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# An Exploration of the Influence of Race and Gender on Sexual Beliefs and Attitudes of Adolescents

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# ABSTRACT

AN EXPLORATION OF THE INFLUENCE OF RACE AND GENDER ON SEXUAL BELIEFS AND ATTITUDES OF ADOLESCENTS

By Kristine Marie Vandenberg

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This study explores factors that influence the sexual attitudes and behaviors of adolescents specifically through an examination of social constructs that measure sexual beliefs and attitudes of adolescents and the relationships between race and gender and sexual beliefs and attitudes. As the U.S. has maintained one of the highest rates of unplanned teen pregnancy and births among industrialized nations, schools and community groups have struggled to combat teen pregnancy and worked toward designing effective prevention programs. Through an emphasis either on abstinence or safe sex practices, these programs strive to influence adolescents' sexual behavior. However, studies and reports reveal a paucity of research that examines adolescents'

attitudes and beliefs of sexual behavior, especially for cultural- and gender- specific groups of adolescents. Drawing from social constructionist theory and multiracial and radical feminist theoretical frameworks, this study utilizes Virginia Abstinence Education Initiative (VAEI) data from surveys administered to adolescents measuring sexual attitudes, beliefs, and behaviors. This study examines race and gender differences among the participants with regard to beliefs and attitudes about sexual behavior. The goal is to both better understand race and gender influences on adolescents' sexual beliefs and attitudes and to provide information to those who are in the position to develop more successful and effective teen pregnancy prevention programs. Consistent with existing literature, findings indicate gender-based differences regarding sexual beliefs and attitudes and minimal race-based differences in this analysis. An intersectional analysis further suggests that although female adolescents across race held similar beliefs and attitudes regarding sexuality, there were differences across race among male adolescents.

# INTRODUCTION

In the United States, our teen pregnancy and teen birth rates continue to outnumber those of all other industrialized nations (Kirby, 2001; Darroch et al., 2001)[1]. Statistics for annual births per 1000 women aged 15 to 19 in 2005 suggested that the United States had approximately two times as many teen births as Great Britain, approximately two and a half times as many as Canada, approximately five times as many as France, and almost ten times as many as the Netherlands and Sweden (Unicef, 2005)[2]. These high rates of teen pregnancy and unplanned births, coupled with a higher rate of unprotected sex, are social issues in great need of further exploration. Extensive studies of the sexual *behavior* of adolescents have provided data used to design programs to prevent teen pregnancy and sexually transmitted infections (STI). However analyses of teens' *beliefs and attitudes* as they have been shaped by their experiences have been understudied and underreported and these may offer additional insight into teens' sexual behavior. This study relies on analysis of secondary data to explore how race and gender impact adolescents' sexual beliefs and attitudes.

The organization of the thesis is as follows. In the first chapter, I introduce a brief description of the background and sociological significance of teen pregnancy and the reasons for exploring adolescents' sexual beliefs and attitudes in relation to race and

[1] In 2001, Darroch et al reported females under 20, 22% had given birth in the U.S., 15% in Great Britain, 11% in Canada, 6% in France, and 4% in Sweden.

[2] In 2005, Unicef reported annual births per 1000 women aged 15-19. Canada had 19, France had 9, the Netherlands had 4, Sweden had 5, Great Britain had 24, and the United States had 49 teen births per 1000 women.

gender. I suggest that a focus on teens' sexual beliefs and attitudes based on race and gender differences will provide additional insight into understanding teens' experiences of adolescence and the development of their sexual behavior. I then review the relevant literature on adolescent sexual behavior and adolescents' beliefs and attitudes regarding sexuality. I also review literature that explores cultural and societal factors that influence teens' sexual beliefs and attitudes and how they are affected by race, class, and gender. In the next chapter, I describe how social construction theory and both multiracial and radical feminist theoretical frameworks inform this analysis. In the methods chapter, I provide a detailed description of the research design, data collection, analysis and findings. In the final chapter, I discuss the overall contribution of this study to the literature on adolescent sexuality and make recommendations for both future research, and for the field of teen pregnancy prevention program development.

**Background and Statement of the Problem**

The U.S. has higher rates of teen pregnancy, birth, and abortion than all other developed countries (Darroch et al., 2001)[3]. In 2000, among all states, Virginia ranked 19th in teen pregnancy rates per 1,000 females aged 15-19 (National Campaign to Prevent Teen Pregnancy, 2002)[4]. Unplanned teen pregnancy poses social, health, and economic risks to the teen, the child, and society. The number of sex education and abstinence education programs (TPPPs) in this country is increasing in an effort to reduce adolescent sexual activity and unplanned teen pregnancy and birth rates. Some

[3] The terms "adolescent" and "teen" will be used interchangeably within the text.

[4] 1 is the lowest and 50 is the highest rank by state for teen pregnancy

of these programs are designed to serve a general population across race, class and gender while others are more characteristic-specific—for example, programs that target low-income urban Puerto Ricans. Some researchers argue for a more universal approach to teen pregnancy prevention/sex education that reaches out to the majority as a whole, while others point out that race, class, culture, and gender are relevant to differences in socialization and social beliefs (Kirby, 2001; Smith et al., 2005; Franklin and Corcoran, 2000; Tolman et al., 2003). Experiences of adolescents vary because of race, class, and gender biases within society and gender, in particular, is a significant factor in the socialization of adolescents (Tolman, et al., 2003; Smith et al., 2005). Assessments of TPPPs often attend to adolescents' sexual behavior and attitudes, levels of self-efficacy, peer influence, parental views, and religiosity—among other variables—to evaluate teens' perceived norms regarding sexuality. Cultural and racial differences, gender differences, media influence, and sexual orientation, however, are rarely—if ever—included (Monahan, 2001). For this reason, a focus on unique population characteristics is critical to TPPP development.

## REVIEW OF THE LITERATURE

In this section, I review literature on adolescent sexual behavior, attitudes and beliefs. I then examine research on cultural norms regarding gender and adolescent sexuality, societal and cultural influences of race on adolescent sexuality, and the influence of socioeconomic status on adolescent sexuality.

### Adolescent Sexual Behavior

Numerous studies have reported statistics for sexual behavior, unplanned pregnancy, and STI rates for American adolescents (Kirby, 2001; Terry-Humen and Manlove, 1997, SEICUS, 2005). The United States Centers for Disease Control conducts the *Youth Risk Behavior Surveillance System (YRBS)* to measure sexual and other behaviors of high school students (grades 9 through 12) at two-year intervals. These data are considered some of the most "current information about adolescent sexual behavior, including history of sexual intercourse, number of sexual partners, and contraceptive use" (SEICUS, 2005). Two additional large databases of adolescent sexual behavior include the Kaiser Family Foundation and the *National Survey of Adolescents and Young Adults (NSAYA)*. However, research has understudied and underreported adolescents' sexual *beliefs and attitudes*, especially the differences influenced by culture, ethnicity, race, class, and gender. Ethnicity, for example, is usually excluded from family planning consideration, in spite of the effect of ethnic and cultural beliefs on sexual decision-making (Asencio, 2002).

**Influences of Race and Gender on Adolescent Sexuality**

A number of inconsistencies in data on adolescent sexual behavior suggest a need for further research in this area that specifically addresses race and gender. For example, teens' sexual beliefs and attitudes are not always congruent with their actual sexual behavior, nor do their sexual beliefs and attitudes necessarily reflect their sexual involvement with others (Martin 1996; Tolman, 2002; Asencio, 2002). Teens may have developed concrete beliefs and attitudes about sexuality without having become sexually active. Many Latinas, for example, feel they should wait to become sexually active until marriage (Asencio, 2002). Often, however, their behavior does not reflect this attitude.

Research indicates race, class, and gender differences among adolescents regarding sexuality. For example, statistically, African American and Hispanic adolescents participate in heterosexual intercourse more often, have their first sexual experience at an earlier age, and are less likely to use contraception than their White counterparts (Kirby, 2001). In addition, adolescents from low-income families have been found to engage in sexual activity at an earlier age (Kirby, 2001), are at the greatest risk for early pregnancy, and have fewer and less negative views of unplanned pregnancy than their higher income counterparts (Newman, 2003). Research also indicates that the beliefs and consistency of contraception use differ for male and female adolescents (Tolman et al., 2003). For example, many girls report that they believe it is up to the male to decide whether or not to use a condom and to provide the condom as well (Asencio, 2002). Several studies report that male adolescents are less

motivated to use contraception than females because they are less aware of the risks or have less fear of pregnancy, have more negative views about contraception, and believe it is the female's responsibility to provide and request contraception (Freeman and Rickels, 1993, Tamkins, 2004). Essentially, adolescent males often view pregnancy as an issue that the female has to contend with on her own. Girls are more likely to be aware of and more concerned with the negative consequences of unprotected sex and are more likely to use contraception with their first sexual experience than boys (Terry-Human and Manlove, 1997).

Differences between sexual beliefs and attitudes and behaviors may be indicative of poor decision-making skills and low self-efficacy of adolescents. Research has shown that knowledge alone does not lead to safer behavior. Healthy sexual attitudes and beliefs, in addition to knowledge, are needed to improve self-efficacy and responsible sexual behavior (Asencio, 2002; Franklin and Corcoran, 2000; Schwab, Zabin and Hayward, 1993). Further research of adolescents' sexual beliefs and attitudes can better direct our understanding of how teens are being socialized to think about their sexuality as well as provide more specific details in order to improve TPPP designs.

The literature indicates associations among race, class, and gender regarding the sexual *behavior* of adolescents as noted in the examples above. My interest in this study is in regards to the *beliefs and attitudes* about sexuality among adolescents. In particular, I am interested in gender and how male and female adolescents are socialized about and, in turn, experience and express their sexuality. Teen pregnancy and teen

sexuality are gendered issues. An exploration of gendered beliefs and attitudes should be an important focus in future TPPP program development. Since gender is interconnected with race and class, I include an analysis of race within this exploratory study[5]. I expect that race and gender influence adolescents' beliefs and attitudes about sexuality.

**Cultural Norms Regarding Gender and Adolescent Sexuality**

Male adolescent sexual behavior is often tolerated if not encouraged in American society, while abstinence is customary for adolescent females. Male virginity is not as strongly valued in our society as female virginity where females are more often expected to remain virgins until marriage (Asencio, 2002). Unplanned adolescent pregnancy and childbearing is considered a female problem where males are rarely, if ever, held accountable, and females are expected to bear the full responsibility. However, adolescent girls often receive either incomplete or inaccurate information about their bodies, their desires, sex, pregnancy, and STI risks (Tolman, 2002). This lack of information for young girls creates both confusion about their body image and an often decreased level of self-esteem and self-confidence (Martin, 1996).

