UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

ADOLESCENTS AND COMMUNICATION REGARDING SAFER SEX BEHAVIOR

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

In partial fulfillment of the requirements for the

Degree of

Doctor of Philosophy

By

Kimberly Ann Parker

Norman, Oklahoma

2004

ADOLESCENTS AND COMMUNICATION REGARDING SAFER SEX BEHAVIOR

A Dissertation APPROVED FOR THE

DEPARTMENT OF COMMUNICATION

BY

Michael Pfau, Ph.D.

Terri DeBacker, Ph.D.

Edward Horowitz, Ph.D.

Amy Johnson, Ph.D.

Sandy Ragan, Ph.D.

ACKNOWLEDGEMENTS

This dissertation and all of my academic endeavors are the product of the love, support, care and commitment of many people. I appreciate my family, friends, colleagues, mentors and loved ones who helped me to follow my dreams and achieve my goals. My family has always been the most important aspect of my life and I owe them the greatest thanks.

First, I would like to thank my family for the years of love and support. You shaped me and helped me to grow into the woman that I am today and I am so proud to be part of such an incredible family. My family is a gift from God that I am thankful for everyday. Dad, you are the most amazing man I have ever known; I will always appreciate all the sacrifices you have made for me and I love you so much. I would like to dedicate this dissertation to Leath M. Parker, my father, and Asa and JoAnn Ikard, my grandparents, who I always considered my parents, also. I owe all of my accomplishments to the three of you for shaping me into the person that I am today; you always believed in me, supported me, loved me, and inspired me.

My brother, James Parker, is the one that convinced me to apply to OU; I would never even have considered finding a home in a Communication Department, if it were not for James's suggestion. We had lots of fun living next door to each other my first two years at OU and it is a time I will always cherish and never forget. I love you and admire you more than words can express. Many thanks to Rebecca Pasternik-Ikard, Aunt Becky, for being the first woman that I ever sought to emulate. I have always admired your intellect, drive and persistence in completing a goal. You are an amazing woman and I love you very much. Of course, I must thank my Uncle Jerry, UJ, for always bringing a

smile to my face throughout this process; you are the happiest person I know and that has always given me something to look forward to when I was discouraged. Thanks for always helping when I needed it and never letting a day pass without saying “I love you”.

I also appreciate the rest of the Brandon clan for their never ending support throughout this endeavor. I have so enjoyed my time at OU with my cousins, Lindsay, Brittany and Lacey. You are such special girls and I will miss seeing you often. Thanks to my Aunt Jill for being such a great friend and someone I can always count on for encouragement. My Grandmother’s sisters have always been a source of great support throughout my life, but I want to thank you so much for all the notes expressing your support, the prayers, the hugs and the calls encouraging me. I have always loved the four of you greatly, but that love has grown monumentally over the last couple of years. You are without a doubt the most incredible, faithful, intelligent, and loving women I have ever known; Ruby Brandon raised amazing girls!

I am also greatly appreciative of my academic advisor, Dr. Michael Pfau, for the countless hours spent investing in my education. Thank you for all you have taught me; I have learned so much from you regarding the communication discipline, research, writing, and the academic world. Thank you for spending time to help me prepare for my general exams and the countless hours spent editing and making suggestions for my dissertation. In particular, thank you for helping me secure an academic teaching position; you were a source of great support in terms of reading and editing my vitae and cover letters, preparing me for interviews and helping me weigh the options in terms of job opportunities. I appreciate the support and guidance you offered in shaping my academic career. Thank you for providing such great mentorship.

Dr. Ed Horowitz provided me with guidance, support, assistance and incredible friendship throughout my academic experience. I will never forget all the times you called to check on me throughout my Grandmother's illness; you went above and beyond the call of duty as a member of my committee and became my friend. I will always be thankful for the care and concern you showed me throughout the two most difficult and painful years of my life. In addition, you always inspired me and offered great support and confidence in me, as I pursued my goals; thanks for believing in me. You are an incredible human being, professor, mentor and friend; I will always admire you greatly.

I would also like to thank the other members of my advisory committee. Dr. Amy Johnson offered sound editing and statistical advice; thanks so much for your suggestions and commitment to this process. Dr. Terri DeBacker shared many ideas and valuable insight throughout this process; thanks for your invaluable perspective regarding adolescents. Dr. Sandy Ragan has provided many suggestions and valuable perspective throughout my education. You are wonderful scholars and I feel privileged to have had the opportunity to learn so much from you.

Kristi Wright deserves a special thank you as a member of our department and as my friend. Kristi, you helped me countless times, as I struggled to have enough time to get everything done throughout my Grandmother's illness. You filled in so many gaps for me and I know that there are so many times that I could not have completed a project or met a deadline without you. You are an incredible woman, and, while I know that I can never re-pay you, I will forever be thankful for all of you assistance; you did so much for me without expecting anything in return and it will never be forgotten.

I would also like to thank my friends; I have been blessed with many, many friends. You have helped me in so many ways throughout graduate school and I love you all dearly. In particular, I would like to thank my dear friend, Vanessa Feisal, for always showing up without me asking for your help. You are the kind of friend that most people only dream of finding and I love you as family. Many thanks to my other very close friends, Mason Barnes, Stephanie Dean and Shari Palmer; you all hold a special place in my heart. Thank you Becky Keeth Flesher for all you did to help me get started at OU. Heather Horton, I will always have a special place in my heart for your friendship and what it meant to me those first few years at OU. Ann Salazar, I owe you so much for the indescribable support you showed me throughout such a difficult time last summer. It makes me smile just to think of you; I have never met a person that I admire more. God truly blessed this world with your presence. Thank you to Johan Wanstrom, Michel Haigh, Beth McFayden and Liz Craig for being a constant support system at school for me; you were always a place I could go for support, ideas, editing, a hug, a smile, a laugh or simply the feeling that I was loved dearly.

Finally, as I finish this degree and start a new life, I dedicate the completion of this work to my husband, Bobi Ivanov. I am incredibly excited about our life together and so looking forward to meeting our little one. The completion of this dissertation is the end of one life for me and the beginning of a new one. As part of the end of one life, I am letting go of the challenges of the last few years and growing more and more excited every day about the joy of our life together. You have brought a love, peace, comfort, calmness and happiness to my life that I have never before experienced. You are my soul mate and my best friend… I love you.

TABLE OF CONTENTS

List of Tables

List of Appendices

ABSTRACT

As adolescent pregnancy, childbearing and STD transmission has continued to be a pervasive problem in American society, it has become more and more critical to understand the nuances of teen sexual behavior. Policy makers, parents, teachers, and community advocates are actively searching and advocating for interventions that will assist young people in reducing the risk associated with sexual involvement. Understanding the antecedents that predict adolescent sexual behavior has become an important part of developing interventions aimed at reducing risky sexual behavior among adolescents. Thus, this research focused on understanding the antecedents that predict adolescents' communication behaviors regarding sexual activity and contraceptive use.

This study focused on 18- and 19-year old adolescent males and females. The research sought to advance our understanding of the theoretical frameworks that may predict or be associated with adolescent sexual and contraceptive communicative behavior. Identity, self esteem and attachment theories were used to investigate these antecedents' influence on adolescent sexual and contraceptive communication. In particular, how these theoretical perspectives affect adolescents' communication self efficacy, comfort discussing sex and contraception and perceived communication self efficacy regarding sex and contraception.

Overall, the results of this research did not find strong support for a relationship between identity, self esteem, attachment and adolescent communicative behavior regarding sex and contraception. However, this study adds to the research in interpersonal communication and adolescent development by probing what theoretical

perspectives may offer a framework for understanding adolescent communication related to sex and contraception. This study illustrates that adolescents' identity status does increase one's communication efficacy, but the results did not confirm the relationship between identity status and sex and contraceptive discussions. It remains to be seen whether identity status differences influence adolescents' communication about their sexual behavior. While this study did not confirm many of the assertions of this research, it does provide a foundation for future research aimed at increasing our understanding of adolescent communication regarding sex and contraception.

Chapter One: Defining the Problem

Adolescent sexual involvement is a pervasive problem in American society, with over one million adolescents becoming pregnant each year (National Campaign to Prevent Teen Pregnancy, 1997). As the age for the onset of puberty has decreased over the years, the number of sexually experienced youth has increased (Kirby, 2001). This has led to an increased number of acts of intercourse, which resulted in increased unintended pregnancy and sexually transmitted diseases among the adolescent population (Kirby, 2001; Moore, Miller, Sugland, Morrison, Glei, & Bluenthal, 2001).

During the last 10 years, teen pregnancy and birth rates have steadily declined (Flanigan, 2001). The decline in rates is attributed to reduced sexual activity among teens, decreases in the frequency of sex among teens and better use of contraception (Flanigan, 2001; Kirby 2001). However, the United States continues to have the highest teen birth rates of any comparable industrialized country (Kirby, 2001). Despite the declining rates, four in ten girls still get pregnant before age 20 and approximately two-thirds of all students have sex before graduating high school (Kirby, 2001).

Oklahoma is consistently ranked among the states with the highest teen birth rates; while births to teens decreased between 1997 and 1999, births to teens in Oklahoma are still above the national average (Annie E. Casey Foundation, 2002). According to the Oklahoma State Department of Health (2001), there were 7,814 births to Oklahoma teens in 1999, with approximately two-thirds of the births being to females aged 18-19 years old.

Adolescent sexual activity contributes to teen pregnancy and childbearing; however, adolescent sexual activity has many implications and consequences beyond and

related to teen pregnancy and childbearing, including contributing to child poverty, high school drop out rates, child abuse and neglect, and sexual disease transmission. "When children have children, their opportunities are diminished right from the start, and the future is one of poverty" (National Campaign to Prevent Teen Pregnancy, 2002, p.10), as children of teen mothers are at higher risk for a variety of health complications (National Campaign to Prevent Teen Pregnancy, 2002) and are more likely to be abused or neglected (George & Lee, 1997).

Among the implications of early sexual activity for adolescents is the risk of acquiring a sexually transmitted disease or HIV. Adolescents have the highest age specific infection rates for sexually transmitted diseases (Kirby, 2001). Their high infection rates are due to a number of factors, including sex with multiple partners, having sex with high-risk partners and non-monogamous relationships (Kirby, 2001; Kirby, Short, Collins, Rugg, et al., 1994). The Office of National AIDS Policy (1996) estimates that one-quarter of all new HIV infections are among the adolescent population. Indeed, 56% of HIV infections occur among teenage girls (Centers for Disease Control and Prevention, 1999).

Clearly, there are many consequences for adolescents associated with early sexual activity. Policy makers, parents, teachers, and community advocates are actively searching and advocating for interventions that will assist young people in reducing the risk associated with sexual involvement. Currently, the government spends over $7-billion per year on costs related to teen childbearing (National Campaign to Prevent Teen Pregnancy, 2001). Therefore, it is imperative to determine what interventions may help reduce risky sexual behavior. Lerner and Galambos (1998) suggest that programs aimed

at reducing risk behaviors among adolescents should promote the overall development of the young person, engaging the individual and antecedent variables affecting the adolescent. Further, Lerner and Galambos (1998) describe this approach as increasing an adolescent's knowledge of risk taking, modeling prosocial behavior from peers, and engaging interpersonal resources, such as values and beliefs. Lerner, Miller, Knott, Corey and Bynum. (1994) also advocate this approach arguing that interventions must recognize the differences in individuals and their context in order to maximize the opportunities to assist young people in avoiding risky behaviors.

"Sexual experience by late adolescence has become so common over the last two decades as to become normative" (Brooks-Gunn & Paikoff, 1993, p. 185). Sonenstein, Pleck and Klu (1989) found that by the time adolescents reach the end of their 19th year three-quarters of white females, four-fifths of white males, and black females and almost all of black males had engaged in sexual intercourse. Moore and Sugland (2001) argue that "by the late teens, most adults accept (even if they do not approve) the need for contraceptive services for teens who have become sexually active" (p. 9). The Youth Risk Behavior Survey (CDC, 2001) shows that by 12th grade 60.5% of adolescents have experienced sexual intercourse; thus, "while most adults and adolescents believe that young people should abstain from sexual intercourse until after they graduate from high school, there is widespread support for providing youth with contraceptive information and education" (Society for Adolescent Medicine, 2000, p. 2).

Condom use among teens is inconsistent, with slightly more than half of teens indicating they use condoms during every sexual interaction (Moore, Driscoll, & Lindberg, 1998). Overall, 60% of students indicated they used a condom during the last three months and 18% indicated they used birth control (CDC, 2001). While approximately 51% of females and 62% of males report using a condom during their last sexual experience (CDC, 1997), clearly not all adolescents are using condoms and they are not using them during every sexual interaction. It is estimated that only 37% of health education nationwide teaches young people how to use condoms correctly (CDC, 1996). Although, programs aimed at younger adolescents would certainly not promote contraceptive use, it may be appropriate among older adolescents. It is critical to model responsible sexual behavior among adolescents, due to the risk factors previously discussed that are associated with unprotected sexual behavior.

