows in direct proportion to a person's honesty. This principle also operates in reverse: people who are not entirely honest quickly lose the trust of others. It's difficult to know how to react to someone who hasn't always been honest in the past. When a teen has a history of dishonesty, a parent has no choice but to doubt the teen. How could a parent know whether or not the teen is telling the truth on any one occasion? Dishonesty – that is, intentionally hiding or changing the truth – creates doubt that grows and damages the parent-child relationship. (521)

The decisions these parents make are meant to be in the best interest of their child and, although they might not make sense to the teen, the textbooks encourage the teen to have empathy toward the difficult position their parents are in. *Essentials of Health and Wellness* asks, "Have you ever considered how difficult parenting must be? Parenting is one of the most important responsibilities a person ever assumes. Yet most parents receive no training in how to be a good parent. Parents are held responsible for their children's behavior, but during the teen years, they are expected to gradually give up control" (307). One of the suggestions made by *Health: Making Life Choices* is for teenagers to treat their parents as if they were the people the teen most admires at school. "You wouldn't barge into a conversation and interrupt the people at school, so don't do that to your parents. You'd probably do some extra-nice things for those people at school so try doing them for your parents," the textbook authors explain, adding, "What many teens have learned is that keeping parents happy is the quickest road to gaining more of what they want at home, and especially to creating a loving home life" (538).

The impetus is placed on teens to make the transition from dependent child to independent young adult easier for their parents. In doing so, they will demonstrate their maturity. *Essentials of Health and Wellness* points out that saying simple words such as 'I love you,' 'Thank you,' and 'I appreciate all the things you do for me,' or doing actions like helping out around the house without being asked can mean a lot to parents and help them feel less "abandoned" by their teens (303).

There is, however, a contradiction in the way parents are constructed in the textbooks. Parents, as constructed by the textbooks, are not impulsive, nor do they make irresponsible decisions. Parents may offer guidance and serve as role models to their teens, but they are experiencing their own life changes. The idea that parents are people too, is common in each of the textbooks. Teens are reminded that their parents have experienced being teenagers, although "they are learning how to deal with you as a teen!" (*Lifetime Health*: 390). As such, teens are told they should have compassion for their parents and realize that their parents have needs, wants, and concerns of their own, such as challenges of middle adulthood, preparing for retirement and caring for their aging parents. If teens attempt to understand their parents' point of view, they can reap benefits ranging from maintaining their parents' goodwill and increasing the harmony of the family to gaining trust, more freedom, and/or an allowance (*Health: Making Life Choices*: 538). *Essentials of Health and Wellness* tells teens, "The next time you say or think, 'I'll never treat my kids like my parents treat me!' remember how much pressure there is on parents of teens today" (515). Thus, teens are reassured that they are not alone in experiencing the challenges of adolescence and the frustrations felt are not one-sided.

Parents are not the only ones who might have problems with teens' desire for more independence and privileges. Teens may find themselves wavering between wanting independence and wanting the security of their families. As *Prentice Hall Health* points out to its readers:

> With adolescence come increased privileges. You are treated more like an adult, and you make decisions that direct your life. However, the other side of privilege is responsibility for yourself and others. Often the move to this new status is not a smooth one. You may be anxious for the privilege, but not so anxious for the responsibilities. Some days you may want to make all your own decisions. Other days you may wish you could hide your head under your pillow and let someone else take charge. Your pathway to adulthood will be marked by a growing responsibility for your own decisions and actions. (524)

Textbook readers are told that part of adulthood involves making decisions and being responsible for oneself. *Essentials of Health and Wellness* tells teens that as they grow older, parents are not as likely to help you when you find yourself in a difficult situation (507). Therefore, it is important that teenagers learn how to make responsible decisions.

How To Make Decisions

Each textbook in my sample provides instructions for how to make decisions (see Appendix B). Teens, armed with the lessons and values they have learned from their family, are told that learning to make decisions will help them progress toward a responsible and satisfying adulthood. It will also help them from being pressured to make poor decisions and live with the consequences of those bad choices.

The number of steps in each textbook's decision-making model varies from four to eight, with two models consisting of six steps and supplemental four-item or five-item strategies. Some textbooks use acronyms like HELP, GREAT, and DECIDE to aid students in recalling the method. Across each model, students are encouraged to think about the situation or problem, consider their options, weigh the pros and cons of the

options, make the best choice, and evaluate whether it really was the best choice. *Glencoe Health*, *Health and Wellness* and *Health: Making Life Choices* explicitly include parental approval as part of the decision making process. The “P” of the HELP decision-making model in *Health: Making Life Choices* stands for “Parent approval” (41). The other decision making models include statements such as “Consider your long-term goals as well as the beliefs of your family and culture” in the description of a step (*Prentice Hall Health*: 17).

Using the decision-making models should result in responsible decisions. According to *Health and Wellness*, a responsible decision is defined as, “a choice that leads to actions that: 1) promote health, 2) protect safety, 3) follow laws, 4) show respect for self and others, 5) follow the guidelines of your parents and/or guardian, 6) demonstrate good character” (168). The given example of a responsible decision in this text is unmarried teens practicing abstinence.

Although the textbooks emphasize that parents should teach their children how to make decisions by example, it is unclear whether the authors expect that parents will follow the same decision-making models or use the acronyms as provided in the textbooks. Teens are not provided with advice for if or when their parents’ decision-making differs or contradicts the model taught in the textbook.

It should be noted that scientific research indicates that the teenage brain does not mature to resemble that of an adult until the early 20s (National Institute of Mental Health 2011). The parts of the brain responsible for controlling impulses and planning ahead are among the last to mature. It could be that authors of these textbooks have taken this research into consideration when prescribing the decision-making models.

However, as such research is not cited or explained, it is unclear if the authors are using science as a reason to promote decision-making or if they are using cultural stereotypes about teens' impulsivity and teens' supposed inability to make good choices.

Furthermore, if one of the goals is to teach teens to make their own decisions that are independent of their parents, the involvement of the parents in a model that is presumably used beyond high school and into adulthood is confounding. On the one hand, teens are told that they need to take responsibility for their choices and their consequences as that leads to maturity. Following a decision-making model can help them have confidence in the option they chose and avoid pressure to change their mind. On the other hand, teens are told that responsible adults consider parental approval when making decisions. If teens face pressure from their peers for their decisions, textbooks tell teens to turn to their parents or guardians for support. It is questionable whether teenage readers of these textbooks can apply the decision-making models to their lives beyond high school or ever.

Dating and Decisions

Good decision-making skills are certainly necessary in at least one facet of teenager's lives: dating. In dating, the relationship skills, communication skills, problem-solving skills learned in the teen's family of origin are put to use. However, teenage relationships are not easy, as *Essentials of Health and Wellness* points out:

> Lack of maturity is a factor that makes all of the other problems in teen relationships more difficult. Just as it is unrealistic to expect a five-year-old to sit quietly for hours at a time, so is it unrealistic to expect to make mature decisions 100% of the time. But in romantic relationships, it is especially important to have the maturity to think about the consequences of your actions and to think about the interests and safety of the other person. As much as possible, you want to keep from hurting both yourself and the other person by your actions and choices. (355)

As a result of this lack of maturity, parents may be very uncomfortable with the idea of their teen dating. The textbooks strongly suggest that their teenage readers consult with their parents about the appropriateness of when to date, who to date, and what to do on dates.

Most parents and guardians do not want to interfere with their teen's emotional, social, or psychological development. Thus, determining when it is appropriate for their teen to start dating is a common concern. *Health and Wellness* tells teens to "discuss the appropriate age to begin dating" with their parents or guardians and to keep in mind that "they want to protect you from the risks of dating too early" (160). *Essentials of Health and Wellness* acknowledges that not all teens necessarily want to date during their teen years. In addition to parental disapproval of dating, teens may lack interest in dating, not see any suitable partners, or may be too busy with other activities. Teens are reassured that it is normal to not date until later in life, just as it is normal for many teens to start dating during high school.

When considering who to date, teens are encouraged to discuss this with their parents. Parents may discourage their son or daughter from exclusively dating one person because they want their teen to go out with different people, spend time with their friends, meet new people, and gain self-confidence through different dating experiences. *Essentials of Health and Wellness* suggests that teens

> Talk to the adult members of your family about the lessons they learned from their dating experiences. What things would they do differently? Is there a particular type of dating they would recommend or avoid? Being willing to learn from the experiences of others is a mark of maturity and good judgment. (354)

One type of dating that is encouraged in textbooks is group dating. According to *Essentials of Health and Wellness*, group dating is popular because teens get to know

many people, pressures associated with dating are reduced, and parents tend to like this option best (353). *Health and Wellness* prompts teens to avoid being in situations in which they may be pressured to engage in sex: "Do not spend time in situations in which you might be vulnerable, such as being in someone's bedroom. Do not go to parties where teens will be drinking alcohol or using other drugs. Avoid watching movies and television shows that imply teen sex is OK" (173).

Ultimately, teens are told that they should follow the dating guidelines as established by their parents. Parents and guardians can also help teens establish their own dating guidelines that they can follow when they are more mature and need to set their own limits. *Glencoe Health* suggests setting limits on the age of people the person dates as well as location, transportation, and activity in order to "help ensure safe and positive dating experiences" (206). *Health and Wellness* is more explicit in its dating guidelines, giving multiple questions and directives for the teen to follow:

1. **Give your parents or guardian information on the person with whom you will have a date** – What is his or her name? How old is he or she? Where does he or she attend school? How can his or her parents or guardian be reached? This information is needed in order to discuss the appropriateness of dating this person.

2. **Tell your parents or guardian your exact plans.** – When will this date occur? What activity has been planned? You need to share details. The timing of the date should not interfere with family activities or with school or work responsibilities. The activity should be appropriate.

3. **Arrange for safe transportation.** – If you have your driver's license, your parents or guardian will emphasize that you obey traffic laws and speed limits and do not drink alcohol or use other drugs. You might rely on older teens for transportation. Your parents or guardian will want to check out anyone who is driving you. Make it clear that drinking alcohol or using other drugs will not be tolerated. Never get into a car if the driver has been drinking alcohol or using other drugs. Call home for help if a problem occurs.

4. **Establish a reasonable curfew** – A curfew is a fixed time when a person is to be at home. Your parents or guardian will establish how late you can stay out. Having a curfew helps guarantee your safety and relieves your parents or guardian of needless worry. Some cities have passed curfew laws that set a time that those under a certain age must be at home.

5. **Establish your code of conduct** – The privilege to date is accompanied by the responsibility to use wise judgment. Issues regarding wise judgment need to be clear. For example, your parents or guardian will have certain expectations regarding adult supervision of activities. Are you permitted to be at someone's house when no adults are present? Money is another issue to discuss. How much can you spend when you go out? Who should pay for what? Be aware of your parents' or guardian's guidelines for sexual behavior. Remember, your parents or guardians establish guidelines to protect you.

6. **Establish the expected code of conduct for the person you date.** – Your parents or guardian may discuss the importance of being respected by anyone you date. Respect is high regard for someone or something. A person you date should never act in a way that shows disrespect for you or your parents' or guardian's guidelines, say cruel words to you, hit or shove you, force you to show affection or be sexually active, or drink alcohol or use other harmful drugs. Your parents or guardian can discuss what to do if these actions occur. (161)

The continued reference to parents and guardians in these guidelines is notable. Teenagers are meant to always consult their parents and/or guardians and follow what they say. There are no suggestions for how to handle dating situations after high school and many of the questions and directives in these guidelines do not make sense for people after they are outside of their parents' household.

Resistance and Refusal Skills

In addition to establishing and enforcing dating guidelines for teens, parents are also meant to help their teen determine limits for physical affection. *Health and Wellness* urges teens to discuss physical affection with their parents or guardians, "be honest about the people and situations that might tempt you or pressure you to break these guidelines," and, with the help of their parents, develop a plan to adhere to

physical affection guidelines (174). Readers are reminded that such guidelines are supposed to protect them and help them live a quality life free from the serious consequences that can occur from being sexually active. *Prentice Hall Health* explains that one such consequence can be lower self-esteem:

> A decision to become sexually involved may go against a person's values. If the person makes the decision anyway, the person may feel guilty or ashamed. The person may feel that he or she has let down parents, friends, and others as well as himself or herself. The result of making snap decisions about sex is often a loss of self-respect. Using sex to prove something to oneself and others can also lower self-esteem. (152)

Thus, having sex can cause emotional trauma or feelings of guilt, fear, or rejection. Teens who are responsible and uphold their values practice abstinence. One way of practicing abstinence and safeguarding self-esteem is through the use of refusal skills. Just as each textbook has decision-making models, each textbook also contains steps to resist peer pressure and refuse certain activities (see Appendix C). *Health: Making Life Choices* offers a specific refusal skills model in order to help teens stay abstinent: STOP Method for Maintaining Sexual Abstinence. On the page in the textbook is a large stop sign with the elements of the STOP Method listed within it. These elements are:

> **S -Stop:** Stop the activity that threatens to get out of control. This first step may be difficult but it is critical for remaining in control.
>
> **T-Think:** Analyze what is happening. Does your present behavior agree with your values? Would your parents approve? Develop in advance a list of questions meaningful to you.
>
> **O-Other Activities:** If your behavior feels out of control – if it conflicts with your values – direct the energy of the moment into other activities (going out for ice cream or to a movie, for example).
>
> **P-Plan:** Make the next time easier by planning how to remain in charge. Decide not to plan dates that involve too much time alone (for example, plan a double date or date in public places). Commit to using this method every time you begin to feel out of control. (504)

These steps are consistent with the recommendations of the textbooks' general refusal skills, that is, recognizing that there is a problem, suggesting alternatives, and taking action. Teens are encouraged to practice these refusal skills ahead of time, just as in the STOP Method they are told to plan how to remain in charge.