This conflict of desire and of meeting the expectations of society often leads to the development of a sexual identity without sexuality for female adolescents (Tolman, 2002). Female adolescents often want to be sexually desirable and to explore their sexual feelings, however they end up stifling their feelings and avoiding sexual

[5] In the case of the VAEI database, neither class nor socioeconomic information were available and therefore are not included in my analysis.

expression for fear of being negatively punished or labeled (Martin, 1996 and Tolman, 2002). Adolescent females are less likely to ask parents or even peers pertinent questions about their bodies and become reactive instead of proactive (viewing their bodies in an objective instead of subjective way) while developing their sexuality (Tolman, 2002). The conflict between societal factors (social constructions of femininity and desire) and biological factors (hormones) that young women must contend with while developing their sexual beliefs, attitudes, and behaviors greatly affects the development of their identity (Tolman, 2002). The patriarchal definitions of gender roles purport the idea of protecting girls, but actually act to control their sexuality—and not men's—and are inherently oppressive (Lorber and Yancy Martin, 1993). Societal definitions of "appropriate" adolescent female behavior disempower young women and do them a great disservice – they do not let young women explore their sexuality on their own terms. Pressure to conform to these accepted notions encourages female adolescents in particular to focus on their body image or their "social body" rather than their physical body and biological needs (Lorber and Yancy Martin, 1993). "Girls are culturally denied knowledge about their bodies, particularly their genitals" (Tolman, 2002:23), which supports the societal emphasis of women being detached from their bodies and hence their sexuality. Embodiment of sexual desire should be a natural part of adolescence but instead many girls are disassociated from their sexual desire (Martin, 1996). This disembodiment, or lack of personifying and connecting with their physical body, often causes girls to experience a lack of agency and a negative body image (Tolman, 2002).

Meanwhile, current research shows that giving adolescents both knowledge and empowerment are likely stronger protective factors against sexual activity and unplanned pregnancy than omitting information and maintaining narrowly defined gender roles and expectations.

> Those females who were more in control of their sexuality and felt more positive about sexual behaviors and taking control of their sexuality seemed also to be more conscientious about protecting themselves (Asencio, 2002:70).

Statistically, adolescent females with higher levels of self-esteem and more positive feelings about their bodies, made healthier and safer decisions for themselves regarding sexual decision-making (Ascencio. 2002; Newman, 2003; Schwab Zabin and Hayward, 1993). However, social difficulties that some adolescents (mostly females) experience often lead to unhealthy sexual behavior. For example, high adolescent pregnancy rates in the U.S. have been correlated with lower levels of self-esteem, a lack or decreased future orientation (ability to direct one's actions toward future hopes and goals), lower levels or an absence of embodiment (an emotional connection to one's physical body), and a lack of self-efficacy (one's belief that they can make decisions that will affect change in their lives) among others (Hulton, 2001; Freeman and Rickels, 1993; Asencio, 2002; Juhasz and Sonnenshein-Schneider, 1987; Newman, 2003; Schwab, Zabin and Hayward, 1993; Tolman et al, 2003). Specifically, the high adolescent pregnancy rates in the U.S compared to other industrialized nations do not reflect a significant difference in sexual activity rates, but rather a lower incidence of contraception use (Darroch, et al, 2001).

**Societal and Cultural Influences of Race on Adolescent Sexuality**

An adolescent's cultural association (race, religion, ethnicity, tradition, and family structure, for example) affects his or her identity development and interpretation of sexual attitudes and gender roles, as well as sexual behaviors (Lorber, 2001). "An individual adolescent's decisions about sexuality and fertility are constrained by the customs and sanctions of a particular cultural group" (Schwab Zabin and Hayward, 1993:1). There are culturally specific differences among sexually active teens in the U.S. For example, African American teens are more likely to be accepting of unplanned teen pregnancy than their White counterparts, and the Hmong and Laotians (of Southeast Asian descent) communities frequently encourage teen marriage and expect teen pregnancy (Kirby and Trocolli, 2003). Statistically, African American and Hispanic adolescents have higher pregnancy and birth rates than non-Hispanic White adolescents (Asencio, 2002; Kirby, 2001; AGI, 2004).[6] Research has also shown that Latinos' rates of pregnancy are related to their level of acculturation (Kirby and Trocolli, 2003). Hispanic populations tend to have higher rates of teen marriage than their White and African American counterparts (Schwab, Zabin and Hayward, 1993). In addition, Latino adolescent males are often socialized to embrace "machismo" (extreme masculinity) and become sexually active earlier in life, while virginity is strongly encouraged for Latinas. Catholicism especially influences these norms in the Latino culture where female adolescent premarital sex is eschewed and birth control and abortion are not permitted within the religion (Tolman, 2002). Catholic teachings

[6] In 2000, an Alan Guttmacher Institute report found 71 per 1,000 White females age 15-19 had a pregnancy, 153 per 1,000 African American females, and 170 per 1,000 Hispanic females.

oppose the use of contraception, infidelity, sex before marriage, and homosexuality but these are not strictly followed by most males or females. However, there is a stronger societal expectation for females to abide by these guidelines within the Latin community (Ascencio, 2002).

Pregnant African American teens are more likely to give birth as a result of their unplanned pregnancy than their White counterparts because they cite fewer reasons not to give birth (Schwab Zabin and Hayward, 1993; Freeman and Rickels, 1993). More specifically, one study showed that adolescents who had parents and peers who did not disapprove of teen parenting had fewer future goals, making the perceived costs of becoming a teen parent seem essentially non-existent and the rewards often minimal (Schwab, Zabin and Hayward, 1993).

Most cultures disapprove of unmarried teen pregnancy but the level of enforcing it "varies according to the perceived rewards of conforming to it and the perceived penalties of diverging from it" (Schwab, Zabin and Hayward, 1993:1). Those cultures that are strongly disapproving of adolescent pregnancy and birth maintain social penalties and deterrents such as shame, lack of friendship or support, loss of social life, or negative impact on education. Within those cultures where teen parenting and single parenting are norms, teens have fewer or no penalties and, in some cases, rewards—whether seen as a rite of passage or creating a commonality among friends—for becoming a teen parent (Schwab, Zabin and Hayward, 1993).

**Influences of Socioeconomic Status on Sexual Outcomes**

Adolescents' sexual outcomes and contraception use are influenced by their

socioeconomic status as well as their race, ethnicity, and gender. Adolescents of lower-income families have less access to information about birth control which leads to them to be more likely to follow traditional cultural beliefs which may not encourage or promote the use of birth control (Asencio, 2002). In addition, research shows that adolescents from lower classes are more likely to desire larger families and have children at younger ages, have narrower views of sexual behaviors, and males in poor communities value unplanned pregnancies more than males of higher socioeconomic status (Asencio, 2002).

Community and economic disadvantages are also noted as precursors to early sexual activity (Kirby, 2001 and Schwab, Zabin and Hayward, 1993) as well as early childbearing (Freeman and Rickels, 1993 and Schwab, Zabin and Hayward, 1993). In making a choice between abortion or giving birth as a result of an unplanned pregnancy, adolescents within families on welfare were more likely to give birth (Freeman and Rickels, 1993).

Based on a review of the literature, it is important to explore race and gender differences in sexual beliefs and attitudes. In addition, an analysis of not only adolescents' behaviors, but also their beliefs and attitudes about their sexuality, is significant for a better understanding of the impact of social influences on adolescents and their sexual decision making.

## CONCEPTUAL FRAMEWORKS

Adolescence is defined as the period of a child's life from the beginning of puberty through high school or adulthood, specifically children 9 years old to 17 years old (Schwab, Zabin and Hayward, 1993). However, adolescence differs from puberty in that puberty is a physical process, while adolescence is a social process (Martin, 1996). Adolescence is the point in the lives of teens signified by the development of self-identity and learning how to develop and negotiate autonomy, particularly in relation to adulthood. A main focus of this transition is the development of sexuality. Sexuality is socially constructed differently for males and females and therefore it is a gendered process. Adolescence, then, is a gendered process. Because of this, a focus on gender in exploring teen sexuality is critical. Sexuality is also constructed differently based on an individual's race due to cultural differences and societal biases. If sexual beliefs and attitudes develop differently for males and females as well as for persons of different races, adolescents' sexual beliefs and attitudes will likely be shaped by race and gender biases within our society.

I explore adolescents' beliefs and attitudes regarding sexuality by incorporating the social construction of gender theory (which emphasizes the social development of our gendered identities), radical feminist analysis (which focuses on the oppressive male control of female bodies and sexuality), and multiracial feminism (because it

reminds us that race must also be considered in a gender analysis, as both elements are socially intertwined).

**Social Construction of Gender**

From the moment we are born we are given messages and cues as to how to act in the social world. "Socialization is the process by which a society's values and norms, including those pertaining to gender, are taught and learned" (Renzetti and Curran, 2003:73). In addition to the practical issues such as how to speak, eat, and play with others, we are taught how to "do" our gender within our interpersonal relationships. West and Zimmerman (1987) first explained that "doing" or performing our gender is the way we act out the gender role that we are socialized to fulfill. Thus we are rewarded or punished for our willingness and ability (or lack thereof) to comply with our culturally defined "gender-appropriate" beliefs, attitudes, and behaviors. The social construction theory analyzes how gender is practiced and performed through discourse and how individuals actively construct gendered identities through social cues and social definitions particularly of "masculine" and "feminine" ideals (Butler, 1994).

In reference to the social construction of *gender,* the social constructionist approach analyzes the "politics of female sexuality" by addressing the "cultural and personal meanings of girls' race and ethnicity, socioeconomic status, and sexual orientation in understanding their sexuality" (Tolman et al, 2003: 6). As opposed, for example, to biological determinism, which emphasizes the biological or physiological differences among the sexes to explain behavioral differences, the social construction of gender theory emphasizes the multiple social influences and power relations that

influence and shape gender identity. This approach provides an analysis that allows us to examine gender relations and, more specifically, explore how females manage and negotiate their sexuality within a social context.

Judith Lorber suggests a new paradigm shift in the feminist analysis of the social construction of gender by viewing gender,

> as an institution that establishes patterns of expectations for individuals, orders the social processes of everyday life, is built into the major social organizations of society, such as the economy, ideology, the family, and politics, and is also an entity in and of itself (Lorber, 1994:1).

Instead of an emphasis on the individual or the interpersonal aspects of gender, Lorber proposes an analysis of gender as a social institution (just as we would explore the social institution of family or education) specifically to explore the way that differences between men and women are created and recreated throughout the institution of gender within our social world (Lorber, 1994).

More recently, Barbara Risman (2004) specifically differentiates gender as a social *structure* as opposed to an *institution* in order to explain human action in that social structures serve as constraints upon our gendered behavior within our social world. Risman describes the social construction of gender based upon three-tiered multiple integrated levels of the individual (socialization), interactions/cultural expectations, and institutional in order to "understand gender in all its complexity and try to isolate the social processes that create gender in each dimension" (Risman, 2004:436). While there is no measure of the social construction of gender, we can explore those processes that create gender as Risman suggests. In my analysis, I

explore gender exclusively from the individual level because of the limitations of both the survey used and the resulting data. The surveys that were used for the secondary data aimed to collect information on the individual attitudes, beliefs, and behaviors of the participants therefore cultural and institutional influences were not likely captured. My analysis focuses on the individual characteristics, as indicated by specific constructs of sexual attitudes and beliefs, that create and define gender at the individual level, as well as an analysis comparing groups[7].

The social construction of gender defines adolescent sexual norms differently for males and females. These societal constructions are based on cultural beliefs about male and female sexuality, bodies and gender relations, social interactions with parents and peers, and personal internalizations (Martin, 2002). The construction of our "gendered selves" is generally developed within the "masculine" and "feminine" dichotomy as defined within our culture. The American ideology of masculinity defines men as stronger, smarter, more reasonable, and more responsible than women. Typically, the societal expectations of males or the "norms of masculinity," encourage and support the idea that males are expected to be comfortable with their sexuality as well as being experienced, confident, and knowledgeable about sex. However, females are expected to be inexperienced, passive, submissive, and unfamiliar with their sexuality. Female adolescent sexuality is viewed and labeled as "problematic" and White, male sexuality as "normal."