The proposed research will be focused on 18- and 19-year old adolescent males and females; this age group was chosen as the focus of this research, as there should be more identity achieved adolescents in this age category. Moore and Sugland (2001) argue that it is important for programs to work with adolescent men and women; however, many programs ignore the male partners. Thus, this proposal will focus on males and females, seeking to open our understanding of young people's communication about their sexual behavior and contraceptive use. In particular, this research seeks to advance our understanding of the theoretical frameworks that may predict or be associated with this communicative behavior. While there are entire journals and books focused on adolescent sexual identity, few of them include a theoretical focus; for example, between 1971 and 1990, only approximately one-quarter of the articles in *The Journal of Sex Research* were

concerned with theoretical development and only 6% of the articles in the *Archives of Sexual Behavior* were classified as theoretical works (Ruppel, 1994). Identity, self esteem and attachment theories will be used to investigate their influence on adolescent sexual and contraceptive communication.

Chapter Two: Literature Review

Adolescence is a time of vast development for individuals as they experiment with adult roles, their own identity and their relationships with others. As part of this developmental process, adolescents often focus their efforts on two general life goals: a) establishing a stable, independent identity, and b) merging that identity with others in personal relationships (Erikson, 1968). The voluntary peer relationships that adolescents form, manage, and maintain with others serve as an important set of experiences that contribute to the realization of these general identity-relevant life goals (Ryan & Lynch, 1989; Simpson & Sippola, 1999; Zani, 1993). "In the realm of sexual development, such tasks include learning to manage feelings of sexual arousal, developing new forms of intimacy and autonomy, experiencing interpersonal relationships with the opposite sex, and developing skills to control the consequences of sexual behavior" (Brooks-Gunn & Paikoff, 1993, p. 180). Brooks-Gunn and Paikoff (1993) argue that adolescent well being and sexuality is characterized by four developmental challenges, including the practice of safer sex for young people that choose to engage in sexual behavior.

While prior research has focused on adolescents' coping behaviors for everyday stressors, such as failing an exam or making mistakes (Seiffge-Krenke, 1993), the management of unusually stressful events, such as illness (Earle, 1979; Stoddard, 1982), or the death of a friend or family member (Meyers & Pitt, 1976), little research has focused on how adolescents manage communication within their romantic pairings. There is not a strong body of research, which advances our understanding of how adolescents manage communication regarding sexual behavior. Further, the communicative decisions that adolescents make and how these decisions are reflective of

their current identity status has been a largely ignored phenomenon. Although research to date has not considered adolescent identity status and adolescents' communicative goals in relational contexts, Levesque (1993) argues that adolescents typically attempt to communicate with partners about relationship problems. As such, it is likely that adolescents generate communicative intentions for their interactions with close relational partners, which are reflective of their identity status. However, because close relationships are often new and experimental for adolescents, they often lack the experience for managing these associations and communicative interactions (Furman & Simon, 1999; Galliher, 1999). In addition, adolescents are often aware of their limited ability to communicate with relational partners; this awareness may further create apprehension regarding how to effectively communicate with romantic partners, especially regarding sensitive subjects, such as sexual behavior and contraceptive use.

Research on adolescents' cognitive development offers insight into how adolescents pursue communicative goals. In particular, scholars argue that the social process of close relationship development and management runs parallel to the cognitive transformations of adolescence, which involve a greater capacity for understanding oneself and an awareness of individuality (Jackson & Rodriguez-Tome, 1993; Zani, 1993). Therefore, depending on the stage of an adolescent's development, s/he may be more or less equipped to pursue goals, which reflect a heightened understanding of the self. As such, a consideration of adolescents' management of communication in their close relationships may be reflective of their interpersonal development. While specific links between the social cognitive abilities and behaviors of adolescent relationships have not been assessed, it

seems reasonable to assume "that an individual who is capable of applying concepts of mutuality and reciprocity to a sexual relationship might also be more willing to communicate with a partner regarding sexual activity and contraception" (Brooks-Gunn & Paikoff, 1993, p. 196). Thus, as adolescents mature, they should be able to consider how their interpersonal communication affects their health choices. As Millstein (1993) notes, older adolescents recognize there are psychological, affective and social components, which are relevant to their health, such as interpersonal relationships and communication.

Prior research suggests that a smaller repertoire of goals that distinguish between independence versus interdependence concerns may be salient for adolescents when communicating with relational partners. For example, Sanderson and Candor (1995) argue that as adolescents assert their independence from their family and experiment with new identities, they face a continual struggle between self-reliance and mutual dependence. As such, adolescents' decisions about close relationship issues are framed around the distinction between the goal to assert their own authority versus the goal to be interdependent. Further, research on adolescents' responses to conflict suggests that adolescents faced with relationship problems may focus primarily on efforts to maintain the relationship. Levesque (1993), for example, observed that adolescents faced with conflicts in their close relationships are often guided by the goal of continuing social interaction. Laursen (1993) implied that adolescents approach relationship conflicts from a dichotomous perspective: either they negotiate to assure the continuation of the relationship or they discontinue the relationship. Thus, it appears that the types of communicative goals that adolescents pursue are primarily focused on concerns regarding

maintaining a relationship with close relationship partners or disengaging a relationship in an attempt to assert one's independence.

In general, close relationships play an important role in creating, reinforcing and sustaining conceptions and judgments about who an individual is (Aron & Aron, 1996; Miller, Potts, Fung, Hoogstra & Mintz, 1990). Such relationships also transform and define the boundaries of an individual's self in relation to close others (Fletcher, Fincham, Cramer & Heron, 1987; Register & Henley, 1992). This influence reinforces one's self conceptions and provides a sense of authenticity that makes people's lives orderly and coherent (Swann, De La Ronde & Hixson, 1994), as well as an understanding of how to relate to others (Youniss, 1986). For adolescents, romantic relationships serve as a central context for their intrapersonal and interpersonal development.

Adolescent Sexual Behavior and Communication

As previously mentioned, the literature is very limited concerning how adolescents manage their communicative goals in their romantic pairings; there is even less evidence regarding how they communicate about sexual behavior. How, when, and if adolescents discuss their sexual behavior is basically an unexplored phenomenon; it has basically been unexplored due to the difficulties associated with talking to young people about their sexual behavior. While it is a topic that often makes adults uncomfortable, it is almost certain to provoke discomfort among young people. Brooks-Gunn and Paikoff (1993) argue that assessing adolescent communication may be difficult because adolescent sexual identity is characterized by secrecy and negativity.

> We do not know how youth feel about their first experiences, with whom they share and from whom they withhold information, or how they decide

> to have sex for the first time (although most recall not having planned for it). Information on the conversations between boys and girls that lead to intercourse or negations regarding the use of contraception is nonexistent (Brooks-Gunn & Paikoff, 1993, p. 183).

Kirby, et al. (1994) suggests that instruction on resistance skills may delay sexual activity. Successful approaches "should discuss the role of coercion in sexual relationships and help both males and females learn strategies to avoid having unwanted sexual experiences and ways to enforce the use of contraception" (Moore, & Sugland, 2001, p. 15). Females believe that their male partners are not likely to want to use condoms and boys report that girls prefer for them to use condoms (Kegeles, Adler & Irwin, 1998). Hence, there is obviously a lack of communication in this area, as females think that males will prefer they do not use a condom and boys assume that girls prefer they use a condom. In addition, boys are more likely than girls to report having the intention to use a condom during sexual intercourse (Brooks-Gunn & Paikoff, 1993). Speculation leads us to believe that boys may have higher intentions of using a condom, because they believe that the girl will expect them use contraception. However, if girls do not communicate their intentions, because they believe boys prefer not to use a condom, this becomes a problematic dilemma for safer sex behaviors to occur. This dilemma confirms the notion that knowledge does not necessarily lead to effective communication regarding the negotiation of safer sex behavior. Thus, while older adolescents are knowledgeable about how to prevent pregnancy, STD and HIV infections, they do not necessarily have the skills to cope with sexual situations (Crowell & Emmers-Sommer, 2000). Further, knowledge does not necessarily translate to the interpersonal skills

necessary to negotiate safer sex behaviors, such as condom use (Crowell & Emmers-Sommer, 2000).

In addition to lack of experience with interpersonal communication, adolescent communication about sensitive topics, such as contraceptive use, may be further inhibited by the emotional states associated with dating and sexual situations. While happiness rises from a variety of different causes, it has one typical core relational theme, which is that we are or soon will be gaining what we desire (Lazarus, 1991). So, happiness includes realizing a goal or making progress toward a goal (Lazarus, 1991). Elation has the potential to distract attention and interfere with reality testing and reasoning among adolescents (Larson, Clore, & Wood, 1999). When adolescents experience positive emotions, they may not properly estimate the possible negative outcomes of unprotected sexual behavior. The positive states associated with being in love for the first time offer the possibility for dating partners to take advantage of positive states and manipulate behavior (Larson, et al., 1999). Thus, adolescents feeling the "high" of being involved with a dating partner may not realistically think about the consequences of their actions, such as unprotected sexual activity. This reasoning suggests that adolescents may not carefully consider the actions of unprotected sexual activity, as the sexual relationships elicit happiness. This lack of reasoning is likely to lead to reduced communication with sexual partners regarding the risks associated with unprotected sexual activity.

Research Focus

While many interventions have been piloted aimed at reducing risky sexual behavior among adolescents, few have been aimed at increasing the communication between adolescents as they negotiate sex and safer sex behavior. Although older adolescents have more knowledge regarding health topics and choices, knowledge is not sufficient for healthy behaviors to occur (Millstein, 1993). Older adolescents do not even rank sexual health as one of their most important health behaviors; they rank their most important behaviors to be brushing their teeth, keeping clean, getting enough sleep, having access to emergency numbers, watching their weight, wearing warm clothing, exercising and seeing the dentist as their primary health concerns (Millstein, 1993). "Interventions need to pay more attention to the situations in which sex occurs" (Brooks-Gunn & Paikoff, 1993, p. 199), with particular attention to helping adolescents learn to manage and negotiate lowering the risk involved with unprotected sexual behavior. Thus, the goal of this research is to further our understanding of how adolescents communicate with one another regarding sexual behavior and what theoretical perspectives may help predict their communicative behavior. Further, this research is exploratory in nature; as previously mentioned, there is little known regarding how adolescents communicate about sexual behavior and what theoretical constructs may guide our understanding in predicting the nature of adolescent sexual communicative intentions and behavior.

Identity Status

It is not until adolescence that individuals develop the physiological growth, mental maturation and social responsibility to experience and pass through the crisis of identity" (Erikson, 1968, p.91); overall, Erikson (1968) argues that the identity crisis is

the psychosocial aspect of adolescence. Erikson reshaped the psychological conception of human development with his recognition of the human identity crisis (Cote, 1996). He argues that the "major psychosocial task linking childhood with adulthood involves developing a viable adult identity" (in Cote, 1996, p. 136).

> In the later school years, young people, beset with the physiological revolution of their genital maturation and the uncertainty of the adult roles ahead, seem much concerned with faddish attempts at establishing an adolescent subculture with what looks like a final, rather than a transitory, or, in fact, initial identity formation (Erikson, 1968, p. 128).

Erikson (in Marcia, 1993) offers eight stages of psychosocial growth, which are chronological with a person's age. The stages are as follows: 1) basic trust and basic mistrust 2) autonomy and shame, doubt 3) initiative and guilt 4) industry and inferiority 5) identity and identity diffusion 6) intimacy and isolation 7) generativiy and stagnation, self absorption, and 8) integrity and despair.

Investigations of developmental differences in identity formation have largely been guided by Marcia's (1966, 1988) argument that identity development is not merely a function of age, but, rather, is developed through repeated experiences that aid in self definition and understanding. As such, Marcia (1966, 1988) argues that adolescents' degree of uncertainty and confusion about who they are determines their identity status.

> Identity formation involves a synthesis of childhood skills, beliefs, and identifications into a more or less coherent, unique individual. This synthesis provides young adults with both a sense of continuity with the past and a direction for the future; identity is content – as well as process

based – more simply, identity, as a structure, refers to how experiences are considered important (Marcia, 1993, p. 3).

Identity status is defined by the presence or absence of active self-exploration and firm identity commitments; varying levels of these two dimensions reflect four different identity statuses: a) achievers b) moratoriums c) foreclosures, and d) diffusions. Marcia (1989) argues that the most productive method for approaching Erikson's psychosocial developmental process is to delineate between the identity statuses. He offers four ways that adolescents, particularly late adolescents (18-22 years old), might be resolving the identity crisis. Identity achievement includes an exploratory period, followed by firm commitments; individuals in moratorium are currently exploring identity options and are expected to eventually move into commitment; foreclosure includes individuals that are generally rigidly committed to an identity, but did not consider an exploratory period; last, identity diffusion involves some exploration, with a lack of commitment and a lack of concern about uncommittedness.

Several scholars, including Marcia (1993) agree that there are no meaningful differences in the process of how adolescent males and females form their adult identities; overall, there are no significant differences in how adolescent males and females form and manage their identities (Cote, 1996). However, there are differences among the domains and content areas, which are explored by young people (Cote 1996). For example, Patterson, Sochting, and Marcia (1992) concluded that females' stronger interpersonal connections create differences in identity formation; further, women tend to define themselves more in terms of their private sphere relationships, whereas men identify more strongly with their public sphere self identity (Cote, 1996). Women also

tend to be higher in intimacy, whereas males tend to offer more pressure to each other and to females to engage in certain activities (Husband, 2003).

