

MOVING BEYOND “RISKY SEX”: ADOLESCENT SEXUAL RESILIENCE
AND SEXUAL HEALTH IN YOUNG ADULTHOOD

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ABSTRACT

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Sexual behaviors in adolescence establish the initial resources an individual carries into sexual relationships in adulthood. Current definitions of sexual resilience in adolescence are defined from a negative, risk-based lens. Resilience theory, more generally defined, considers both internal and external factors that promote adaptation to challenging situations. A direct, capital-based approach to studying adolescent sexual resilience has not been found in the extant literature and I propose that a new, more inclusive definition of sexual resilience in adolescence will be more strongly correlated with sexual health in young adults than the risk-based definition. This study creates mutually exclusive risk-based and capital-based measures of adolescent sexual resilience and examines their associations with sexual health outcomes in young adulthood. The data did not produce significant findings, yet descriptive results provide direction for future research. Research in this area is of critical importance as adolescence and young adulthood are unique life stages that involve significant development in areas that influence health, both short and long term. This research, through a proper resilience lens, will better guide adolescent sexual education to develop internal resources as well as provide adequate external resources for adolescents that promote better sexual health and agency outcomes in adulthood.

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TABLE OF CONTENTS

Introduction	1
The Resilience Paradigm	2
Sexual Resilience	6
Sexual Health	9
Current Study	13
Methods	15
Data	15
Measures	16
Analytic Strategy	18
Results	20
Descriptive Results	20
Analytic Results	22
Discussion	25
Limitations	30
Conclusions	31
References	34
Curriculum Vitae	

Introduction

Choices made in adolescence have both immediate and long-term effects on health (Satcher 2001; Winfield 1994; Yancey et al. 2010). Sexual decisions are no exception. Studies on adolescent sexuality and sexual behavior are generally conducted to measure negative outcomes such as how many engage in sexual activity, contract sexually transmitted infections (STIs) and/or become pregnant. Rarely if ever do they include discussions of sexual feelings or behaviors as normal aspects of human development, expressed from early childhood on. The need for sexual competence is ignored and positive aspects are rarely mentioned (Ehrhardt 1996).

As the United States has among the highest rates of teenage pregnancies, abortions and STIs in the developed world (Rose 2003), perhaps it is time to rethink our approach to adolescent sexual behavior and sexual health. In this thesis, I consider a method of looking at and understanding adolescent sexual behaviors and sexual health that seems to be lacking in sociological research. I propose a different conceptualization of sexual resilience in adolescence, and its potential affect on sexual health in young adults. Data from the Young Women's Project will be used to take this different approach. A better insight into sexual resilience may allow for more effective intervention programs designed to strengthen adolescent sexual resilience as well as promote sexual health in young adults.

Prevention and intervention programs geared toward negative adolescent sexual outcomes such as STIs and pregnancies may be better served with an approach designed to understand and acknowledge adolescent sexual behaviors, as well as sexual health in a holistic and developmental light. It may allow for programs and policies to be more effective in their endeavor to reduce such negative outcomes and provide adolescents with the information and abilities to understand and negotiate their sexual feelings and behaviors. The ability to successfully negotiate life situations fraught with both negative and positive

contexts and consequences may have a profound affect along the life-course, and is commonly referred to as resilience.

The Resilience Paradigm

In studying children and adolescents, some researchers, about 40 years ago, began to look at those who seemed to do well despite being burdened with individual and environmental factors that would lend themselves to adversity (Masten 2001). These researchers soon realized that this resilience was indeed multidimensional and contextual. Additionally, many of the risks for problems co-occur, and their cumulation is related to rising risk for poor outcomes on many indicators of development, such as psychosocial competence and health (Masten 2001). These approaches are based on Bronfenbrenner's ecological theories of development reflected by the influence of the environmental systems of an individual (see Figure 1) (Luthar and Zelazo 2003).

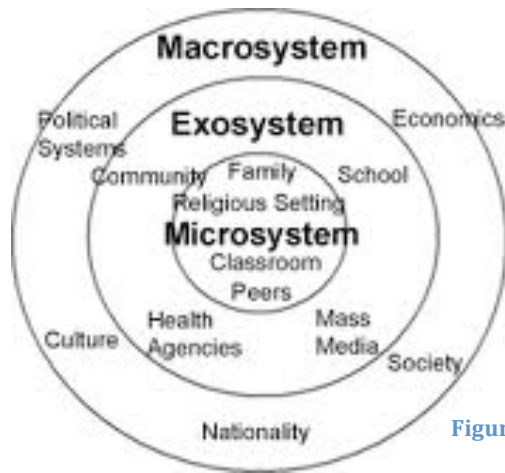


Figure 1

Individual characteristics play an important role in resilience and are made of both genetic predispositions and social and cognitive developmental factors. Characteristics such as cognitive capabilities, self-regulating behaviors and social support levels play important roles. Social support is essential to youth development and resiliency, and assists in the development of self-esteem and self-efficacy among adolescents and young adults (Brennan

2008). Positive or negative outcomes result from the interplay between these individual characteristics and environmental and familial factors (Resnick et al. 1997). While specific process descriptions vary, several researchers such as Brackenreed (2010) and Winfield (1994) agree that there are four protective processes, those that: (1) alter or reduce exposure to risk, (2) reduce negative reactions to risk exposure/bad experiences, (3) provide opportunities, and (4) promote self-esteem and self-efficacy.

First, some protective processes act to intervene in an individual's social environment that may serve to alter or reduce exposure to risk. Winfield (1994) asserts that resilience addresses the interaction between an individual and his/her environment. The relative strength of individual characteristics and external protective processes are compared to the influence of risks and vulnerabilities in the external environment (p. 2). Risk factors are those hazards that increase an individual's vulnerability to negative developmental outcomes and protective factors are those that enhance the ability to resist stressful life events while developing the ability to adapt to and deal with those situations (Blinn-Pike 1999).