[7] Current theoretical literature suggests a lack of congruency between an adolescents' sexual beliefs and attitudes and their sexual behavior. This is an important consideration with data and analyses of adolescents' sexual behavior or predicted sexual behavior based on self-reported beliefs and attitudes.

In addition to the influence of social structures, an adolescent's sexuality is greatly influenced by her or his individualized body image. Body image is the mental image of oneself and varies over time and within different contexts. It is how an individual sees him or herself, how one perceives others' feeling about them, and what one thinks they look like to others. It is not defined by the view of others but rather develops through interactions with people within our environment. The more negative our perception of our body, the more negative we feel about ourselves. Therefore, our beliefs and feelings about our bodies (our self-esteem) influence our behavior and how we interact with other people. Specifically, our body image often dictates what kinds of decisions we make about our body, our health, and our sexuality. Many adolescent girls in particular struggle with developing a positive body image as they try to fulfill societal definitions of what it means to be "female" (Pipher, 1994; Wolf, 1997).

As most girls are experiencing adolescence, they begin to learn that they do not fit into the normative definition of "femininity." An "ideal type" for young women is meant to emulate societies' definition of the "perfect female" based on social definitions of feminine appearance and "appropriate" female behavior. Ideal types[8] are meant to be unattainable, yet social norms encourage young women to spend a great amount of time and effort striving toward them in the creation of what is deemed a positive identity. Since our identities are tied up with our body image and self-esteem, confusion about our identity, especially our sexual identity, often leads to lower self-esteem and poor decision-making, especially for adolescent girls. Instead of being encouraged to

[8] Max Weber coined the term "ideal type" which is an analytical construct to serve as a measure for the purpose of comparative study of phenomena that does not correspond to concrete reality (Stark, 1994).

explore and develop healthy beliefs and attitudes about sexuality, adolescents are encouraged to

> [c]onstruct their bodies in ways that comply with their gender status and accepted notions of masculinity and femininity. That is, they try to shape and use their bodies to conform to their culture's or racial ethnic group's expectations of how a woman's body, a man's body, a girl's body, or a boy's body should look (Lorber and Yancy Martin, 1993:261).

Girls are encouraged to look and behave as "sexy" but are expected to not be sexually active. Our cultural ideology mandates (and the media reiterates) that girls should not have premarital sex but should be sexually desirable and available. This gender double-standard creates mixed-messages which are difficult for female adolescents to decipher and often increase their confusion and inability to develop healthy beliefs and attitudes about their sexuality. American cultural ideology discourages girls from being prepared to negotiate sexual relations and teaches that it is not socially acceptable for girls to use contraception or carry condoms. A key to sexual responsibility is acknowledging one's sexuality and accepting responsibility for one's behavior. However, since society does not allow girls to be sexual beings, they often lack the ability to embrace sexuality or act responsibly. Therefore, for female adolescents in the U.S., there is a pervasive lack of support and empowerment, "accurate" sex education, and information on how to effectively use contraception.

**Radical and Multiracial Feminist Theory**

Judith Lorber (2001) organizes contemporary feminisms into three categories: gender-reform, gender-resistance, and gender-rebellion. Gender-reform feminisms acknowledge similarities of women and men and highlight the *social* differences among

the sexes working towards legal and economic equality through reform. These include liberal, Marxist, socialist, and development feminisms. Gender-resistance feminisms highlight the physical *and* social differences among men and women and work towards ending the oppression and exploitation of women through resisting socially defined gender roles. These include radical, lesbian, psychoanalytic, and standpoint feminisms. Third, gender-rebellion feminisms highlight the interrelationships of inequalities based on race, class, gender, sexuality, and ability and work toward changing socially defined gender stratification, identity development, the gender binary, and gender performance by rebelling against gender norms. These include multiracial, men's, social constructionist, postmodern, and queer theory feminisms.

I use both radical and multiracial feminist theories to guide my analysis. Radical feminism focuses on the physical and social oppressions of female bodies, thus female sexuality. I also use multiracial feminism because it examines gender inequality within the race, class, and gender or intersectionality framework.

Radical feminist theory is a type of gender-resistance feminism that is based on the concept that men and women have different experiences, which are not based solely on biology but on the inequality of the genders within the current social structure. The key foundation of radical feminism is that at the root of female oppression is male domination (patriarchy), where the main focus is on male control of women's bodies, health care, and sexuality. The structure of patriarchy serves to provide straight, White upper-class men with power over women. These men have many opportunities to control women and therefore benefit from this arrangement because the oppression of

women is embedded within our social institutions. Patriarchy is a system in which the privileged (most straight, upper-class, White males) define themselves, their beliefs, their experiences, and their needs as the norm or "right way," and they may use these ideals in a dominant and powerful way against those who conflict, differ, or do not conform.

A radical feminist analysis explores the question, "what maintains this power differential?" and works to create solutions to overcome gender inequality. An analysis and rejection of unequal and biased gender roles and structures is crucial in combating women's oppression. Because reproductive freedom has long been a political issue and one that some men use, or try to use, to control women, radical feminism also focuses on the social issues related to women's health and sexuality. Reproductive control (decisions surrounding pregnancy and childbirth) involves sexuality and the body and is viewed not as a personal issue but instead is treated as a political and moral issue involving the right to life, religion, and personal freedom. The majority of men in our society benefit from women not having reproductive freedom because their reproductive control of women reinforces gender roles and male dominance. Women of all ages practicing the freedom to be sexual on their terms, choosing whether or not to be a wife or a mother, and deciding when or when not to have children are often considered a challenge to traditional male-dominated social norms. In order to maintain the gender hierarchy, some men seek to control women's reproduction and maintain gender inequality. Specifically, women's sexual autonomy conflicts with societal definitions of "femininity" and is often perceived as a threat to masculinity. Radical

feminism highlights the unequal distribution of rights, power, and privilege determined by one's sex in our society. For this reason, the philosophy questions and challenges oppressive gender roles and social institutions and works towards redefining and rebuilding them to better serve women within society.

Multiracial feminism[9], in addition to a focus on gender, is equally inclusive of race and class to "examine structures of domination, specifically the importance of race in understanding the social construction of gender" (Baca Zinn and Thornton Dill, 2003:81). Multiracial feminism serves as a framework to focus on the interrelationships of inequalities in our society and how they interact with gender because race and class determine how someone is "gendered" and how they are expected to "do" gender (Lorber, 2001). More specifically, multiracial feminism focuses on the "multiple systems of domination" and emphasizes the "treatment of race as a basic social division, a structure of power, a focus of political struggle, and hence a fundamental force in shaping women's and men's lives" (Baca Zinn and Thornton Dill, 2003:83). While culture and social class are important in feminist gender analysis, race is not analogous to ethnic or cultural definitions and is specifically significant in analyzing privilege and oppression. Key to understanding the interrelationships of inequalities is Patricia Hill Collins' concept of the "matrix of domination" which depicts race, class, and gender as

[9] Multiracial Feminism is generally analogous to "Third World Feminism" and "Multicultural Feminism." However, Maxine Baca Zinn and Bonnie Thornton Dill prefer to use the term "Multiracial" in order to emphasize *race* in their definition to highlight it as "a power system that interacts with other structured inequalities to shape genders" (2003:84), Margaret Andersen and Patricia Hill Collins consider the differentiation important in that it is an analysis that goes beyond embracing diversity in that an exclusive focus on cultural diversity, "frequently ignores social conditions of power, privilege, and prestige" and highlights group similarities as opposed to individual social placement or the intersectionality of race, class, and gender (1995:xiii).

interlocking systems of oppression and privilege. The "matrix of domination" framework reflects how the interconnections of race, class, and gender shape the structure of our society by "recognizing and analyzing the hierarchies and systems of domination that permeate society and that systematically exploit and control people" (Andersen and Hill Collins, 1995:xiii). Prior to the "matrix of domination" concept, race, class, and gender were often studied independently of one another, focusing on the differences between groups of different women and at the same time defining "women" as universal (Baca Zinn and Thornton Dill, 2003). Patricia Hill Collins' framework is more inclusive and views the individual woman within her social world with respect to the impact of privilege and oppression within social institutions. Just as people are shaped by social institutions, "institutions themselves are constructed through race, class, and gender relations" (Andersen and Hill Collins, 1995:xv). Race, class, and gender are not fixed but are socially constructed, such that the meaning of each is malleable over time and across contexts.

> The idea of the matrix is that several fundamental systems work with and through each other. People experience race, class, gender, and sexuality differently depending upon their social location in the structures of race, class, gender, and sexuality (Baca Zinn and Thornton Dill, 2003:85).

An individual may experience privilege on one dimension of the matrix and oppression on another. All men, for example, are not privileged all the time or in all contexts within the social world.

In addition, a multiracial framework addresses dominant social structures as well

> Analyzing race, class, and gender is more than "appreciating cultural diversity." It requires analysis and criticism of existing systems of power and privilege; otherwise understanding diversity becomes just one more privilege for those with the most access to education – something that has always been a mark of the elite class (Andersen and Hill Collins, 1995:xiii).

An understanding of how society shapes sexual beliefs and attitudes differently for men and women and those of different races is critical for supporting healthy adolescent sexuality and working towards equality. It is important to consider that "race, class, and gender are interlocking categories of experiences that affect all aspects of human life; they simultaneously structure the experiences of all people in this society" (Andersen and Hill Collins, 1995:xi). It is critical that we consider the race, class, and gender interconnections and recognize, for example, that low-income urban African-American adolescent females have a very different experience developing their sexuality and transitioning into adulthood than White adolescent females from affluent suburbs.

The social construction of gender theory, radical feminist analysis, and multiracial feminism frameworks are used to explore the influences of race and gender among sexual beliefs and attitudes of adolescents in order to examine indications of the societal biases and influences on adolescents and how they develop their sexuality within their "social locations" structured by race, class, culture, and gender.

# METHODS

## Research Design

I conducted a secondary analysis of a dataset comprised of survey responses to examine the relationship between sexual beliefs and attitudes and respondents' race and gender. Survey data for this project are from the Virginia Department of Health, Office of Adolescent and Sexual Health, Virginia Abstinence Education Initiative. The self-administered questionnaires were designed to evaluate the effectiveness of the program based on pre- and post-test participant survey comparisons. Surveys were administered to participants in several abstinence programs at multiple sites in Virginia. This study analyzed pre-test data from six programs at six sites from the first three years of the program. The dataset was made available to graduate students in the Department of Sociology at Virginia Commonwealth University in 2004.

For this study the independent variables were race and gender and the dependent variables were adolescents' sexual beliefs and attitudes. Class information was not available from this data set because it was not collected from the participants. Collecting socioeconomic status from adolescents is very difficult and is therefore often not included in the data. School aged children rarely are aware of their parental or guardian income or level of standard of living and are unable to respond to such questions in a survey.

The database included data from six different sites within Virginia, each of which utilized a different version of a teen pregnancy prevention program. The sample

for my research project included data from all six sites within Virginia. However, I only used data from the first three years because the survey questions and content changed significantly after the year 2000. In addition, I used data collected from pre-tests only where participants completed the survey before participating in the abstinence education program because I was most interested in the adolescents' beliefs before being exposed to the TPPP. The pre-test data were more representative of the adolescents' socially and culturally influenced beliefs, attitudes, and peer influence, whereas the post-test data likely represented an influence from the program content. Data were from 1998, 1999, and 2000 and I combined data from all three years.