Teens Who Have Already Had Sex

Given that teens are supposed to rely upon their parents to help them navigate decisions, dating, and physical affection, choosing to engage in sexual activity can have a negative impact on their relationships with their parents and/or guardians. Not only does sexual activity harm teens' ability to pursue new interests and friendships, they can hurt their relationships with family members. *Glencoe Health* explains, "Parents who discover that their teen is sexually active may express disappointment and worry. These feelings can cause tensions in the family" (209). This does not mean that teens should refrain from telling their parents that they have had sex. After all, some teens will have engaged in sex before they encounter these health textbooks in high school. Textbooks emphasize that it is never too late for sexually active teens to choose abstinence. Thus, in approaching the topic of disclosing teen sexual activity to parents, *Health and Wellness* assumes that one reason teens are disclosing their sexual activity is so that they can declare that they are now deciding to practice abstinence. Readers are told that parents may be upset when they learn about their behavior, but will support the teen's decision to change:

> They can offer suggestions to strengthen you as you make changes. They can help you with the sexual relationship in which you were involved. They can help you decide what to do about this relationship. They can help you set new guidelines for expressing affection. They can discuss appropriate health care with you. (174)

It is likely that parents will also be upset with the person the teen had sex with. It is implied in *Health and Wellness* that the teen will be expected to cut off contact with their sexual partner. If the teen has a discussion with their partner, it should only be done with the permission of their parents. In this discussion, the teen is to share his or her reasons for making a renewed commitment to practice abstinence as well as a farewell if their parents have decided their teen should not see their partner again. *Health and Wellness* also reminds teens “your parents or guardian gave you the privilege to date. They believe you are trustworthy and responsible” (169). This implies it is a privilege that parents and guardians can take away; however, such threats will likely be idle in a few years for the readers of these textbooks.

It is important to note that, in the textbooks’ discussion of teens who have had sex, there is an understanding that the teens have voluntarily chosen have sex. Teens who were forced to have sex through sexual assault or rape should not be discussed in the same manner as those who chose to have sex. Unfortunately, they are not addressed at all in this context. There is no distinction between those who voluntarily chose to have sex and those who were forced or coerced into having sex. Sex is not always a voluntary choice for teens. Teens who were under the influence of alcohol or drugs or received pressures from their partners may feel conflicted about the extent of their choice or ability to consent to have sex. Teens may have difficulty making distinctions between sex that was voluntarily chosen and sex that was forced when all sex before marriage is portrayed as bad as well as freely chosen in these textbooks. Thus, by failing to discuss these issues, textbooks ignore sexual assault victims and may even further stigmatize these teens by reinforcing abstinence as the only good option.

Ignored Issues

Now I will analyze the issues ignored by the textbooks, including the prevalence of teens who have experienced sexual assault or violence, that parents and families can be dysfunctional, and differences of class and race-ethnicity.

According to data from the Youth Risk Behavior Surveillance Survey, in 2013, 7.3 percent of high school students had been forced to have sexual intercourse when they did not want to (Kann et al. 2014). Of the 73.9 percent of survey respondents who went on dates in the prior year, 10.3 percent had experienced physical dating violence and 10.4 percent of students had experienced sexual dating violence. In the textbooks, sexual activity is treated as if it is often a choice that people make. This may send mixed messages to those who are victims of dating violence, especially since they presumably chose to go on a date with the individual who harmed them. Teens who were raped or forced to have sexual intercourse when they did not want to could have problems with the messages condemning those who have been sexually active, such as when abstinent teens are told to avoid teens who are sexually active. Textbooks do encourage teens to seek help if they experience dating violence or abuse; however, the textbooks do not discuss the prevalence of dating violence, nor do they discuss the various types of coercive experiences teens can have and what those experiences mean in the context of abstinence messages.

The next issue ignored by the textbooks is that people are not always raised in functional, healthy families. Research does show a protective effect of family strengths - family closeness, support, loyalty, protection, love, importance, and responsiveness to health needs – against teen pregnancy and early initiation of sexual activity (Hillis et al.

2010). However, not all teens are fortunate enough to be raised in such an environment. The Center for Disease Control's Adverse Childhood Experiences (ACE) Study lists five characteristics of household dysfunction and their prevalence in a sample of 17,337 participants: mother treated violently (12.7%), household substance abuse (26.9%), household mental illness (19.4%), parental separation or divorce (23.3%), and incarcerated household member (4.7%) (Felitti et al. 1998). The more exposure to such dysfunction, the greater the health risk factors later in life. Some textbook readers are experience at least one or more of these categories of household dysfunction. The textbooks suggest that such readers try to overcome the dysfunction while, at the same time, adamantly press teens to turn to their parents for guidance. It is problematic that textbooks assume that all readers will live in functional, healthy households where the parents can be trusted to be decision-making models and provide useful advice.

The last issues ignored in textbooks are differences of class and race-ethnicity in regard to childrearing, negotiation of unsupervised time, and dating. Parents from different socioeconomic classes socialize their children in distinctive ways regardless of if their race-ethnicity is white or black. According to Lareau (2003), families in middle classes raise their children according to the logic of concerted cultivation. Under concerted cultivation, an emerging sense of entitlement is encouraged in the children as the parents question and intervene on their child's behalf with professionals and institutions. Working-class and poor families raise their children according to the logic of accomplishment of natural growth. Under accomplishment of natural growth, an emerging sense of constraint is encouraged in the children, as the parents tend to be deferential and outwardly accepting of professionals and institutions. The textbooks do

not acknowledge how parents from different classes may socialize their children differently, and in turn teach them different methods of decision-making. Lareau found that the use of these different logics of childrearing was more class-based than race-ethnicity-based. In other words, both white and black parents in the middle class used concerted cultivation; both white and black parents in the working class and poor used accomplishment of natural growth. Thus, it is unclear how decision-making models like DECIDE and refusal skills models like STOP may apply across or be received across all classes and race-ethnicities.

Research has also found class and race-ethnicity differences in regard to negotiation of unsupervised time with peers. Borawski et al. (2003) examined four items to assess the degree and conditions under which parents manage their children's requests for independence and freedom: staying out past curfew as long as the teen called home first, having friends over while parents are not home as long at the teen told their parents beforehand, having opposite sex friends in bedroom, and having a private spot for the teen to share with their friends in their house where parents will not bother them. Students living in census tracts with higher median household incomes and lower proportions of households living in poverty reported higher levels of negotiated unsupervised time. White adolescents reported significantly higher negotiated unsupervised time compared to their African-American and Hispanic peers. Notably, adolescents whose parents allow them to negotiate unsupervised time were more likely to be sexually active than adolescents whose parents did not allow them to negotiate. The textbooks in this study do not address how class and race-ethnicity may play a role

in how willing a parent may be to negotiate with their teen for unsupervised time with their peers.

Much of the research on class and race-ethnicity differences in regard to dating focuses on dating violence. In regard to race-ethnicity and dating, most teens, regardless of race-ethnicity, report having ever dated; however, white teens were more likely to report than African American teens (Wood, Avellar, and Goesling 2008). Crissey (2005) found that white adolescents, especially girls, are more likely to have dating relationships compared to black and Hispanic adolescents. Differences between income groups using data from the National Longitudinal Survey of Youth's 1999 wave were insignificant (Wood, Avellar, and Goesling). Data from the National Longitudinal study of Adolescent Health (Add Health) suggest that adolescents tend to select partners similar to themselves in terms of socioeconomic status and race-ethnicity (Carver, Joyner, and Udry 2003). Textbooks do not address how dating may differ in accordance with class or race-ethnicity. For example, teens who cannot afford to go out to dinner and movies with friends may find their options limited to hanging out in a boyfriend or girlfriend's living room or bedroom. Teens may also choose to date interracially or inter-ethnically and may face challenges unaddressed by textbooks that implicitly assume teens date within their own race-ethnicity. Thus, it is also unclear how the dating suggestions made within the textbooks are received by teens of all race-ethnicities and classes.

Summary of Distrust of Teens' Decision-Making Skills

In this chapter, I have detailed how the health textbooks exhibit a distrust of teens' decision-making skills. According to the textbooks in my sample, families

provide a testing ground for teens to develop the relationship skills that will influence their relationships throughout their lives. Teens, however, have to make a conscious effort to spend time with their families, which may be difficult as they are also craving independence and time with their friends rather than their families. The changing relationship between teens and their parents can be challenging for them both. Parents may, for example, feel a sense of loss as their child is spending less time with them. The textbooks encourage their teen readers to have a sense of empathy for their parents and to try to please them in order to gain parental trust. However, there is a contradiction in the textbooks' construction of the parental role. On the one hand, teens are supposed to show compassion toward the difficulties of being a parent. On the other hand, teens are also meant to look to their parents for guidance in making responsible decisions.

Textbooks emphasize that teens' path toward responsible and satisfying adulthood is by learning how to make decisions. Armed with lessons and values they have learned from their families, teens are told they can use the steps in the textbook's decision making model to further protect themselves from making poor decisions that lead to negative consequences. Parental influence is present not only in the decision-making models, but also in one significant facet of many teenager's lives: dating. Throughout the textbooks' lessons on dating are suggestions for teens to have discussions with their parents or guardians. Readers are told that parents/guardians provide dating guidelines that cover who to date, when to date, what to do on a date, and how far their child can express physical affection – all in the name of their teens' health and safety. Of paramount concern is sexual abstinence. As a result, each textbook also provides refusal skills to help teens avoid negative consequences of sexual activity,

such as feeling shame, guilt, and fear. Teens who have already had sex are encouraged to embrace abstinence and to tell their parents about their sexual behavior. Textbooks ignore some issues, such as the prevalence of teens that have experienced sexual assault or violence, that parents and families can be dysfunctional, and differences of class and race-ethnicity in how children are raised, how parents negotiate unsupervised time and dating.

Overall, the textbooks aim to instruct teens on how to make responsible decisions and how to refuse engaging in behaviors the textbooks construe as deviant. Teens are prompted to talk with their parents about all aspects of relationships, from whom to date to how to express physical affection without having sex. While this might be acceptable and reasonable for teens who live at home with their parents, I question whether these lessons are applicable to the readers' lives beyond high school or ever. It may be unrealistic to expect teens to rely on various acronyms when making decisions, especially into adulthood.

Chapter 6: Risk Prevention

In this chapter, I focus on how textbooks emphasize that sex is a high-risk activity that teens should avoid in favor of abstinence. The textbooks utilize a negative discourse in regard to sexual activity, issuing warnings about a myriad of consequences that can befall sexually active teens. This chapter begins by defining what the textbooks mean by "sex" and how the definitions are associated with procreation. Next, I examine the risk factors that could make a teen more likely to engage in sex. Then, I address each of the negative consequences associated with sex, including sexually transmitted infections, HIV/AIDS, teen pregnancy, rape and sexual violence, and negative emotional effects. This is followed by an analysis of how contraceptives are discussed in my sample. I conclude this chapter by evaluating the suggested alternatives to sex offered by the textbooks and addressing the issues textbooks ignored, such as the need to control fertility, sexual pleasure, and race-ethnicity and class differences.

Defining Sex

First, we must determine what the textbooks mean by "sex." In all the textbooks, sex is used as a general term to mean sexual intercourse between men and women. Most of the textbooks use an essentialist definition of sexual intercourse by utilizing terms of reproduction and fertilization. For example, *Lifetime Health* defines sexual intercourse as "the reproductive process in which the penis is inserted into the vagina and through which a new human life may begin" (443). Notably, in four of the textbooks, the penis and sperm are emphasized in the definitions of sexual intercourse. The sentence that follows *Lifetime Health's* definition of sexual intercourse is, "During sexual intercourse,

the penis can deliver millions of sperm to the female." The woman's genitals are passive receptacles for the man.

Health and Wellness does not specifically define sex or sexual intercourse. Instead, it defines sexual feelings and when they may occur:

> Sexual feelings are feelings that result from a strong physical and emotional attraction to another person. Sexual feelings may occur when you see a certain person, kiss or touch that person, look at a person, or read certain material. These feelings are normal, but it is important to learn how to control them. It is important to you to know how sexual feelings intensify when you express physical affection. Kissing and hugging may result in stronger sexual feelings. (167)

The textbook also describes the physical changes that occur with arousal, specifically increased blood flow to the penis and vagina. The physical arousal of the body is also described in detail in *Health: Making Life Choices*. It is one of three textbooks that mention the clitoris and the only textbook that describes female arousal, including clitoral engorgement and vaginal lubrication. *Health: Making Life Choices* also outlines the stages of sexual response – excitement, plateau, orgasm, and resolution – for both men and women (581). This textbook also stands out for addressing pleasure in its definition of sex:

> Sexual relationships also bring joy and intimacy that is very special to the couple… Although it is a simple physical act, sexual intercourse is also complex. The two people who engage in it bring to it their moods, ideas, self-concepts, feelings about their relationship, and everything else that makes them unique. (580)

Overall, the textbooks' construction of the sexual act is heteronormative. Men and women engage in sex for procreation. This means that many issues related to sex are ignored in descriptions of sexual intercourse. That sex could be a pleasurable act or done as recreation is ignored. That there are types of sexual acts other than penis-in-vagina is ignored. That people who are not heterosexual have sex is ignored.

What is very clear from the textbooks, however, is that sex is high-risk and can lead to a variety of negative consequences. *Lifetime Health* warns that "sex is not a game, and neither is having a baby or a sexually transmitted disease" (476). *Prentice Hall Health* cautions readers, stating:

> As you think about sexual intimacy, there are some important issues for you to consider. Sexual intimacy is not risk free. The risks include effects on your emotional health, the effect on your relationship, the risk of pregnancy, and the risk of sexually transmitted infections. (152)

In other words, sex is something that should be taken very seriously because it can be very dangerous.

Risk Factors

While reading the textbooks, some teens may learn that they are more likely to become sexually active than others. Teens are encouraged to closely examine their group of friends and determine if their friends' influence is good or bad. *Lifetime Health* points out that sexually active teens may pressure their friends to be sexually active, whereas teens that spend their time with people who share their commitment to abstinence will have an easier time remaining abstinent (465). However, as research has indicated, the extent to which sexually active teens pressure their non-sexually active peers to have sex is unclear (Ali and Dwyer 2011; Miranda-Diaz and Corcoran 2012). Textbooks also caution teens to be careful about when they start dating and whom they date. *Health and Wellness* states that "teens who begin dating at a young age and form steady relationships are more at risk for becoming sexually active," becoming teen parents, and being infected with HIV or other sexually transmitted infections (160). Furthermore, the textbook claims teens that date older people may find it more difficult to resist sexual pressures.

Health: Making Life Choices also lists family and peer factors that may make teens more likely to engage in risky sexual behaviors:

- an unsupportive, unstable, or abusive home life
- one or more parents who abuse substances
- peer groups who abuse alcohol and other drugs, commit crime, or are truant from school
- poverty and the social disadvantages it brings (444).

The textbook states that, by adulthood, a teen with one or more of the above factors "may have had more sexual partners than most people do in a lifetime, while being less likely than most to take precautions against STDs" (445).