Second, certain processes contribute to reducing negative reactions to exposure to risk or bad experiences, allowing someone to more effectively cope with and recover from such experiences. Fergus and Zimmerman (2005) agree that resilience is the process or overcoming negative effects of risk exposure, such as successfully coping with traumatic experiences and avoiding negative trajectories associated with risk. Individual aspects of resiliency are represented by such characteristics as cognitive capabilities, self-regulating behaviors and levels of social support (Brennan 2008; Benard 1997). This individual resiliency is often described as a self-righting mechanism, and is the capacity to change and adapt to situations no matter what the risk. These self-righting abilities are present in most

children and risk factors are often less influential than positive and caring relationships (Benard 1997; Brackenreed 2010).

Third, providing opportunities is another important protective process. Providing situations in which children can learn skills and invest in prosocial activities allows them to develop a sense of personal control as well as learn to negotiate relationships with others (Winfield 1994). Engaging in challenging roles and activities promotes this development (Gavin, Catalano and Markham 2010). Opportunities to develop and maintain positive and caring interpersonal relationships are another aspect of this process. Social support plays an important role in all resilience processes (Halpern-Felsher et al. 2004; Morrison-Beedy et al. 2008).

Fourth, increased self-esteem and self-efficacy have long been shown to have positive effects on multiple areas of life, including sexual behaviors. Several studies have found that an overall belief in one's self-efficacy can serve as a protective factor regarding negotiating safer sex, resisting peer pressure or avoiding risky behaviors (Buhi and Goodson 2007). While these studies may identify self-efficacy as a protective factor that affects sexual outcomes and behaviors, no studies investigate such efficacy *regarding* sexual behaviors and relationships.

Protective or promotive factors of resilience can be either individual assets or external resources; external resources can be a focus of change to help adolescents. Assets are positive factors that reside within an individual such as competence or self-efficacy, and external resources are comprised of things as parental support, mentoring or community involvement (Fergus and Zimmerman 2005). The term "resources" stresses the influence that the social environment plays on adolescent health and development, another reminder of the ecological manner of resilience theory (p. 399).

Because of this influence, resilience is dynamic and contextual. An adolescent may show resilience in one situation, yet not in another. Furthermore, the resilience process may vary not only by situation, but may also vary according to differences in adolescent groups, as they do not all experience situations in the same way, making it more difficult to conceptualize. Researchers often seem to pick and choose only specific aspects or factors to study, and in studying them individually, fail to focus on resilience as a whole, missing the comprehensive and interactive role of such factors. While scholars' specific definitions of resilience may vary, the concept behind each is the same: a common process that results from basic human adaptational systems (Masten 2001). Resilience theory aims to understand mechanisms that act to modify the impact of risk and the developmental process by which young people successfully adapt, and must look at both risks that may intensify reactions to adversity as well as factors that ameliorate an individual's response to adversity (Olsson et al. 2003).

Resilience paradigms look at the threats children face to their well-being, as well as things that shape their adjustment. They are multidimensional and see child development as transactional (Luthar and Zelazo 2003). In its complete conceptualization, however, resilience takes a more positive approach to understanding adolescent behavior than the common risk-based approach. As opposed to merely looking at risk factors - things that are going wrong in adolescents' lives - resilience seeks to understand and promote the ability to successfully adapt to challenging or threatening events. As nearly one half of all American youth will experience a turbulent path at some point (Brackenreed 2010), it is important to understand what processes work to promote this successful adaptation. Children facing such challenges suffer from a loss of social capital - the norms, values and human resources that parents and adults must make available to children for educational and social development. Taking the risk/deficit approach to understanding adolescent behaviors seeks

to fit children into social and institutional structures as opposed to using those tools to fit children's needs (p. 113).

The same can be said for looking at adolescent sexual behaviors. As previously discussed, they are rarely discussed as positive. We should consider the possibility that a teenager may be able to have positive, healthy sexual behaviors with a regular partner, which may foster intimacy and closeness. For an individual from an "at-risk" home, this closeness may be crucial to a sense of well-being and acceptance. While sexual intercourse in adolescence is generally seen as negative, it may in fact be promoting a healthy self-identity and the development of healthy interpersonal relationships.

Sexual Resilience

Narrowing the resilience perspective down to focus specifically on sexual resilience can be complicated. For adolescents, participating in any sexual intercourse is often listed as a risk factor (Blinn-Pike 1999) and in research is generally defined or measured in terms of absence - as either never having engaged in sexual activity (Resnick 1997) or not contracting an STI or getting pregnant (Yancey 2010). In an attempt to avoid such negative sexual outcomes in adolescence, the same message is currently, consistently provided to teens: abstinence is the only 100% effective method to avoid pregnancy and infection. Blinn-Pike (1999) asserts that those who have not had sex before adulthood "...can be labeled as sexually resilient in the face of peer and media messages" (p. 295); in essence these kids are seen as having faced the same opportunities and pressures as their sexually active peers, yet they remain abstinent. This seems to define adolescent sexual resilience in terms of avoidance or refusal as opposed to being able to successfully negotiate a given sexual situation.

Fergus, Zimmerman and Caldwell (2007) looked at sexual risk behaviors using the sum of three measures: the frequency of sexual intercourse during previous year, number of

sexual partners and frequency of condom use (reverse coded). Here again we see that sexual behaviors are labeled as negative or risky. There is no discussion of healthy sexual behaviors. This is far from any common resilience perspective in that no protective factors, such as assets or resources, are discussed or given any mediating value in adolescents' lives.

The omission of external factors in the discussion of sexual resilience in adolescence is also problematic. Without taking into consideration information or lack thereof, received from school, parents, peers or partners, or pressures to conform or perform sexual behaviors, sexual resilience is placed solely within the individual. Indeed, all resilience perspectives address the need to consider both internal and external factors that both promote and hinder adaptation to challenging situations.