While the competing goals of establishing an independent identity and establishing personal relationships serve to guide behavior during adolescence (Sanderson & Cantor, 1995), psychologists suggest that adolescents differ in the extent to which they possess a stable sense of self (Markstrom-Adams, 1992; Samet & Kelly, 1987). Hence, adolescents' varying degrees of self-identity development should have implications for how they manage interactions in their personal relationships, including negotiating sexual behavior and safer sexual behavior. As Erikson (1968) notes, "to a considerable extent, adolescent love is an attempt to arrive at a definition of one's identity by seeing it thus reflected and gradually clarified" (p. 132). Adolescents' close friendships and romantic pairings have been observed to have positive consequences for both the self-esteem (Samet & Kelly, 1987) and social competence (Neeman, Hubbard & Masten, 1995) of young people. These relationships serve as an important context for learning how to manage interactions and problems that may occur in these voluntary associations.

Erikson (1968) argues that true intimacy is a function of an identity that is well on its way to development. Further, he argues that true intimacy involves openness and sharing, indicative of healthy interpersonal communication (Erikson, 1968). Thus, sexual intimacy is only part of intimacy; although, sexual intimacies often precede the capacity for true interpersonal, psychological and emotional intimacy. Further, he argues that adolescents without clear identities may avoid interpersonal intimacy, due to their uncertainty of the self; however, the same adolescent may engage in promiscuous sexual

activities, throwing oneself into acts of intimacy, which are not truly representative of the self (Erikson, 1968).

Variations in adolescents' identity status should have implications for the nature of their communicative goals when discussing sexual behavior. In particular, identity should have implications for the perceived importance of particular goals and how strongly one intends to communicate those goals; hence, adolescents' self identity would serve as an important explanatory mechanism for the nature of adolescents' communicative intentions regarding sexual behavior.

Adolescents characterized as achievers, who are committed to a particular interpersonal style and attitude towards sexual behavior, should consider and communicate those goals that will maintain a consistent identity. These adolescents have made judgments about their personal beliefs and goals and should feel it is important to convey their beliefs and goals through effective communication. In general, these adolescents have high self esteem and high levels of self-responsibility (Marcia, 1989), which should promote their ability to communicate about sexual behavior in a manner that will promote behavior that is consistent with their attitudes and beliefs. Hence, achievers should be the most likely to communicate with dating partners about sexual behavior and safer sex behavior.

Young people in the moratorium state tend to be ambivalent about their relationships with others (Marcia, 1989). While these adolescents have a relatively high self esteem and enjoy autonomy, they have not yet firmly committed to a particular identity. It might be difficult for these individuals to engage in clear communication about their goals when discussing sexual behavior. It is likely that such young people

have not yet discovered exactly how they feel about the appropriateness of sexual behavior or the importance (or lack of) of safer sexual behavior. While these individuals are exploring their identity and are expected to commit at some point, it seems that communication about such a value-laden topic, such as sexual behavior, would be difficult for young people who have not yet developed a clear sense of self identity.

Adolescents characterized as diffusions are not committed to a particular identity; thus, one would expect that they may consider a variety of goals or no particular goal at all when communicating about sexual behavior. These adolescents tend be in a state of uncertainty about life choices and sexual behavior is certainly reflective of an important life choice. In addition, these adolescents tend to have generally poor relations with others, making it difficult to engage in effective communication. While often incapable of occupational and ideological commitment, the diffused individual may be attractive to others and may even engage in short relationships (Marcia, 1989); thus, this individual "at least has managed to package him/herself in a socially saleable way" (Marcia, 1989, p. 292). Thus, the nature of short relationships characterizing diffused individuals may further inhibit communication about sexual behavior, as these relationships may not have the opportunity to develop to a level that promotes healthy communication. Further, it may be difficult for this adolescent to engage in communicative behavior regarding sexual relations, as this young person may not have a clear idea of what her or his communicative intentions are.

Last, individuals operating from a foreclosed identity status are generally rigid in the conformation to a particular identity. Thus, such individuals should feel strongly about their values and beliefs, even though the ideals are not the result of personal

exploration. These individuals tend to have low self esteem and self-directiveness (Marcia, 1989) and their identity is a reflection of family values and a pressure to adopt family values. Thus, this proposal submits that these young people would operate similar to achievers, as they have an established identity and would probably communicate in a fashion that is consistent with their identity status and the ideals they deem important in maintaining a consistent identity. However, if their ideals are challenged, they may not be able to communicatively defend their beliefs and values, since their identity is not the product of active exploration. This lack of exploration may interfere with their ability to engage in healthy discussions regarding sexual behavior and contraceptive use.

Given the previous discussion, this research asserts that adolescents operating from an achieved identity status will more likely to engage in active communication regarding sexual and contraceptive behavior. Achieved adolescents have engaged in the process of exploration and committed to a particular identity style, which increase their communication efficacy and comfort discussing such sensitive issues. The process of exploration that these young people engaged in offers a framework for such adolescents to communicate their sexual and contraceptive intentions.

H1: In comparison with adolescents operating from other identity statuses, adolescents who are identity achieved report higher levels of communication efficacy.

H2: In comparison with adolescents operating from other identity statuses, adolescents who are identity achieved report higher levels of comfort discussing sexual behavior with their sexual partners.

H3: In comparison with adolescents operating from other identity statuses, adolescents who are identity achieved are more likely to report higher levels of perceived self efficacy in discussing sex and contraception.

Self Esteem

In order to understand adolescents' communication regarding risk taking behaviors, one must also account for other individual personality characteristics, particularly self esteem and attachment style. As previously mentioned, adolescence is a time of self-discovery, physical, emotional and cognitive development and overall change. As these changes occur, feelings about the self are also changing and developing. By late adolescence, young people have a more balanced view of the self, have better accepted their limitations, and have created their own ideals toward which they aspire (Harter, 1999).

Self-esteem reflects a global feeling about oneself (Baumeister, Tice & Hutton, 1989; Brown, 1993). During adolescence, self-concept is at its most highly differentiated state (Byrne & Shavelson, 1996), operating with multiple selves rather than one succinct self (Harter, 1997) as adolescents are continuing to assess their feelings about the self. As the self-concept becomes more differentiated, adolescents will begin to rate their performance in different situations (Knox, 1998). Conceptions of self-esteem equate it with the balance of positive and negative conceptions one has about oneself (Banaji & Prentice, 1994). Thus, adolescents are engaged in rating their performance in situations and building their overall conception of themselves, based on their performance in interpersonal and social settings. The more positive self-conceptions one assesses and the

fewer negative self-conceptions one assesses, the higher self-esteem one will develop (Banaji & Prentice, 1994).

Baumeister and colleagues (1989) have suggested there is a relationship between self-esteem and one's self-presentation. The authors posit that self-presentation is related to an individuals' ability to take risk in social situations. Banaji and Prentice (1994) further describe the relationship between self-presentation and an individual's self-esteem. They assert that individuals with high self-esteem will present themselves in a self-enhancing fashion and that individuals with low self-esteem will present themselves in a very protective fashion, seeking to avoid risks in social situations.

This reasoning posits that an individual's social and interpersonal functioning is related to their respective self esteem. Therefore, adolescents with lower self-esteem may be more likely to engage in risky sexual behavior by not utilizing contraception. In addition, their propensity to avoid risks in social situations may inhibit their ability to communicate effectively with sexual partners regarding contraceptive use.

H4: Adolescents with higher self-esteem report higher levels of communication efficacy.

H5: Adolescents with higher self-esteem report more comfort discussing sex and contraceptive use.

H6: Adolescents with higher self-esteem report more perceived self efficacy in discussing sex and contraception with sexual partners.

Attachment

In addition to understanding how an adolescents' self esteem affects their communication and risk taking behavior, one must understand their attachment to primary relationships, such as their parents. Attachment theory (Bowlby, 1969, 1988; Hazan & Shaver, 1987) suggests that experiences with significant others influence the way in which individuals perceive and respond to relationally-relevant situations. Thus, an individual's response to their relationships in adolescence is directly related to their relationships with their parents. This suggests that a person develops a schema in childhood that is attached to their view of themselves and others. Cassidy and Berlin (1999) define this as a representational model, linking representations of parents to representations of the self and others. Further, they state that relationships with parents develop as part of a behavioral system and that parents serve as a secure base for young people.

As previously addressed, attachment theory proposes that the ways in which individuals think about and react to their relationships is a product of prior experiences with significant others (Hazan & Shaver, 1987). Three categories of attachment styles have previously been identified: secure, anxious ambivalent and avoidant (Hazan & Shaver, 1987). The categories are descriptive of the representative models of attachment that adults hold, based on previous relational experiences.

Secure individuals have positive models of themselves and others, are comfortable with closeness and experience little anxiety over relationships (Samp, 2001). These individuals are comfortable with relationships with others and feel they deserve the love and care of others. Secure individuals develop relationships with ease and are

comfortable having others depend on them (Samp, 2001). Bowlby (1988) suggests that the secure representational model of attachment helps the child build a complementary view of the self as a lovable person; thus the child is not only lovable by the parents, but, also, by others. Individuals that are secure not only feel loveable, but also are comfortable exploring away from their parents (Bowlby, 1988).

Anxious-ambivalent individuals possess negative models of themselves and positive, yet guarded models of significant others (Bartholomew & Horowitz, 1991). Samp (2001) also describes these individuals as being comfortable in closeness with others, yet experiencing anxiety over their relationships. Samp (2001) describes them as reluctant to get close and feeling their partners do not really love them. While these individuals may be involved in relationships with significant others, they may not feel truly worthy of the love of their partner or completely trust the love of the significant other. These individuals may be unsure about exploring the world, as they are uncertain about the availability of their parents, which may lead to separation anxiety (Bowlby, 1988).

Avoidant individuals are characterized as uncomfortable with closeness, excessively self-reliant and distancing from others (Ainsworth, Blehar, Waters, & Wall, 1978). These individuals have felt unloved by their attachment figures and have attached that schema to other relationships. These individuals have a negative view of the self (Samp, 2001) and view themselves as unlovable. Bowlby (1973) states that if a child feels unloved by his/her parents she/he will believe that she/he is not loveable by anyone. Therefore, due to the lack of positive attachment to their parents, these individuals will feel an overall lack of attachment to significant others, as their negative view of

themselves leads them to believe they are unworthy of the love of others. Hence, these individuals attempt to live without the emotional support of others, due to their experiences of support elicitation being rejected (Bowlby, 1988).

Several researchers (Bowlby, 1969; Cassidy, & Berlin, 1999; Samp, 2001) have posited that peer relationships are linked to the attachment relationships. Appealing to attachment theory (Bowlby, 1969), this research posits that adolescents who feel less securely attached to their parents will engage in more risk taking behaviors, such as unprotected sexual activity. Therefore, adolescents that are securely attached to their parents and have positive representational schemas of being loved will be less likely to engage in risky sexual activity.

H7: Individuals' attachment orientations with respect to their parents are associated with communication efficacy, such that comfort with dependence and intimacy are associated with communication self efficacy.

H8: Individuals' attachment orientations with respect to their parents are associated with comfort discussing sexual activity and contraception, such that comfort with dependence and intimacy are associated with communication with dating partners about sex and contraception.

H9: Individuals' attachment orientations with respect to their parents are associated with contraceptive discussions, such that comfort with dependence and intimacy are associated with perceived self efficacy regarding sex and/or contraceptive use.

Chapter Three: Method

Participants and Procedures

Two-hundred-eighty-seven adolescents completed a survey about dating relationships and discussions about sexual activity and contraception. The subjects in this study were high school and college aged, although all of the adolescents were 18 or 19 years of age. This research was focused on a particular age group, rather than an adolescents' school rank, so students were chosen from both high school and college. The students were recruited from the Communication Department at the University of Oklahoma and the Teen Outreach Program at three inner city high schools; the inclusion of students from inner city schools, as well as college students also increased the diversity of the students included in the study. The students participated voluntarily, although the college students received class credit or extra credit and the high school students received one hour of community service credit for completing the survey. Each of the students voluntarily agreed to participate in the research and signed an informed consent; since all of the students were 18 or 19 years old, parental consent was not required.

Two-hundred- twenty-four (77%) were from a large southwestern university and 63 (22%) were from three southwestern high schools (age range: 18 to 19, M = 18.58, SD = .49*).* Overall, 284 students indicated their sex, which included 153 (54%) females and 131 (46%) males. Many of the questions asked respondents to answer questions regarding communication with their dating partner; all of the respondents indicated that they currently or previously had been involved in a dating relationship. (See Table 1)

Adolescents completed a survey that included questions aimed at understanding their communication with dating partners. The survey was administered during February 2004; the questionnaire assessed identity status, self-esteem, parental attachment, attitudes towards sexual behavior and communication regarding sexual behavior, communication efficacy and communicative intentions regarding sexual behavior. The questionnaire assessed demographic variables pertaining to gender, age, dating partner's gender and age, length of dating relationship, and parents' marital status. In addition, the survey asked if the subject was sexually active with their dating partner and what type of contraception was used.