In contrast, teens that have protective factors are more likely to avoid sexual activity. *Lifetime Health* includes having a good relationship with one's parents, being involved in school and the community, good performance in school, practicing religious beliefs and having made a personal commitment to remain abstinent as protective factors against risky behaviors (467).

Sex is Risky

The textbooks in this sample overwhelmingly depict sex as a highly risky behavior. The main method that they use to portray sex as a dangerous act is by describing the negative consequences of sex: sexually transmitted infections, HIV/AIDS, teen pregnancy, rape and sexual violence, and negative emotional effects. I will now address each of these consequences.

Sexually Transmitted Infections

Glencoe Health relies upon statistics about the incidence of sexually transmitted infections to stress the risk of sex:

> Each year, about half of the diagnosed cases of STDs occur among teens and young adults between the ages of 15 to 24. Although many STDs can be treated

> and cured if diagnosed early, some STDs have no cure. If left untreated, some STDs can cause sterility in males and infertility in females. This means that a person may never be able to have a child. Other STDs, such as the herpes virus and HIV/AIDS, have no cure. In the case of AIDS, the disease can be fatal. (209)

The textbook adds that it is impossible to look at someone and tell if that person has an STI. Furthermore, because many STIs go undiagnosed, it is not enough for a partner to simply say that he or she does not have an STI. Therefore, teens should be abstinent because it is the only sure, 100 percent effective method of preventing STIs.

That many people do not talk about sexually transmitted infections is part of what makes it a silent epidemic. “Many people who suffer the effects of STDs find it difficult to talk about them because they fear embarrassment or social rejection,” *Health: Making Life Choices* explains (420). The silence and embarrassment mean that people are less likely to seek treatment. Teens also may not realize that their still-growing bodies may not fight infections as well as adults’ bodies, placing them at higher risks of getting STIs.

There are many extenuating factors that the textbooks address as having led to the spread of STIs. *Health: Making Life Choices* mentions the use of alcohol and other drugs, lack of health insurance, lack of understanding the signs and symptoms of STIs, belief in erroneous information such as hormonal birth control methods preventing STIs, and the lack of negative consequences in portrayals of sex in the media (420). High-risk behaviors described in *Glencoe Health* include being sexually active with high-risk partners, taking a person’s word about past behaviors, lowered inhibitions, and having a series of sexual relationships with one person at a time (666). *Prentice Hall Health* accounts for the STI epidemic by including ignoring risks, having multiple partners, and

not seeking treatment as high-risk behaviors (575). To avoid STIs, the textbook suggests practicing abstinence, avoiding drugs, and choosing responsible friends.

Although one may think that descriptions of the signs and symptoms of sexually transmitted infections would be accompanied with information on prevention, this is not the case in most of the textbooks. In mentioning protected sex, *Glencoe Health* focuses on its inferiority compared to abstinence:

> Even protected sex, or barrier protection, is not 100 percent effective in preventing the transmission of STDs. Abstaining from sexual activity is the only method that is 100 percent effective in avoiding STDs. (666)

Health: Making Life Choices also includes the use of condoms as a means of reducing STI risk. In a textbox, *Health: Making Life Choices* states:

> People can completely protect themselves from sexual transmission of STDs by:
>
> 1. Practicing sexual abstinence.
>
> 2. Having a responsible, mature, mutually monogamous sexual relationship with an uninfected partner.
>
> People can reduce their STD risks by:
>
> 1. Avoiding contact with the partner's semen or vaginal fluids and blood.
>
> 2. Using latex condoms throughout every sexual act to keep body fluids from being exchanged.
>
> 3. Refusing alcohol or other drugs.
>
> 4. Avoiding high-risk behaviors, and avoiding relations with others who engage in high-risk behaviors such as drug and alcohol use, and engaging in unprotected sex. (441)

Ultimately, teens are encouraged to inform themselves about sexually transmitted infections, from their incidence nationwide to their symptoms; however, most of the

textbooks do not give information on how to prevent infection aside from being sexually abstinent.

HIV and AIDS

The next negative consequence used to depict sex as a high-risk behavior is infection with HIV. *Lifetime Health* tells teens:

> The only way to eliminate the risks of HIV infection is to avoid risky behaviors. Don't take a chance with your life! Practice abstinence. Make the decision now to practice abstinence until marriage. Abstinence is the only method that is 100 percent effective in preventing the sexual transmission of HIV. Try to avoid all situations in which you may be pressured to engage in sexual activity. For example, avoid being alone with someone you do not know very well. Instead, go out in groups of friends. (505)

In other words, teens can eliminate the risk of getting HIV if they do not engage in any behaviors known to transmit HIV. Other protective healthful behaviors are described in *Glencoe Health*: practicing abstinence, not sharing needles, avoiding alcohol and drugs, and using refusal skills when feeling pressure to engage in risky behaviors (675). Notably, all of those behaviors involve relationships. Therefore, *Glencoe Health* encourages teens to ask themselves the following questions: "What do I know about the people in my life and their behaviors? Will they put me at risk for getting HIV/AIDS? How can I be sure another person is not HIV-positive?" (675). This may serve to stigmatize those who are HIV-positive. It is also questionable whether knowing a person's HIV status is absolutely necessary if he or she is not a sexual partner.

As with STIs, contraceptives are not addressed in conjunction with the discussion of HIV/AIDS in most of the textbooks. However, *Prentice Hall Health*'s sole mention of condoms is in reference to HIV and some other STIs:

> People can reduce the risk of HIV infection by using a condom during every sexual encounter. The condom must be made of latex or polyurethane, be free of tears, and be used in accordance with the directions on the package. Condoms

> serve as a physical barrier against HIV and some other pathogens that cause STIs. It is important to know that condoms are not 100 percent effective in preventing the transmission of HIV. Abstinence is the best way to protect yourself from HIV and other STIs. (593)

Prentice Hall Health encourages people in long-term relationships to use condoms because a person cannot be sure that their partners remain faithful and uninfected by HIV and/or other STIs. Thus, according to that textbook, sex can never be risk free.

Teen Pregnancy

The possibility of teen pregnancy is the third negative consequence of sex included in the textbooks. *Essentials of Health and Wellness* points out how teen pregnancy is a challenge to the nation because teens are often unable to support themselves. According to the textbook:

> Teen pregnancies cost taxpayers more than $7 billion a year. These costs include Medicaid and welfare expenditures, plus the loss of the teen mother's productivity in the workplace. Teen pregnancies tend to involve high risks because many teen mothers seek prenatal care late in their pregnancies, if at all. Although the rate of teenage pregnancies is declining, the United States still has the highest teen pregnancy rate, teen birth rate, and teen abortion rate in the Western industrialized world. (547)

Society bears a high cost for pregnant teens in terms of lost education, lost earning power, and increased need for support. *Health: Making Life Choices* describes how teen pregnancies often result in interruption of education, early marriages with a high likelihood of divorce, high risks of poverty, low infant survival rates, and lifetime tendencies toward having more than the average number of children (501).

Teenage pregnancies also pose serious health problems for the mother and baby. The bodies of teens, while technically able to bear children, are not ready for the physical stress of pregnancy. *Glencoe Health*, *Lifetime Health*, and *Prentice Hall Health* draw attention to the possibility that the pregnant teen may not obtain the needed

prenatal care, such as medical treatment and proper nutrition, especially in the early months.[19]

Many teens may have unrealistic expectations about teenage pregnancy. *Health: Making Life Choices* describes some of the misinformed notions teens may have:

> They may think, 'If I have a baby, I'm sure someone will take care of it. The father will marry me, or the mother will take care of it; or my parents will help; or I'll be an adult, then, so somehow it'll be okay.' In fact, teens may believe that pregnancy must be all right or else it wouldn't happen. Some think pregnancy is a way from an unhappy home life. Many teens have no idea the enormous burden that comes with being a parent. Teens who have jobs may feel that they have lots of money to support a child. However, most teens are not responsible for paying for a home, groceries, insurance, and all the other costs of maintaining a home and family. (619)

Teens are not prepared to be responsible for a child twenty-four hours a day because they have many responsibilities that include school, their social development, and other learning experiences. One such learning experience is how to be a parent; without it, the child can suffer as a result.

Lifetime Health draws attention to the United States having the highest teen pregnancy rate and teen birth rate of any developed nation, in part because teens think, "It won't happen to me" (477). Teens may also believe that they cannot get pregnant if they are having sex for the first time (*Glencoe Health* 209). *Health and Wellness* gives many examples of "faulty thinking" regarding teen pregnancy. One example is the belief that, "I can have a baby now. My mother had a baby when she was a teen and she managed OK" (198). *Health and Wellness* disputes this faulty thinking by describing the generational cycle of teen pregnancy and the poverty often associated with it.

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[19] Textbooks outline the prenatal care pregnant women need to obtain. The textbooks do not acknowledge barriers to access that include not knowing signs of pregnancy, denial about being pregnant, embarrassment or shame, financial costs, transportation issues, etc.

Another misconception disputed in *Health and Wellness* is the idea that "It's up to her to set the limits; after all 'boys will be boys'" (200). In discussing teenage pregnancy, the textbooks emphasize that both parents are responsible for the baby when it is born. *Health and Wellness* tackles the misconception of pregnancy being only the woman's responsibility by encouraging the man to consider the need a baby has for a father in terms of developing self-confidence, emotional support, and financial support. Teen fathers are less likely to graduate from high school or college or marry the mother of their child.

A teen facing an unintended pregnancy must make an important decision that involves their feelings, judgments, and values. They must decide between carrying the child to term or seeking an abortion. In the textbooks, adoption tended to be discussed in terms of families seeking to adopt a child rather than placing a child up for adoption. *Health: Making Life Choices* is the only textbook that discusses adoption in the latter terms: "Adoption agencies can sometimes find childless couples who are willing to pay some of the expenses of carrying a child to term. Some agencies may directly provide certain needed resources, such as prenatal and postnatal medical care" (617). *Health: Making Life Choices* is also the only textbook to discuss abortion:

> Each female facing an unintended pregnancy also faces the decision of whether or not to continue her pregnancy. For some, the choice is really no choice. Some females may have already come to a decision about whether she would consider abortion, a procedure to end a pregnancy before the fetus can live outside the uterus. Abortion is not a method of contraception. Contraception means 'to prevent conception.' Abortion interrupts a pregnancy that is already under way. (614)

The textbook does not take either option lightly. Teenage pregnancy overall is portrayed as a serious consequence and risk of sexual activity.

Rape and Sexual Violence

The fourth risk of sexual activity is rape and sexual violence. *Health and Wellness* defines rape as "the threatened or actual use of physical force to get someone to have sex without giving consent" (687). The textbook stresses the importance of the words "without consent":

> If a person does not willingly agree to have sex, there is no consent, and so in this case is considered rape. The law states that people under a certain age and people who do not have certain mental abilities are considered unable to give consent, even if they agree to have sex. A person who has sex with someone described as not able to give consent is guilty of committing rape. Anyone under the influence of alcohol or other drugs cannot give legal consent to have sex. In other words, having sex with someone who has been drinking or using drugs can be considered rape in a court of law, even if the person did not say no. (688)

Although the textbooks draw attention to the incidence of rape by a stranger, they emphasize that the majority of rape cases involve acquaintance rape, or rape in which the victim knows the rapist. This information is accurate, as data from the National Crime Victimization Survey indicate that from 2005-2010, 78 percent of sexual violence involved an offender who was a family member, intimate partner, friend, or acquaintance (Planty et al. 2013). *Lifetime Health* even points out that rape can occur between married couples and is a form of domestic violence (116). *Health: Making Life Choices* defines sexual violence as a serious crime that includes rape as well as inappropriate touching, verbal sexual threats, and exposing genital organs to children or other innocent people (510).

The textbooks each have suggestions for how people can protect themselves from becoming rape victims; however, most of the tips are directed toward women. For example, *Health: Making Life Choices* asks, "How can a woman protect herself from becoming a victim of rape?" and suggests that women should avoid putting themselves

in situations where rape may occur (511). Other tips seem gender-neutral. *Lifetime Health* offers the following list of directives to protect oneself from date rape:

- When going on a date, know who the person is, where you are going, and what you will be doing. Make sure friends and family know this information, too.
- Don't be alone with your date. Go on dates in public places.
- Go on double dates or group dates.
- Do not accept drugs or alcohol.
- Do not allow anyone to have an opportunity to put drugs in your beverage.
- Be wary of meeting anyone on the Internet.
- Know where a phone is at all times.
- Set limits, and communicate these limits clearly and firmly ahead of time. (117)

Other textbooks attempt to be gender-neutral, but end up being merely gender-blind. For example, although both men and women are acknowledged to be both rapists and victims of rape, a discussion of rape in *Health and Wellness* focuses on men as aggressors and women as in need of protecting themselves from rape. The textbook states that people need to be consistent at all times in clearly saying 'no' and discouraging sexual advances. Using "people" rather than "women" fails to be gender-blind, especially when the textbook points out how non-verbal messages need to be accounted for as well:

> If a female puts herself in a risk situation – perhaps by accompanying a male to his home or being alone with a male she doesn't know very well – do her actions indicate consent to have sex even if she says 'no'? No, they do not. If a male forces a female to have sex, even when she is in a risk situation, he has committed rape. Females should avoid putting themselves in risk situations. If they do put themselves in a risk situation, it can be difficult to defend themselves or to get help if sexual advances occur. Males must always stop when a female says 'no.' If a female wears clothes that a male considers to be revealing, do her clothes indicate consent to have sex even if she says 'no'? No, they do not. If a male assumes that a female wants to have sex and forces her to do so, he has committed rape. While people have the right to wear what they want without threat of harm, females should realize that others might not respect that right. Males must realize that the clothing a female wears does not equal consent for sex. Forced sex is always rape. Both males and females must

> understand that rape is never the victim's fault. The perpetrator is always the one at fault. (687)

Health and Wellness also addresses the concerns of men being falsely accused of rape.[20] Abstinence is a way to protect from that situation. As the textbook explains, "When you practice abstinence, there is no chance of having sex with an unwilling partner. You cannot be accused of rape" (169).