An alternative way of looking at sexual resilience leans more towards the traditional resilience perspective and the idea of sexual capital. Michael (2004) uses Grossman's ideas regarding health capital and applies it to sexual behavior in adults. He defines sexual capital as the present value of flow of benefits from sexual enjoyment over one's remaining lifetime (p. 644). Generally, capital is defined as the value of the skills and capabilities that make up ones' sexual resources. This is almost impossible to do with sexual capital however, because it has no market unit of measurement such as a wage rate, so its valuation must be in utility terms. Sexual capital is stock embedded in an individual and is partly produced by that person's choices, efforts and experiences. It is also produced by training, practice and expertise and has costs and yields returns over the life course. Michael (2004) discusses both public and private components of sexual capital. The public aspect deals with commonly discussed aspects of sexual behavior – mainly negative externalities and by-products of behaviors, such as unwanted pregnancies or STIs. The private component is sexual intimacy, which he asserts may not only give sexual behavior its salience, but also why it is associated with ethical values and personal character.

The concepts behind sexual capital may be relevant to the ideas of developing sexual health in young adults, even though sexual behavior in adults may differ significantly from that of adolescents. Adolescence is a period of great transition and change, and adolescent behavior can be seen as a form of transitional behavior that stems more from his/her society and role therein than from any biological or physical phenomenon, such as puberty. Sociologically, adolescence is that time in life when society no longer considers one a child, but will not yet afford him/her the rights, functions and roles of an adult (Hollingshead 1949). It is this deficit of bestowing, or the willingness to bestow, such rights and responsibilities on adolescents that shows how an individual's society views these physical and emotional changes. This view inevitably constrains adolescents and their ability to make choices.

Though adults' sexual behavior is influenced by such factors as age, gender and marital status, the influence of other factors such as education, income, race or religion declines as one gets older (Michael 2004). These items may well make an enormous difference in the sexual behaviors and experiences of adolescents that establish the resources they take into sexual relationships in adulthood. Skills and resources used in decision making processes are part of sexual capital, and these skills can easily influence subsequent behavior and overall well-being.

Sexual capital is cumulative. As with other forms of capital, skills and experiences are taken from one situation to the next, then those are again taken to the next. This ongoing investment in one's self and sexual capital is involved in both the public and private aspects of sexual behavior. For example, in regards to preventing STIs, an individual must negotiate several things – choosing a partner from a social network, how well one does or does not know that partner, and expectations about behaviors (Michael 2004). In developing intimacy with one's partner, one must expose her/his naked body, reveal

desires and how far s/he is willing to go to please a partner. These revelations, if positively received and returned, lead to the development of trust, which is important to developing partner intimacy (Michael 2004).

The concept of sexual capital is supported by the idea of agency, which is also an important aspect of sexual resilience, and may serve as a protective factor for adolescents. The belief that one can take control of and successfully negotiate her/his sexual behaviors and relationships, including communicate with partners about sexual feelings and contraception, may reduce exposure to risk, as well as promote self-esteem through achievement. Offering this alternative perspective of sexual resilience allows an opportunity for looking at it, as well as a traditional view of resilience to see which, if either, has an effect on sexual health in young adulthood.

Sexual Health

Just as narrowing down the resilience perspective to focus on sexual resilience can be difficult, so can narrowing down a general health perspective to focus on sexual health. Health is defined as far more than the absence of disease and includes physical and mental aspects as well as social functioning (Ware 1986). Sexual health, too, is more than the lack of STIs or unwanted outcomes. It is a multi-faceted concept which reflects into further areas of life than those to which it is directly tied.

Defining sexual health is important and difficult. Sexual health, as health in general, is multidimensional. This multidimensionality is well reflected in both the World Health Organization and the National Commission on Adolescent Sexual Health. Overall, sexual health involves the abilities to: develop and maintain meaningful personal relationships, appreciate one's body, interact with both genders in respectful and appropriate ways, and express love, affection and intimacy in accordance with one's own beliefs and values (Tolman, Striepe and Harmon 2003). Tolman, Striepe and Harmon (2003) also assert that it

is important to recognize the broader contexts of the relationships and the community as part of sexual health.

Health is rated by most Americans as the greatest source of happiness and most important quality to preserve in life (Tiefer 1996). The ideology of healthy living has a moral code, and signs of unhealthy living, such as drinking or smoking are often highly stigmatized. The continued medicalization of many aspects of life only perpetuates this stigma. Tiefer's (1996) look at medicalization and sexuality sheds light on the problematic aspects of medicalizing sexuality and sexual behavior.

She asserts that medicalization actually began as a way to avoid stigma surrounding sickness or health problems. If some problem could be seen through medical eyes and therefore beyond an individual's control, it would remove blame from that individual. This can be seen in the example of HIV/AIDS – methods of contracting this infection are heavily value laden. She found that most sex researchers, even going back to the 1930s, consider sex not only beneficial, but in some cases, essential to the overall general health and well-being of an individual (p. 252).

People are often secretive and insecure about sexual feelings and issues, and doctors have long been seen as both the scientific and cultural authorities sought for help with such things (Tiefer 1996). Because sexual behaviors are often value laden as well, many individuals may seek a doctor's supposed objective and scientific authority, to remove any value from questions or concerns. This authority, however, often leaves one lacking any alternate source of knowledge. In adolescence, peers, not doctors, are those often consulted as such alternate sources.

A comparison of Dutch and American sex education, and parental and societal attitudes towards adolescent sexual activity, illustrates the importance of how adolescent sexual behavior and sexual health is acknowledged and addressed by society. Research

shows that in the Netherlands adolescent sexual behaviors are seen as healthy and normative, yet the Dutch have one of the lowest rates of teen pregnancies and abortions in the developed world (Santelli and Schallet 2009). Their ability to normalize sexual activity among teenagers as opposed to medicalizing or vilifying these behaviors seems to lend itself to a more positive overall development in sexual well-being and in interpersonal skills in adolescence.