**Sample**

The study population was students ranging from grade 3 to grade 11 in Virginia and the sample was comprised of students from six areas in Virginia (Fauquier, Lynchburg/Bedford, Newport News/Hampton, Sussex, Norfolk, and Powhatan) who participated in an abstinence education program in 1998, 1999, and 2000. The majority of participants (67%) were in the 7$^{th}$ grade which is most often represented by adolescents that are 12 or 13. Another 21% of participants indicated being in the 8$^{th}$ grade. Participants who were in the 5$^{th}$ grade were 6%, participants that indicated being in the 3$^{rd}$, 9$^{th}$ 10$^{th}$, and 11$^{th}$ grades were each less than 1% and participants that indicated being in the 4$^{th}$ or 6$^{th}$ grade were each less than 2%, The participants had already opted to participate in the abstinence education program and were asked to voluntarily take the survey as part of the program. Students' parents gave consent and students gave assent to participate in the study. The sample size from this database for participants

who took the pre-test survey was 2012 and the sampling design used for the survey was purposive sampling. This study was confined to surveys fro adolescents from the state of Virginia participating in an abstinence education program. This study was based on data from six areas in the state of Virginia and results were from students volunteering to participate.

**The Survey Instrument**

The survey instrument was designed by several community outreach coordinators and university professors specifically for use by the Virginia Department of Health to survey adolescents for the Virginia Abstinence Education Initiative. This survey was described to the participants as intending:

> [T]o find out how young people like you think about love, relationships, marriage, and sex. Your answers on this survey will be kept confidential. Results of this survey will be reported in group format and will not identify any individual respondents (Survey of Youth Attitudes and Behaviors, Virginia Department of Health, 2000).

The questionnaire cover page collected the date of birth, age, and gender of the participant and was combined with specific letters from the respondent's first and last names to create an ID code.

The gender categories were either male or female and the categories for race were: White/Caucasian, black/African American, Asian/Pacific Islander, Latino/Hispanic, American Indian/Aleutian/Native Alaskan or Eskimo, biracial/multiracial (fill in the blank), or other (fill in the blank).

Instructions for the survey were as follows:

> Please work on this survey by yourself and answer each item as honestly and completely as you can. You may skip any questions you do not want to answer. Please read each item very carefully. It may seem, at times, that you are being asked the same question over and over again. However, if you read very carefully, you will notice some minor but important differences. In addition, please pay close attention to the instructions for each item. You may be asked to skip some items that do not apply to you. In addition, there are times when you may be asked to select more than one response. Below are some definitions that may help you. Please read these carefully before you begin (Survey of Youth Attitudes and Behaviors, Virginia Department of Health, 2000).

Three definitions that were included in the survey for the participants were; *parent* refers to the adult(s) who is most responsible for raising you, *sex* refers to sexual intercourse (sometimes it is also called "going all the way" or "doing it," and *abstinence, to remain abstinent*, and *to abstain* refers to not having sex."

The survey instrument (depending on the year) included 50 to 60 questions separated into four categories:

- ***Tell us something about yourself***- aims to collect information about the participant's race, school grade, religion, and parent communication. A sample survey question from this section is, "Do you hide a lot from your parents about what you do during nights and weekends?"

- ***Tell us something about your parents***- aims to collect information about the participant's guardians, home setting, and parental involvement. A sample survey question from this section is, "Do your parents know what you do during your free time?"

- ***Tell us what you think***-aims to collect information about the participant's views on sexual behavior, peer influence on sexual behavior, beliefs about abstinence, and future orientation (explain). A sample survey question from this section is, "How sure are you that you could avoid getting into a situation that might lead to sex (like going to a bedroom, drinking alcohol, doing drugs)?"

- ***Tell us something about what you do***- aims to collect information about the participant's involvement with use of substances, sexual history, and beliefs and

pledge to abstinence. A sample survey question for this section is, "Would your close friends approve or disapprove of people your age having sex?"

Most survey questions were forced choice with the exception of a few open-ended questions, for example, "If you think you will/might get married, how old do you think you will be when this happens?" Likert responses were ranges from "always" to "never," "strongly agree" to "strongly disagree," and "not at all sure" to "very sure." There were several questions with "yes" or "no" response options and the last question in the survey allowed the participant to write in further comments or thoughts.

Since I did not handle any of the surveys, I did not breach any confidentiality of the participants and the participants were made aware that their survey results would be analyzed for research purposes. I will also destroy the data once the research is completed per request of the Virginia Department of Health.

**Measures**

Although there were participants in each of the seven race categories, the number of Asian/Pacific Islanders, Latino/Hispanics, American Indian/Aleutian/Native Alaskan or Eskimos, biracial/multiracial, and "other" categories were each less than 30 which is considerably small in number to make statistical comparisons compared to the large numbers of both African Americans (n = 948) and Whites (n = 1064) in the sample. Therefore, I explored responses from the White and African American participants only and recoded to rename and select only those two.

Constructs (also know as indices) were originally developed along with the surveys however, each survey and construct differed from year to year, therefore I was unable to use them for my analysis. Utilizing surveys from 1998, 1999, and 2000, I used the original indices as a guide and coded for "value marriage," "affirming abstinence," "sex proves love," "love justifies sex," "independence from peer influence," "personal efficacy," "future orientation," "reasons to abstain" (consequences), "behavioral intent," "sexual values" (rejection of sexual activity), and "sexual behavior." I then found questions that were common among all three surveys. From those, I chose questions that contained answers with a Likert scale response ranging from 1 to 5 and created six new indices. I then computed Cronbach's alpha to test for inter-item reliability for each index to establish which indices to use. From the six indices that I created, I eliminated one (Value Marriage) due to low reliability which resulted in a final five indices for my analysis.

The Affirmation of Abstinence (AA) index was a 3-item scale to assess

participants' feelings about remaining abstinent until marriage. Cronbach's alpha was .886, which was an acceptable level of reliability. This index was operationalized as follows:

Q14 - Having sex before marriage is against my personal standards
Q18 - It is important for ME to remain abstinent until I get married
Q23 -I have a strong commitment to remain abstinent until I am married

The Likert response scale for these three questions was a range of 1 to 5 (1 = strongly agree, 2 = somewhat agree, 3 = not sure, 4 = somewhat disagree, 5 = strongly disagree).

The Rejection of Sexual Activity (RSA) index was a 2-item scale to assess participants' feelings about engaging in sexual activities. The index was originally a 3-item scale using survey questions 3, 15, and 21. However the reliability test yielded an alpha of .635, which was improved to .702 after removing question 21. This index was operationalized as follows:

Q3 -Having sex now is a good way to be prepared for marriage
Q15 - It's OK to have sex with a serious boyfriend-girlfriend

The Likert response scale for these two questions was a range of 1 to 5 (1 = strongly agree, 2 = somewhat agree, 3 = not sure, 4 = somewhat disagree, 5 = strongly disagree).

The Reasons to Abstain (RA) index was a 5-item scale to assess participants' feelings about the consequences of engaging in sexual activity and reasons to abstain from sexual activity. The reliability test yielded an alpha of .841, which was an acceptable level of reliability. This index was operationalized as follows:

Q27 – One reason for me to abstain is because I don't want to risk a pregnancy
Q28 – One reason is because I don't want to risk AIDS
Q33 – I don't want to be used or taken advantage of
Q34 – I don't want to disappoint my parents

Q35 – I don't want to disappoint others whom I respect

The Likert response scale for these five questions was a range of 1 to 5 (1 = strongly agree, 2 = somewhat agree, 3 = not sure, 4 = somewhat disagree, 5 = strongly disagree).

The Personal Efficacy (PE) index was a 4-item scale to assess participants' feelings about their confidence and ability to abstain from sexual activity. The reliability test yielded an alpha of .863, which was an acceptable level of reliability. This index was operationalized as follows:

"If you were going out with someone you really liked and did not want to have sex, how sure are you that you could do each of the following?"

Q36a – You could stick with your decision not to have sex.
Q36c – You could avoid getting into a situation that might lead to sex (like going to a bedroom, drinking, doing drugs).
Q36d – You could firmly say "no" to having sex, and explain your reasons if your girl/boyfriend pushes you to have sex.
Q36e – You could stop seeing your girl/boyfriend if he/she continues to push you to have sex.

The Likert scale for these questions was a range of 1 to 5 (1 = "not at all sure" with statement to 5 = "very sure" with statement).

The Behavioral Intent (BI) index was a 2-item scale to assess participants' feelings about their abstinence intentions in the future. The reliability test yielded an alpha of .831, which was an acceptable level of reliability. This index was operationalized as follows:

Q24 – How likely do you think it is that you will remain abstinent until you are married?
Q26 – If someone did try to get you to have sex with them, what would you do?

The Likert response scale for question 24 was a range of 1 to 5 (1 = "sure I will abstain" to 5 = "sure I will not abstain") and the scale for question 26 was a range of 1 to 5 (1 = "definitely would not do it" to 5 = "definitely would do it").

Next, I examined each question within each index to see if they all were asking questions with responses in the same direction of agreement along the Likert scale. The questions within each index were in the same direction of agreement; however, the scale for the Affirmation of Abstinence, Reasons to Abstain, and Behavioral Intent indices was a range of 1 to 5 where low numbers indicated strong agreement with the index concept. I reversed the direction of the responses for these three indices (1=5, 2=4, etc.), so that a high number meant strong agreement with the statement (such as strong affirmation for abstinence or strong agreement with reasons to abstain) and a low number was strong disagreement with the index concept. Responses for the Rejection of Sexual Activity scale were already organized in the survey so that the lowest value (1) indicated strong agreement with being sexually active and the highest value (5) indicated strong disagreement with being sexually active/agreement with abstaining. Responses for the Personal Efficacy scale were also already organized in the survey so that the lowest value (1) indicated weak agreement with avoiding sexual activity and the highest value (5) indicated strong agreement with avoiding sexual activity. Therefore the strongest agreement for all five index concepts was indicated by the highest number value, which represented the strongest agreement with abstaining from sexual activity.

The frequency distributions for the Sexual Beliefs and Attitudes indices were examined for the purpose of recoding them for use in the crosstabulations. Responses

from each index were collapsed and recoded to form a range of 1 to 4 where 1 was strong disagreement and 4 was strong agreement with the index concept. Therefore, high numbers indicated strong agreement affirming abstinence, rejecting sexual activity, affirming reasons to abstain, being confident in personal efficacy, and having behavioral intent to avoid sexual activity. Although collapsing the responses lost some variance, this allowed for easier interpretability in the crosstabulations.

The recodes for the crosstabulations were as follows:

The Affirmation of Abstinence index was operationalized with three questions, each with a minimum value of 1 and a maximum value of 5. Therefore, the minimum value for this index was 3 (strong disagreement) and the maximum value was 15 (strong agreement. For this index I recoded so that 1=3 through 6, 2=7 through 9, 3=10 through 12, and 4=13 through 15.

The Rejection of Sexual Activity index was operationalized with two questions each with a minimum value of 1 and a maximum value of 5 therefore the minimum value for this index was 2 (strong disagreement) and the maximum value is 10 (strong agreement). For this index I recoded so that 1=2 through 4, 2=5 and 6, 3=7 and 8, and 4=9 and 10.