Emotional Effects

The next negative consequence associated with the riskiness of sex as addressed in the textbooks is emotional effects. Having a sexual relationship as a teen is putting oneself at risk of emotional harm. By practicing sexual abstinence, the threat of emotional trauma linked to unexpected pregnancy or sexually transmitted infection is eliminated (*Essentials of Health and Wellness* 355). Thus, one of the benefits of sexual abstinence is having no feelings of guilt or regret. *Glencoe Health* explains that most teens are not prepared for the emotional demands of a sexual relationship:

> Teens who engage in sexual activity before reaching emotional maturity may experience: hurt because partners are not committed as in a marital relationship, guilt because teens are not usually truthful to their parents about being sexually active, loss of self-respect because sexual activity goes against personal and family values, regret and anxiety if sexual activity results in an unplanned pregnancy or an STD. (209)

The threat of a loss of self-respect is mentioned frequently in the textbooks. *Prentice Hall Health* notes that the decision to have sex may go against a person's values and, as a result, the person may feel that he or she has let down parents, friends, and others. The textbook states, "The result of making snap decisions about sex is often a loss of self-

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[20] Statistics from the Federal Bureau of Investigation (1997) indicate roughly 8 percent of rape cases are false accusations. A 2010 study by Lisak et al. of rape allegations over a 10-year period at a major Northeastern university found that, of 136 cases, 8 (5.9%) were coded as false allegations. The authors conclude this is consistent with other findings that have placed false rape allegations within a range of 2 to 10 percent.

respect. Using sex to prove something to oneself and others can also lower self-esteem" (152). Self-respect results from sticking to one's limits rather than giving in to peer pressure. A suggested limit that demonstrates self-respect is abstinence from sex. *Health and Wellness* tells its readers, "Your peers will respect you for being able to resist the peer pressure to have sex" (170).

Abstaining from sex not only protects one's reputation, it also protects the good reputation of one's friends or people one dates. As *Health and Wellness* explains:

> Practicing abstinence from sex shows respect for self and others. You maintain a good reputation. Reputation is a person's overall character as judged by other people. Having a good reputation improves your relationships with peers. If peers know you practice abstinence from sex, they know that you protect your health and safety, and that you respect yourself and others. They know that you do not cave in to peer pressure and choose wrong actions. (169)

Readers are reminded that they will have to deal with the consequences of becoming sexually active and it will not gain the respect of others. Given cultural double standards about men's and women's sexual activity, these gender-neutral warnings about reputation are not, in reality, gender-blind. Women tend to be judged more harshly for their sexual behavior than men. Readers are also told that the pressure to engage in sexual activity does not contribute to a healthy relationship and may damage them instead. *Essentials of Health and Wellness* points out, "among the problems associated with teens having sex is that the experience may leave them with emotional scars following the event" (355). Although sexual activity may seem like a way to experience emotional intimacy, *Lifetime Health* warns that being sexually active as a teen may complicate life and create distance within one's relationships (460). Instead of trying to create emotional intimacy through sex, teens should stick to their limits and avoid high-pressure situations.

What About Contraceptives?

Only two of the textbooks in this sample discuss contraceptives in depth. *Essentials of Health and Wellness* examines the pros and cons of contraceptive use, why condoms fail, and what people can do to decrease their chances of getting any STIs, including HIV. The main contraceptive discussed in this textbook is the condom and, with every discussion about it is a reminder that abstinence is the only 100 percent effective method of preventing pregnancy and STIs.

Health: Making Life Choices discusses a variety of contraceptive methods, how to use them, how to obtain them, and their potential side effects. The contraceptives addressed include: oral contraceptives, hormone patches and injections, intrauterine devices, vaginal spermicides, diaphragms, cervical caps, contraceptive rings, male condoms, female condoms, sterilization, and the fertility awareness method.

The textbook encourages couples to discuss everything that can happen before having sexual intercourse, including the type of contraception that should be used, and that such a discussion may bring the couple closer together and strengthen their relationship as it demonstrates concern for the partner's well-being. According to *Health: Making Life Choices*, "the more a couple cares about each other, the more likely they are to protect each other with contraception. The older and more sexually experienced they are, the more likely they are to use it. And the more they see pregnancy prevention as a shared responsibility, the more they will use it" (618).

According to *Health: Making Life Choices*, fewer than half of sexually active teens report that they consistently use contraceptives (618). Teens may avoid using contraception for a number of reasons. They may fear discovery and the disapproval of

their parents, may be too embarrassed to purchase condoms or seek the help of professionals in obtaining contraceptives, may lack information about contraception, or may fail to realize that sexual intercourse leads to pregnancy. *Health: Making Life Choices* surmises that emotional maturity and risk taking may also play a role:

> An immature person may reject sexuality as part of the person's self-image. The assumption seems to be that sex is great, but nice people don't plan for it – it 'just happens.' Young people who confuse sexual activity with love are less likely to use contraception. They trust 'love' to be in control, and simply hope for the best. Another group failing to use contraception is made up of people who seem prone to taking chances and risks of all sorts. Such people may smoke tobacco, drink alcohol, take illegal drugs, or commit crimes – and they often engage in risky sexual behaviors. (618)

Other reasons why a couple, regardless of age, may not use contraception is that they have moral, religious, or personal reasons to consciously decide against it. However, *Health: Making Life Choices* points out that most teen pregnancies are unplanned and are not the result of conscious choice, but of failure to use contraception (618).

Alternatives to Sex

Given that sex is portrayed as such a high-risk act with serious consequences, the textbooks provide a number of alternatives to sex. These alternatives include self-control, planning, other activities, and masturbation. Ultimately, textbooks advocate that abstinence is best.

Self-control is the first alternative to sex suggested by textbooks. *Glencoe Health* defines self-control as "a person's ability to use responsibility to override emotions" (207). The textbook states that, although it is normal to have sexual feelings and that those feelings cannot be prevented, the reaction to those feelings can be controlled. In order to stay firm in a decision to practice abstinence and maintain self-control, *Glencoe Health* encourages readers to set limits for expressing affection and

communicate with their partner, talk with trusted adults, seek low-pressure dating situations such as group dating, attend parties where adults are present, and date people who respect and share their values. *Health and Wellness* states that one of the benefits of staying in control is the ability to maintain self-respect and the respect of a dating partner (170). Thus, it is important to set limits on physical affection so that the body's message does not attempt to override the brain's message.

In order to express sexual feelings in appropriate ways that do not involve sexual intercourse, *Health: Making Life Choices* states that it is necessary for individuals to come up with plans in advance to fight temptation (504). People who have clearly determined plans are better suited to fight the heat of the moment in sexual situations, although people who are thrill seekers will face a harder battle. Remaining abstinent may present challenges and requires teens to give thought to how they will resist pressure to have sex. *Health and Wellness* encourages readers who feel pressure to engage in sex to practice their resistance skills and develop reasons for why they do not want to be sexually active. Readers should:

> Repeat several times your reasons for practicing abstinence from sex. For example, you might say, "No, I do not want to be sexually active. I practice abstinence from sex to promote my health. I do not want to experience emotional trauma or feelings of guilt, fear, or rejection. I do not want to get pregnant or get someone pregnant. I do not want to compromise my goals by becoming a teenage parent. I do not want to become infected with STDs, such as genital herpes and genital warts. I do not want to become infected with HIV and develop AIDS. (173)

By repeating this statement several times, *Health and Wellness* claims that teens will be prepared to face high-pressure situations and convince the person pressuring them that they want to remain abstinent. *Health and Wellness* also suggests that teens utilize their decision-making model – promote health, follow laws, show respect for self and others,

follow guidelines of parents or guardians - in order to devise their own reasons for practicing abstinence (172).

Textbooks may also suggest other activities that teens can engage in to express affection without having sex. According to *Health: Making Life Choices*, sexual energy can be diverted into activities like dancing, sports, walking, writing, speaking, singing, painting, or other expressive activities (504). In addition, teens can develop their skills at home and at school, enjoy outdoor activities, and spend time with positive people rather than have sex. In order to express love for one's partner without having sexual intercourse, the textbook suggests doing activities that demonstrate extra thought or effort on the part of the giver. Examples include giving hugs, giving small gifts, doing favors, or confiding in one's partner. *Prentice Hall Health* recommends choosing emotional intimacy over physical intimacy:

> How can two people be intimate without being sexually involved? They can trust each other with personal feelings or dreams that they haven't told anyone else. They can exchange 'inside' jokes. They can do kind things for each other and be best friends. Emotional intimacy refers to the openness, sharing, affection, and trust that can develop in a close relationship. (154)

Honesty, acceptance and support can grow emotional intimacy and help the couple become closer without being sexually intimate.

Another way for a person to express sexual feelings and release sexual tension is through masturbation. *Health: Making Life Choices* is the only textbook to discuss masturbation at all. The textbook states that as adolescents' bodies produce more hormones, teens tend to think more about their sexual feelings and experience sexual tension. "One way to release this sexual tension is through masturbation, rubbing or stimulating one's own genitals until orgasm occurs," *Health: Making Life Choices* explains. "Medical experts believe that masturbation is healthy and provides a way to

release sexual tension and avoid the risks of sexual activity, including pregnancy and STDs" (580). Despite reassurances that masturbation is healthy and that it does not cause pimples, warts, or excessive hair growth, the textbook acknowledges that some people are opposed to masturbation. These people may believe masturbation is wrong and harmful, may feel guilty and ashamed, or may feel that their parents and other adults do not approve.

Ultimately, textbooks advocate that abstinence is best. *Health and Wellness* claims that practicing abstinence promotes emotional health and allows teens to adhere to their values and family guidelines (168). The threat of unplanned pregnancy, STIs, and HIV infection can make teens fearful and anxious. In addition, having sex outside of a marital commitment can increase risks of feeling rejected, used, or compared to someone else. *Health and Wellness* tells its teen readers that they can protect themselves from those sources of emotional trauma if they practice abstinence from sex. *Lifetime Health* points out that there are significant social benefits for those who avoid sexual activity during their teen years. The social benefits include:

> The freedom to pursue a variety of friendships, less complicated relationships, the ability to focus on interpersonal aspects of relationships, better relationships with parents and other trusted adults, the chance to learn to build strong, lasting relationships based on mutual trust and respect, and better reputation among peers. (462)

Abstinence may also provide emotional benefits, such as:

> Being free from worry and stress about sexually transmitted diseases and pregnancy, allowing time to develop the maturity needed to make important decisions, avoiding being manipulated or used by others, having an increased sense of self-control and self-respect, and staying true to your personal values, such as respect, honesty, and morality. (462)

Thus, abstinence is portrayed as the best way to avoid health, emotional, and social risks associated with sexual activity.

Ignored Issues

Now I will analyze the issues ignored by the textbooks, such as the desire to control fertility, sexual pleasure, and differences of race and class.

Only two of the textbooks in my study discuss contraceptives in any depth. The other textbooks emphasize that abstinence until marriage is the best way to avoid unintended pregnancy. However, even people who do wait until marriage to have sex will likely want to control their fertility. Data from the 2006-2010 National Survey of Family Growth indicate that 77.4 percent of currently married women are using some method of contraception (Jones, Mosher, and Daniels 2012). By not including any substantial information about contraceptive methods, the textbooks are putting those readers at a significant disadvantage. The textbooks do not prepare readers to discuss contraceptives with their sexual or marital partners or what to do, for example, if a partner has a latex allergy, if a condom breaks, or if hormonal birth control is causing side effects. Pregnancy, even if not within adolescence, can still be unplanned; through contraceptives, though, it can also be prevented.

The next issue most of the textbooks ignore is sexual pleasure. In portraying risk as a very risky activity imbued with shame for those who have it before marriage, most of the textbooks are not mentioning that sex can be pleasurable. The majority of textbooks also do not address masturbation and how it can allow a person to receive sexual pleasure and relieve sexual frustration. Furthermore, most of the textbooks do not include the clitoris in its diagrams of the female reproductive system, nor do they discuss its purpose. By ignoring the clitoris – an organ that enables the majority of women to achieve orgasm - textbooks imply that only men are entitled to sexual

pleasure.[21] Textbooks do not need to provide instruction on how to give or receive sexual pleasure; however, to ignore that sex can be pleasurable seems naïve or irresponsible. The call to include sexual pleasure in sex education has been made before. In 1988, psychologist Michelle Fine expressed concern that, if teaching about sexual pleasure was not included in the education of women and girls, women would be unable to negotiate their sexual fears and desires. Fine argued, "The absence of a discourse of desire, combined with the lack of analysis of the language of victimization, may actually retard the development of sexual subjectivity and responsibility in students" (1988: 49). Over twenty-six years later, discourse of desire is still absent. In focus groups following the 2006-2007 Toronto Teen Survey, youth ranked sexual pleasure as one of the top three topics they wanted to learn more about (Oliver et al. 2013). Teaching teens about pleasure would give them the tools to negotiate what they do and do not want in sexual relationships, encourage them to have conversations about healthy relationships and give them agency. In contrast, the message from textbooks seems to be that healthy relationships do not require discussion of sexual pleasure.

The last issues ignored in the textbooks are differences of class and race-ethnicity, specifically in regard to prevalence of having had sexual intercourse, contraceptive use, sexual activity, and discourse. Add Health data show that girls whose mothers have higher levels of education were less likely to transition into sexual intercourse and may also have higher educational expectations (McNeely et al. 2002). Other socioeconomic indicators, such as family composition and household size also play a role in sexual onset. Findings from a multilevel study of Chicago youth showed

[21] People of other genders can have clitorises and penises; however, for the sake of clarity, I limited this statement to cisgender individuals.

that the presence of two biological parents and smaller household size were negatively associated with sexual onset (Browning, Leventhal, and Brooks-Gunn 2004). Furthermore, introduction of neighborhood concentrated poverty into models largely explained differences between African American teens and both white and Latino teens, showing that socioeconomic features of a neighborhood have a consequence for teens' likelihood of experiencing first intercourse. Such findings are consistent with 2006-2010 National Survey of Family Growth data that show that both male and female teenagers were less likely to be sexually experienced if they lived with both parents, had a mother who had their first birth at age 20 or over, and/or had a mother that graduated from college (Martinez, Copen, and Abma 2011).

Textbooks ignore that there are race-ethnicity differences in regard to having ever had sex. In the 2013 Youth Risk Behavior Surveillance Survey, the prevalence of having ever had sexual intercourse was higher among black (60.6%) than white (43.7%) and Hispanic (49.2%) students (Kann, et al. 2014). Nationwide, 15 percent of students have had sexual intercourse with four or more individuals during their life and 34 percent of students had sex with at least one person in the three months prior to the survey. Notably, of the currently sexually active students, 59.1 percent reported that they used a condom and 19% reported using birth control pills. Yet, 13.7 percent reported that no contraceptive method was used. The prevalence of non-use was higher among black (21.2%) and Hispanic (23.7%) females than black (11.2%) and Hispanic (15.4%) males.