Adolescence and young adulthood are unique life stages that present opportunities and challenges to improving health (Mulye et al. 2009). These stages involve significant growth and development, and early events may shape later outcomes. Habits and behaviors may influence health in both the short- and long-term. As adolescents transition into young adulthood, they gain both the rights and the privileges of adulthood, yet often lose support from social institutions. Those individuals more reliant on such institutions may have a harder time with this transition. Additionally, the onset of adolescence generally marks a time of raised expectations regarding an individual's ability to assume responsibility for their own functioning (Zimmerman and Cleary 2006).

This expectation may also be internal, and the ability to originate and direct actions for a given purpose is the concept of personal agency. The belief in one's effectiveness in performing specific tasks is the notion of self-efficacy. As this diminishes, it may become part of a downward cycle where one may ally him/herself with those who have less favorable views of a certain aspect of life, while those with stronger self-efficacy may be able to counteract and resist such views. This downward cycle may occur in sexual health and behaviors as well as other aspects of self and life. Some of the challenges involved in the life stages mentioned above include dealing with sexual maturity and becoming a healthy sexual being. Adolescents are notoriously bad at setting goals and anticipating potential consequences for various actions. Possessing knowledge and skills does not guarantee that

one will use them wisely, or at all. Those with higher levels of self-efficacy and personal agency about effectively managing and coping with difficult circumstances have a higher probability of succeeding (Zimmerman and Cleary 2006).

Adolescent sexual behavior differs from other behaviors labeled as problematic or risky in that its undesirability is generally a result of a lack of age (Halpern 1995) and is tantamount to a status offense, such as smoking or drinking. It is behavior acceptable for those deemed old enough, yet not for adolescents. The specific contexts in which initial sexual experiences occur are important to later health outcomes. Additionally, the timing of first intercourse is related to long-term sexual health outcomes. Indeed, delaying the initiation of sexual activity may impede the development of emotional, cognitive and interpersonal skills crucial to satisfactory sexual functioning and general well being (Sandfort et al. 2008). This success in adolescence may promote sexual health in young adulthood. Development of adult sexuality at least partially comes from experiences during adolescence (Tolman 1994).

Current Study

The multidimensional quality of resilience, risk and sexual health makes redefining adolescent sexual resilience and sexual health in young adulthood difficult. The fact that this process is developmental only adds to the complexity. As shown previously, choices made in adolescence affect long-term life quality. Due to the potentially serious nature of sexual behavior outcomes, it is crucial to both understand and promote adolescent resilience and young adult sexual health. Resilience is not fixed, so it is something that can be changed and therefore improved. Factors that promote overall resiliency and health can be applied to sexual health as well. Determining those aspects of adolescent sexual resilience that may contribute to sexual health in young adults can have far reaching implications for public policies, such as those regarding sex education, for developing future research in adolescent resilience and sexual health studies, and simply further understanding how sexual health develops.

The common definition of adolescent sexual resilience as teens that have not had sex will not be considered here for two reasons. One, the sample set contains almost none of these cases. More importantly, sexual health for the purposes of this project is defined as overall sexual well-being and quality of sex life; this is difficult to discuss if there is no reported sexual activity. I do not argue against one being sexually healthy without being sexually active, there simply is not enough relevant data to include in this study.

This project seeks to determine if sexual health in young adults can be predicted using various sexual resilience definitions. My research questions use both a common risk-based definition, as well as my proposed capital-based definition. Is sexual resilience as defined as no STI or unwanted pregnancy in adolescence a predictor of sexual health in young adults? Or does agency – the self-confidence and agency to successfully negotiate sexual relationships and behaviors – predict sexual health? What if both work together? It is

my hypothesis that agency over sexual behaviors will be a stronger predictor of sexual health in young adults than absence of pregnancy or STI in adolescents.

A more complete understanding and approach to adolescent sexual resilience may provide not only more positive sexual outcomes and overall sexual health among adolescents, but will also lay the groundwork for understanding the development of healthy adult sexuality, an important component of overall health and well-being. The potential applications and expansions for such research are numerous. If we can understand factors of adolescent sexual resilience that promote sexual health in young adults in one group (i.e. young Black women), we are then better equipped to attempt to understand it in other groups as well, such as young White women or young men. This research has much potential for commonly marginalized groups such as homosexual and transgender teens as well as young adults. Understanding sexual resilience and sexual health among such marginalized groups may help promote positive sexual identity formation.

Methods

Data

The Young Women's Project (YWP) is a longitudinal study of young women, their sexual behaviors, and sexual partners. The full sample (N=387) is primarily African-American (93%) and was recruited either from a Primary Care Adolescent clinic in Indianapolis or their primary health care providers. Respondents were recruited as young as 14 years old and informed consent was obtained from them and from their parents. Respondents participated in yearly and quarterly interviews, and also kept journals of their sexual activities.

This analysis is comprised of those young women who completed both an initial quarterly interview and then at least one more interview up to five years later (N=94). This allows for the comparison of measures of sexual resilience in adolescence to measures of sexual health in young adults. The five year span was chosen so that those recruited at the youngest possible age, 14 years old, would have reached 19 years old, my designation for young adulthood. These coincide with Erikson's developmental stages (Harder 2002). He designates adolescence as 12-18 years old and young adulthood from 18-35 years old. As girls were not eligible for this study until they were 14 years old, and because these categories are not exclusive, adolescence here will be considered from 14-18 years old and young adulthood will be at 19 years old.

It is important to note that there are some inconsistencies in the number of girls who answered each of the questions measured. For example, not all of the girls who qualified by completing both the initial interview and another five years later, had data for whether she had an STI or had been pregnant. All respondents were divided into those who had and those who had not answered such measures, and then compared to see if any differences existed between them. This was done in order to address any possible selection

bias between those who had answered all questions at both intervals and therefore could be included, and those that had not and therefore had data that could not be considered.