Variables

Identity status was measured using the 25 Ego Identity Process Questionnaire (EIPQ; Balistreri, Busch-Rossnagel, & Geisinger, 1995). The original measure includes 40 items, however, several items were dropped, as they did not appear to answer the questions proposed by this project. The EIPQ measure determines the four categories of identity status; the scale assesses ego identity utilizing a variety of ideological domains (e.g., personal values, beliefs, religion, education). The scale included 13 commitment items and 12 exploration items strongly disagree; 5 = strongly agree. Respondents completed each item on a 5-point scale (1 =). The measure included the following items:

1. Regarding religious beliefs, I know basically what I believe and don't believe.
2. I've spent a great deal of time thinking seriously about what I should do with my life.
3. I've more-or-less always operated according to the values with which I was brought up.
4. I've spent a good deal of time reading and talking to others about religious ideas.
5. When I discuss an issue with someone, I try to assume their point of view and see the problem from their perspective.
6. I know what I want to do with my future.
7. I've always had purpose in my life; I was brought up to know what to strive for.
8. I have some consistent political views.
9. I'm really into my schoolwork right now.
10. I've spent a lot of time reading and trying to make some sense out of political issues.
11. I've spent a lot of time and talked to a lot of people trying to develop a set of values that make sense to me.
12. Regarding religion, I've always known what I believe and don't believe; I never really had any serious doubts.
13. I have a definite set of values that I use in order to make personal decisions.

14. I think it's better to have a firm set of beliefs than to be open-minded.
15. When I have a personal problem, I try to analyze the situation in order to understand it.
16. I find it's best to seek out advice from professionals (e.g., clergy, doctors, lawyers) when I have problems.
17. I think it's better to have fixed values, than to consider alternative value systems.
18. I find that personal problems often turn out to be interesting challenges.
19. Once I know the correct way to handle a problem, I prefer to stick with it.
20. When I have to make a decision, I like to spend a lot of time thinking about my options.
21. I prefer to deal with situations where I can rely on social norms and standards.
22. I like to have the responsibility for handling problems in my life that require me to think on my own.
23. When making important decisions I like to have as much information as possible.
24. To live a complete life, I think people need to get emotionally involved and commit themselves to specific values and ideals.
25. I find it's best for me to rely on the advice of close friends or relatives when I have a problem.

In line with Schwartz, Mullis, Waterman and Dunham (2000), identity status assignments were formed by median splits, where scores above the median on exploration (*Md* = 3.5) or commitment (*Md* = 3.5385) were classified as high. The median splits were only used for the purpose of grouping the adolescents into their identity status category; the median splits were not used for the analysis. Adolescents

who were deemed high on both exploration and commitment were considered to be achievers (*n* = 93; 31% of the sample). Foreclosures scored low on exploration and high on commitment (*n* = 49; 14% of the sample). Individuals who were high on exploration and low on commitment (*n* = 51; 16% of the sample) were defined as moratoriums. Finally, adolescents who were low on both dimensions were labeled as diffusions (*n* = 94; 33% of the sample). (See Table 1).

Self-esteem was measured using Rosenberg's Self-Esteem Scale (Rosenberg, 1979). The questions will be measured on a five-point Likert scale. The questions assess each individual's feelings about the self and the responses range from "strongly agree" to "strongly disagree" (1 = strongly agree; 5 = strongly disagree). Self esteem assignments were formed on median splits, where scores above the median on self esteem (*Md* = 4.0593) were deemed as high self esteem (*n* = 141) and those below the median were deemed as low self esteem (*n* = 146). The self esteem items were as follows:

1. On the whole, I am satisfied with myself.
2. Sometimes I think I am no good at all.
3. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I am a person of worth, at least on an equal plane with others.
8. I wish that I could have more respect for myself.
9. All in all, I am inclined to feel that I am a failure.
10. I take a positive attitude toward myself.

The attachment orientation scale (Fenney, 1995) assessed each individual's feelings of attachment towards their parents. This scale included 13 questions, each on a five-point Likert scale. The range of responses was from "strongly agree" to "strongly disagree" (1 = strongly agree; 5 = strongly disagree). The scale was divided into three parts, with five of the questions measuring comfort with intimacy, five questions measuring comfort with dependence, and five of the questions measuring an individual's anxiety over relationships. The comfort with intimacy and comfort with dependency questions are designed to assess how secure an individual's attachment is to her/his parents. While the categorical measures of attachment have been used as the basis for explicating and understanding attachment theory, more recently other scholars (Fenney, 1995; Samp, 2001) have found that the dimensional approach is a more appropriate measure for an individual's attachment orientation. This approach integrates the attachment categories into underlying dimensions, rather than distinct groups. When attachment is defined as a dimension, rather than a category, the problems associated with categorizing individuals into concrete groups is avoided. This measure assumed three underlying dimensions of attachment orientation: comfort with closeness, comfort with dependence and anxiety over relationships. The scale included the following items:

1. I find it easy to get close to my parent(s).
2. I'm not very comfortable having to depend on my parent(s).
3. I'm comfortable having my parent(s) depend on me.
4. I don't worry about being left by my parent(s).
5. I don't like my parent(s) getting too close to me.
6. I'm uncomfortable being too close to my parent(s).

7. I find it difficult to trust my parent(s).

8. I'm nervous whenever my parent(s) gets too close to me.

9. My parent(s) want me to be closer than I feel comfortable being.

10. My parent(s) do not get as close as I would like.

11. I often worry that my parent(s) do not really like me.

12. I don't worry about my parent(s) leaving me.

13. I am very attached to my parent(s).

The self efficacy scale (Schwarzer, 1992) measured general self efficacy. However, five of the questions were aimed at measuring communication efficacy; only those five questions are included in the questionnaire. The scale included 10 statements; the answers were measured on a four-point Likert scale from "not at all true" to "exactly true" (1 = not at all true; 4 = exactly true).

1. I am comfortable communicating with others.

2. When I feel others will not agree with me, I can still communicate my opinion.

3. It is easy for me to communicate my beliefs and goals to others.

4. I am confident that I have the communication skills to deal with difficult situations.

5. I can solve most problems by communicating with others.

Perceived communication self efficacy regarding sex and contraception was measured using Brafford and Beck's (1991) condom self-efficacy scale for college students. The original scale includes 28 items; the scale was altered to only include the items focused on communication behavior. The final scale included in the questionnaire featured 11 items, with the wording of the items changed from condom use to contraceptive use. The items were measured on a five-point Likert scale ranging from

"strongly disagree" to "strongly agree". The following 11 items were included in the questionnaire:

1. I would feel confident in my ability to discuss contraception usage with my partner.
2. I would feel confident in my ability to suggest using contraception with my partner.
3. I would feel confident I could suggest using contraception without my partner feeling "diseased".
4. If I were to suggest using contraception to my partner, I would feel afraid that s/he would reject me.
5. If I were unsure of my partner's feeling about using contraception, I would not suggest it.
6. I would feel comfortable discussing contraception use with my partner before we ever had any sexual contact, such as kissing, hugging or caressing.
7. I would feel confident in my ability to persuade a partner to accept using contraception when we have intercourse.
8. I would not feel confident suggesting contraceptive use with my partner because I would be afraid s/he would think I have a sexually transmitted disease.
9. I would not feel comfortable discussing contraception use with my partner before we ever engaged in intercourse.
10. I would feel confident that I would remember to discuss contraception even after I had been drinking.
11. If my partner did not want to use contraception during intercourse, I could easily convince him/her that it was necessary to do so.

Comfort discussing sex was measured using six items. The items were measured on a seven-point Likert scale ranging from "strongly disagree" to "strongly agree". The author

developed this scale for the purposes of this research, as a scale measuring this specific variable could not be located.

1. I would feel comfortable discussing sex with my dating partner.

2. I would feel comfortable discussing contraceptive options with my dating partner.

3. I would be comfortable talking to my boyfriend/girlfriend about sex.

4. Communicating with my dating partner about sex is important to me.

5. I would feel comfortable discussing contraceptive use with my boyfriend/girlfriend.

6. It is important to me to talk to my current or most recent boyfriend/girlfriend about sex.

Reliability analysis. The reliabilities for each of the items were as follows: self esteem, $\alpha = .84$; communication self efficacy, $\alpha = .82$; comfort discussing sex and contraception, $\alpha = .80$; and perceived communication self efficacy regarding sex and contraception, $\alpha = .84$. The attachment scale included the following reliabilities: comfort with intimacy, $\alpha = .85$; comfort with dependence, $\alpha = .64$; and anxiety with relationships, $\alpha = .53$. The identity scale included a scale measuring identity commitment, $\alpha = .79$; and identity exploration, $\alpha = .72$. The alpha level for the anxiety with relationships scale was low; hence, the scale was dropped in the analysis. (See Table 2)

Chapter Four: Results

Descriptives

For reported relationships, 143 (51%) discussed their communication with a current dating partner, whereas, 159 (55%) reported about their communication with a previous dating partner. One-hundred-fifty-six (55%) of the dating partners were male and 131 (45%) were female. The age of the dating partners ranged from 14 to 34 (*M = 19.14; SD = 2.16*) and the length of the dating period ranged from one month to 97 months (*M = 15.00; SD = 14.62*). One-hundred-eighty nine (66%) of the subjects indicated that their parents were married to each other. Overall, 173 (63%) of the adolescents indicated that they were sexually active. (See Table 3)

When discussing contraceptive use, birth control pills (31%) and condoms (32%) were the most popular contraceptive method. Three percent of the sample indicated they used the birth control patch. A small portion of the sample (.4%) indicated that they used diaphragms and a similarly small portion (.4%) indicated that they used an IUD. A small number of subjects (5.2%) reported they did not use contraception. (See Table 4)

All of the students in the sample were assigned an identity status based on their commitment and exploration scores on the EIPQ (Balistreri, Busch-Rossnagel, & Geisinger, 1995). The high school students and the college students were vastly different in the percentages of students in each identity status category. Nineteen percent of the achievers were high school students, compared to 81% of the achievers being college students; in contrast 81% of the foreclosures were high school students and 19% of this category were college students. Eighty-four percent of the moratoriums included high school students, whereas the college students accounted for 16% of the moratoriums. The

diffusions included 80% high school students and 21% college aged students. (See Table 1)

As previously mentioned, the sample included both high school and college aged 18 and 19 year old adolescents. While the sample represents different ages in schools, they are all in the same age group; however, it was still important to determine if the subjects varied on key variables related to their dating relationships and sexual activity due to their classification as a high school or college student before collapsing them into one group based on their age for the purpose of this study. An independent sample *t*-test was conducted to ensure that the two groups were not statistically different on key variables, including age of dating partners, length of dating relationship and the number of sexually active subjects. The *t*-test indicated that the sample was not statistically different on any of the variables regarding their dating relationships, since the focus of this investigation is adolescent dating relationships. There were no significant differences regarding the age of their dating partners for high school students (*M = 19.47; SD = 3.13*) and college students (*M = 19.06; SD = 1.85*), $t(271) = 1.264$, $p = .207$ (two tailed). For the length of the dating relationship, no significant relationship was found between the high school (*M = 13.63; SD = 15.07*) and the college student sample (*M = 15.30; SD = 14.52*), $t(272) = -.766$, $p = .444$ (two tailed). Regarding the number of sexually active adolescents in the sample, there were not statistical differences between the high school students (*M = .62; SD = .49*) and the college students (*M = .63; SD = .49*), $t(274) = -.160$, $p = .873$ (two tailed).

Tests of Hypotheses

A multivariate analysis of covariance (MANCOVA) was computed for hypotheses 1 thru 3, holding self esteem constant; identity status (achieved or not achieved) was the independent variable and communication self efficacy, comfort discussing sex and contraception, and perceived communication self efficacy regarding sex and contraception were the dependent variables. Subject self esteem, which is linked to the antecedents of childbearing (Kirby, 2001), was included as a covariate. The omnibus Wilks' Lambda revealed a statistically significant main effect, $F(1, 285) = .000$, $p < .000$, partial $\eta^2 = .043$. The Wilks' Lamda also indicated a significance for the covariate self esteem, $F(1, 285) = .000$, $p < .000$, partial $\eta^2 = .083$. The univariate tests will be reported individually in relation to each hypotheses. See Table 5 for the means and standard deviations that correspond to each hypotheses.

Hypothesis 1 posited that adolescents who are identity achieved would report higher levels of communication efficacy than adolescents operating from the other identity statuses. Univariate tests supported this hypothesis: $F(1, 286) = 11.03$, $p = .001$, $eta^2 = .035$. The pattern of the means in Table 5 reveals that the identity achieved individuals scored higher in terms of communication self efficacy.

Hypothesis 2 was not supported. As Table 5 illustrates, identity-achieved individuals did not report more comfort discussing sex and contraception. The univariate tests did not reveal differences in the scores among the identity statuses.