The Reasons to Abstain index was operationalized with five questions each with a minimum value of 1 and maximum value of 5 therefore the minimum value for this index was 5 (strong disagreement) and the maximum value was 25 (strong agreement). For this index I recoded so that 1=5-10 2=11-15, 3=16-20, and 4=21-25.

The Personal Efficacy index was operationalized with four questions each with a minimum value of 1 and a maximum value of 5 therefore the minimum value for this index was 4 (strong disagreement) and the maximum value was 20 (strong agreement). For this index I recoded so that 1=4 through 8, 2=9 through 12, 3=13 through 16, and 4=17 through 20.

The Behavioral Intent index was operationalized with two questions each with a minimum value of 1 and a maximum value of 5 therefore the minimum value for this index was 2 (strong disagreement) and the maximum value was 10 (strong agreement). For this index I recoded so that 1=2 through 4, 2=5 and 6, 3=7 and 8, and 4=9 and 10.

**Statistical Analysis**

This data analysis included two independent variables, race and gender, and five dependent variables, which were the five indices representing adolescents' sexual beliefs and attitudes. Crosstabs were performed in order to compare percentages of agreement levels for the five recoded indices by gender and race. Then *t* tests were performed to test whether the two races and genders had equal means, i.e. whether there were no race and gender differences, on the sexual beliefs and attitudes represented by the indices. Linear regression analyses were performed to examine the relationships between the independent variables (race and gender) and the five indices.

My research question was: "How do race and gender impact adolescents' sexual beliefs and attitudes?" The five indices tested the following ten hypotheses derived from the literature:

1. Male participants will have stronger levels of agreement with confidence in personal efficacy than females.

Female participants will have stronger levels of agreement with _____ than males.

2. affirmation of abstinence
3. rejection of sexual activity
4. reasons to abstain from sexual activity
5. behavioral intent to avoid sexual activity

White participants will have stronger levels of agreement with _____ than African Americans.

6. affirmation of abstinence
7. rejection of sexual activity
8. reasons to abstain from sexual activity
9. confidence in personal efficacy
10. behavioral intent to avoid sexual activity

In addition to testing these hypotheses, group mean comparisons and one-way analysis of variance were conducted in order to examine the intersections of race and gender to see whether there were significant race differences within each gender category, and whether there were significant gender differences within each race category.

# RESULTS

The sample for this study was comprised of male and female African American and White respondents (N = 2012). Males represented a slightly smaller percentage of the sample (47%) than females (53%) (with one case missing) and Whites represented a slightly larger percentage of the sample (53%) than African Americans (47%).

Of the six location sites in Virginia, 50% of the participants were from Fauquier, 9% from Lynchburg/Bedford, 8% from Newport News/Hampton, 18% from Sussex, 4% from Norfolk, and 11% from Powhatan.

The five Sexual Beliefs and Attitudes indices for this study were Affirmation of Abstinence (AA), Reject Sexual Activity (RSA), Reasons to Abstain (RA), Personal Efficacy (PE), and Behavioral Intent (BI).

**Table 1: Sexual Beliefs and Attitudes by Gender**

| | | | Gender | | |
|---|---|---|---|---|---|
| **Index** | **Range** | | **Male** | **Female** | **Total** |
| **AA** | 3-15 | Mean | 9.70 | 11.96 | **10.97** |
| | | N | 547 | 702 | **1249** |
| | | SD | 4.72 | 4.08 | **4.51** |
| **t=-9.056(1247), p<.001** | | | | | |
| **RSA** | 2-10 | Mean | 6.13 | 7.64 | **6.93** |
| | | N | 930 | 1051 | **1981** |
| | | SD | 2.53 | 2.25 | **2.50** |
| **t=-14.06(1979), p<.001** | | | | | |
| **RA** | 5-25 | Mean | 19.97 | 23.01 | **21.84** |
| | | N | 473 | 754 | **1227** |
| | | SD | 5.52 | 3.50 | **4.63** |
| **t=-11.79(1225),p<.001** | | | | | |
| **PE** | 4-20 | Mean | 11.95 | 16.03 | **14.13** |
| | | N | 883 | 1008 | **1891** |
| | | SD | 5.17 | 4.45 | **5.21** |
| **t=-18.43(1889),p<.001** | | | | | |
| **BI** | 2-10 | Mean | 6.38 | 8.44 | **7.53** |
| | | N | 532 | 671 | **1203** |
| | | SD | 3.13 | 2.16 | **2.83** |
| **t=-13.44(1201),p<.001** | | | | | |

Table 1 presents the mean values of level of agreement with the five Sexual Beliefs and Attitudes indices by gender. In comparing mean scores, female students had stronger agreement with all five index concepts than males. The greatest difference in means is for personal efficacy, where females indicated stronger agreement (M=16.03, SD=4.45) than males (M=11.95, SD=5.17).

T-tests were performed to test whether male and female participants had equal means on their sexual beliefs and attitudes represented by the indices. Regarding gender, t-test results show differences between male and female participants in their levels of agreement for all five indices as indicated by the large t values and p values that do not exceed .05 (Table 1).

**Table 2: Sexual Beliefs and Attitudes by Race**

| | | | Race | | |
|---|---|---|---|---|---|
| **Index** | **Range** | | **White** | **African American** | **Total** |
| **AA** | 3-15 | Mean | 11.20 | 10.68 | **10.97** |
| | | N | 691 | 558 | **1249** |
| | | SD | 4.44 | 4.58 | **4.51** |
| **t=-2.01(1247),p=.045** | | | | | |
| **RSA** | 2-10 | Mean | 7.01 | 6.82 | **6.93** |
| | | N | 1056 | 926 | **1982** |
| | | SD | 2.48 | 2.51 | **2.50** |
| **t=-1.70(1980),p=.089** | | | | | |
| **RA** | 5-25 | Mean | 21.84 | 21.83 | **21.84** |
| | | N | 659 | 569 | **1228** |
| | | SD | 4.62 | 4.65 | **4.63** |
| **t=-.015(1226),p=.988** | | | | | |
| **PE** | 4-20 | Mean | 14.21 | 14.03 | **14.13** |
| | | N | 1024 | 868 | **1891** |
| | | SD | 5.25 | 5.16 | **5.21** |
| **t=-.771(1890),p=.441** | | | | | |
| **BI** | 2-10 | Mean | 7.83 | 7.14 | **7.53** |
| | | N | 679 | 524 | **1203** |
| | | SD | 2.66 | 2.99 | **2.83** |
| **t=-4.24(1201),p<.001** | | | | | |

Table 2 describes the mean race comparisons for the five indices which indicated very minimal differences in mean scores for all five indices. White participants had stronger agreement with all five index concepts than African Americans. The largest difference in means scores was indicated by Whites (M=7.83, SD=2.66) who had slightly more participants with strong levels of agreement with behavioral intent to avoid sexual activity than African Americans (M=7.14 SD=2.99).

T-tests were performed to test whether White and African American participants had equal means on their sexual beliefs and attitudes represented by the indices. Regarding race, t-tests indicated minimal differences between African American and White participants in their level of agreement with the Reasons to Abstain, Rejection of Sexual Activity, and Personal Efficacy indices as indicated by the small t values and p-values that exceed the alpha level of .05 for all five indices. Differences between African American and White participants in their levels of agreement with Affirmation of Abstinence and Behavioral Intent were indicated by the large t values and p values that do not exceed .05 (Table 2). There was not as much of a difference in level of agreement with the five index concepts for race as there was for gender.

**Table 3: Affirmation of Abstinence and Rejection of Sexual Activity Percentages by Gender and Race**

| | | GENDER | | RACE | |
|---|---|---|---|---|---|
| | | **Male** | **Female** | **African American** | **White** |
| **Affirmation of Abstinence** | (3-6) strong disagreement | 27% | 15% | 22% | 20% |
| | (7-9) | 24% | 26% | 22% | 17% |
| | (10-12) | 22% | 22% | 21% | 23% |
| | (13-15) strong agreement | 27% | 47% | 35% | 40% |
| | **Total** | **100%** | **100%** | **100%** | **100%** |
| | Chi-square=71.34 (p<.001) gamma=.386 | | | Chi-square=18.61 (p<.001)gamma=.102 | |
| **Rejection of Sexual Activity** | (2-4) strong disagreement | 9% | 2% | 21% | 18% |
| | (5-6) | 12% | 3% | 27% | 21% |
| | (7-8) | 18% | 9% | 21% | 26% |
| | (9-10) strong agreement | 61% | 86% | 31% | 35% |
| | **Total** | **100%** | **100%** | **100%** | **100%** |
| | Chi-square=170.90 (p<.001) gamma=.423 | | | Chi-square=14.68 (p=.002)gamma=.098 | |

Table 3 describes the percentages for gender and race for the AA and RSA indices. In comparing the two gender groups, males (27%) were about two times more likely than females (15%) to have the strongest disagreement of affirmation of abstinence and

females (47%) were about two times more likely than males (27%) to have the strongest level of agreement for affirmation. A significant number of females (86%) indicated the strongest level of rejection of sexual activity while only a little more than half (61%) of males indicated the strongest level of rejection of sexual activity.

Regarding race, White and African Americans were approximately equal in their levels of agreement with affirmation of abstinence and rejection of sexual activity with slightly more Whites (40%) with the strongest level of agreement with affirmation of abstinence and rejection of sexual activity (35%) than African Americans (35% and 31% respectively).

The Chi-square tests indicated statistical significance for AA and gender ($p<.001$), for AA and race ($p<.001$), for RSA and gender ($p<.001$), and for RSA and race ($p=.002$) indicating that relationships did exist among the variables and supported the hypotheses that race and gender were probably related to certain sexual beliefs and attitudes of adolescents.

**Table 4. Reasons to Abstain, Personal Efficacy, and Behavioral Intent Percentages by Gender and Race**

| | | GENDER | | RACE | |
|---|---|---|---|---|---|
| | | **Male** | **Female** | **African American** | **White** |
| **Reasons to Abstain** | (5-10) strong disagreement | 9% | 2% | 4% | 5% |
| | (11-15) | 13% | 3% | 8% | 6% |
| | (16-20) | 18% | 9% | 12% | 12% |
| | (21-25) strong agreement | 61% | 86% | 76% | 77% |
| | **Total** | **100%** | **100%** | **100%** | **100%** |
| | Chi-square=108.35 (p<.001) gamma=.570 | | | Chi-square=1.97 (p=.580) gamma=.014 | |
| **Personal Efficacy** | (4-8) strong disagreement | 31% | 9% | 19% | 19% |
| | (9-12) | 22% | 14% | 19% | 16% |
| | (13-16) | 23% | 20% | 23% | 21% |
| | (17-20) strong agreement | 24% | 57% | 39% | 44% |
| | **Total** | **100%** | **100%** | **100%** | **100%** |
| | Chi-square=259.13 (p<.001) gamma=.536 | | | Chi-square=6.20 (p=.102) gamma=.071 | |
| **Behavioral Intent** | (2-4) strong disagreement | 40% | 10% | 28% | 19% |
| | (5-6) | 7% | 10% | 12% | 6% |
| | (7-8) | 14% | 11% | 11% | 14% |
| | (9-10) strong agreement | 39% | 69% | 49% | 61% |
| | **Total** | **100%** | **100%** | **100%** | **100%** |
| | Chi-square=169.32 (p<.001) gamma=.537 | | | Chi-square=29.52 (p<.001) gamma=.227 | |

Table 4 describes the percentages for gender and race for the RA, PE, and BI indices. In comparing the two gender groups, a significant number of females (86%) indicated the strongest level of agreement with reasons to abstain while only a little more than half (61%) of males indicated the strongest level of agreement.