Table 1 below shows no statistical differences in this division. Various measures are shown and this lack of difference applies to measures of both definitions of resilience, and well as those who were deemed to be sexually healthy. As can be seen in the table, differences in the individual measures were minimal. This small variation was not statistically significant and so was determined to be acceptable, and the final number in the sample is 94.

Table 1 - Selected characteristics of those included in and those omitted from the final sample

Measure	Included	Omitted
Ever Have STI	19.32% (n=94)	17.95% (n=7)
Ever Been Pregnant	31.91% (n=94)	26.67% (n=4)
Risk-based Adolescent Resilience	53.19% (n=94)	71.79% (n=28)
Capital-based Adolescent Resilience	56.38% (n=94)	40% (n=6)

Note: None are significant according to Chi square tests.

Measures

Risk-Based Adolescent Sexual Resilience: Risk-based resilience is comprised of variables that asked about those items included in “common” definitions of resilience. The questionnaire asked respondents whether they had ever had an STI. It also asked how many times in their lives they had ever been pregnant (1-Never to 6-Five times or more). This was recoded into a dichotomous variable to determine simply if she had ever been pregnant. If the respondent reported never being pregnant or having an STI, she was determined to be sexually resilient according to the common method of measuring risk-based resilience.

Capital-Based Adolescent Sexual Resilience: My proposed resilience definition is measured by combining several questions that were originally designed to measure sexual

compulsivity. When reverse coded, however, I assert that these may also illustrate the agency and capital inherent to the full definition of sexual resilience, and were the most appropriate from the survey with which to do so. I began with six questions: “How often do you feel shameful about your sexual behavior,” “How often do you promise to change your sexual behavior,” “How often do you feel that your sexual behavior is not normal,” “How often do you feel unable to control your sexual behavior,” “How often do you use sex to deal with problems in your life,” and “How often do you feel emotionally close when having sex?” (0-Almost all of the time to 3-Never).

Cronbach’s alpha, which is used to measure the intercorrelation among items, was run on all 6 items and individual values were used to assess reliability among them. Measures were removed one at a time according to their individual alpha values in order to strengthen the internal consistency. There is theoretical support for the remaining items used as best suited to form a new measure of resilience. From the six that were available, only the first three measures listed (“How often do you feel shameful about your sexual behavior,” “How often do you promise to change your sexual behavior,” “How often do you feel that your sexual behavior is not normal?”) were included in the final analysis. These were determined to best measure the capital-based adolescent resilience given the items available, and the final Cronbach’s alpha for these three items is .7451.

Resilience, as discussed earlier, is a dynamic process. This is difficult to measure, especially since the current study is using pre-designed items to do so. Given that the questionnaire was not originally designed to measure resilience in any fashion, these were the best and only items available that could be used in this study. In keeping with the standard method of seeing adolescents as either resilient or not, as well as attempt to take a single “snapshot” view of the comparison of resilience to sexual health, my capital-based resilience measure was also divided into a resilient/not resilient dichotomy. In order to

push the boundaries of the parameters and take the most conservative approach possible, only those that had a mean of 3 for all items are considered resilient, while any others are considered not resilient.

Young Adult Sexual Health: These items were answered up to five (5) years after all of the data was reported for resilience measures, both risk-based and capital-based. Sexual health was measured by using three items from a larger scale used to rates respondents' feelings about their sexual relationships. Respondents ranked their current sexual relationships along three spectrums: good to bad, pleasant to unpleasant, and positive to negative. These rankings ranged from 1 (lowest or most negative) to 7 (highest or most positive). These combined scores were then used to create three different sexual health categories. They were divided both by quartiles (top 25%, middle 50%, bottom 25%) and by the mean of scores. When divided by the mean, most scores fell at the top end of the scale, in excellent health. A more even division was gained by using quartiles, and this was determined to be the best categorization of health: excellent health, good health, and poor health. Cronbach's alpha on these three items is .9397.

Analytic Strategy

As mentioned above, both the risk-based and capital-based adolescent resilience variables were created by combining the selected measures as described. Tabulations were then run on both definitions of resilience, as well as on each individual item, to find frequencies, means and the range of responses for each. Alpha scores were run on the items that comprised both measures of resilience to determine the average correlation between items, and scale reliability. The same was done with sexual health, and the individual items used to comprise it. ¹

¹ The sample is very homogenous, but both race and age were controlled for to see if they had any bearing on the results. After running a logistic regression on these variables, there was little to no difference reflected in the results. Again, this is likely due to the similarities among subjects.

Chi square tests were performed to investigate the relationship between these two measures of resilience and sexual health. These tests compare the actual observed frequencies in a population with those frequencies expected if there is no relationship between the variables. It is a test of the null hypothesis, and informs the degree of confidence possible in accepting or rejecting a hypothesis. They were performed to compare risk-based adolescent resilience with young adult sexual health, and compare capital-based adolescent resilience with sexual health in young adults. Chi square tests were also run on each individual variable in both definitions of resilience. Individual cells' contributions were examined to assess which items were propelling differences toward overall chi square values.

Results

Descriptive Results

As previously discussed, respondents were able to enter the study as young as 14 years old. There is a fairly even spread among the ages of respondents and Table 2 shows the breakdown of the age of all respondents. Just over 25% began the study at the youngest age possible and just fewer than 15% entered the study at 17 years old.

Table 2 – Age of Participants

	Frequency	Percentage
14 years old	25	26.6%
15 years old	33	35.11%
16 years old	22	23.4%
17 years old	14	14.89%
Total	94	

To discern how many young women in the study fell under either definition of resilience, a simple tabulation was run. Table 3 shows the number of adolescent girls that reported an STI or pregnancy during the course of their enrollment in the YWP. More than 4 out of 5 have never had an STI while a little over 2/3 have never been pregnant. Only 3 respondents had experienced both. When combined into the risk-based parameters of resilience, just over 53% could be defined as sexually resilient adolescents.