Data from Cycle 6 of the National Survey of Family Growth also show differences in sexual behavior by class and race-ethnicity (Lindberg, Jones, and Santelli

2008). Teens in high socioeconomic households were 2.9 times as likely to have oral sex and anal sex as teens in low socioeconomic households. However, teens from low socioeconomic status households were more likely to report having vaginal sex. White females were more likely to indicate having given oral sex compared to white males, Hispanic females, and black females. Twice as many black teens, both males and females, indicated receiving oral sex compared to giving oral sex. The likelihood of anal intercourse did not differ by race-ethnicity overall, though Hispanic males were more likely to report engaging in anal sex compared to non-Hispanic white males. Both oral sex and anal sex were generally more common among white teens.

Discourse about sexual activity and sex education also differs by race-ethnicity and class. Mollborn (2010) examined pregnancy norms, specifically whether teens would be embarrassed at the prospect of a teenage pregnancy. She found that white teens living in predominantly white neighborhoods were more likely to report embarrassment. African American and Latino teens and those who lived in predominantly African American or Latino neighborhoods were less likely to report embarrassment. Furthermore, 74 percent of those living in high socioeconomic status neighborhoods and 72 percent of those with incomes at 301 to 400 percent of the poverty line reported embarrassment. The difference is striking when compared to the 46 percent of respondents from low socioeconomic status neighborhoods and 48 respondents with household incomes below the poverty line that reported embarrassment. Socioeconomic status mediates the association of the race-ethnicity composition of a neighborhood and embarrassment.

Non-white and low-income teens tend to be referred to as populations “at risk” of being “children having children.” Fields (2005) examined debates of sex education policies in a North Carolina county where the school system is predominantly African American and low-income. She found that both advocates of abstinence-only and abstinence-plus curricula promoted the idea of childhood sexual innocence. These claims about “children” were, on the surface, race-ethnicity-neutral and class-neutral. However, given the population of the school system, Fields argues that the “at risk” and “children having children” rhetoric is implicitly about African American and low-income female teens. Fields writes, “In national debates over sexuality education, ‘those kids’ are sexually misbehaving girls and aggressive boys. In a racialized setting like Southern County, ‘everybody knows’ that those misbehaving girls and aggressive boys are low-income and African American” (2005: 562). By framing the African American and low-income students as children, the adults were ostensibly using universalism to obscure the racism and classism in the sex education debate.

The textbooks also frame their discussion of risk prevention in universal terms. The message from the textbooks is the same to all teens, regardless of class or race-ethnicity: abstinence. Issues about class and race-ethnic differences in the prevalence of having had sexual intercourse, contraceptive use, sexual activity, and discourse are ignored.

Summary of Risk Prevention

In this chapter, I have detailed how the health textbooks emphasize that sex is a high-risk activity. According to the textbooks in my sample, sex is a procreative activity and there are few indications that sex is a pleasurable act. Sex is also portrayed as a

serious event that is linked with many negative consequences. Some teens may have risk factors that make them more likely to engage in high-risk behaviors such as sex; however, they can choose to be proactive in protecting themselves by closely examining their friends and making personal commitments to abstinence.

Textbooks focus on the negative consequences associated with sexual activity. Readers are told that sexual activity can lead to sexually transmitted infections, HIV/AIDS, teen pregnancy, rape and sexual violence, and negative emotional effects. Although contraceptives may be able to protect teens from sexually transmitted infections, infection with HIV, and teen pregnancy, the majority of the textbooks do not discuss contraceptives. Only one textbook in my sample gives detailed information about different types of contraceptives, how to obtain them, and how to use them. In lieu of this information, most of the textbooks stress that abstinence is the only, best, most effective, 100 percent guaranteed way to protect oneself from STIs, HIV and teen pregnancy. To support their readers' commitment to abstinence, the textbooks offer alternative activities for teens to do to express their intimate feelings, such as dancing or disclosing personal confidences. However, textbooks also ignore some issues, such as the need to control fertility, sexual pleasure, and differences by class and race-ethnicity.

Overall, the textbooks aim to stress that engaging in sexual intercourse is a serious decision that exposes teens to many risks. Teens are prompted to educate themselves about the consequences of having sex, from unintended pregnancy to ruined reputations. While sex can indeed result in children, herpes, and/or disappointed parents, emphasizing that sex is risky rather than pleasurable does not equip teens to navigate their sexual lives as teens or as adults.

Chapter 7: Summary – What Textbooks Say About Abstinence

Given the fervent concern over sexually active teens as expressed by politicians, religious leaders, and social critics, amplified by the seemingly unending debate over what should and should not be taught about sex in health classes, I became interested in learning more about the content of high school health textbooks, particularly the discourse about abstinence. I wondered about how teen readers of these textbooks were told that they needed to wait to have sex until marriage and what they were told the consequences were for violating that directive. Through the analyses performed for my study of high school health textbooks, the messages about abstinence have been illuminated.

In this chapter, I will summarize my analyses of six high school health textbooks by reviewing the major themes and conclusions I drew. Then, drawing from the conclusions of the analyses, I will develop a theory of patronizing exclusivism that accounts for the implicit and explicit messages high school health textbooks have about abstinence. The third section of this chapter will contain a discussion of the limitations of my study. Finally, I will conclude with suggestions for future research.

Emphasis on Marriage

In chapter four, I detailed how high school health textbooks emphasize that marriage is the only appropriate place for people to have sex. Thus, the message is that people should abstain from sex until they make the lifelong, permanent commitment of marriage. As marriage is a serious decision and not a fairy tale, textbooks provide reasons why someone might get married as well as suggestions on how to find a suitable marriage partner. Readers are also given many reasons for why it is important

to remain abstinent until marriage: to demonstrate healthful family values, to show good character, to protect against STIs including HIV, and to reserve marital sex as a special act. However, given the current demographic make-up of the United States, placing such an emphasis on abstinence until marriage may be unrealistic. As a result, the textbooks overlook a number of issues, such as the period of emerging adulthood, the increasing prevalence of single adults, the reality of cohabitation as a legitimate option for couples, the lives of lesbian, gay, bisexual, and transgender individuals, the context of divorce and remarriage as an adult and differences of class and race-ethnicity. By explicitly tying sex to marriage and stigmatizing sex before marriage, as most of the textbooks do, it is questionable whether adolescents are given the skills needed to navigate their sexual health or develop positive views of sexuality.

Distrust of Teens' Decision-Making Skills

In chapter five, I focused on how the health textbooks exhibit a distrust of teens' decision-making skills. According to the textbooks, teens should develop their relationship skills among their family members. The readers are encouraged to spend time with their families, especially as their relationship with their parents change. Teens are meant to show compassion toward the difficulties of being a parent while also looking to their parents for guidance in making responsible decisions. Equipped with the lessons and values learned from their families, teens are told they can use the steps in the textbook's decision making model to further protect themselves from making poor decisions that lead to negative consequences. Parental influence is evident in the decision-making models as well as in an important facet of teenager's lives: dating. Teens are encouraged to have discussions with their parents or guardian throughout the

textbooks' lessons on dating. Parents and guardians can provide the teens with dating guidelines including whom to date, when to date, what to do on a date, and how much physical affection their child can express – all for the sake of their teens' health and safety. Sexual abstinence is a key concern and teens are given refusal skills to help them avoid the negative consequences of sexual activity. Teens who have already had sex are encouraged to embrace abstinence and to tell their parents about their sexual behavior. Textbooks ignore the prevalence of teens that have experienced sexual assault or violence, that parents and families can be dysfunctional, and differences of class and race-ethnicity. Overall, the lessons in the textbooks are likely appropriate for teens that live at home with their parents; however, they may be less applicable once the readers are beyond high school.

Risk Prevention

In chapter six, I described how the health textbooks stress that sex is a high-risk activity. Sex, as defined by the textbooks in my sample, is a procreative activity and there are few indications that sex is a pleasurable act. Sex is portrayed as a serious event associated with many negative consequences. Teens, even those who have risk factors that make them more likely to engage in high-risk behaviors like sex, are meant to be proactive by closely examining their friends and making personal commitments to abstinence. The textbooks inform readers that sexual activity can lead to sexually transmitted infections, HIV/AIDS, teen pregnancy, rape and sexual violence, and negative emotional effects. The majority of the textbooks do not discuss contraceptives although contraceptives may protect teens from some sexually transmitted infections, including HIV, and teen pregnancy. Instead, the textbooks emphasize that abstinence is

the only, best, most effective, 100 percent guaranteed way to protect oneself from STIs, HIV, and teen pregnancy. To support teens in their commitment to abstinence, textbooks offer alternatives for teens to engage in to express intimate feelings without having sex, such as dancing or disclosing personal confidences. Textbooks also ignore some issues, such as the need to control fertility, sexual pleasure, and race-ethnicity and class differences. Ultimately, while sex can result in an unintended pregnancy, STIs, a ruined reputation and/or disappointed parents, accentuating the risks of sex and ignoring sexual pleasure does not necessarily prepare teens to navigate their sexual lives as teens or as adults.

A Theory of Patronizing Exclusivism

Through systematic analysis of the implicit and explicit messages about abstinence in six high school health textbooks, I discovered six characteristics shared by the textbooks. They all perpetuate of the stereotypical ideal family, deny demographic realities, assume that teens are impulsive, conflate sex with morality, encourage stigma of the sexually active, and promote sex negativity – features that serve as messages about abstinence. In the following section, I discuss each feature as it is manifested in the textbooks' content and conclude with a summary of the theory constituted by these elements.

Perpetuation of Ideal Family Stereotype

In all of the textbooks studied, families are very important. They not only provide socialization, but they are sources of unconditional support, love, guidance, acceptance, and advice. Parents are portrayed as being very knowledgeable and, as such, always knowing what is best for their child. Teens are meant to look to their parents to

teach them how to make decisions. According to the textbooks, parents can instruct their teens on how to weigh the pros and cons of various options as well as demonstrate the virtue of patience over impulsiveness. Thus, textbooks portray parents as never making impulsive or bad decisions.

Textbooks emphasize that rules and guidelines should be obeyed because parents set them in the best interest of the health and safety of their offspring. Likewise, teens should accept that their parents might not trust them; therefore, teens should do things without being asked and be open with their parents if they wish to gain trust. The suggestions for teens to carry out in lessons about healthy families – make spending time with family a priority over spending time with friends, tell parents that they appreciate everything that their parents do for them – read more like a wish list of the textbooks' authors rather than information about parent-child relations.

By stressing the wisdom and guidance of parents, the textbooks seem to be ignoring that some parents are not very good role models. Parents who take a "do as I say, not as I do" approach to childrearing send mixed messages to their teens about acceptable behavior. For example, a teen who has grown up with a parent and a series of that parent's live-in partners may accuse their parent of hypocrisy if told he or she is to wait to live with someone until they are married. Furthermore, parents do not always explain the reasoning behind their decisions or share the thought process they go through in making one choice over another. Parents in textbooks are always forthcoming in their reasoning and thought processes and do not give "because I said so" as a response to inquiring teens.

Health and Wellness admits that on a continuum from completely dysfunctional to completely functional families, most families fall somewhere in the middle (135). However, the textbooks emphasize the characteristics of healthy, functional families. Healthy families are portrayed as the best and as what readers should strive to have with their families. Granted, textbooks also acknowledge that families will have challenges. Healthy, functional families overcome these challenges by using conflict resolution and communication skills that the teens can hone and use in their adult relationships. Unhealthy, dysfunctional families are addressed in the textbooks as well, but tend to be in a separate lesson or section of the textbook alongside information on abuse. Teens are directed to try to improve dysfunctional family relationships either on their own or in combination with other family members so that they can learn how to relate in responsible and healthful ways. The impetus is put on teens to recognize the characteristics of their dysfunctional family, such as alcoholism or gambling, and get help.

Ultimately, textbooks tell teens that they should strive for healthy families. As marriage is described as the cornerstone of the family unit, marital commitments should also be a goal for readers of these textbooks. The textbooks in this study promote the traditional family by stressing that marriage is a serious, lifelong commitment, and that sex is a procreative activity only acceptable within the context of a monogamous marital relationship.

Denial of Demographic Realities

The textbooks demonstrate a denial of demographic realities in the United States. The lived experiences of many readers are unlikely to match the experiences described

in the textbook. The textbooks operate under the assumptions that people do not cohabitate before marriage and that people get married before they have children. This is not the case for many adult couples. Cohabitation has become common among all socioeconomic classes and is now a significant context for childbearing and childrearing (Cherlin 2010). In fact, the majority of marriages and remarriages start as cohabiting relationships and most young men and women cohabit at some point in their lives (Smock 2000). That only one textbook in my sample mentions cohabitation is a disservice to students, most of whom will likely experience cohabiting with a partner. Until the fall of 2014 in many states, cohabitation was the only form of partnership available to lesbian women and gay men. Furthermore, cohabitation does not mean that individuals do not strongly believe in the institution of marriage. As Edin and Kefalas (2005) found in *Promises I Can Keep*, the path to marriage for women from lower-class and poor classes is not the same as those in the middle-class; despite their fervent belief in the institution of marriage, they are neither willing to forego having children nor commit to marriage without financial stability.

The second demographic reality denied is the rising number of single individuals, especially among those classified as in the emerging adulthood stage of the life course. Nearly fifty percent of American adults are single, and people who live alone compose twenty-eight percent of all U.S. households (Klienenberg 2012). The fastest growing segment of unmarried and unpartnered adults who are heading their own households is the eighteen to thirty-four year-old category. As stated previously in this study, those in the emerging adulthood stage are likely to explore different life

directions and seek risky experiences possibly because they are less likely to be monitored by parents or constrained by the responsibilities of marriage or childrearing.

The third demographic reality denied by most of the textbooks is the existence of lesbian, gay, bisexual, and transgender people. Even if discussion were limited to same-sex couples, that would at least be acknowledging that such couplings happen. It would require that textbooks broaden their definition of sexual intercourse beyond being the act of procreation. If textbooks were to discuss safe sex practices, they would have to consider a range of ways to have sex and protective methods. Abstinence until marriage is the default message for all who wish to be sexually active. As same-sex couples could not get married in the majority of states until the fall of 2014, the implication in these textbooks published prior to 2014 was that lesbian women and gay men would just remain abstinent and their need for information specific to their sexual health was moot. Furthermore, transgender individuals are completely ignored.