Hypothesis 3 predicted that identity-achieved individuals would report more perceived communication self efficacy regarding sex and contraception; this hypothesis was not supported. Univariate tests did not reveal a difference between the groups.

Next, a multivariate analysis of variance (MANOVA) was conducted to test hypotheses 4 thru 6; self esteem (low or high) was designated as the independent variable and communication self efficacy, comfort discussing sex and contraception and perceived communication self efficacy regarding sex and contraceptive discussions were designated as the dependent variables. The omnibus Wilks' Lambda revealed a statistically significant main effect, $F(1,285) = .000$, $p < .000$, partial $\eta^2 = .987$; subsequent univariate tests revealed only one significant result on communication self efficacy $F(1, 286) = 18.95$, $p = .000$ $eta^2 = .062$. The univariate tests are reported individually in relation to each hypotheses. Table 6 includes the means and standard deviations that correspond to each hypotheses.

Hypotheses 4 posited that adolescents with higher self esteem would report higher levels of communication efficacy. The univariate tests and pattern of means supported this hypothesis: $F(1, 286) = 18.95$, $p = .000$ $eta^2 = .062$.

Hypothesis 5 and 6 were not supported. No significant differences in self esteem were found on the dependent variables of comfort discussing sex and contraception or perceived communication self efficacy regarding sex and contraception. However, self esteem means on perceived communication self efficacy regarding sex and contraception approached statistical significance, but did not reach the .05 level of significance: $F(1, 286) = 3.360$, $p = .068$ $eta^2 = .012$. The pattern of means revealed that higher self esteem is associated with greater communication regarding contraception.

Hypotheses numbers 7, 8 and 9 addressed associations involving adolescents' comfort with intimacy and dependency and specific communication patterns. Pearson *r* correlations were computed to address these predictions. The following includes the results for each hypothesis individually; see Table 7 for the correlations associated with these hypotheses.

Hypothesis 7 predicted that comfort with dependency and intimacy would be associated with higher levels of communication self efficacy; this hypothesis was supported. The data supported this hypothesis for comfort with intimacy (*r=.15; p=.007*) and comfort with dependence (*r=.12; p=.021*) , both of which describe and individual's level of secure attachment.

Hypothesis 8 was also supported. The hypothesis posited that adolescents' comfort with dependency and intimacy would be associated with comfort discussing sex and contraception with dating partners. Pearson *r* results supported this hypothesis for comfort with intimacy (*r=.14; p=.007*) and for comfort with dependence (*r=12; p=.02*) , both of which describe and individual's level of secure attachment.

Hypothesis 9 asserted that adolescents who are more comfortable with dependency and intimacy would report greater perceived communication self efficacy regarding sex and contraception. Pearson *r* results supported this hypothesis, revealing a significant relationship for comfort with intimacy (*r=.13; p=.02*) and for comfort with dependence (*r=.11; p=.03*) , both of which describe and individual's level of secure attachment.

Chapter Five: Discussion, Conclusions, and Limitations

While we know that adolescents are engaging in sexual behavior and that to some extent they use contraception, we have little knowledge about what it is that adolescents say to each other regarding sex and contraception, if they say anything at all. Kirby (1997) states that adolescents' sexual attitudes and beliefs are related to sexual and contraceptive behavior; thus, the intention of this study was to determine what theoretical perspectives may influence our understanding of adolescents' communication about their sexual behavior. In particular, this research examined the relationship between personality characteristics, including identity status, self esteem, and attachment styles and how these individual characteristics may influence adolescents' communication efficacy, comfort discussing sex and contraception, and perceived communication self efficacy regarding sex and contraceptive discussions.

Overall, there was little evidence that identity status or self esteem influence adolescents' comfort discussing sex and contraception or perceived communication self efficacy regarding sex and contraceptive discussions; although these personality characteristics do influence overall communication self efficacy. However, one of the hypotheses showed a pattern of means consistent with the claims of this research and one was nearly significant, so, while many of claims did not reach statistical significance, the data was in the direction of the claims of this research. In addition, a correlation was found between attachment styles and communication self efficacy, comfort discussing sex and contraception and perceived communication self efficacy regarding sex and contraception discussions, providing evidence that this theoretical perspective may influence our understanding of adolescents' communication regarding sex and

contraception. Kirby (1997) argues that most studies focus on only a few number of antecedents and that it may be the combination that influences adolescents sexual behavior. This study considered three antecedents, and, while the combined characteristics appeared to influence communication behavior, the theoretical explanations did not offer an adequate explanation individually.

Identity status

In considering the influence of identity status on communication regarding sex and contraception, the results of this investigation did not provide support for the assumptions. The results did provide compelling evidence that identity status does influence communication self efficacy, such that adolescents that are identity achieved are more likely than adolescents in other identity statuses to report higher levels of communication self efficacy. Thus, adolescents operating from an achieved identity status have higher overall communication efficacy, but the results of this study did not confirm that it influences their sexual and contraceptive communication. However, hypothesis three showed a pattern of means consistent with the claims of the hypothesis, such that identity achieved adolescents did have higher means on perceived self efficacy regarding sex and contraceptive discussions. Thus, while the results did not yield statistical significance, the data was moving in the right direction, offering some evidence for the fact that identity status may influence sexual and contraceptive discussions.

It is surprising that the results of this investigation did not provide evidence for the influence of identity styles on communication regarding sex and contraception, especially given that the data demonstrated that there is a positive correlation between communication self efficacy and comfort discussing sex and contraception ($r = .16$, $p =$

.005) and communication self efficacy and perceived communication self efficacy regarding sex and contraceptive discussions (*r = .207, p = .000*); thus, communication self efficacy is related to communication about sex and contraception. Perhaps, it is possible that the effect of identity status on communication regarding sex and contraception is subtler than what was measured in this investigation, or that a relationship between the variables, in fact, does not exist. It remains to be seen whether identity differences influences such subtle judgments in the context of communication about sex and contraception.

Future studies might consider communication self efficacy as an intervening variable that is influenced by identity status, then influences communication about sex and contraception. While previous research did not lead this study in that direction, it seems possible that one's identity status does not necessarily predict communication behavior about sex and contraception, as one must also have strong overall communication self efficacy to communicate to feel comfortable enough to discuss sexual behavior and contraception. Hence, while identity status may influence one beliefs and attitudes about sex and contraception, adolescents perceived communication self efficacy to communication their ideals may intervene in the relationship between identity and sex and contraceptive discussions; future research may consider the relationship of these three variables together.

During late adolescence, young people are examining domains including careers, family roles, ideology, religion and sexuality (Marcia & Archer, 1993). When reviewing the literature, sexuality is always mentioned as an important part of identity development at this stage, although, there is little research confirming that adolescents actually

seriously explore their sexual identity; “the connection of the sexual self to the other selves is unexplored at least for adolescents” (Brooks-Gunn & Garber, 1999, p. 175); thus, it is a possibility that while this has been included as a theoretical consideration, more empirical testing is needed to conclude if interpersonal and sexual identity are a component of identity exploration and commitment. As Erikson (1968) notes, healthy interpersonal communication is indicative of openness and sharing, although, little empirical evidence has been found to support this statement, which is why this research was exploratory in nature. It may be possible that scholars have assumed that adolescents with achieved identities are achieved in all domains; however, the reality may be that achieved adolescents are achieved in the areas of education, vocation, religion or politics, but the interpersonal self, particularly the sexual self, has never been the subject of active exploration and/or commitment.

Future empirical research needs to further consider the importance of exploration and commitment in varying domains and contexts. We need to understand our understanding of identity development beyond the four domains (vocation, education, religion, and politics), which have been the focus of most empirical research. Previous theoretical claims presuppose that identity development is broader than the empirical research supports. This research is the first in a series of studies, designed to broaden the scope of what identity development and status encompass.

Self esteem

Similar to identity status, this study provided evidence that self esteem may be a predictor of communication self efficacy; however, the results of this study did not offer support for the assertion that self esteem predicts comfort discussing sex and

contraception or perceived self efficacy in discussing sex and contraception. Higher self esteem is considered a protective antecedent of the initiation of sex (Miller, Christensen, & Olson, 1987), use of contraception (Hombeck, Crossman, Wandrei, & Gasiewski, 1994), pregnancy (Pete-McGadney, 1995) and childbearing (Kowaleski-Jones & Mott, 1998; Robinson & Frank, 1994). Thus, it is surprising that self esteem was not a predictor of communication behaviors related to sex and contraception.

However, while the data did not confirm these relationships, hypothesis 6 was nearly significant at the .10 level. Hence, the pattern of means was in the predicted direction, which provides a foundation for future research. It remains to be seen if identity status is influencing sexual and contraceptive communication and more research is needed to confirm or deny the possibility of this relationship. Similar to the pattern of means in hypotheses 2 and 4, the data did not support the hypotheses when sexuality became part of the discussion.

As previously mentioned, we know very little about the nature of adolescents' communication regarding sex and contraception. Since self esteem is associated with so many other variables related to sexual behavior and attitudes, it is unclear why it is not related to comfort and self efficacy related to sexual and contraceptive communication. Possibly, adolescents are discussing sex so randomly that there is not a particular pattern to what predicts their behavior; it may be that there is not a particular theoretical framework, such as self esteem that alone will predict these communication patterns. Again, as Kirby (1997) states, it may be the combination of these antecedents that offers predictive power, not single theoretical frameworks.

Attachment styles

Parental support and family connectedness is an important antecedent of adolescent sexual behavior and offers a protective factor in terms of adolescent sexual behavior and pregnancy (Bearman & Brucker, 1999; Dittus & Jaccard, 2000; Kirby, 2001). Previous research has confirmed that adolescents attachment orientations influence young people's dating and sexual behavior (Tracy, Shaver, Albino & Cooper, 2003); thus, it is not surprising that attachment styles to parental figures was correlated with higher communication self efficacy, comfort discussing sexual behavior and perceived communication self efficacy to discuss sex and contraceptive behavior.

Adolescents operating from a secure attachment framework, which is reflective of their positive view of the self, exhibit more comfort with interpersonal intimacy; conversely, anxious and avoidant adolescents are less comfortable with healthy interpersonal intimacy (Tracy, et al., 2003).

> Secure individuals tend to have enjoyable sexual experiences and, presumably, are learning something valuable about intimacy, communication, compromise, and reliance on a peer as a potential attachment figure. Avoidant and anxious adolescents who engage in sexual intercourse may do so in less favorable contexts (Tracy, et al., 2003, p. 155).

These conclusions are similar to the conclusions that may be drawn from this research, although, this research may only conclude on the basis of comfort with dependence and comfort with intimacy, both of which determine the secure

status; since the anxiety with relationships offered a low reliability that scale could not be used to determine each adolescent's identity status. Similar to other research findings, the adolescents in this study engaged in more communication related to sex and contraception if operating from an attachment orientation consistent with a secure style. While the correlations in this study were low, they were still important, as it may be difficult to obtain higher correlations, due to the possibility that adolescents do not discuss sex often. Thus, the correlations still inform our understanding of adolescent sexual and contraceptive communication, even if they are not highly correlated.

Sexuality is a normative, healthy feature of adolescence; we certainly know that adolescents are engaging in sexual exploration, but the circumstances under which they engage in this exploration are an important factor when considering how to construct interventions, which protect their health and increase the educational and professional opportunities for young people. If adolescents that are more comfortable with relationships and dependence are more comfortable and have more perceived communication self efficacy discussing sex and contraception, then interventions for these individuals should be shaped differently than for young people that have low comfort and perceived self efficacy. Hence, it is possible that interventions with secure attachment styles need to focus on what to discuss during sexual communication, such as safer sex options and HIV and pregnancy prevention. In contrast, interventions for other adolescents may need to be more focused on what healthy sexual communication consists of and why it is important in romantic and sexual relationships.

Limitations

Overall, a limitation of this research is that it is exploratory in nature, since there is so little information regarding how adolescents manage their communication with romantic partners. In addition, since communication about adolescent sexual behavior and contraceptive use has been a largely ignored phenomenon (Brooks-Gunn & Paikoff, 1993), there is certainly little information tying theoretical constructs to this behavior. Surprisingly, the results of this research provided little evidence for the influence of identity status or self esteem on communication related to sex or contraception. It is possible that the effect of identity on sexual and contraceptive communication is more subtle than what was measured in this investigation, due to the exploratory nature of the study.

While there are limitations to this study associated with its exploratory nature, there are also limitations, which are specific to this study. One limitation in this study is the use of a convenience sample. The students selected as subjects for this study were not randomly selected; in fact, the students were directly solicited from the Communication Department at the University of Oklahoma and from three particular high schools, where the researcher had established relationships with the teachers.

A second limitation is that only one dating partner completed the survey. This limitation is particularly relevant when examining comfort discussing sex and contraception and contraception discussion. Would the dating partner have the same account of the subject's report of her/his comfort discussing sex and contraception? Further, would both dating partners' reports change the results of the study or be inconsequential? There is not evidence that leads us to infer how this would affect the

outcome of this study, since there is such a limited body of research on adolescents' communicative intentions and comfort discussing sex and contraception. It would be interesting in future research to involve both parties in dating relationships when examining this phenomenon.