Table 3 also shows that just over 56% of those who were measured according to the capital-based definition of adolescent resilience can be deemed sexually resilient. For each individual item, the mean indicates that most participants responded positively to these relationship assessment measures used to comprise it. For each of the three questions that comprise this measure, more than 60% of all participants answered “3-Never.” More than 2/3 reported never feeling shameful about their sexual behavior, and more than 4 out

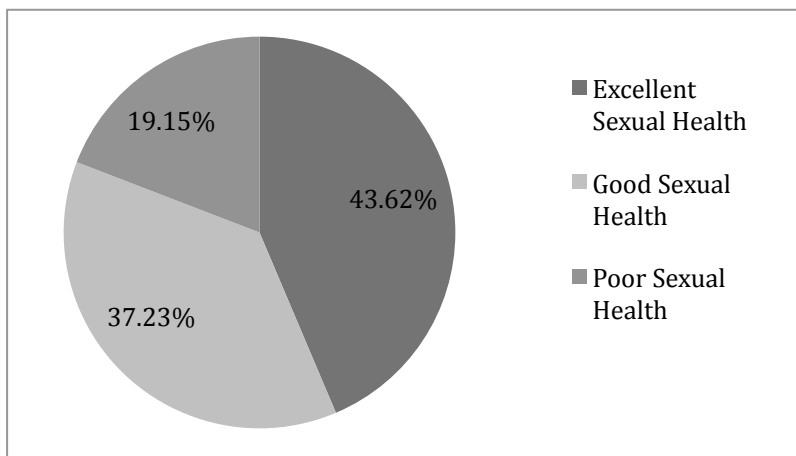
of 5 reported never feeling that their sexual behavior is abnormal. These responses seem to reflect a strong level of comfort and confidence with these young ladies' adolescent sexual behaviors.

Looking at the low number of those that have experienced STIs or pregnancies, commonly referred to as negative adolescent sexual outcomes, we can see that more than half of adolescent girls may qualify as resilience under current definitions. One third of the sample (N=31, 58% of those measured as resilient under either definition) are resilient under both definitions. In other words, each measure uniquely identifies 1/5 of the participants as resilient. While a difference of only 3% between these two forms of resilience (53% vs. 56%) may seem minimal, reviewing measures individually provides a clearer view that these measures identify different young women as resilient. Just under 1/3 of those who reported an STI are resilient under the capital-based definition, as are more than 50% of those who had been pregnant. This shows that an adolescent may indeed experience an STI or pregnancy and still be considered resilient according to this definition, indeed maybe because of it. Experiencing an STI or pregnancy at a younger age may serve as a wake-up call to take better care of oneself, and be more cautious during sexual activities.

Table 3 - Resilience Characteristics of the Sample

	Mean	Range
Risk-based Resilience	.53	0-1
Ever been pregnant	.32	0-1
Ever had an STI	.19	0-1
Capital-based Resilience	.56	0-1
How often do you feel shameful about your sexual behavior?	1.393	0-3
How often do you make promises to change your sexual behavior?	1.659	0-3
How often do you feel your sexual behavior is not normal?	1.308	0-3

The pie chart below shows the breakdown of what level of sexual health respondents were classified as in young adulthood. Again, sexual health was broken down by quartiles, so that excellent sexual health represents the top 25% of respondents, good health the middle 50% and poor health the lowest 25%. I use the term good health vs. normal health as to avoid any value laden terminology surrounding the study as well as to coincide with common research language. As can be seen, almost $\frac{3}{4}$ of the entire sample can be considered in at least good sexual health.



Analytic Results

This study is designed to investigate whether the risk-based definition of adolescent resilience or a capital-based definition of such is associated with sexual health in young adulthood. Tables 4 and 5 reflect the results of the analysis of each of these types of resilience. The individual chi square values for each factor are included in both tables to show the strength of influence of that particular category. Table 4 illustrates the relationship between the risk-based measure of adolescent resilience and the three “levels” of sexual health used in young adulthood – excellent, good and poor. Most of these respondents can be classified as sexually healthy in some way, according to the results obtained. Of the 50 respondents who were classified as resilient during adolescence according to the risk-based definition, 44% were determined to be in excellent sexual

health. A similar portion (43%) of teens classified as not resilient was determined to be in excellent sexual health in young adulthood. Overall, the risk-based measure of resilience is not significantly related to sexual health during young adulthood.

Table 4 – Risk-based Adolescent Resilience and Sexual Health

	Excellent Sexual Health	Good Sexual Health	Poor Sexual Health	Prob. Ratio
Resilient	44% (0.0)	38% (0.0)	18% (0.0)	.954
Not Resilient	43% (0.0)	36.36% (0.0)	20.45% (0.0)	

Note: Individual Chi square values ()

Table 5 also illustrates that a large portion of the 53 respondents who are sexually resilient in adolescence according to the capital-based definition are in either excellent or good sexual health in young adulthood. Less than 1/5 of all these girls report poor sexual health. A larger percentage of girls labeled as resilient (47%) report excellent health than those labeled as not resilient (39%); however, the overall chi square indicates no statistically significant association between capital-based resilience and young adult sexual health.

Table 5 – Capital-based Adolescent Resilience and Sexual Health

	Excellent Sexual Health	Good Sexual Health	Poor Sexual Health	Prob. Ratio
Resilient	47.17% (0.2)	35.85% (0.0)	18% (0.1)	.700
Not Resilient	39% (0.2)	39% (0.0)	18% (0.2)	

Note: Individual Chi square values ()

It is important to take note of the individual chi square values in each cell, for each table. These individual calculations, which represent the differences from expected values on these measures, demonstrate the impact of each item. Individual categories of risk-based adolescent resilience values from Table 4, shown in parenthesis, are all 0.0 and so do not reflect a heavy influence on the chi square value. Capital-based adolescent resilience values in Table 5 illustrate some influence for excellent (0.2) and poor health (0.1). This may be

indicative that this view of resilience may provide more insight into excellent sexual health than the risk-based measure of resilience.