Females were about two times more likely to have the strongest behavioral intent (70%) and the strongest personal efficacy (57%) when compared to males (39% and 24% respectively). Males were four times as likely as females to indicate the strongest disagreement with reasons to abstain, personal efficacy, and behavioral intent to avoid sexual activity.

Regarding race, Whites and African Americans were equal in their agreement with reasons to abstain. There were some differences in level of agreement with personal efficacy and behavioral intent where more Whites (44%) than African Americans (39%) indicated the strongest personal efficacy and more Whites (61%) than African Americans (49%) indicated the strongest behavioral intent to avoid sexual activity.

The Chi-square tests indicated statistical significance for RA and gender ($p<.001$), BI and gender ($p<.001$), and PE and gender ($p<.001$). There was also an indication of a relationship for BI and race ($p<.001$). However, relationships were not indicated for RA and race ($p=.580$) or PE and race ($p=.102$).

The crosstabulation results in Tables 3 and 4 also present the values for gamma. Gamma values for race for AA (.102), RSA (.098), RA (.014), PE (.071) and BI (.227)

were close to 0 indicating independence among the variables or very weak association. However, gamma values for gender, especially RSA (.423), RA (.570), and PE (.536) were closer to 1 and therefore indicated considerably stronger associations. This supports t-tests results which also indicate a stronger relationship between gender and sexual beliefs and attitudes than race.

Considering the percentages among all five indices (Tables 3 and 4), all of the participants -females (86%), males (61%), African Americans (76%) and Whites (77%) - indicated the strongest agreement for Reasons to Abstain and all participants –females (43%), males (22%), African Americans (31%), and Whites (35%) - indicated the weakest agreement for Rejection of Sexual Activity among all five indices.

**Table 5: Linear Regression Analysis for Sexual Beliefs and Attitudes by Gender and Race**

| | GENDER | | | | RACE | | | |
|---|---|---|---|---|---|---|---|---|
| | **B** | **Beta** | ***t*-value** | **p-value** | **B** | **Beta** | ***t*-value** | **p-value** |
| **AA** $R^2$=.066, df=2,1249,p<.001 | 2.275 | .250 | 9.145 | <.001 | .583 | .064 | 2.357 | .019 |
| **RSA** $R^2$=.092, df=2,1978, p<.001 | 1.511 | .302 | 14.076 | <.001 | .197 | .039 | 1.830 | .067 |
| **RA** $R^2$=.102, df=2,1224, p<.001 | 3.039 | .319 | 11.793 | <.001 | 6.176 | .007 | .246 | .806 |
| **PE** $R^2$=.153 df=2,1888, p<.001 | 4.078 | .391 | 18.436 | <.001 | .210 | .020 | .949 | .343 |
| **BI** $R^2$=.148, df=2,1200, p<.001 | 2.078 | .365 | 13.696 | <.001 | .746 | .131 | 4.909 | <.001 |

Linear regression analyses were performed to examine the relationships between the independent variables (race and gender) and the five Sexual Beliefs and Attitudes indices. Results are presented in Table 5. The small Beta values (very close to 0) for the five indices for race supported that race had minimal influence upon sexual beliefs and attitudes when controlling for gender. The Beta values for gender were larger and all had p-values of less than .001 supporting the relationship between gender and the dependent variables. R squared values for the indices were closer to 0 than 1 for all five indices for race and gender, indicating somewhat of a weak association between the

variables. Results did indicate statistical significance for the five indices for gender and statistical significance for both AA and BI for race. Therefore, race and gender influenced sexual beliefs and attitudes of adolescents; however data indicated that they were weak to average predictive variables.

**Table 6: Analyses of Variance for Sexual Beliefs and Attitudes by Race within Gender**

| | | MALE | | FEMALE | |
|---|---|---|---|---|---|
| | | **African American** | **White** | **African American** | **White** |
| **AA** | N | 235 | 312 | 323 | 379 |
| | Mean | 8.92 | 10.29 | 11.97 | 11.95 |
| | SD | 4.60 | 4.73 | 4.12 | 4.05 |
| F=31.99 (3,1245), p<.001 | | | | | |
| **RSA** | N | 432 | 498 | 493 | 558 |
| | Mean | 5.85 | 6.37 | 7.69 | 7.60 |
| | SD | 2.45 | 2.58 | 2.25 | 2.25 |
| F=70.08 (3,1997), p<.001 | | | | | |
| **RA** | N | 213 | 260 | 355 | 399 |
| | Mean | 19.62 | 20.26 | 23.16 | 22.87 |
| | SD | 5.42 | 5.59 | 3.51 | 3.49 |
| F=47.53 (3,1223), p<.001) | | | | | |
| **PE** | N | 402 | 481 | 465 | 543 |
| | Mean | 11.65 | 12.21 | 16.08 | 15.99 |
| | SD | 4.83 | 5.43 | 4.53 | 4.38 |
| F=114.32 (3,1887), p<.001 | | | | | |
| **BI** | N | 224 | 308 | 300 | 371 |
| | Mean | 5.66 | 6.90 | 8.24 | 8.60 |
| | SD | 3.09 | 3.07 | 2.37 | 1.96 |
| F=72.66 (3,1199), p<.001) | | | | | |

Table 6 describes the mean values for African American and White males and African American and White females for the five Sexual Beliefs and Attitudes indices, providing an analysis of race differences within gender as guided by the multiracial feminism framework. In comparing White and African American females, the percentages were equal for all five indices therefore race was not a determinate variable in sexual beliefs and attitudes among females.

However, in comparing White and African American males, there were differences in means with two of the indices, where more Whites than African Americans indicated stronger agreement for affirmation of abstinence and behavioral intent. Therefore, race was a determinate variable in some of the sexual beliefs and attitudes among males.

Also, in comparing male and female White participants, there were minimal differences in levels of agreement with the five indices. The largest difference in means among Whites was for PI and BI with females indicating stronger agreement than males for both indices. In comparing male and female African American participants, there were significant differences in levels of agreement with all five indices, In both race groups, more females indicated stronger levels of agreement with AA, RSA, RA, PE, and BI than males of their same race group. Therefore, gender was a determinate variable, even within the same race, in sexual beliefs and attitudes among Whites and African Americans with a greater level of disagreement between male and female African Americans.

A one-way ANOVA was performed to test for differences among African American and White males and African American and White females (Table 6). The F tests for all five indices were significant at $p<.001$, indicating differences in means among the four groups for the Sexual Beliefs and Attitudes indices. The largest F-test statistic was for the Personal Efficacy Index ($F(3,1887)=114.32$, $p<.001$), indicating the greatest difference in means between groups for this index. ANOVA results suggest significant variation between the four groups and that race and gender were likely related

to the participants' sexual beliefs and attitudes.

In addition, post hoc comparisons were performed with the Bonferroni test at the.05 statistical significance level. Results showed that for Affirmation of Abstinence, Rejection of Sexual Activity, and Behavioral Intent, African American males were significantly different (weaker levels of agreement) from the other three groups, and White males had significantly stronger levels of agreement than African American males and significantly weaker levels of agreement than White females for these three indices. For Reasons to Abstain and Personal Efficacy, both African American and White males were significantly different (weaker levels of agreement) from African American and White females but were not significantly different from each other. For all five indices, there were no statistically significant differences between African American and White females.

A review of the ten hypotheses after data analysis is as follows:

Hypothesis 1 predicted that male participants have stronger levels of agreement with confidence in personal efficacy than females. Based on the test results, females had stronger levels of agreement than males with confidence in personal efficacy. Hypothesis 1 was not supported.

Hypothesis 2 predicted that female participants have stronger levels of agreement with affirmation of abstinence than males. Based on the t-test results, females had stronger levels of agreement than males in affirming their beliefs of abstinence. Hypothesis 2 was supported.

Hypothesis 3 predicted that females have stronger levels of agreement with

rejection of sexual activity than males. Based on the test results, females indicated stronger levels of agreement regarding rejection of sexual activity. Hypothesis 3 was supported.

Hypothesis 4 predicted that female participants have stronger levels of agreement with reasons to abstain from sexual activity than males. Based on the test results, females had stronger levels of agreement than males with reasons to abstain. Hypothesis 4 was supported.

Hypothesis 5 predicted that female participants have stronger levels of agreement in their behavioral intent to avoid sexual activity than males. Based on the results, females had stronger levels of agreement than males in affirming their behavioral intent to avoid sexual activity. Hypothesis 5 was supported.

Hypothesis 6 predicted that White participants have stronger levels of agreement in their affirmation of abstinence than African Americans. Based on the test results, there were minimal differences between White and African American participants in their levels of agreement in affirming their beliefs of abstinence where White participants had slightly stronger levels of agreement in their beliefs of abstinence. Therefore, Whites had stronger levels of agreement, although minimal, in their affirmation of abstinence than African American participants in this sample. Hypothesis 6 was supported.

Hypothesis 7 predicted that Whites have stronger levels of agreement with rejection of sexual activity than African Americans. Based on the test results, there were

minimal to no differences between White and African American participants in their level of agreement with rejection of sexual activity. Hypothesis 7 was not supported.

Hypothesis 8 predicted that Whites have stronger levels of agreement with reasons to abstain from sexual activity than African Americans. Based on the test results, there were minimal to no differences between White and African American participants in their level of agreement with reasons to abstain. Hypothesis 8 was not supported.

Hypothesis 9 predicted that Whites have stronger levels of agreement with confidence in personal efficacy than African Americans. Based on the test results, there were minimal to no differences between White and African American participants in their level of agreement with confidence in personal efficacy. Hypothesis 9 was not supported.

Hypothesis 10 predicted that Whites have stronger levels of agreement with behavioral intent to avoid sexual activity than African Americans. Based on the test results, there were minimal differences between White and African American participants in their level of agreement where, White participants had slightly stronger levels of agreement in their behavioral intent. Therefore, Whites had stronger levels of agreement, although minimal, with behavioral intent to avoid sexual activity. Hypothesis 10 was supported.

In addition, race within gender comparisons indicated differences among gender and race for the five indices. Differences between African American males and White males were evident, with White males indicating stronger agreement for all five indices.

However, differences between African American females and White females were not evident. African American females and White females indicated stronger agreement than African American males for all five indices and stronger agreement than White males for some of the indices. Race was an influence for males for Sexual Beliefs and Attitudes but not for female participants.

In sum, data indicated that gender was related to sexual beliefs and attitudes and race had a minimal relationship to sexual beliefs and attitudes of the participants.

# DISCUSSION AND CONCLUSIONS

Differences in adolescents' beliefs and attitudes by race and gender were predicted because race, class, culture, and gender are relevant to differences in socialization and social values, especially with regard to sexuality. In addition, the literature indicates associations among race and gender regarding the sexual *behavior* of adolescents and therefore an association regarding sexual beliefs and attitudes was hypothesized.