The last demographic reality that textbooks ignore is the incidence of divorce and remarriage. Although the textbooks include information on how teens can handle their parents' divorce and remarriage, they do not indicate how common divorce and remarriage are in the United States. Over 20 percent of married couples separate or divorce within five years of marriage and, of those whose relationship began with cohabiting, over 50 percent end their relationship within five years regardless of whether or not they married (Cherlin 2010). The propensity for a child to live with both parents has fallen for a number of reasons, including the high levels of divorce, the dissolution of cohabiting relationships, and the increase of childbearing among unpartnered adults. In other words, children are likely to have a parent living elsewhere.

Cherlin (2010) points out that children are likely to experience multiple partnerships of their parents while they are growing up. Parents may cohabit and/or marry new partners who may have their own children. Stepfamilies remain an “incompletely institutionalized” group, and textbooks do not alleviate such uncertainty about, for example, the roles of stepparents, stepchildren, and stepsiblings (Sweeney 2010). Textbooks stress the lifelong-nature and permanence of marriage; however, divorce and remarriage are real possibilities that textbook readers may experience themselves.

Teens Are Impulsive

As exemplified in the chapter on distrust of teens’ decision making, the textbooks promote the assumption that teens are impulsive. Teens’ sexual impulses are assumed to be overpowering and difficult to control. Textbooks attempt to instill self-regulation through lessons on decision-making and refusal skills as well as carefully limiting their access to information about contraceptive methods.

In lessons about decision-making, teens are cautioned in the textbooks to seriously consider the consequences of their actions, especially in regard to sex. The textbooks offer alternative activities for teens to engage in so that they do not give in to their hormonal urges. Practicing refusal skills, such as repeating the reasons why they are abstinent, is also strongly recommended by the textbooks. In *Health: Making Life Choices*, a graphic of a stop sign accompanies the steps for how to remain abstinent. When teens are feeling internal or external pressure to have sex, they are to remember those steps – Stop, Think, Other activities, and Plan - and the stop sign. Many of the refusal skills and reasons for being abstinent have to do with the physical and psychological dangers of sexual activity. Sex is constructed as such a risky act that

giving in to one’s impulses before marriage is akin to drinking alcohol or doing drugs – other behaviors that teens are to abstain from doing.

While teens might not make the best decisions and maturity may be an issue, I argue that the textbooks are not giving them all of the details they need in order to make informed, responsible decisions. Giving teens various acronyms to help them remember how to make responsible decisions may not be the most effective life tool. Likewise, foregoing instruction on contraceptives and strongly emphasizing that abstinence is the best, only, most effective, 100 percent guaranteed way to avoid STIs and unplanned pregnancy is not preparing teens for decision-making in their adult sex lives.

Conflation of Sex with Morality

Each of the textbooks in my study contains a conflation of sex with morality. Although the textbooks do not refer to saving oneself for marriage as maintaining virginity, the idea of staying abstinent until marriage in order to make sex within marriage special is, I argue, implicitly the same message. Thus, sexual purity is something to be treasured and highly valued because it indicates that a person has been good, obedient, and moral. In contrast, having sex before marriage is something that brings a person’s values and character into question. A person who has had sex prior to marriage does not adhere to healthful family values and does not appreciate the importance of delayed gratification. According to the textbooks, not only is this person not being responsible by exposing themselves to myriad risks, they are also going to be filled with shame, guilt, and regret as a result of their behavior. Ultimately, to be abstinent until marriage – especially if one’s partner has also been abstinent – is to

belong to an exclusive group that is, by virtue of the conflation of sex with morality, better than everyone else.

Furthermore, readers are told that having sex before marriage will disappoint their parents. According to most of the textbooks, one of the key lessons parents are meant to impart to their children is the importance of waiting until marriage to have sex. Sex before marriage is considered bad; there is no distinction between those who voluntarily chose to have sex and those who were forced or coerced into having sex. By setting dating guidelines for their teen, parents are trying to create rules about acceptable behavior to be followed, not obstacles to be circumvented. Dating guidelines may also serve to help parents believe they are protecting their teen from rape and sexual assault. Parents want their children to be good, and to be good is to not have sex. The disappointment of one's parents is supposed to carry more weight for the teen than the sexual frustrations he or she might feel or the potential displeasure of his or her partner. However, there are limits to how long parents and their potential disappointment will hold teens back. As teens enter adulthood and parents' all-encompassing influence is lessened, their feelings may hold less sway.

Some of the textbooks mention a consequence of having sex before marriage is a ruined reputation among peers; however, textbooks do not mention that gossip about how a teen is "frigid," a "prude," a "tease," or could not "get it up" can also be damaging to one's reputation. Although the peers a teen chooses to surround herself or himself with and the people she or he chooses to date may shelter them from such comments, teens are still subject to criticism whether or not they have sex. Abstinent men may be ridiculed for being virgins, whereas women's promiscuity may be a source

of criticism. Abstinent women may be called “goody-goodies” and promiscuous men might be called “man whores.” In other words, although the textbooks associate abstinence with goodness and an unsullied reputation, peers do not necessarily hold the same standards.

Encourage Stigmatization of the Sexually Active

Through each of the textbooks, those who have been or are sexually active are implicitly stigmatized. Sexually permissive individuals are at a higher risk of social rejection and aggression from their peers, even those who are sexually permissive themselves (Vrangalova, Bukberg, and Rieger 2014).[22] Although teens cannot always choose their peers, research shows that people tend to associate with those similar to themselves with respect to a wide range of demographic, institutional, cultural, behavioral, and attitudinal factors (McPherson, Smith-Lovin and Cook 2001; Smith, McPherson, and Smith-Lovin 2014). Textbook readers are told that one way they can preserve their status as sexually abstinent is to spend time with good, responsible peers. These peers should also be abstinent and support each other’s decision to be abstinent; peers who are sexually active are deviants to be avoided. The exclusivity associated with one’s status as abstinent must be maintained. People who are sexually active are portrayed as putting pressure on abstinent classmates to have sex or engage in high-risk behaviors. They are also depicted as making fun of those who are abstinent, thus requiring the abstinent to develop many responses to ridicule that point out how sex is risky and should be saved until marriage. However, as research has shown, the extent to which this pressure and ridicule occurs is unclear and the sexually active feel more

[22] Vrangalova, Bukberg, and Rieger (2014) define sexual permissiveness as attitudes or behaviors that are more liberal than what is normal in a social group, including actual or desired frequent, premarital, casual, or group sex, early sexual debut, or nonverbal cues (like clothing) signaling availability.

pressure to have sex than those who are not sexually active (Kaiser Family Foundation 2003).

The textbooks also imply that living with a sexually transmitted infection is extremely traumatic and shameful. Sexually transmitted infections are portrayed as scary diseases, many of which are asymptomatic. Readers are informed that STIs can lead to infertility, cancer, psychological distress, serious damage to internal organs, and babies with birth defects. That many of those possible long-term effects are in people who have delayed or not received treatment is glossed over. The numbers about the incidence of sexually transmitted infections are meant to scare teens into being abstinent, not to reassure them that they are not alone in their diagnosis. I am not arguing that the spread of STIs among teens and young adults is not problematic; however, since most of the textbooks do not inform readers on how to prevent STIs aside from abstinence, students may be primed for failure. Of note, many of the textbooks mention that STIs often go undiagnosed and untreated because some people are too embarrassed or fearful to seek help.[23] Given the stigma surrounding STIs that textbooks are complicit in encouraging, such reluctance to seek diagnosis and treatment is not surprising.

HIV and AIDS carry a stigma on their own, but textbooks encourage further stigmatization and exclusion. In *Prentice Hall Health*, the sole mention to condoms is made in reference to HIV and AIDS, thus implying that preventing HIV and AIDS is condoms' only use. In all the textbooks, readers are informed about the ways in which HIV is spread, the symptoms of HIV, and how to protect themselves from HIV

[23] The Center for Disease Control seem to confirm this reasoning, pointing out that adolescents and young adults face many barriers to accessing quality STI prevention services, such as "lack of health insurance or the ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality" (2013: 59).

infection. One suggestion made by textbooks is for students to know whether the people in their lives are HIV-positive. In *Essentials of Health and Wellness*, students are told the story of Ryan White, a hemophiliac who contracted HIV from a blood transfusion in the 1980s and who died at age 18 after living with AIDS for 5 years. Discrimination against Ryan at school led Congress to create the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. Readers of the textbook are encouraged to ask their parents if they feel the infected student should have a right to attend school. *Health: Making Life Choices* has quotes from teens responding to the question, "Would your behavior toward a classmate change if that person contracted AIDS?" (442). The students admit that, while they would try not to behave any differently toward their classmate, they would likely act differently around them. One student mentions that their behavior would depend on how their classmate had contracted the virus. Another student says that if the infected classmate were to cut himself or herself, they would be made very uncomfortable.

Although all of the textbooks state that people with HIV have relatively normal lives, those lives apparently do not include a right to privacy or choice about disclosure. Thus, textbooks further stigmatize those who have HIV or AIDS. People who are perceived to have AIDS or HIV, and the individuals with which those people are associated, are often subject to prejudice, discounting, discrediting, and discrimination (Herek 1999). The textbooks seem to emphasize two of the characteristics associated with AIDS that are likely to evoke stigma: responsibility and fear of contagion (Herek 1999; Goffman 1963). Stigma is attached to HIV and AIDS because its cause is perceived to be the bearer's responsibility. Stigma is also associated with conditions

perceived to be contagious and place others in harm's way. The above examples from *Health: Making Life Choices* demonstrate how textbooks may be adding to, rather than lessening, HIV and AIDS-related stigma.

Sex Negativity

In all of the textbooks, the discourse is sex negative as opposed to sex positive. Negative discourse abounds in textbooks' lessons about sex. The definitions of sex found in the textbook are, by virtue of their focus on procreation, essentialist. Sex before marriage is construed as a source of danger ranging from unwanted pregnancy and disease to moral corruption and social ostracism. Teens are to avoid sex and, if pressured, insist that "no means no." Those who have sex no longer belong to the exclusive, morally upstanding group of the sexually abstinent. Sex is not acknowledged as an act that can be pleasurable, nor is affirmative consent addressed.

Sex positivity, on the other hand, views consensual sex as healthy and pleasurable. The core of sex positivity is affirmative consent, or "yes means yes." In other words, instead of depending on one partner to stop the act using verbal or nonverbal behavior, affirmative consent requires both partners to be actively and enthusiastically involved. Sex is not portrayed as dangerous, shameful, or disgusting, nor is there a "normal" way to have it. Furthermore, sexual intercourse is not defined exclusively in terms of procreation and essentialism; there are many sexualities and ways to have sexual intercourse. Although pleasure is a focus in sex positivity, the risks of sex are also acknowledged to allow individuals to make informed decisions about their sexual activity. By accentuating only the negative aspects of sex, from the risks to

“no means no,” the textbooks miss the opportunity to show that sex can be safe and pleasurable.

The strong emphasis on abstinence and the portrayal of sex as a dangerous act can also make sex as an adult difficult for those who did wait until marriage. People are not provided with the tools necessary to view sex as healthy when they are ready to have it. The only tool most of the textbooks provide teen readers with is that of self-control. Students are taught that they can control their sexual impulses through responsible decision-making and utilizing refusal skills. Within the safe context of marriage, the negative aspects of sex are no longer to be a concern and the sense of control should be lessened or relinquished. Marital sex is meant to be special; however, since most textbooks do not link sex and pleasure, people are not prompted to discuss satisfaction or dissatisfaction with their partners.

The Theory of Patronizing Exclusivism

In the six textbooks studied, the feature of sex negativity – the last common characteristic identified – serves as the base from which a theory of patronizing exclusivism can be developed. Sex negativity connects and makes sense of the five other features. All of the textbooks depict sexual activity as a high-risk behavior that should be exclusive to married couples. By stressing abstinence through implicit and explicit messages, the textbooks are able to give some information about sexual health without endorsing teen sexual activity.

A strategy of sex negativity helps textbooks promote abstinence until marriage and aligns with the idea that marriage is the cornerstone of the healthy family unit. Textbooks are demonstrably patronizing in how they encourage readers to seek out the

advice of their parents and to follow their parents' rules and guidelines, especially in regard to dating. After a suitable period of dating, couples may get married and have sex; having sex outside of the context of a mutually monogamous, faithful marriage is against the expected standard of sexual activity. In stressing the importance of marriage, however, textbooks deny many demographic realities, such as the increase in cohabiting couples, the increase in unmarried, unpartnered single adults, the existence of same-sex couples, and the incidence of divorce and remarriage.

Sex negativity also serves an important function in the assumption that teens are impulsive. Lessons on decision-making and refusal skills are shared within the textbooks, while access to information about contraceptives is carefully limited. In this way, textbooks are patronizingly attempting to teach teens self-control and self-regulation. Teens must not let their sexual urges overpower their knowledge of the risks of sex and forego their commitment to abstinence. By maintaining sex negativity, textbooks also conflate sex with morality – abstaining from sex is the moral thing to do. Therefore, if people are not abstinent until marriage, they are considered immoral and without healthful family values. By choosing to abstain from sex until marriage, teens can join an exclusive group that, due to the conflation of sex and morality, is perceived as better than those who have been or are sexually active. Thus, from the association of immorality and sexual activity comes the stigmatization of the sexually active. Teens that have been or are sexually active are told to avoid those who engage in high-risk behaviors such as sex. Teens who are victims of sexual violence may be further stigmatized, as their potential conflict over involuntarily having sex is unaddressed. Teens who are lesbian, gay, or bisexual are assumed not to have sex at all since they are

virtually ignored in the textbooks. Transgender people are ignored entirely. Sexually transmitted infections are portrayed as scary and embarrassing threats and people with HIV or AIDS are deviants who should not be allowed to hide their status. Thus, sex negativity enables messages about abstinence to shame those who have had or are having sex before marriage. Textbooks encourage not only the exclusivity of the abstinent, but also the exclusion of the sexually active.