Discussion

This study was designed to test a new way to define adolescent sexual resilience and investigate its potential association with a more holistic approach to sexual health in young adults. The hypothesis proposed was that, compared to the standard, risk-based definition, a new, more inclusive definition of sexual resilience in adolescence will better predict sexual health in young adults. This hypothesis was not supported in the data analysis. Though no results were statistically significant, the individual components of both definitions of resilience provide some fodder for discussion when compared with levels of sexual health in young adulthood. While the analytic findings were not statistically significant, the descriptive analysis can shed light on the underlying, theoretical ideas.

My sample consisted almost entirely of young, urban, low income, Black girls. This is a group that is often researched as “at-risk,” yet most of them were determined to be resilient, regardless of the measurement used. An even higher percentage than those who are resilient under risk-based definitions of resilience were reported as resilient under my proposed, capital-based definitions. More than 4 out of 5 had never had an STI and more than 2/3 had never been pregnant, which may seem contradictory based on expectations of at-risk teenagers. The majority of this sample qualifies as resilient, even according to risk-based measures that do not include any protective factors included in overall resilience theory.

That risk-based resilience seems to provide no insight into levels of sexual health may be indicative that these individual measures of resilience are insufficient to an overall assessment of resilience. While the young women in this study may be at higher risk pregnancies or STIs than other adolescent populations, such as middle-class White adolescents (Ramirez-Valles, Zimmerman and Newcomb 1998), findings indicate that an alternate conception of both resilience and “at-risk” may be in order. This study was bound

to only individual factors, yet inclusion of external factors and resources may provide a better understanding of what factors constitute an at-risk denotation.

The parameters used for measuring capital-based resilience were not as all encompassing as would be ideal for a valid measure of resilience, yet the items used address respondents' shame regarding their own sexual behaviors, their intent to alter these behaviors and whether they perceive their sexual behaviors as normal. These items not only had the strongest intercorrelation, but also were those available to reflect back on some of the four protective processes asserted earlier: alter or reduce exposure to risk, reduce negative reactions to risk exposure/bad experiences, provide opportunities and promote self-esteem and self-efficacy (Winfield 1994; Brackenreed 2010). I assert that each of these questions addresses aspects of multiple processes, even if they do not do so directly. Assessing the level of shame surrounding one's sexual behavior may reflect one's level of self-esteem. Her intent to alter these behaviors directly addresses feelings of self-efficacy – that she can instill such changes. Self-esteem and self-efficacy have the potential to decline if she feels that her own sexual behavior is deviant or abnormal. It is challenging to infer how these questions address providing opportunities as described earlier, as these opportunities are generally viewed in the realm of external resources and these were not included in this study.

The most revealing findings stem from those surrounding sexual health in these young adults. Regardless of the definition of resilience, or the measures used, more than $\frac{3}{4}$ of the sample reported being in at least good health, and more than 43% are in excellent sexual health. Remembering that sexual health involved the ability to develop and maintain meaningful personal relationships, appreciate one's body, interact with both genders in respectful and appropriate ways and express love and affection in accordance with one's own beliefs and values (Tolman, Striepe and Harmon 2003), these young women are rating

their sexual relationships very strongly, which again seems contradictory given that the sample would generally be considered to be an at-risk population.

Tolman (1994) asserts that gender norms and socialization surrounding sexual activity for young women can be constricting and may impede the development of sexual feelings and behaviors. She found that young Black women reported concerns regarding social perceptions of their sexual feelings. These concerns surround the contradiction between enjoyment of their sexual activities and expressing desires with fears of being negatively sanctioned for having either. My sample also seemsto contradict these norms. It may be that our assumptions or understandings of sexual feelings and behaviors are based on comparisons of dissimilar groups, such as comparing young White women to young Black women. As is common in Western culture, holding the whole of American society to the “White standard” often times provides a skewed or incorrect vision of what is actually happening in such specific populations. That these young women generally report positive feelings toward their sexual behaviors supports the idea that this more holistic approach to sexual health may provide a clearer understanding of the sexual lives of young adults. It also illustrates the importance of studying different social groups. What promotes sexual resilience and health in one group may not be quite the same as what promotes it in another (Loosier and Dittus 2010). Social diversity necessitates the consideration of differences in many social factors when studying any population. In lieu of attributing sexual health to lack of disease, investigating sexual health through a lens that includes looking at its multi-dimensional properties may give more insight into which factors contribute the most to overall sexual health.

While many aspects of health, both sexual and in general, concern individual behavior, such as attempts to quit smoking, exercise, eat better, etc., it is important to also look at the overall social conditions that contribute to the sexual outcomes of American

youth. Link and Phelan (1995) see this view as not counteracting current social research, but instead as the progression of social science. They assert that social conditions are aspects that involve one's relationships to other people, which also address the potential to provide opportunities to promote resilience. It is this intersection that may provide the future framework for a more encompassing look at both adolescent sexual resilience and sexual health.

This view is known as fundamental cause theory, and may open the door to a different perspective of these young women. This theory posits that social conditions and considerations must be taken into account when researching any health matters in the populace. It also strives to understand both the risk and protective factors in ones' life that specifically relate to disease. This is reminiscent of Bronfenbrenner's (1979) assertions of the role of external factors in development.

Even though adolescents that fell under either definition of resilience reported high levels of sexual health, the individual components of the capital-based definition indicated a stronger, even if statistically insignificant relationship, with excellent health than the risk-based definition. This capital-based definition, in fact, seemed to have the most influence on excellent sexual health reported by all of these young women. It may be that some of these young women came to the clinic to the clinic to exercise their sexual agency, seeking advice or help regarding sexual behaviors, rather than simply seeking contraception or treatment of some kind. It may be that this measure of resilience, which encompasses individual protective factors, reflects those factors that most strongly correlate with excellent sexual health. There may be external differences that were not measured that account for high reported levels of sexual health. Perhaps there are differences in those who sought help due to pregnancy as opposed to those who went for testing or treatment for an STI.