Overall, while there are limitations to this study, it is important in increasing our understanding of adolescent identity development and communication about sex and contraception. This study is useful in informing the development of interventions and prevention programs for young people. If identity achieved adolescents are not more likely to discuss issues related to sex and contraception, then we must be developing interventions for young people that teach all young people the importance of discussing these critical issues. We cannot assume that identity achieved adolescents have engaged in active exploration and commitment in all domains and are more equipped to discuss such sensitive issues as sex and contraception.

Conclusion

In conclusion, this study adds to the research in interpersonal communication and adolescent development by probing what theoretical perspectives may offer a framework for understanding adolescent communication related to sex and contraception. This study illustrates that adolescents with identity status does increase one's communication efficacy, but the results did not confirm the relationship between identity status and sex and contraceptive discussions. It remains to be seen whether identity status differences influences adolescents' communication about their sexual behavior. While this study did not confirm many of the assertions of this research, it does provide a foundation for future research aimed at increasing our understanding of adolescent communication

regarding sex and contraception; because the pattern of means related to perceived self efficacy regarding sexual and contraceptive discussions are in the direction of the claims of this research, it is still not possible to deny that there is a relationship between identity status and sexual and contraceptive discussions.

> Further investigation of the development of differences sexual identities and the role that different behaviors lay for youth with different identities would potentially lead to more effective programming with those youth engaging in the most health-compromising behaviors (Brooks-Gunn & Graber, 1999, p. 175).

In future studies, it will be critical to better ascertain the nuances associated with the personality characteristics and communication regarding sexual behavior and contraception. In particular, it is important to further probe the process of identity development and draw stronger empirical conclusions regarding the domains that are included in the exploration and commitment process. If interpersonal and sexual identity is going to be included in the theoretical literature, there needs to be an empirical basis for those claims. Hence, it is critical to draw stronger conclusions about what the boundaries are for identity achievement and what it means for adolescents to be achieved in some domains, but not others; currently, the theory is broader than what the empirical research will support. As such, this project is the first in a series of studies to come, aimed at providing stronger empirical evidence for the domains, which are to be included in identity exploration and commitment, and how identity development relates to the context of interpersonal and sexual communication.

References

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment.* Hillsdale, NJ: Erlbaum.

Annie E. Casey Foundation (2002). *Right start online.* Washington, D.C.: Annie E. Casey Foundation.

Aron, E. N., & Aron, A. A. (1996). Love and expansion of the self: The state of the model. *Personal Relationships, 3,* 45-58.

Balistreri, E., Busch-Rossnagel, N. A., & Geisinger, K. F. (1995). Development and preliminary validation of the Ego Identity Process Questionnaire. *Journal of Adolescence, 18,* 179-190.

Banaji, M. R., & Prentice, D. A. (1994). The self in social contexts. *Annual Review of Psychology, 45,* 297-332.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four category model. *Journal of Personality and Social Psychology, 61,* 226-244.

Baumeister, R. F., Tice, D. M., & Hutton, D. G. (1989). Self-presentational motivations and personality differences in self-esteem. *Journal of Personality, 57,* 547-579.

Bearman, P.S., & Bruckner, H. (1999). *Power in numbers: Peer effects on adolescent girls' sexual debut and pregnancy.* Washington, D.C.: The National Campaign to Prevent Teen Pregnancy.

Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment.* New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Brafford, L. J., & Beck, K. H. (1991). Development and validation of condom self-efficacy scale for college students. *College Health, 39,* 219-225.

Brooks-Gunn, J. & Graber, J.A. (1999). What's sex got to do with it? The development of sexual identities during adolescence. In R.J. Contrada and R.D. Ashmore (Eds.), *Self social identity, and physical health: Interdisciplinary explorations* (pp. 155-184). New York: Oxford University Press.

Brooks-Gunn, J., & Paikoff, R. L. (1993). Sex is a gamble, kissing is a game: Adolescent sexuality and health promotion. In S.G. Millstein and A.C. Petersen (Eds.), *Promoting the health of adolescents: New directions for the twenty-first century* (pp. 180-208). Oxford University Press: New York.

Brown, J. D. (1993). Self-esteem and self-evaluation: Feeling is believing. In J. Suls (Ed.*), Psychological perspectives on the self* (pp. 27-58). Hillsdale, NJ: Erlbaum.

Byrne, B.M., & Shavelson, R.J. (1996). On the structure of social self-concept for pre, early and late adolescents: A test of the Shavelson, Hubner and Stanton (1976) model. *Journal of Personality and Social Psychology, 70,* 599-614.

Cassidy, J., & Berlin, L.J. (1999). Understanding the origins of childhood loneliness: Contributions of attachment theory. In Rotenberg, K.J. & Hymel, S. (Eds.), *Loneliness in childhood and adolescence.* Cambridge: Cambridge University Press.

Centers for Disease Control and Prevention (1996). *Youth Risk Behavioral Surveillance Report.*

Centers for Disease Control and Prevention (1997). *Youth Risk Behavioral Surveillance Report.*

Centers for Disease Control and Prevention (1999). *HIV/AIDS Surveillance Report, 11,* 1-44.

Centers for Disease Control and Prevention (2001). *Youth Risk Behavioral Surveillance Report.*

Cote, J.E. (1996). Identity: A multidimensional analysis. In G.R. Adams, R. Montemayor, and T. P. Gullotta (Eds.), *Psychosocial development during adolescence: Progress in developmental contextualism* (pp.130-180). Sage Publications, Inc.: California.

Crockett, L.J., & Petersen, A.C. (1993). Adolescent development: Health risks and opportunities for health promotion. In S.G. Millstein and A.C. Petersen (Eds.), *Promoting the health of adolescents: New directions for the twenty-first century* (pp. 13-37). Oxford University Press: New York.

Crowell, T. L., & Emmers-Sommer, T.M. (2000). Examining condom use self-efficacy and coping in sexual situations. *Communication Research Reports, 17,* 191-202.

Dittus, P.J., & Jaccard, J. (2000). Adolescents' perceptions of maternal disapproval of sex: Relationship to sexual outcomes. *Journal of Adolescent Health, 26,* 268-278.

Earle, E. M. (1979). The psychosocial effects of mutilating surgery in children and adolescents. *Psychoanalytic Study of the Child, 34,* 527-546.

Erikson, E. (1968). *Identity: Youth and crisis.* New York: Norton.

Feeney, J. A. (1995). Adult attachment and emotional control. *Personal Relationships, 2,* 143-159.

Flanigan, C. (2001). *What's behind the good news: The decline in teen pregnancy rates during the 1990s.* Washington, D.C.: The National Campaign to Prevent Teen Pregnancy.

Fletcher, G. J. O., Fincham, F. D., Cramer, L., & Heron, N. (1987). The role of attributions in the development of dating relationships. *Journal of Personality and Social Psychology, 53,* 481-489.

Furman, W., & Simon, V. A. (1999). Cognitive representations of adolescent romantic relationships. In W. Furman, B. B. Brown, & C. Feiring (Eds.), *The development of romantic relationships in adolescence* (pp. 75-98). New York: Cambridge University Press.

Galliher, R. V. (1999). Power and psychological well-being in late adolescent romantic relationships. *Sex Roles, 40,* 689-711.

George, R.M., & Lee, B.J. (1997). Abuse and neglect of the children. In Maynard, R. (Ed.), *Kids having kids: Economic costs and social costs of teen pregnancy* (pp. 205-230). Washington, D.C.: The Urban Institute Press.

Harter, S. (1997). The personal self in social context: Barriers to authenticity. In R. D. Ashmore & L. Jussim (Eds.), *Self and identity: Fundamental issues* (pp. 81-105). New York: Oxford University Press.

Harter, S. (1999). *The construction of the self*. New York: Guilford Press.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52,* 511-524.

Holmbeck, G.N., Crossman, R.E., Wandrei, M.L., & Gasiewski, E. (1994). Cognitive development, egocentrism, self-esteem, and adolescent contraceptive knowledge, attitudes, and behavior. *Journal of Youth and Adolescence, 23,* 169-193.

Husband, S. (2003). http://luna.cas.usf.edu/~husband/develop/teen_soc.htm

Hutchins, J. (2000). *The next best thing: Helping sexually active teens avoid teen pregnancy.* Washington, D.C.: National Campaign to Prevent Teen Pregnancy.

Jackson, S., & Rodriguez-Tome, H. (1993). Adolescence: Expanding social worlds. In S. Jackson & H. Rodriguez-Tome (Eds.), *Adolescence and its social worlds* (pp. 1-13). Hillsdale, NJ: Lawrence Erlbaum.

Kegeles, S. M., Adler, N.W., & Irwin, C. E. (1988). Sexually active adolescents and condoms: Changes over one year in knowledge, attitude, and use. *American Journal of Public Health, 78,* 460-461.

Kirby, D. (1997). *No easy answers.* Washington, DC: National Campaign to Prevent Teen Pregnancy.

Kirby, D. (2001). *Emerging answers: Research findings on programs to reduce teen pregnancy.* Washington, D.C.: The National Campaign to Prevent Teen Pregnancy.

Kirby, D., Short, L., Collins, J., Rugg, D., Kolbe, L., Howard, M., Miller, B., Sonenstein, F., & Zabin, L.S. (1994). School-based programs to reduce sexual risk behaviors: A review of effectiveness. *Public Health Reports, 109,* 339-360.

Knox, M. (1998). Adolescents' possible selves and their relationship to global self-esteem. *Sex Roles: A Journal of Research; 39,* 61-80.

Kowaleski-Jones, L., & Mott, F. (1998). Sex, contraception, and childbearing among high-risk youth: Do different factors influence males and females? *Family Planning Perspectives, 30,* 163-169.

Larson, R.W., Clore, G.L., & Wood, G.A. (1999). The emotions of romantic relationships. In W. Furman, B.B. Brown, & C. Feiring (Eds.), *The Development of Romantic Relationships in Adolescence (*pp. 19-49). Cambridge, UK: Cambridge University Press.

Laursen, B. (1993). Conflict management among close peers. *New Directions for Child Development, 60,* 39-54.

Lazarus, R.S. (1991). *Emotion and adaptation.* New York: Oxford University Press.

Lerner, R.M., & Galambos, N.L. (1998). Adolescent development: Challenges and opportunities for research, programs, and policies. *Annual Review Psychology, 49,* 413-446.

Lerner, R.M., Miller, J.R., Knott, J.H., Corey, K.E., & Bynum, T.S. (1994). Integrating scholarship and outreach in human development research, policy, and service: A developmental perspective. In D.L. Featherman, R.M. Lerner, & M. Perlmutter (Eds.), *Life Span Development and Behavior* (pp. 249-273). Hillsdale, N.J.: Erlbaum.

Levesque, R. (1993). The romantic experience of adolescents in satisfying love relationships. *Journal of Youth and Adolescence, 22,* 219-251.

Marcia, J. E. (1966). Development and validation of ego identity status. *Journal of Personality and Social Psychology, 3,* 551-558.

Marcia, J. E. (1988). Common processes underlying ego identity, cognitive/moral

development, and individuation. In D. K. Lapsley & F. C. Power (Eds.), *Self, ego, and identity: Integrative approaches* (pp. 159-178). New York: Springer-Verlag.

Marcia, J.E. (1989). Identity diffusion differentiated. In M. A. Luszcz & T. Nettelbeck (Eds.), *Psychological development: Perspectives across the lifespan* (pp. 289-294). Elsevier Science Publishers: North Holland.

Marcia, J. E. (1993). The ego identity status approach to ego identity. In J. E. Marcia, A. S. Waterman, D. R Matteson, S. L. Archer, & J. L. Orlofsky (Eds.), *Ego identity: A handbook for psychosocial research* (pp. 3-21). Springer-Verlag: New York.

Marcia, J. E., & Archer, S. L. (1993) Identity status in late adolescents: Scoring criteria. In J. E. Marcia, A. S. Waterman, D. R Matteson, S. L. Archer, & J. L. Orlofsky (Eds.), *Ego identity: A handbook for psychosocial research* (pp. 205-240). Springer-Verlag: New York.

Markstrom-Adams, C. (1992). A consideration of intervening factors in adolescent identity formation. In G. R. Adams, T. P. Gullotta, & R. Montemayor (Eds.), *Adolescent identity formation* (pp. 173-192). Newbury Park, CA: Sage.

Meyers, J., & Pitt, M. W. (1976). A consultation approach to help a school cope with the bereavement process. *Professional Psychology, 7,* 559-564.

Miller, B.C., Christensen, R. B., & Olson, T.D. (1987). Adolescent self-esteem in relation to sexual attitudes and behavior. *Youth and Society, 19,* 93-111.

Miller, P., Potts, R., Fung, H., Hoogstra, L., & Mintz, J. (1990). Narrative practices and the social construction of the self in childhood. *American Ethnologist, 17,* 292-311.

Millstein, S. G. (1993). A view of health from the adolescent's perspective. In S.G. Millstein & A.C. Petersen (Eds.), *Promoting the health of adolescents: New directions for the twenty-first century* (pp. 97-118). Oxford University Press: New York.