The theory of patronizing exclusivism developed from the six textbooks, then, identifies six primary features: perpetuation of the stereotypical ideal family, denial of demographic realities, assumption that teens are impulsive, conflation of sex with morality, encouragement of stigma of the sexually active, and promotion of sex negativity.[24] Promotion of sex negativity is the root strategy and facilitates the implicit and explicit messages about abstinence in high school health textbooks. Ultimately, patronizing exclusivism advocates a certain lifestyle, dictating how one should behave, from how to make decisions to how to refuse to participate in behavior that is counter to the lifestyle. In this case, the lifestyle is abstinence. By following this abstinent lifestyle and conforming to the norms and rules laid out within the text, readers can be part of an exclusive group. This group, by virtue of having chosen abstinence, is considered good and moral. Textbooks encourage readers to become part of this exclusive group. Parents, according to the textbooks, want their children to be a part of this exclusive group. Members of the group need to support each other, help each other control their sexual impulses by seeking alternative activities, and avoid non-group members. Thus, those who have had sex are, in essence, tainted and are excluded. Sex is a highly risky activity

[24] See Figure 3 for a diagram of theory of patronizing exclusivism.

with many negative consequences. Textbooks encourage readers who have had sex to choose abstinence again and come up with other plans, like eating ice cream, rather than having sex. Patronizing exclusivism uses sex negativity as a means of separating teens into those who are obedient and abstinent and those who are risky and sexually active.

Strengths of the Study

There are several strengths of this study. My study is the first content analysis of high school health textbooks conducted with a sociological lens. Sociologists have not conducted an examination of the ways in which abstinence is addressed in high school health textbooks, nor, to my knowledge, has such a study been published in another field.

In addition, this study not only recognizes the issues within the textbooks, but also addresses the issues ignored by the textbooks. When textbooks ignore issues, I feel that this makes students less likely to take lessons seriously and/or ignore the information. In other words, when students do not see themselves or their concerns in a textbook, they may think that the information does not apply to them at all.

This study's findings may be of interest to a wide range of groups, from sociologists and educators to parents and health advocates. When I have told people about this study, they always express interest in the topic and tend to tell me what their sex education experience (if any) was like. Many of those I have spoken with express frustration with the promotion of abstinence in education as well as the dearth of information about contraceptives. In other words, I believe the definite interest in this topic is a strength of the study.

Last, this study can contribute to literature on sex education and help impact policy about how sex education should be taught and what should be included. Government policies influence the content of high school health textbooks by tying funding to promotion of abstinence. Legislators must be made aware of how their decisions impact not only institutions like Planned Parenthood, but also the textbooks their constituents use. Policies that have trickled down to effect textbook content do not alleviate the state of America's sexual illiteracy.

Limitations of the Study

There are several limitations to this study, most of which pertain to the actual use of the textbooks. First, I have assumed that the textbooks are used in the classroom as a part of the health course curriculum. Actual use of the textbooks in the classroom may vary from school district to school district as well as from classroom to classroom. All of the textbooks in my sample are adopted by at least one state with statewide textbook adoption. Furthermore, an inquiry of school districts across states without statewide adoption revealed that each textbook is being assigned nationwide. Textbook companies consider adoption rates and sales figures to be trade secrets and I was unable to obtain this information (Loewen 1995). An additional consideration is that school districts may use different editions of textbooks, such as older editions rather than the most recent versions that I used. Students may learn the information from these textbooks though the books may be, by virtue of their age, difficult for the teens to relate to their lives. In the case of states with statewide adoption, textbooks are chosen on a five to seven year cycle; however, budget limitations may force a state to postpone new textbook adoptions for another year.

Another limitation of my study is that it analyzes the formal curriculum rather than the hidden curriculum. As Fields (2008) points out, there is a difference between the formal curriculum – a planned course of study that educational institutions use to transmit a body of knowledge – and the hidden curriculum – the non-sanctioned lessons that emerge through the process of learning and the delivery of formal materials. Teachers may provide information about contraceptive methods that the textbooks do not have or they may supplement information from the textbook with a presentation from a Planned Parenthood educator.[25]

My conclusion also might have been expanded had I included the supplemental materials, such as *Glencoe Health's Human Sexuality* booklet, that some school districts may use to teach abstinence. Some school districts, such as those in California and New York, have specific sex education programs they use in high school classrooms. Other school districts use online textbooks. I did not use such sources in the formulation of my theory of patronizing exclusivism content in high school health textbooks. In some cases, my status as a university instructor and not a high school teacher or administrator or parent of a high school student precluded my access to resources. For example, purchase of California's Positive Prevention curriculum must be done by an agency such as a school district and it comes with the stipulation that it can only be used under certain circumstances.

One possible limitation of my study does not pertain to the data as much as it does to me as the researcher. My background is not in health or education, two of the fields in which high school health textbooks are naturally situated. However, while my

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[25] Planned Parenthood (2014) has dedicated health educators that work with community groups, youth groups, faith based organizations, human services departments, schools, and individuals. They provide age-appropriate information on a variety of sexual health-related topics.

lack of background could be viewed as a limitation, it could also be seen as advantageous by allowing for sociological insight into the content of the textbooks.

Suggestions for Future Research

The limitations of this study provide some threads from which future studies may be woven. First, the textbooks in my study provided the beginnings of a theory of patronizing exclusivism that is articulated through implicit and explicit messages in the textbooks. More information about the usage of high school health textbooks in the classroom is needed in order to demonstrate that the textbooks are getting assigned to students, not just adopted by school districts or states. A survey of high school health teachers could be conducted to ask not only what textbook is assigned, but also whether they frequently use the textbook in their teaching. Attempting to obtain sales information from textbook publishers does not seem to be a fruitful avenue for future research.

From the theory of patronizing exclusivism derived from the textbooks, a second thread of inquiry needed is to test the theory on the alternative and supplemental materials used in sex education. For example, the booklets on human sexuality that accompany some of the textbooks, online textbooks, curriculum designed for home schooled students, abstinence-promoting school presentations, and sex education curriculum used in California and New York might be analyzed to discover whether the theory articulated in this study is evident in those as well. A third area of inquiry would analyze middle school health textbooks; however, it is not clear how many school districts have health classes in middle school.

A fourth area of future inquiry is a re-examination of future editions of textbooks to see how they address contemporary technology such as sexting and sending nude selfies. It will be interesting to see how those issues will be handled since they do not directly involve sexual intercourse and the threats of unwanted pregnancy and STIs are removed. Thus, one future study might investigate if textbook messages indicate that actions using contemporary technology carry the same stigma as having had sex. Furthermore, marriage equality and emerging support of lesbian, gay, bisexual, and transgender teens in society may be reflected in future textbooks. Thus, another study may examine the placement of topics relating to lesbian, gay, bisexual, and transgender individuals and whether such placement reinforces negative stereotypes or marginalizes lesbian, gay, bisexual, and transgender people.

A fifth area of inquiry might explore how students from different racial-ethnic, class, and religious backgrounds, students who are lesbian, gay, bisexual, and transgender, and students who have been victims of sexual assault interpret the messages in high school health textbooks. Because the health textbooks in this study were found to promote a white, middle-class, heterosexual, cisgender point-of-view, future studies could explore how individuals feel about their apparent exclusion from textbooks and whether that leads them to dismiss the textbooks as a whole.

An additional area of inquiry could examine the backgrounds of the textbook authors.[26] Textbooks are cultural artifacts and reflect the biases of their creators. Although we know some things about the textbook authors from information found

[26] See Table 7 for information I could find on the textbook authors. Only Cengage Learning provided an author biography on the textbook's webpage.

online, we do not know what epistemological biases may have guided their writing and reasoning.

A final thread of inquiry could involve designing a study in which the six textbooks are used across six different high school health classes. A study of this nature could have a pre-test and post-test to discover whether the students' attitudes about abstinence and/or commitment to abstinence change as a result of messages imparted in the textbooks. This would also provide an opportunity to compare the formal and hidden sex education curriculums in the high school health classroom.

Concluding Remarks

Through framing sex education in this study, I have developed a theory of patronizing exclusivism to understand how sex education is currently framed in American high school health textbooks, I have made a valuable contribution to dialogue about how sex education should be taught and what should be included. My theory of patronizing exclusivism developed in this analysis of high school health textbooks uses sex negativity to promote the idea that abstinent teens are a special group that is more obedient, good, and moral compared to their peers who have had sex. Textbooks associate choosing abstinence with healthy, satisfied lives and, in doing so, ignore the diversity not only of the student population, but of the paths that teens' lives will take after high school into adulthood. Abstinence-only sex education as exemplified in high school health textbooks does not adequately prepare individuals to navigate their sex lives as adults. Understanding the implicit and explicit messages about abstinence found in high school health textbooks illuminates why sex negative attitudes persist and why some Americans are sexually illiterate. Based upon my research, these books should be

revised so that they are relevant in framing sexuality and relationship formation in a 21st century context. Until then, we will continue to live in a sexually illiterate society and our textbooks will not help solve that problem.

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Appendix A: Sex Ed Content in Sample

Essentials of Health and Wellness (2005)		
Section	Unit	Unit-Chapter
Understanding Growth and Development	Personal Health	2 – 7
Healthy Relationships at Home	Social Health	5 – 16
Healthy Peer Relationships		5 – 17
Resolving Conflict		5 – 18
Healthy Romantic Relationships		5 – 19
Infectious Diseases	The Greatest Risks to Health and Wellness	6 – 23
Stressors of Adulthood	Healthy Adulthood	8 – 28
The Healthy Family		8 – 29
Contributing to a Healthy Community		8 – 30

Glencoe Health (2011)		
Section	Unit	Unit-Chapter
Foundations of a Healthy Relationship	Skills for Healthy Relationships	3 – 6
Respecting Yourself and Others		
Communicating Effectively		
Healthy Family Relationships	Family Relationships	3 – 7
Strengthening Family Relationships		
Help for Families		
Safe and Healthy Friendships	Peer Relationships	3 – 8
Peer Pressure and Refusal Skills		
Practicing Abstinence		
Male Reproductive System	Endocrine and Reproductive Health	5 – 16
Female Reproductive System		
Prenatal Development and Care	Beginning of Life Cycle	6 – 17
Birth Through Childhood		
Changes During Adolescence	The Life Cycle Continues	6 – 18
Adulthood, Marriage, and Parenthood		
Health Through the Life Cycle		
Sexually Transmitted Diseases	Sexually Transmitted Diseases & HIV/AIDS	8 – 24
Preventing and Treating STDs		
HIV/AIDS		
Preventing and Treating HIV/AIDS		

Health: Making Life Choices – Glencoe (2010)		
Section	Unit	Unit-Chapter
Making Decisions and Solving Problems	Emotional Health	1 – 2
Your Changing Personality		1 – 3
Sexually Transmitted Diseases	Disease Prevention	5 – 16
Dating, Commitment, and Marriage	The Life Cycle	6 – 18
Family Life		6 – 19
From Conception through Parenting		6 – 20
Understanding Sexuality		6 – 21
Preventing Pregnancy and STDs		6 – 22

Health and Wellness – Glencoe (2008)		
Section	Unit	Unit-Lesson
Developing Healthful Family Relationships	Family and Social Health	3 - 13
Adjusting to Family Changes		3 - 14
Examining Dating and Friendships		3 - 15
Practicing Abstinence from Sex		3 - 16
Recognizing Harmful Relationships		3 - 17
Preparing for Marriage and Parenthood		3 - 18
Learning about Reproductive Systems	Growth and Development	4 - 20
Using Communication Skills	Health Skills	5 - 6
Reducing the Risk of STDs and HIV	Communicable and Chronic Diseases	8 - 46
Protecting Yourself from Sexual Violence	Injury Prevention and Personal Safety	11 - 66

Lifetime Health – Holt, Rinehart and Winston (2009)		
Section	Unit	Unit-Chapter
Making GREAT Decisions	Skills for a Healthy Life	1 – 2
Resisting Pressure from Others		
Sexual Abuse and Violence	Preventing Violence and Abuse	1 - 5
Marriage	Marriage, Parenthood, and Families	4 - 17
Parenthood		
Families		
Male Reproductive System	Reproduction, Pregnancy, and Development	6 - 18
Female Reproductive System		

Lifetime Health – Holt, Rinehart and Winston (2009) - continued		
Section	Unit	Unit-Chapter
Responsible Relationships	Building Responsible Relationships	6 - 19
Benefits of Abstinence		
Coping with Pressures		
What are the Risks?	Risks of Adolescent Sexual Activity	6 - 20
What are Sexually Transmitted Diseases?		
Common STDs		
HIV and AIDS Today	HIV and AIDS	6 - 21
Understanding HIV and AIDS		
Protecting Yourself from HIV and AIDS		

Prentice Hall Health (2010)		
Section	Unit	Unit-Chapter
The DECIDE Process	Making Healthy Decisions	1 - 1
Families Today	Family Relationships	2 – 5
Family Problems		
Keeping the Family Healthy		
Skills for Healthy Relationships	Building Healthy Peer Relationships	2 – 6
Friendships		
Responsible Relationship		
Choosing Abstinence		
Developing Refusal Skills		
Male Reproductive System	Reproduction and Heredity	6 – 18
Female Reproductive System		
Development Before Birth	Pregnancy, Birth, and Childhood	6 – 19
A Healthy Pregnancy		
Childbirth		
Adolescence: A Time of Change	Adolescence and Adulthood	6 – 20
Adolescence and Responsibility		
Adulthood and Marriage		
The Risks of Sexual Activity	Sexually Transmitted Infections and AIDS	7 – 22
Kinds of STIs		
HIV and AIDS		
Protecting Yourself from HIV and AIDS		

Appendix B: Decision-Making Models

Essentials of Health and Wellness – IDEAL Problem Solving Strategy (p. 53-55)
Identify the problem **D**escribe possible solutions **E**valuate each solution and reach a decision on which one to use **A**ct on a chosen solution **L**earn
Glencoe Health – Decision-Making Steps (p. 42)
1. State the situation 2. List the options 3. Weigh the possible outcomes 4. Consider values 5. Make a decision and act on it 6. Evaluate the decision
Health: Making Life Choices – HELP Strategy (p. 41)
Healthful. Does this choice present any health risks? **E**thical. Does this choice reflect your personal values? **L**egal. Does this choice violate local, state, or federal laws? **P**arent approval. Would this choice be approved by your parents or guardians?
Health and Wellness – Responsible Decision Making Model (p. 61)
1. Describe the situation that requires a decision 2. List the possible decisions you might make 3. Share the list of possible decisions with a parent, guardian, or other responsible adult 4. Use six questions to evaluate the possible consequences of each decision: - Will this decision result in actions that promote health? - Will this decision result in actions that protect safety? - Will this decision result in actions that follow laws? - Will this decision result in actions that show respect for myself and others? - Will this decision result in actions that follow the guidelines of my parents and of other responsible adults? - Will this decision result in actions that demonstrate good character? 5. Decide on which decision is most responsible and appropriate 6. Act on your decision and evaluate the results
Lifetime Health – GREAT Decisions Model (p. 30-31)
Give thought to the problem **R**eview your choices **E**valuate the consequences of each choice **A**ssess and choose the best choice **T**hink it over afterward
Prentice Hall Health – DECIDE Process (p. 16-17)
Define the problem **E**xplore the alternatives **C**onsider the consequences **I**dentify your values **D**ecide and act **E**valuate the results