The basic research question of this study was whether race and gender had an influence on adolescents' sexual beliefs and attitudes. The data analyses did indicate associations. Gender was clearly an influence on adolescents' sexual beliefs and attitudes. Race, although minimal, was also an influence on some of the adolescents' sexual beliefs and attitudes. There were associations among race and affirmation of abstinence and behavioral intent to abstain from sexual activity. However, race was not as strong an influence as gender on reasons to abstain, rejection of sexual activity, or confidence in personal efficacy to avoid sexual activity.

Overall, teens' sexual beliefs and attitudes indicate differences between genders but minimal differences between race categories. Therefore, gender is a more significant factor in the socialization of adolescents within this sample than race as predicted by the frameworks used in this analysis.

The social construction of gender perspective suggests that gender differences among adolescents are based on the differences in how sexuality is constructed for

males and females. When adolescents are "doing their gender" they are subscribing to the "gender-appropriate" beliefs, attitudes, and behaviors that have been defined by society based on "masculine" and "feminine" ideals. As Barbara Risman (2004) describes, these social constructions greatly constrain gendered behavior and sexual norms develop differently for males and females in our society. Invariably, these constraints are the root of the gender double-standard –what is acceptable for males is not necessarily acceptable for females. As the social construction of gender theory would predict, differences between male and female participants in this analysis were evident.

Radical feminist theory suggests that female adolescents are likely to feel more inhibited, embarrassed, and uncomfortable about sexuality than males and therefore have more conservative and restrictive sexual beliefs and attitudes. With an emphasis on addressing oppressive socially defined gender roles, radical feminism highlights the ways in which male dominance negatively affects female sexuality. Females are not granted freedom of expression because it is often considered a threat to the "norms of masculinity." Adolescent females are expected to lack desire, reject sexual activity, and maintain abstinence until marriage and therefore are not given complete and accurate information about sexual desire, sexual behaviors, or safe sex practices. As radical feminist theory would predict, female participants indicated stronger agreement with all Sexual Beliefs and Attitudes indices, supporting the theory that females are socialized to express their sexuality less and feel more pressure to conform to society's gender role expectations of adolescent girls.

Multiracial feminist theory states that multiple variables such as race, class, and gender work together as predictive factors regarding adolescents' sexual beliefs and attitudes based on societal biases and influences during adolescence. Therefore, multiracial feminism suggests that Whites and African Americans would have different levels of agreement with the Sexual Beliefs and Attitudes indices. Multiracial feminism highlights the importance of race influencing the social construction of gender and addresses systems of power and privilege. Race is constructed as a "social division" (Baca Zinn and Thornton Dill, 2003) and therefore simultaneously influences the development of a gendered identity. Therefore, males, especially White males, tend to feel more empowered about their abilities and decision-making than females and persons of color. Whites also tend to have stronger agreement with affirmation of abstinence, rejection of sexual activity, and beliefs in attaining future hopes and goals than their African American counterparts. The theoretical frameworks, as well as the literature on adolescent sexuality, suggest both cultural and structural influences on these differences that are not captured by the survey used by the VAEI. For example, men of color and poor/working class men are more likely than privileged men to emphasize strong physical symbols, ideals and behaviors of masculinity (such as engaging in sexual activity) in order to solidify their gender identity if they lack access to economic sources of power.

As multiracial feminism would predict, race was an influence in some of the Sexual Beliefs and Attitudes indices (affirmation of abstinence and behavioral intent to avoid sexual activity) and race within gender comparisons indicated differences

between White and African American males for three of the indices. However, differences between White and African American females were not evident in this analysis.

The findings suggest that for this sample, and based on this survey instrument, gender is more of a predictive factor than race regarding an adolescent's sexual beliefs and attitudes and that there is a greater race difference among male than female participants, especially for African Americans.

Consistent with the literature, female adolescents indicated stronger agreement with affirmation of abstinence, rejection of sexual activity, reasons to abstain from sexual activity, and behavioral intent to avoid sexual activity than their male counterparts. Teen girls may be more conservative and restrictive because of practical reasons such as a greater fear of STIs and pregnancy, a greater concern for future goals, or a stronger desire for parental approval for example. Or perhaps more teen girls have stronger agreement due to social restrictions such as fear of being negatively labeled as sexually active, or embodiment restrictions such as feeling disconnected from their bodies, fear of being sexually expressive, or a fear of their own desires. On the other hand, male adolescents indicated weaker agreement for affirmation of abstinence, rejection of sexual activity, reasons to abstain from sexual activity, and behavioral intent to avoid sexual activity, suggesting more liberal and permissive sexual beliefs and attitudes. This is likely due to the generally accepted, unequal view by and double-standard of society of the "boys will be boys" mentality. Current literature suggests that male adolescents indicate less concern with STIs and pregnancy and tend to feel more

comfortable being sexually active than female adolescents. There is also less peer judgment or negative labeling among male teens versus females.

Contradictory to the literature, males did not indicate stronger levels of agreement with personal efficacy than female adolescents. Male adolescents were expected to have stronger agreement with self-efficacy for several reasons. Previous data reports that levels of self-efficacy are higher with increased sexual knowledge (Smith, et al, 2005). Since males have greater access to sexual knowledge and greater social status, it was predicted that they would have more confidence in their belief of effectively following through with their intentions. Also, low self-efficacy is associated with anxiety and helplessness which may be pervasive feelings of adolescent girls regarding their sexuality. However, additional research has found that female adolescents report higher levels of self-efficacy for sexual abstinence, perhaps related to the fact that girls are more likely than their male counterparts to be inundated by parents' and educators' admonitions to affirm abstinence (Hulton, 2001). Considering the stronger peer and parental influence, societal expectations, and stronger agreement with reasons to abstain from sexual activity experienced by girls, it follows that female adolescents would report higher levels of personal-efficacy regarding confidence in avoiding sexual activity.

Also consistent with the literature, although minimal, race differences were evident from the data. White adolescents did indicate stronger agreement with affirmation of abstinence and behavioral intent to avoid sexual activity than African American adolescents. Current literature suggests that White adolescents tend to

indicate more conservative and restrictive sexual beliefs and attitudes compared to their African American counterparts. This discrepancy is likely a result of race, class, and gender privileges in society where white males of higher socioeconomic status are more confident and "successful" than females, persons of lower socioeconomic status, and persons of color due to their access to greater social and economic resources. Females in general, and white females in particular, tend to cite stronger reasons such as concerns with parent approval and social stigma for avoiding pregnancy and STIs than males and persons of color. This discrepancy is likely a result of race and gender expectations in society where females, and white females especially, are expected to make more "appropriate" decisions than males and persons of color.

Differences by race *within* gender were also predicted. Based on the literature, African American females and African American males were expected to be less likely to indicate strong agreement with the five indices than their White counterparts, however both female groups indicated similar levels of agreement regarding their sexual beliefs and attitudes. This commonality likely reflects the social construction of gender that denies women autonomy and control over their sexuality. White males were higher in agreement levels than African American males for three of the indices, with the greatest difference indicated with personal efficacy. Results from this analysis also support the literature which suggests that White adolescents report a stronger confidence in personal efficacy than their African American counterparts.

The data results are concordant with previous data regarding gender and sexual beliefs and attitudes supporting a significant difference between male and female

adolescents. Mean differences were noted between White male and females and even greater differences between African American males and females were noted for all five indices. These also support the argument for gender-specific programs targeting male and female adolescents in ways that address specific issues related to their gendered experience of adolescence and working to break down some of the harmful stereotypes and unequal expectations placed upon adolescents in our society.

The data results are also concordant with previous data regarding race and sexual beliefs and attitudes supporting a difference (although minimal) between White and African American adolescents. I don't believe the weak associations are necessarily indicative of a change in beliefs and attitudes among adolescents(although it is possible), but rather a speculation that the *survey* did not capture these differences. It is also possible that this *analysis* did not capture statistically significant race differences for all of the Sexual Beliefs and Attitudes indices. The probability value of .05 was chosen as the cutoff for statistical significance; however, this level was not overemphasized in this analysis, particularly because this was an exploratory study and I was more interested in describing differences (when evident) as opposed to whether or not they were "statistically significant."

Predicted significant differences among participants may not have been found because a teen's sexual beliefs and attitudes are not always congruent with their actual sexual behavior. In addition, the data were self-reported and may have been influenced by "social desirability bias" where respondents may have provided the answers they thought they should give. It is important to also consider response error with the self-

report method because the responses may include inaccurate information due to "not understanding the question, faulty memory, the desire to present a good image, and trying to answer in a way that fits the respondent's assessment of researcher's expectations" (Adler and Clark, 2003:240). Moreover, Adler and Clark point out that gender role stereotypes also contribute to response error but do not devalue data from questionnaires. Specifically, female adolescents are expected to have conservative beliefs, attitudes, and behaviors regarding sexuality and females may be less likely to be candid and honest about themselves in their self-reports.

Also of importance is a consideration of the age of the majority of respondents. Most of the participants (67%) were either 12 or 13 years of age ($7^{th}$ graders) and may not have been sexually active or been in a situation where they would have had to make a decision or develop a personal belief or attitude about the various concepts related to sexual beliefs and attitudes within the survey.

Perhaps the analyses did not suggest significant race differences due to the absence of socioeconomic status of the participants. As noted above, class is a critical influence on the socialization and development of adolescent sexuality and may be relevant to the lack of a strong association of race and sexual beliefs and attitudes of the participants. I would expect that socioeconomic status as a third independent variable in this analysis would have provided more specific information about the participants. Perhaps a significant portion of the African American participants were from a more affluent area in Virginia and therefore had more access to information, more positive reinforcement and support from their parents (among other variables), and therefore

responded stronger than expected (closer to White participant levels) in their agreement with the five indices. Or conversely, perhaps the majority of White participants were from low-income families and therefore had less sexual education information, less positive influences or support from parents, and therefore responded weaker than expected (closer to African American participant levels). In addition, considering the cultural beliefs and attitudes about male and female sexuality within our society, it is important to consider whether the findings are reflective of true behavior or societal expectations (especially for adolescent females of all races). The "norms of masculinity" allow males to both report more honestly as well as allow them to be more permissive in their actual sexual behavior.

Lastly, perhaps the analyses did not indicate differences for race that were as significant as those for gender, because gender may truly be more of an influence on adolescents' sexual beliefs and attitudes than race. For example, Santelli, et al (2004) found that gender was the most significant predictive factor for adolescents initiating sexual activity over race, demographic characteristics, or academic achievement.

Possible weaknesses within this study could be the survey itself in that it was implicitly based on and directed toward dominant and privileged categories of race, class, gender, and sexuality of program participants. Abstinence-based programs have been criticized for reinforcing traditional gender norms, and standardized survey measures have been criticized for being created based on privileged respondents' experiences. In this case, data was based on surveys created by the Virginia Department of Health, for an abstinence-based program. Therefore, the program and

the surveys were designed within an abstinence ideology. Possible value biases within the survey questions include the direction of the question towards a desired outcome (pro-abstinence), the question leading the participant to want to answer as desired (pro-abstinence), and the type of wording used. For example, language referring to sexual activity outside of marriage may have been used in a negative connotation while language referring to abstinence was used in a positive way. Since these programs were abstinence-based, they reinforced abstinence and (heterosexual) marriage and therefore likely influenced the participants' responses. Therefore, results from abstinence-based data constrain what kind of information we are able to capture from the respondents.

In addition, each program instructor may have presented the surveys to each group differently, or provided directions for the survey differently, possibly adding to variability in responses. There could also be weaknesses within data collection or statistical procedures.