Moore, K.A., Driscoll, A. K., & Lindberg, L.D. (1998). *A statistical portrait of adolescent sex, contraception, and childbearing.* Washington, D.C.: The National Campaign to Prevent Teen Pregnancy.

Moore, K.A., Miller, B.C., Sugland, B.W., Morrison, D.R., Glei, D.A., & Bluenthal, C. (2001). *Beginning too soon: Adolescent sexual behavior, pregnancy and parenthood: A review of research and interventions.* Washington, D.C.: Child Trends.

Moore, K.A., & Sugland, B.W. (2001). *Next steps and best bets: Approaches to preventing adolescent childbearing.* Washington, D.C.: Child Trends.

National Campaign to Prevent Teen Pregnancy (1997). *Whatever happened to childhood? The problem of teen pregnancy in the United States.* Washington, D.C.: National Campaign to Prevent Teen Pregnancy.

National Campaign to Prevent Teen Pregnancy (2001). *Halfway there: A prescription for continued progress in preventing teen pregnancy.* Washington, D.C.: National Campaign to Prevent Teen Pregnancy.

National Campaign to Prevent Teen Pregnancy (2002). *Not just another single issue: Teen pregnancy prevention's link to other critical social issues.* Washington, D.C.: National Campaign to Prevent Teen Pregnancy.

National Center on Addiction and Substance Abuse at Columbia University (1999). *Dangerous liaisons: Substance abuse and sex.* New York: National Center on Addiction and Substance Abuse.

Neeman, J., Hubbard J., & Masten, A.S. (1995). The changing importance of romantic relationship involvement to competence from late childhood to late adolescence *Development and psychopathology, 7,* 727-751.

Office of National AIDS Policy (1996). *Youth and HIVAIDS: An American agenda.* Washington, D.C.: Office of National AIDS Policy.

Oklahoma State Department of Health (2001). *Oklahoma vital records.* Oklahoma City, Oklahoma: Oklahoma State Department of Health.

Patterson, S. J., Sochting, I., & Marcia, J. E. (1992). The inner space and beyond: Women and identity. In G. R. Adams, T.P. Gullota, & R. Montemayor (Eds.), *Adolescent identity formation* (pp. 9-24). Newbury Park, CA: Sage.

Pete-McGadney, J. (1995). Differences in adolescent self-concept as a function of race, geographic location, and pregnancy. *Adolescence, 30,* 95-105.

Register, L. M., & Henley, T. B. (1992). The phenomenology of intimacy. *Journal of Social and Personal Relationships, 9,* 467-481.

Robinson, R.B., & Frank, D. I. (1994). The relation between self-esteem, sexual activity, and pregnancy. *Adolescence, 29,* 27-35.

Rosenberg, M. (1979). *Conceiving the self.* New York: Basic Books.

Ruppel, H.J., Jr. (1994). *Publication trends in the sexological literature: A comparison of two contemporary journals.* Unpublished doctoral dissertation, Institute for the Advanced Study of Human Sexuality, San Francisco, CA.

Ryan, R. M., & Lynch, J. H. (1989). Emotional autonomy versus detachment: Revisiting the vicissitudes of adolescence and young adulthood. *Child Development, 60,* 340-356.

Samet, N., & Kelly, E. W. (1987). The relationship of steady dating to self-esteem and sex role identity among adolescents. *Adolescence, 22,* 231-245.

Samp, J.A. (2001). Relationship and self-driven influences on goal characteristics for problematic events: Components of a cybernetic cycle. *Communication Studies, 51,* 329-351.

Sanderson, C. A., & Cantor, N. (1995). Social dating goals in late adolescence: Implications for safer-sex activity. *Journal of Personality and Social Psychology, 68,* 1121-1134.

Schwartz, S. J., Mullis, R. L., Waterman, A. S., & Dunham, R. M. (2000). Ego identity status, identity style, and personal expressiveness: An empirical investigation of three convergent constructs. *Journal of Adolescent Research, 15,* 504-521.

Schwarzer, R. (Ed.) (1992). *Self efficacy: Thought control of action.* Washington, DC: Hemisphere.

Seiffge-Krenke, I. (1993). *Stress, coping, and relationships in adolescence.* Mahwah, NJ: Erlbaum.

Simpson, J. A., & Sippola, L.K. (1999). Getting to know the "other": The characteristics and developmental significance of other-sex relationships in adolescence. *Journal of Youth and Adolescence, 28,* 406-418.

Society for Adolescent Medicine (2000). Position paper of the society for adolescent medicine, *Journal of Adolescent Health, 27,* 290-291.

Sonenstein, F. L., Pleck, J. H., & Klu, L. C. (1989). Sexual activity, condom use and AIDS awareness among adolescent males. *Family Planning Perspectives, 21,* 152-158.

Stoddard, F. J. (1982). Coping with pain: A developmental approach to the treatment of burned children. *American Journal of Psychiatry, 139,* 736-740.

Swann, W. B., De La Ronde, C., & Hixson, J. G. (1994). Authenticity and positivity strivings in marriage and courtship. *Journal of Personality and Social Psychology, 66,* 857.

Terry, E., & Manlove, J. (2000). *Trends in sexual activity and contraceptive use among teens.* Washington, D.C.: Child Trends.

Tracy, J. L., Shaver, P. R., Albino, A. W., & Cooper, M. L. (2003). Attachment styles and adolescent sexuality. In P. Florsheim (Ed.), *Adolescent romantic relations and sexual behavior: Theory, research, and practical implications* (pp. 137-162). Mahwah, New Jersey: Lawrence Erlbaum Associates, Inc.

Youniss, J. (1986). Development in reciprocity through friendship. In C. Zahn-Waxler, E. M. Cummings, & R. Iannotti (Eds.), *Altruism and aggression: Biological and social origins* (pp. 88-106). Cambridge, England: Cambridge University Press.

Zani, B. (1993). Dating and interpersonal relationships in adolescence. In S. Jackson & H. Rodriguez-Tome (Eds.), *Adolescence and its social worlds* (pp. 95-119). Hillsdale, NJ: Erlbaum.

Endnotes

[1] Kirby argues that the average age for the onset of puberty has decreased and the average age of marriage has increased, which has created a larger time frame for youth to sexually experiment; this gap increases the number of sexually experienced youth.

Table 1

Identity Status

Sample Demographics		*Identity Status*			
	Total Sample	*Achievers*	*Foreclosures*	*Moratoriums*	*Diffusions*
Total Sample	287 (100%)	93 (31%)	49 (18%)	51 (19%)	94 (32%)
Females	153 (54%)	47 (57%)	27 (63%)	18 (47%)	41 (46%)
Males	131 (46%)	35 (43%)	16 (37%)	20 (53%)	47 (54%)
High School	62 (22%)	16 (19%)	35 (81%)	32 (84%)	70 (80%)
College	223 (77%)	66 (81%)	8 (19%)	6 (16%)	18 (21%)
Age of Total Sample	*M = 18.58* *(SD = .49)*	M = 18.62 *(SD = .49)*	*M = 18.56* *(SD = .50)*	*M = 18.68* *(SD = .47)*	*M = 18.56* *(SD =.50)*

Table 2

Scale Frequencies and Reliabilities for Measures

	M	SD	α
Self Esteem	*4.06*	*.59*	*.84*
Communication Self Efficacy	*3.32*	*.51*	*.82*
Comfort Discussing Sex and Contraception	*5.78*	*1.20*	*.80*
Perceived Communication Self Efficacy Regarding Sex and Contraception	*4.06*	*.67*	*.84*
Comfort with Intimacy	*3.85*	*.84*	*.85*
Comfort with Dependence	*3.47*	*.75*	*.64*
Anxiety with Relationships	*1.94*	*.71*	*.53*
Identity Commitment	*3.56*	*.53*	*.79*
Identity Exploration	*3.50*	*.48*	*.72*

Note. Self esteem was measured using a five-point scale. Higher scores indicate high self esteem and lower scores indicate low self esteem.

Communication self efficacy was measured using a four-point scale. Higher scores signify more communication self efficacy and lower scores indicate lower communication self efficacy.

Comfort discussing sex and contraception was measured using a seven-point scale. The higher scores indicate higher comfort discussing sex and contraception and lower scores signify less comfort discussing sex and contraception.

Perceived communication self efficacy regarding sex and contraception was measured using a five-point scale. Higher scores designate higher levels of communication about contraception and lower scores indicate less communication about contraception.

Attachment, which includes comfort with intimacy and dependence and anxiety in relationships was measured on a five-point scale. Higher scores indicate more comfort with intimacy and dependence and higher anxiety in relationships.

Identity commitment and exploration were measured using a five-point scale. Higher scores indicate higher identity commitment or exploration and lower scores indicate low identity commitment or exploration.

Table 3

Relational Demographics

Relational Status	*Identity Status*			
	Total Sample	*Achievers*	*Foreclosures*	*Moratoriums*	*Diffusions*
Current Dating Partner	143 (51%)	42 (51%)	22 (51%)	13 (34%)	45 (51%)
Previous Dating Partner	159 (55%)	46 (56%)	18 (42%)	25 (66%)	47 (53%)
Dating Partner Male	156 (55%)	46 (56%)	26 (61%)	18 (47%)	39 (44%)
Dating Partner Female	131 (45%)	34 (42%)	14 (33%)	20 (53%)	49 (56%)
Dating Partner's Age	*M = 19.14 (SD = 2.16)*	*M = 19.53 (SD = 2.80)*	*M = 18.87 (SD = 1.51)*	*M = 19.03 (SD = 1.98)*	*M = 18.86 (SD = 1.68)*
Length of Dating Relationship (Months)	*M = 15.00 (SD = 14.62)*	*M = 16.41 (SD = 16.12)*	*M = 18.08 (SD = 12.93)*	*M = 13.84 (SD = 16.96)*	M = 13.02 *(SD =13.24)*
Parents Married	189 (66%)	57 (70%)	29 (67%)	31 (82%)	54 (61%)
Sexually Active	173 (63%)	41 (50%)	24 (26%)	26 (68%)	62 (71%)

Table 4

Identity Status Contraceptive Use

	Birth Control Pill	*Condom*	*Diaphragm*	*Do Not Use Contraception*	*Birth Control Patch*	*IUD*	*Other*	*Not Sexually Active*
Total Sample	31%	32%	.4%	5.2%	3%	.4%	3%	25%
Achievers	23%	26%	0%	6%	2%	0%	9%	34%
Foreclosures	24%	38%	0%	3%	3%	0%	0%	32%
Moratoriums	24%	46%	0%	6%	0%	3%	0%	21%
Diffusions	44%	30%	1%	4%	4%	0%	3%	14%

Table 5

Means and Standard Deviations for Identity Status

Dependent Measures	Identity Status	
	Achiever	Non-Achiever
Communication Self Efficacy		
M (SD)	3.48[a] (.52)	3.24 (.48)
n	92	195
Comfort Discussing Sex and Contraception		
M (SD)	5.79 (1.18)	5.77 (1.18)
n	92	195
Perceived Communication Self Efficacy Regarding Sex and Contraception		
M (SD)	4.14 (.68)	4.03 (.60)
n	92	195

Note.

[a] significant compared to non-achievers at $p < .05$.

Identity commitment and exploration were measured using a five-point scale. Higher scores indicate higher identity commitment or exploration and lower scores indicate low identity commitment or exploration.

Communication self efficacy was measured using a four-point scale. Higher scores signify more communication self efficacy and lower scores indicate lower communication self efficacy.

Comfort discussing sex and contraception was measured using a seven-point scale. The higher scores indicate higher comfort discussing sex and contraception and lower scores signify less comfort discussing sex and contraception.

Perceived communication self efficacy regarding sex and contraception was measured using a five-point scale. Higher scores designate higher levels of communication about contraception and lower scores indicate less communication about contraception.

Table 6

Means and Standard Deviations for Self Esteem

Dependent Measures	Self Esteem	
	High	Low
Communication Self Efficacy		
M (SD)	3.45[a] (.52)	3.20 (.46)
n	141	146
Comfort Discussing Sex and Contraception		
M (SD)	5.85 (1.13)	5.71 (1.22)
n	141	146
Perceived Communication Self Efficacy Regarding Sex and Contraception		
M (SD)	4.14[b] (.63)	4.00 (.63)
n	141	146

Note.

[a] significant compared to non-achievers at $p < .001$.

[b] nearly significant compared to non-achievers at $p < .10$.

Self esteem was measured using a five-point scale. Higher scores indicate high self esteem and lower scores indicate low self

esteem.

Communication self efficacy was measured using a four-point scale. Higher scores signify more communication self efficacy

and lower scores indicate lower communication self efficacy.

Comfort discussing sex and contraception was measured using a seven-point scale. The higher scores indicate higher comfort

discussing sex and contraception and lower scores signify less comfort discussing sex and contraception.

Communication about contraception was measured using a five-point scale. Higher scores designate higher levels of

communication about contraception and lower scores indicate less communication about contraception.