Appendix C: Refusal Skills Steps

Essentials of Health and Wellness (p. 325)
1. Ask questions.
2. Name the problem.
3. Identify the consequences.
4. Suggest alternatives.
5. Leave. If the person persists, leave.
Glencoe Health (p. 666)
1. Say no in a firm voice.
2. Explain why you are refusing.
3. Suggest alternatives to the proposed activity.
4. Back up your words with body language.
5. Leave if necessary.
Health: Making Life Choices (p. 72)
1. Sort out feelings and identify them accurately.
2. Judge persuasion tactics against your beliefs and values.
3. Use effective communication skills to turn them to your way of thinking.
4. Be assertive.
5. Take wise actions such as walking away.
6. Ask for help from parents or school authorities if someone suggests something dangerous or illegal.
Health and Wellness (p. 171)
1. Say “no” with self-confidence.
2. Give reasons for saying “no.”
3. Repeat your “no” response several times and use nonverbal behavior to match verbal behavior.
4. Avoid people who make wrong decisions, resist pressure to engage in illegal behavior, and influence others to make responsible decisions.
Lifetime Health (p. 466)
1. Clearly identify the problem.
2. State your thoughts and feelings about the problem.
3. State what you would like to have happen instead.
4. Explain the results if the change in plans is made.
5. Explain the results if the requested change in plans is not made.
Prentice Hall Health (p. 379)
1. Give a reason for your refusal.
2. Use body language to reinforce what you say.
3. Show your concern for others.
4. Provide alternatives.
5. Take a definite action.

Appendix D: Tables and Figures

Table 1. Approaches to Sex Education

Abstinence-Only Until Marriage Programs	Teaches abstinence until marriage is the only option for teenagers. Proponents of abstinence-only education argue against any discussion about contraception and safer sex. Marriage is the only benchmark at which abstinence can safely end and a healthy sexual relationship can begin. (Kaiser Family Foundation 2003; Koller 2012) See also: Title V, Section 510 A-H Guidelines in Table 2.
Comprehensive Sex Education	Includes information about both abstinence and contraception. Although abstinence is taught as the preferred choice, information about birth control and disease prevention is provided. (Kaiser Family Foundation 2003)

Table 2. Definition of Abstinence-Only Education under Section 510 of the Social Security Act

Under Section 510, abstinence education is defined as an educational or motivational program that: (A) has as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity; (B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children; (C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, STDs and other associated health problems; (D) teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity; (E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects; (F) teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society; (G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and (H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

United States Code Service, Title V, Section 510 (b)(2)(A-H) of the Social Security Act (P.L.104-193).

Table 3. Texas Education Code Regarding Sex Education Materials

Any course materials and instruction relating to human sexuality, sexually transmitted diseases, or human immunodeficiency virus or acquired immunodeficiency syndrome shall be selected by the board of trustees with the advice of the local school health advisory council and must:

(1) present abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried persons of school age;

(2) devote more attention to abstinence from sexual activity than to any other behavior;

(3) emphasize that abstinence from sexual activity, if used consistently and correctly, is the only method 100 percent effective in preventing pregnancy, sexually transmitted diseases, infection with human immunodeficiency virus or acquired immunodeficiency syndrome, and the emotional trauma associated with adolescent sexual activity;

(4) directs adolescents to a standard of behavior in which abstinence from sexual activity before marriage is the most effective way to prevent pregnancy, sexually transmitted diseases, an infection with human immunodeficiency virus or acquired immunodeficiency syndrome; and

(5) teach contraception and condom use in terms of human use reality rates instead of theoretical laboratory rates, if instruction on contraception and condoms is included in curriculum content.

Texas Education Code 28.004(e)

Table 4. High School Health Textbooks in This Study

Title	Author	Year	Publisher	ISBN
Essentials of Health and Wellness	Robinson and McCormick	2005	Cengage Learning	9781401815233
Health and Wellness	Meeks and Heit	2008	Glencoe (McGraw-Hill)	9780078760266
Lifetime Health	Friedman, Stine and Whalen	2009	Holt, Rinehart and Winston (Harcourt Education)	9780030962196
Prentice Hall Health	Pruitt, Allegrante, Prothrow-Smith	2010	Pearson	9780133672503
Health: Making Life Choices	Sizer-Webb and DeBruyne	2010	Glencoe (McGraw-Hill)	9780078800436
Glencoe Health	Bronson	2011	Glencoe (McGraw-Hill)	9780078913280

Table 5. State Adoption of Textbooks

Essentials of Health and Wellness	
Arkansas (2005)	
Michigan (2005)	
Texas (2005)	
Glencoe Health	
Arkansas (2007)	North Carolina (2009)
California (2005)	New Mexico (2011)
Florida (2007, 2014)	Oklahoma (2009)
Georgia*	Oregon (2007)
Idaho (2009)	South Carolina (2006)
Indiana*	Tennessee (2009)
Kentucky (2008)	Texas (2005)
Michigan (2011)	Utah (2011)
Mississippi+ (2004, 2009, 2011)	West Virginia (2005)
Nevada (2011)	
Health: Making Life Choices	
Idaho (2010)	
Health and Wellness	
Idaho (2008)	Oregon (2008)
Michigan (2008)	South Carolina (2006)
Mississippi+ (2008)	Tennessee (2008)
North Carolina (2008)	Texas (2005)
New Mexico (2008)	Utah (2008)
Lifetime Health	
Alabama (2009)	North Carolina (2009)
Arkansas (2007)	New Mexico (2009)
California (2008)	Oklahoma (2009)
Florida (2007)	Oregon (2007)
Georgia*	South Carolina (2006)
Idaho (2009)	Tennessee (2009)
Indiana*	Texas (2005)
Kentucky (2009)	Utah (2007)
Louisiana (2009)	West Virginia (2004)
Michigan (2007)	
Prentice Hall Health	
Arkansas (2007)	Mississippi+ (2007, 2010, 2014)
Florida (2007)	Nevada (2007, 2010)
Georgia*	North Carolina (2010)
Idaho (2010)	New Mexico (2007)
Indiana*	Oklahoma (2010)
Kentucky (2007)	Oregon (2007)
Louisiana (2010)	Tennessee (2010)
Michigan (2010)	Utah (2010)

The approved edition year is given in parentheses.
* = No edition year given
+ = Not officially adopted, but considered ancillary material

Table 6. Criteria for Grounded Theory Studies

Credibility
Has your research achieved intimate familiarity with the setting or topic?
Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data.
Have you made systematic comparisons between observations and between categories?
Do the categories cover a wide range of empirical observations?
Are there strong logical links between the gathered data and your argument and analysis?
Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and *agree* with your claims?
Originality
Are your categories fresh? Do they offer new insights?
Does your analysis provide a new conceptual rendering of the data?
What is the social and theoretical significance of this work?
How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?
Resonance
Do the categories portray the fullness of the studied experience?
Have you revealed both liminal and unstable taken-for-granted meanings?
Have you drawn links between larger collectives or institutions and individual lives, when the data so indicate?
Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?
Usefulness
Does your analysis offer interpretations that people can use in their everyday worlds?
Do your analytic categories suggest any generic processes?
If so, have you examined these generic processes for tacit implications?
Can the analysis spark further research in other substantive areas?
How does your work contribute to knowledge? How does it contribute to making a better world?

Source: Charmaz (2006), pg. 182-183

Table 7. About Authors of High School Health Textbooks

Essentials of Health and Wellness	
James Robinson III, Ed.D., FAAHE	Professor and graduate coordinator in the Department of Public Health Sciences at New Mexico State University.
Deborah J. McCormick, Ph.D.	Associate Clinical Professor in the Department of Health Sciences in the College of Health and Human Services at Northern Arizona University
Glencoe Health	
Mary H. Bronson, Ph.D.*	Information not found
Health: Making Life Choices	
Frances Sizer Webb, MS, RD, FADA*	Charter fellow of the American Dietetic Association and founding member of Nutrition and Health Associates
Linda Kelly DeBruyne, MS, RD*	Founding member of Nutrition and Health Associates
Health and Wellness	
Linda Meeks, Ph.D.	Associate Professor Emeritus in The Ohio State University College of Education and Human Ecology
Philip Heit, Ph.D.	Professor Emeritus of Physical Activity and Educational Services at The Ohio State University
Lifetime Health	
David P. Friedman, Ph.D.*	Professor in Department of Physiology and Pharmacology at Wake Forest School of Medicine
Curtis C. Stine, M.D.*	Associate Chair, Department of Family Medicine and Rural Health, Director of Clinical Programs, Curriculum Development, and Evaluation at Florida State University's College of Medicine
Shannon Whalen, Ph.D.*	Associate Professor in the Department of Health Education at Springfield College
Prentice Hall Health	
B.E. Pruitt, Ed.D.	Professor of Health Education in Department of Health and Kinesiology at Texas A&M University
John P. Allegrante, Ph.D.	Professor of Health Education in Teachers College at Columbia University and Adjunct Professor of Sociomedical Sciences at Columbia University's Mailman School of Public Health
Deborah Prothrow-Smith, M.D.	Consultant at Spencer Stuart; Adjunct Professor at Harvard School of Public Health

* = Names not on the book cover

Figure 1. Property Box in High School Health Textbooks

THIS BOOK IS THE PROPERTY OF:

STATE ____________________
PROVINCE ____________________
COUNTY ____________________
PARISH ____________________
SCHOOL DISTRICT ____________________
OTHER ____________________

Book No. __________
Enter information in spaces to the left as instructed

ISSUED TO	*Year Used*	*CONDITION*	
		ISSUED	*RETURNED*

PUPILS to whom this textbook is issued must not write on any page or mark any part of it in any way, consumable textbooks excepted.

1. Teachers should see that the pupil's name is clearly written in ink in the spaces above in every book issued.
2. The following terms should be used in recording the condition of the book: New; Good; Fair; Poor; Bad.

Figure 2. Diagram of The Grounded Theory Process

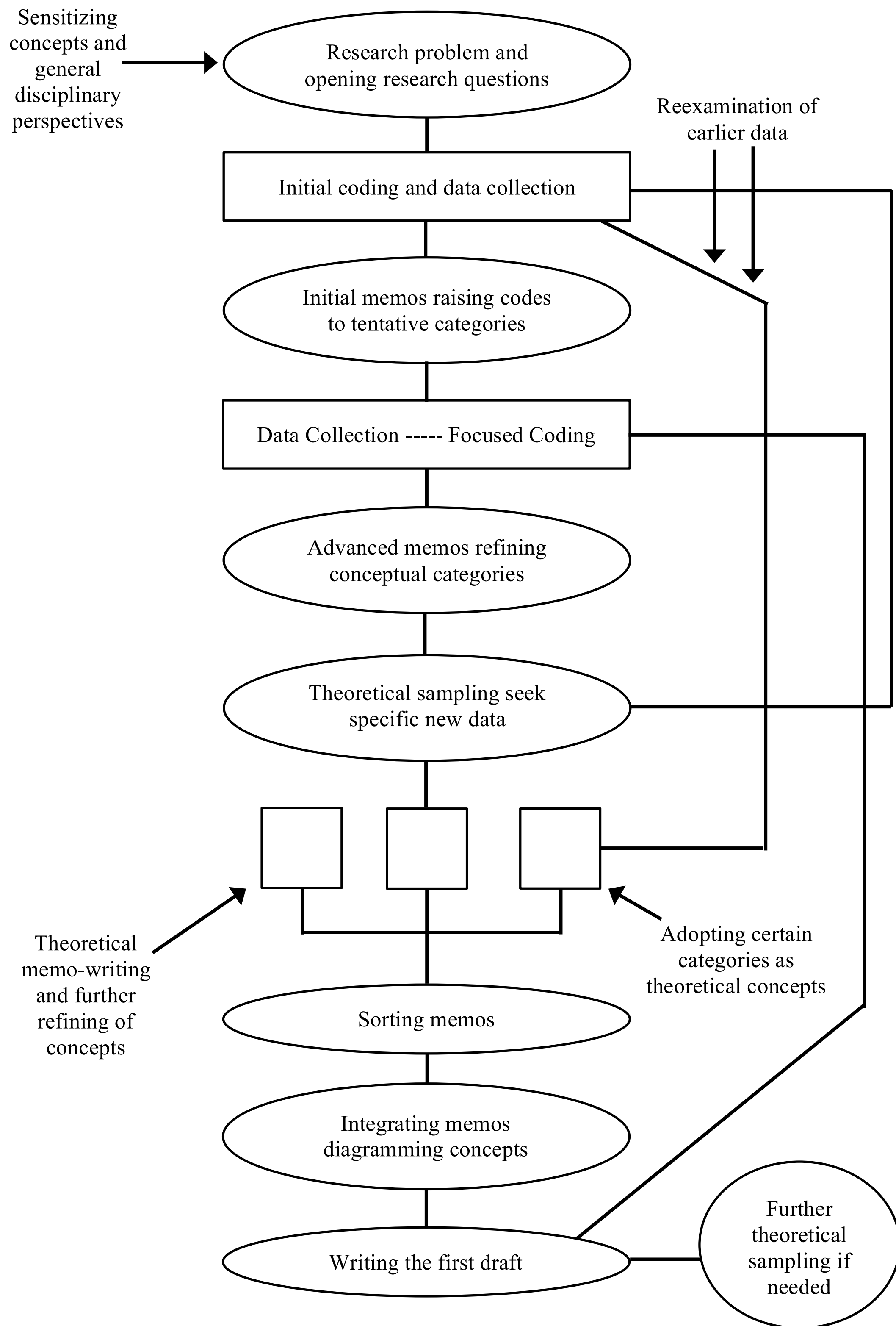

Figure adapted from Charmaz (2006: 11)

Figure 3. Diagram of Theory of Patronizing Exclusivism