The five Sexual Beliefs and Attitudes indices were designed to capture a generalized response from each participant regarding the strength of their agreement with restrictive views regarding sexuality in order to make race and gender comparisons. In addition, each index was designed to capture specific beliefs and attitudes about abstinence, sexual activity, reasons for abstaining from sexual activity, predicted level of efficacy, and predicted behavioral intent regarding sexual activity for each participant. Findings did indicate variation in strength of agreement among the indices for each individual. As indicated in the results above, (while there were differences between the groups) all participants indicated the strongest agreement for

reasons to abstain from sexual activity and the weakest agreement for rejection of sexual activity of all five indices. This is an interesting contradiction in that an acknowledgement of the reasons to abstain from sexual activity would likely support an equal agreement in rejection of sexual activity from each individual. As suggested above, it may also indicate a recognition on the part of adolescents on the difficulty in avoiding sexual activity regardless of one's ideological intentions.

These findings are also interesting and important from a program development perspective. Since reasons to abstain (risk of pregnancy and STIs, desire not to disappoint parents or peers, and not wanting to be taken advantage of) seem to speak the strongest to adolescents, yet confidence that they can avoid sexual activity is weak, the argument for comprehensive sex education is further supported with these results. Current literature (especially data from the National Campaign to Prevent Teen Pregnancy in Washington, DC) indicate that abstinence-only education is not proving to be an effective strategy in decreasing unplanned teen pregnancy and birth rates in the United States. If adolescents can acknowledge reasons to abstain from sexual activity, but their sexual activity rates are not changing, the use of fear tactics and abstinence-only rhetoric are not having the intended effect. Instead, TPPPs need to emphasize the true risks involved in sexual activity and encourage positive reasons for adolescents protecting themselves, specifically including information on how to use different forms of contraception.

An additional problem with the survey, as well as abstinence-only education in general, is the definition and measurement of sex. We must recognize the limitations of

the definition of sex as "sexual intercourse" for adolescent sexual behavior. This definition is most often defined based on a heterosexual model that assumes *only* heterosexual activity and specifically assumes sexual intercourse as penile-vaginal. This assumption also ignores other sexual behaviors such as oral sex and overlooks individuals who ceased sexual behavior or only participated in a sexual behavior one time. This narrow, heterosexual model therefore limits our understanding of adolescent sexuality and must be taken into consideration regarding sexual behavior statistics and analyses. For example, adolescents may commit to abstinence and to avoid sexual intercourse but may believe that anal sex, oral sex, and other sexual activities are acceptable because they are not considered "sex." Also, adolescents who are sexually active with same-sex partners or transgender partners may feel unsure as to how to respond to questions regarding "sex" since it may be assumed to mean penile-vaginal only.

Also of importance is the fact that the sample, although considerably large, includes participants exclusively from the state of Virginia and data may not be necessarily representative of teens throughout the U.S.

This project aims to better understand adolescents' sexual beliefs and attitudes and offer more insight into race and gender differences as they may impact a teen's transition into adulthood. While results may not reflect differences as significant as predicted, current assessments of different TPPPs describe race, class, and gender differences. This evaluation provides evidence that there are some differences in these

adolescents' sexual beliefs and attitudes among race and gender and that working toward improving TPPPs is a valuable and important goal.

Perhaps teen pregnancy is not decreasing at the rate that is expected because many of the programs are not "speaking" to some of the participants. TPPPs focus on delaying or decreasing sexual activity, increasing the use of contraceptives, and lowering unplanned teen pregnancy but often do not focus on adolescent empowerment, debunking myths, or analyzing gender roles or cultural influences.

Implications of the results of this project support the idea of developing TPPPs to be more inclusive and more effective by designing characteristic-specific programs. In addition, they encourage more comprehensive teen pregnancy prevention programs to address the social constraints and biases of race, culture, class, and gender placed upon American adolescents. More of a focus on body image and self-esteem as well as comprehensive sex education is needed to support teens in making healthier decisions. Also addressing and rejecting the unequal and biased gender roles and structures within society will encourage and support healthy adolescent development. Redefining what it means to be "masculine" and "feminine" and rebuilding gender roles that are more flexible and more inclusive needs to be within the framework of discussing sexuality with adolescents. Also, those working with adolescents need to be aware of the importance of race in understanding the construction of gender and not grouping all females or all males into one category. School and program leaders need to develop a focus on the interrelationships of inequalities within our society because race, culture, and class determine how someone is "gendered" and therefore are related to their sexual

beliefs, attitudes, and behaviors. Race, class, and gender are constructs defined by our society and therefore we can all work towards redefining them.

The social construction of gender theory, radical feminism, and multiracial feminism provide a multidimensional framework for the study of adolescents' sexual beliefs and attitudes. These theories were sufficient for this analysis and are in need of further support, especially with regards to expected significant race differences among adolescents. The minimal differences found among race in this analysis warrant further study. Additional data would help to clarify whether race differences are more difficult to capture in a survey or whether gender is in fact more of an influence than race on adolescents' sexual beliefs and attitudes. Further studies regarding self-efficacy and race, class, and gender are also warranted, considering that level of self-efficacy is a predictive factor for sexual behavior in adolescents. A better understanding of the development of self-efficacy and self-esteem are critical in future TPPP development. Future studies of adolescents' sexual beliefs, attitudes, and behaviors are needed in order to explore the societal biases and influences on adolescents and how they develop their sexuality within their "social locations" structured by race, class, culture, and gender.

**Recommendations for Further Research**

Further studies of beliefs and attitudes based on experiences of adolescents and the development of sexual behavior will contribute to the body of knowledge of adolescent sexuality as well as provide additional data for consideration in future teen pregnancy prevention program development. Based on current U.S. statistics, it is

critical that we continue to address the high rates of unplanned teen pregnancy and birth rates and continue to work on improving TPPPs. We can do this by better understanding adolescents' sexual behavior and decision-making and in order to do this most effectively, we need to increase our understanding of teens' experiences of adolescence and the development of their sexual beliefs and attitudes.

Survey research utilizing data from probability samples and data throughout the U.S. would provide more valid and larger datasets which may provide more comprehensive knowledge regarding race and gender comparisons for adolescent sexual beliefs and attitudes. In addition, class or socioeconomic status needs to be included in future data collection and analyses.

Teen pregnancy prevention programs and surveys need to be designed with an acknowledgement of value biases and work towards minimizing those influences. While many TPPPs have specific aims and goals, collecting the most accurate data possible from the participants should be of the utmost importance. Specifically, programs and surveys should be peer reviewed and the questions and constructs should be phrased and directed without an expected or desired outcome.

I would also suggest that surveys and TPPPs be more inclusive of individuals by not depending on the gender binary of only the "male" and "female" categories and allowing participants to chose "other" in order to be supportive of transgender participants. In addition, future surveys and programs need to break out of the heterosexual model and not make assumptions about an individual's sexual orientation. This would include not only a survey question that asks for the individual's sexual

orientation but also using wording within questions that do not assume heterosexuality. We must also keep in mind the importance of being ethnically and culturally sensitive while encouraging empowerment, healthy behavior, and positive decision-making. While it is important to recognize the differences among race, class, gender, and culture, we also need to work towards equal treatment of all adolescents which includes the same social expectations. We will not see adolescents making healthier, more educated decisions until we address everyone equally, openly, and honestly.

Transitioning into adulthood is an important social issue and developing and implementing the most effective, culturally relevant, and respectful teen pregnancy prevention programs are crucial to healthy adolescent development, a reduction in adolescent STIs and unplanned pregnancies, and social betterment. Using the social construction of gender theory, radical feminism, and multiracial feminism frameworks and understanding the matrix of domination will best assist our work in improving Teen Pregnancy Prevention Programs. While "no single program can hope to combat the media messages that bombard young people at every socioeconomic level or the peer pressures and partner pressures that surround them," more race, class, and gender specific interventions may be one of the best options available (Schwab Zabin and Hayward, 1993:88). Incorporating a better understanding of the target population will likely have a more positive effect on the participants.

What makes a teen prevention program *effective*? While not enough programs have been evaluated to provide unequivocal answers, Douglas Kirby, well known in the TPPP community for program evaluation, notes what have made programs *successful*.

Among ten recommendations, this strategy is included: "incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students" (Kirby, 2001:6). More importantly, teen programs need to be characteristic-specific. The characteristics of a population have an impact on program effectiveness in delay of sexual activity, consistent contraception use, or prevention of unplanned teen pregnancy (Kirby, 2001). Knowing how differences in sexual beliefs and attitudes vary among race, class, culture, and gender can better assess population specifics. Teen pregnancy prevention programs, sex education, and abstinence education would better serve the community by being inclusive of race, class, culture, gender, and sexual orientation issues and the ways in which they intersect in order to be most effective in their approach as well as to create more valid data which are truly representative of the participants. The most obvious limitations in this study are due to the exclusion of class and sexual orientation. Neither of these was asked of the participants so they are not available in this data set. It would be beneficial for future research if surveys were more inclusive and specific in asking for parents' education and economic standing as well as the participant's sexual orientation.

While TPPP evaluations are continuing to provide more valid and reliable data, adolescent characteristics are beginning to be considered and programs have recently been developed that target a specific population. For example, Quantum Opportunities is specifically designed to educate African American adolescents, the Children's Aid Society Carrera Program is specifically geared to Latinos, and the Best Friends Program specifically targets female adolescents regarding pregnancy prevention.

> When an adolescent population is taken as a whole, an evaluation may miss important impacts that only occur within specific subgroups… The effect of exposure to a program may differ with age, prior sexual experience, ethnicity, gender and prior exposure to other programs (Schwab Zabin and Hayward, 1993:91).

Community assessment could help to "tailor" each program by learning about a population's needs, interests, barriers, and cultural differences. In addition, an understanding of societal influences on adolescents (especially the media) is important for program development. Acknowledging gender roles and how adolescents are portrayed in the media are crucial to understanding their decision-making, development of sexual beliefs and attitudes, and self-efficacy. Socially, we need to learn the best ways that we can be supportive of adolescents and guide them in a healthy transition into adulthood. In our efforts to discourage teen pregnancy, we should never use blaming or shaming but clearly show how teen pregnancy limits opportunities and try to motivate teens to be proactive in preventing unplanned pregnancy.

> Poor education, joblessness, and restricted opportunities also are undeniable forces in early, unmarried childbearing. For many disadvantaged teenagers, childbearing reflects – rather than causes – the limitations in their lives (Freeman and Rickels, 1993:163).

As long as girls are discouraged from being strong, standing up for themselves, and saying "no" when they need to they will continue to be passive participants in their adolescence, particularly in their sexual experiences. As long as boys are discouraged from being emotionally expressive, giving equal consideration to females, and being responsible for their behavior they will continue to be aggressive, disconnected from women, and less responsible partners and fathers. As a society we need to recognize

that the "problem" is not adolescents but the societal factors that cause these social problems.

> One may hope that society will eventually address the deep-rooted social malaise that underlies high rates of unwanted conception and pregnancy among the young (Schwab Zabin and Hayward, 1993:89).

This study attempts to encourage TPPP developers and program leaders to use multiple feminist and multiracial frameworks in order to explore ways of being more inclusive and critical in their approach to educating and supporting adolescents' efforts in teen pregnancy prevention and healthy decision-making specifically by incorporating a communities characteristics based on race, gender, class, cultural, and societal differences.

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