Table 7

Correlations for Attachment Styles

Communication Measures	*Attachment Style*	
	Comfort with Intimacy	Comfort with Dependence
	N = 287	
Communication Self Efficacy	.15*	.12*
Comfort Discussing Sex and Contraception	.14*	.12*
Perceived Communication Self Efficacy Regarding Sex and Contraception	.13*	.11*

Note.

* Correlations are significant at the 0.05 level (1-tailed).

Comfort with intimacy and dependence in relationships was measured on a five-point scale. Higher scores indicate more comfort with intimacy and dependence in relationships.

Communication self efficacy was measured using a four-point scale. Higher scores signify more communication self efficacy and lower scores indicate lower communication self efficacy.

Comfort discussing sex and contraception was measured using a seven-point scale. The higher scores indicate higher comfort discussing sex and contraception and lower scores signify less comfort discussing sex and contraception.

Perceived communication self efficacy regarding sex and contraception was measured using a five-point scale. Higher scores designate higher levels of communication about contraception and lower scores indicate less communication about contraception.

Table 8

Pearson's Correlations Between Variables Identified in the Hypotheses Excluding Identity Status

Variables	1	2	3	4	5	6	7	8
				(N = 287)				
1. Self Esteem	__	.27**	.19**	.15*	.32**	.29**	.11	.31**
2. Communication Self Efficacy		__	.15**	.19**	.15*	.12*	.19**	.16**
3. Comfort Discussing Sex and Contraception			__	.55**	.14*	.12*	.03	-.03
4. Perceived Communication Self Efficacy Regarding Sex and Contraception				__	.13*	.11	.12*	.11
5. Comfort with Intimacy					__	.61**	.16**	.30**
6. Comfort with Dependence						__	.19	.34**
7. Identity Exploration							__	.41**
8. Identity Commitment								__

Note.

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 9

Spearman's Correlations Between Variables Identified in the Hypotheses Including Identity Status

Variables	1	2	3	4	5	6	7
			(N = 287)				
1. Self Esteem	__	.34**	.15*	.16**	.30**	.29**	.16**
2. Communication Self Efficacy		__	.17**	.21**	.18**	.13*	.26**
3. Comfort Discussing Sex and Contraception			__	.57**	.18**	.15**	.02
4. Perceived Communication Self Efficacy Regarding Sex and Contraception				__	.17**	.14*	.12
5. Comfort with Intimacy					__	.63**	.23**
6. Comfort with Dependence						__	.15*
7. Identity Status							__

Note.

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Appendix A

Relationships Study

This research is about relationships with your boyfriends and girlfriends. The following pages will ask you questions about yourself, as well as your boyfriend/girlfriend.

All of your answers to the questions will be kept private and we will never ask for your name.

There are no right or wrong answers to these questions, so try to answer each question as honestly as possible.

Thank you for helping with this research!

Turn to the next page…

The questions on the this page are about you. For each question, please circle the right response or fill in the blank.

1. Are you male or female? (Circle One) Male
   Female

2. How old are you? (Fill in the Blank)
   _____ years old

3. Are you in high school or college? High School
College

4. Are your parents married to each other? (Circle One) Yes
   No

5. Do you have a boyfriend or girlfriend? (Circle One) Yes
   No

SKIP NUMBER 6, IF YOU ANSWERED YES TO NUMBER 5

6. Have you had a boyfriend or girlfriend previously? Yes
   No

7. Please answer all of the following about your current or previous boyfriend/girlfriend:

   a. Is/was this person male or female? (Circle One) MALE
   FEMALE

   b. How old is/was your boyfriend or girlfriend? (Fill in the Blank)
   _____ years old

   c. How long has/was this person been your boyfriend/girlfriend? ____ months ___ years

   d. Are/were you and your boyfriend/girlfriend sexually active? (Circle One)
Yes No

   e. If you are/were sexually active, what form of contraception do you *most often* use?
   (Circle One)

   Birth Control Pill Birth Control Patch

Condom

Diaphragm

Do Not Use Contraception

IUD

Other: _____

Not Sexually Active

Turn to the next page…

The questions on this page are about <u>yourself</u>. Circle the number that shows how much you agree or disagree with each statement.

Use this scale:

STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
1	2	3	4	5

1. On the whole, I am satisfied with myself	1	2	3	4	5
2. Sometimes I think I am no good at all	1	2	3	4	5
3. I feel that I have a number of good qualities	1	2	3	4	5
4. I am able to do things as well as most other people	1	2	3	4	5
5. I feel I do not have much to be proud of	1	2	3	4	5
6. I certainly feel useless at times	1	2	3	4	5
7. I feel that I am a person of worth, at least on an equal plane with others	1	2	3	4	5
8. I wish that I could have more respect for myself	1	2	3	4	5
9. All in all, I am inclined to feel that I am a failure	1	2	3	4	5
10. I take a positive attitude toward myself	1	2	3	4	5

The next questions are about <u>your</u> feelings about your parents. "Parent" may be the person in your life that you designate as your parents; it does not need to be your birth parents. Circle the number that shows how much you agree or disagree with each statement.

Use this scale:

STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
1	2	3	4	5

1. I find it easy to get close to my parent(s) 1 2 3 4 5

2. I'm not very comfortable having to depend on my parent(s)
   1 2 3 4 5

3. I'm comfortable having my parent(s) depend on me
   1 2 3 4 5

4. I don't worry about being left by my parent(s)
   1 2 3 4 5

5. I don't like my parent(s) getting too close to me
   1 2 3 4 5

6. I'm uncomfortable being too close to my parent(s)
   1 2 3 4 5

7. I find it difficult to trust my parent(s) 1 2 3 4 5

8. I'm nervous whenever my parent(s) gets too close to me
   1 2 3 4 5

9. My parent(s) want me to be closer than I feel comfortable being
   1 2 3 4 5

10. My parent(s) do not get as close as I would like
    1 2 3 4 5

11. I often worry that my parent(s) do not really like me
    1 2 3 4 5

12. I don't worry about my parent(s) leaving me
    1 2 3 4 5

13. I want to always be with my parent(s) 1 2 3 4 5

14. I would like our relationship to last a long time
    1 2 3 4 5

15. I am very attached to my parent(s) 1 2 3 4 5

Now, you will find a number of statements about beliefs, attitudes, and/or ways of dealing with issues. Read each statement carefully, then use it to describe yourself. Circle the number that reflects the extent to which you think the statement represents you.

Use this Scale:

NOT AT ALL LIKE ME	NOT LIKE ME	NEUTRAL	LIKE ME	VERY MUCH LIKE ME
1	2	3	4	5

1.	Regarding religious beliefs, I know basically what I believe and don't believe	1	2	3	4	5
2.	I've spent a great deal of time thinking seriously about what I should do with my life	1	2	3	4	5
3.	I've more-or-less always operated according to the values with which I was brought up	1	2	3	4	5
4.	I've spent a good deal of time reading and talking to others about religious ideas	1	2	3	4	5
5.	I know what I want to do with my future	1	2	3	4	5
6.	I'm not really sure what I believe about religion	1	2	3	4	5
7.	I've always had purpose in my life; I was brought up to know what to strive for	1	2	3	4	5
8.	I have some consistent political views	1	2	3	4	5
9.	I'm really into my schoolwork right now	1	2	3	4	5

10.	I've spent a lot of time reading and trying to make some sense out of political issues	1	2	3	4	5
11.	I've spent a lot of time and talked to a lot of people trying to develop a set of values that make sense to me	1	2	3	4	5
12.	Regarding religion, I've always known what I believe and don't believe; I never really had any serious doubts	1	2	3	4	5
13.	I have a definite set of values that I use in order to make personal decisions	1	2	3	4	5
14.	I think it's better to have a firm set of beliefs than to be open-minded	1	2	3	4	5
15.	When I have a personal problem, I try to analyze the situation in order to understand it	1	2	3	4	5
16.	I find it's best to seek out advice from professionals (e.g., clergy, doctors, lawyers) when I have a problem	1	2	3	4	5
17.	I think it's better to have fixed values, than to consider alternative value systems	1	2	3	4	5
18.	I find that personal problems often turn out to be interesting challenges	1	2	3	4	5
19.	Once I know the correct way to handle a problem, I prefer to stick with it	1	2	3	4	5
20.	When I have to make a decision, I like to spend a lot of time thinking about my options	1	2	3	4	5
21.	I prefer to deal with situations where I can rely on social norms and standards	1	2	3	4	5
22.	I like to have the responsibility for handling problems in my life that require me to think on my own	1	2	3	4	5

23. When making important decisions I like to have as much information as possible.....	1	2	3	4	5
24. To live a complete life, I think people need to get emotionally involved and commit themselves to specific values and ideals	1	2	3	4	5
25. I find it's best for me to rely on the advice of close friends or relatives when I have a problem	1	2	3	4	5

Next, we would like you to think about your communication skills. After each statement, circle your response using the following scale:

1	2	3	4
NOT AT ALL TRUE	HARDLY TRUE	MODERATELY TRUE	EXACTLY TRUE

1. I am comfortable communicating with others. 1 2 3 4

2. When I feel others will not agree with me, I can still communicate my opinion. ……. . 1 2 3 4

3. It is easy for me to communicate my beliefs and goals to others 1 2 3 4

4. I am confident that I have the communication skills to deal with difficult situations ……... 1 2 3 4

5. I can solve most problems by communicating with others 1 2 3 4

Now, we would like to know about your comfort discussing sex and/or contraception with your current or most recent boyfriend/girlfriend. After each statement, circle your response using the following scale:

1	2	3	4	5	6	7
Strongly Disagree			*Neutral*			*Strongly Agree*

1. I would feel comfortable discussing sex with my dating partner
1 2 3 4 5 6 7

2. I would feel comfortable discussing contraceptive options with my dating partner
1 2 3 4 5 6 7

3. I would be comfortable talking to my boyfriend/girlfriend about sex
1 2 3 4 5 6 7

4. Communicating with my dating partner about sex is important to me
1 2 3 4 5 6 7

5. I would feel comfortable discussing contraceptive use with my boyfriend/girlfriend
1 2 3 4 5 6 7

6. It is important to me to talk to my current or most recent boyfriend/girlfriend about sex 1 2 3 4 5 6 7

Now, we would like you to consider how you communicate with your dating partner regarding contraceptive use. CONTRACEPTION INCLUDES ANY FORM OF BIRTH CONTROL THAT YOU AND YOUR PARTNER MIGHT USE (CONDOM, BIRTH CONTROL PILLS, BIRTH CONTROL PATCH, DIAPHRAGM, ETC.) If you and your partner are not sexually active, please circle the response the coincides with how you WOULD communicate regarding sexual behavior.

Use this scale:

STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
1	2	3	4	5

1. I would feel confident in my ability to discuss contraception usage with my partner 1 2 3 4 5

2. I would feel confident in my ability to suggest using contraception with my partner 1 2 3 4 5

3. I would feel confident I could suggest using contraception without my partner feeling “diseased” 1 2 3 4 5

4. If I were to suggest using contraception to my partner, I would feel afraid that s/he would reject me 1 2 3 4 5

5. If I were unsure of my partner’s feeling about using contraception, I would not suggest it 1 2 3 4 5

6. I would feel comfortable discussing contraception use with my partner before we ever had any sexual contact, such as kissing, hugging or caressing 1 2 34 5

7. I would feel confident in my ability to persuade a partner to accept using contraception when we have intercourse ……1 2 3 4 5

8. I would not feel confident suggesting contraceptive use with my partner because I would be afraid s/he would think I have a sexually transmitted disease …
1 2 3 4 5

9. I would not feel comfortable discussing contraception use with my partner before we ever engaged in intercourse ……1 2 3 4 5

10. I would feel confident that I would remember to discuss contraception even after I had been drinking ……1 2 3 4 5

11. If my partner did not want to use contraception during intercourse, I could easily convince him/her that it was necessary to do so 1 2 3 4 5

Last, we would like to know about your conversations with your dating partner about sexual behavior and contraceptive use. Please answer the questions by circling your answers or filling in the blanks below.

1. In general, when you and your boyfriend/girlfriend discuss contraception use, when do the conversations take place (circle one only)?

1. long before we start having sex
2. soon before we start having sex
3. just before we have sex
4. after we already started having sex
5. other _____

2. Now, thinking back to the last time you had sex with your boyfriend/girlfriend, when did your conversation about contraception take place (circle one only)?

1. long before we start having sex
2. soon before we start having sex
3. just before we have sex
4. after we already started having sex
5. other _____

3. Many people say that talking about contraception with their boyfriend/girlfriend can sometimes be difficult. What part of talking about sex and/or contraception is difficult for you?

_____
_____
_____

4. Some people say that their boyfriend/girlfriend refuses to use contraception. Have you ever had to convince your boyfriend/girlfriend to use contraception when they did not want to use it? YES

NO **(If no, skip to question 5.)**

4a. If yes, what did you say to convince your boyfriend/girlfriend?

_____
_____

4b. In the end, did your boyfriend/girlfriend use contraception?

YES NO

5. Has your boyfriend/girlfriend ever tried to convince you to use contraception when you did not want to use it (circle one)?

YES NO

5a. If yes, how did you explain why you did not want to use it?

_____
_____
_____

5b. In the end, did you use contraception?

YES NO