Risk-based resilience research addresses the risk factors common to resilience theory, yet entirely omits any protective or supportive factors. Nor does it take into account both the individual and social components involved. None of the assets or resources that contribute to resilience is considered, and these resilient adolescents merely represent teenagers who have not become pregnant or contracted an STI. There are no indications of their abilities to negotiate sexual feelings or situations, nor are there any measures that indicate sexual health, even though under a more comprehensive view, some of these young women would be considered sexually resilient.

As risk-based approaches indicate little regarding any level of sexual health, the capital-based approach seems unable to comment on poor sexual health. Levels of poor sexual health were reported at the same levels for these young women (roughly 10% of each group), regardless of measures of resilience. So while it may help us to understand what is working to support sexual resilience in adolescence, it does nothing to illuminate factors which contribute to poor sexual health. This reinforces my assertion that a change of perspective regarding adolescent sexual behaviors is important. It is not simply the converse of risk that is important, but the complete multi-dimensional view.

Researchers have gotten close to studying a capital-based approach to adolescent resilience by studying general factors such as social support or environmental constraints such as parental relationships, or self-efficacy, and the positive effects these have on sexual outcomes (Gavin, Catalano and Markham 2010; Morrison-Beedy et al. 2008). Buhi and Goodson (2007) conducted a meta-analysis on these factors and the role they play on sexual behaviors and intentions of adolescents, and similarly found that strong levels of social support and/or self-efficacy also have positive effects on sexual outcomes. These components of resilience are studied in regards to their effects on sexual behaviors and

outcomes, yet they are not comprehensive in that they generally include only one of these factors, nor are they conducted from a resilience perspective.

Risk reduction strategies do not promote competency in development that might help adolescents negotiate relationships and employ prevention strategies in their lives (House et al. 2010). I have attempted to address the individual-level factors of resilience that may contribute to sexual health in young adulthood. My analysis found that these factors may be stronger indicators of excellent sexual health than poor sexual health, yet none of the findings were significant enough to draw strong conclusions. Perhaps for this population, it is external factors, such as those that are part of Bronfenbrenner's exo- and macrosystems, which carry those resilience aspects that truly promote sexual health in young adults. Perhaps if these were combined, and then studied from a multi-faceted resilience focus, it may shed light on which factors carry the most weight and therefore guide intervention programs.

Limitations

Although a new measure of adolescent sexual resilience and its effects on sexual health in young adults are important, there are limitations to this project. The sample size is small, and the respondents are homogenous in terms of race and socio-economic status. Therefore, these findings cannot be generalized to a larger, more diverse population. They may, however, be applicable to a larger population of young Black women from similar backgrounds in other areas of the U.S.

Consent was required from both respondents and their parents, which may have affected which adolescents were willing or able to participate in the project. All quarterly and yearly interviews were conducted at the clinics from which respondents were recruited, requiring more visits to the clinic than may have happened otherwise. This may have served as an intervening force in behaviors or outcomes by creating a Hawthorne

effect. Avoiding such issues emphasizes the importance of having social scientists involved in research occurring in medical settings.

All measures used were the best possible items given that they were taken from a secondary dataset. They were not designed specifically to measure a new and different idea of sexual resilience in adolescence. There are many facets to resilience that should be taken into account. No measurement of social support or other external factors was included in the measure. Additionally, this study was only able to view a single perspective – a onetime look- at resilience in the lives of these adolescents. Resilience is a cumulative process and a study designed to view it as such would be even more enlightening. These represent important limitations of my study that should be addressed in future investigations.

Conclusions

Notwithstanding this project's limitations, some theoretical ground may have been broken in the search for a definition of sexual resilience that more closely mirrors the concept of resilience in general. As discussed, sexual resilience is currently viewed through the lens of absence of risk. When we look at sexual behaviors in adolescence and see only risk, we deny the very idea that adolescents can have sexually healthy behaviors. This denial is counterintuitive to social research, in that we strive to not only identify areas for improvement, but work toward improving them as well. Teaching children and adolescents to "just say no" denies the blossoming sexual being she (or he) is becoming and does not prepare them to negotiate sexual behaviors or relationships or to make informed decisions about them.

The risk-based view of adolescent sexual resilience fails to provide young people the tools that could be used to prevent negative outcomes from their sexual behavior. Sexual health is tied to physical and mental health. Physical and mental problems may lead to sexual dysfunction and vice versa (Satcher 2001). The multi-faceted aspects of sexual health illustrate the need for a wider lens to include other aspects beyond lack of disease, such as agency, self-efficacy and the ability to negotiate their sexual relationships. Health outcomes are grounded in social environments and mediated by behaviors (Healthy People 2020). Failing to take these issues into account is costly at the individual and societal level because adolescents do not learn the skills needed to develop into capable, confident, sexually healthy adults.

Most of the respondents in this study were found to be sexually healthy. A comprehensive approach to sexual resilience, following the resilience paradigm, is necessary to see if the influential factors here can indeed work together to strengthen sexual health. Individual factors in resilience theory have been studied, but separately, and

findings support the positive outcomes that would be incorporated into capital-based resilience. Most importantly these factors seem to have the desired outcomes that spending billions of dollars on things such as abstinence only sex education cannot accomplish. The inclusion of external factors such as resources and social support is necessary to complete a comprehensive approach to sexual resilience.

Additionally, if we could learn to understand what factors interact to play a role in promoting and developing sexual agency, we may be able to reduce those sexual outcomes that sex education has tried so hard to prevent. Such findings may not only encourage the teaching of sex education, but should supply the framework for doing so. Instead of prevention programs, programs can be created that are geared toward empowering adolescents, so that the choices and outcomes involved in sexual behaviors will be only those desired.

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