

# To Be Seen and Not Heard: Femininity Ideology and Adolescent Girls' Sexual Health

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This study used a feminist developmental framework to test the hypothesis that internalizing conventional ideas about femininity in two domains—inauthenticity in relationships and body objectification—is associated with diminished sexual health among adolescent girls. In this study, sexual health was conceptualized as feelings of sexual self-efficacy (i.e., a girl's conviction that she can act upon her own sexual needs in a relationship) and protection behavior (i.e., from both STIs and unwanted pregnancy). A total of 116 girls (aged 16–19) completed measures of femininity ideology, sexual self-efficacy, sexual experiences, and protection behavior. Results revealed that inauthenticity in relationships and body objectification were associated with poorer sexual self-efficacy and sexual self-efficacy, in turn, predicted less sexual experience and less use of protection. Further, the two components of femininity ideology were associated with different forms of protection. The importance of a feminist developmental framework for identifying and understanding salient dimensions of sexual health for female adolescents is discussed.

**KEY WORDS:** adolescent girls; femininity ideology; sexual health; sexual risk taking; sexual self-efficacy.

## INTRODUCTION

A bad thing about guys is sometimes they, they like don't want to talk to you on the phone or something, or if they do want to talk to you on the phone, they don't want to talk to you in front of their guy friends because they're like "I have a girlfriend, girlfriend's there to look nice, shut up don't say anything, girls should be seen, not heard," you know?

—Kim, a study participant

Adolescent girls come of age in a patriarchal society in which they are under pressure to be seen and not heard. Girls experience immense pressures to behave in feminine ways, both in their relationships with other people (i.e., by suppressing their own authentic thoughts and feelings) and in their relationships with their own bodies (i.e., by suppressing bodily hungers and desires to conform to prevailing images of beauty and attractiveness). At

the same time that girls are learning to navigate the demands of femininity, they are exploring their sexuality and becoming adult sexual beings (Tolman, 2002). The development of healthy sexuality is a critical developmental task (Ehrhardt, 1996), much of which takes place during adolescence (Christopher, 2001; Tolman, 2002).

## Sexuality Development in Adolescence

From a developmental perspective that acknowledges the normative expectation of girls' developing sexuality in adolescence, a conceptualization of adolescent sexual health must include, among other things, the ability to acknowledge one's own sexual feelings, the freedom and comfort to explore wanted sexual behavior and refuse unwanted behavior, and the requisite knowledge and ability to protect oneself from sexually transmitted infections (STIs) and unwanted pregnancy (Tolman, Striepe, & Harmon, 2003). In the current study, we chose to focus on three specific aspects of this broad definition of sexual health. First, we considered girls' overall level of accumulated sexual experience. Although much of the previous research on girls' sexuality has

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focused exclusively on sexual intercourse, this approach ignores the much broader family of sexual experiences that many girls explore during adolescence. Accordingly, we incorporated a range of noncoital sexual behaviors in addition to sexual intercourse including kissing, genital touching, and oral sex (SIECUS, 1995; Tolman, 1999).

Second, we considered girls' conviction that they can act upon their own sexual needs in a relationship (i.e., sexual self-efficacy). Sexual decisions concerning the choice of activity or use of contraception often involve negotiation between partners; being able to voice and enact one's own desires, interests, and needs is necessarily central to our conceptualization of sexual health. Third, we consider girls' use of protection during sexual interactions (i.e., protection behavior). In the United States, young people and adolescent girls in particular are at heightened risk for contracting STIs such as HIV, chlamydia, and gonorrhea (CDC, 2003a, 2003b). Further, 10% of all girls and young women aged 15–19 become pregnant each year (Alan Guttmacher Institute, 1999) and 78% of these pregnancies are unplanned (Henshaw, 1998). Because of the effectiveness of condoms and hormonal contraception at preventing these outcomes (Davis & Weller, 1999; Walsh et al., 2004), girls' protection behaviors constitute an important aspect of their sexual health.

### A Feminist Developmental Framework

The current study used a feminist developmental framework to explore the extent to which adolescent girls' internalization of conventional ideas about femininity was associated with their sexual health. This framework refers to a set of theories that assume a feminist standpoint (e.g., Jagger, 1983) and describe the ways in which girls' development is shaped by, and is responsive to, the sociocultural context of patriarchy. A feminist developmental framework calls for attention to how girls develop an internalized recognition of themselves as women in their behavior, thoughts, and feelings and through others' responses to them. In particular, girls enter a patriarchal world in which they experience pressure to behave in "feminine" ways in their relationships with other people (i.e., by avoiding conflict, suppressing anger, being "nice") and through their relationships with their own bodies (i.e., by managing their own bodies and habits to conform with prevailing images of beauty and attractiveness) (Tolman, Impett, Tracy, & Michael, *in press*). Below, we describe these two specific aspects of femininity ideology, namely inauthenticity in relationships and body objectification, and their possible implications for adolescent girls' sexual health.

### *Inauthenticity in Relationships and Sexual Health*

Traditional theories of human development have described the key tasks of adolescence as achieving separation and autonomy (Erikson, 1968). In contrast, a feminist psychodynamic developmental perspective suggests that, for women in particular, the importance of relationships is central to adolescent development. Anchored in self-in-relation theory (e.g., Jordan, Kaplan, Miller, Stiver, & Surrey, 1991), this perspective describes how the experience and development of a sense of self is intimately bound to relationships and that a woman's (and a developing girl's) sense of self is based, in large part, on her ability to maintain important close relationships (see also review by Cross & Madson, 1997). Qualitative research that has focused on girls' own perspectives has shown that the negotiation of, and the desire to maintain, changing relationships is a primary struggle in adolescence (e.g., Brown, 1998; Brown & Gilligan, 1992). One way in which girls and women maintain important relationships is to silence their own needs and desires as a strategy to reduce conflict. This tendency has been described as "inauthenticity in relationships" (e.g., Tolman & Porche, 2000), "loss of voice" (e.g., Brown & Gilligan, 1992; Gilligan, 1982), "false-self behavior" (e.g., Harter, Waters, & Whitesell, 1997), or "silencing the self" (e.g., Jack & Dill, 1992) and is enacted when girls hide their true thoughts and feelings, especially those that are deemed unfeminine, such as anger.

Girls who silence their own needs and desires may be more likely to struggle with making their *sexual* needs and desires known as well. This disregard for the self in the ostensible service of relationships may be especially true in a culture that defines sex in terms of men's desires and denies women's sexual desire and agency (Holland, Ramazanoglu, Sharpe, & Thomson, 1998; Tolman, 2002; Tolman, Spencer, Rosen-Reynoso, & Porche, 2003). That is, girls and women may be particularly vulnerable to making their own sexual needs and desires including the need for protection against STIs and unwanted pregnancy secondary to the desires of their partners (Amaro, 1995; Wingood & DiClemente, 1998). While no quantitative research has explicitly examined the possible link between girls' ability to be authentic in relationships and sexual decision making, research on sexual communication has shown that women who do not communicate with their sexual partners about sexual issues use condoms less consistently than women who feel comfortable communicating with their partners (e.g., Quina, Harlow, Morokoff, Burkholder, & Dieter, 2000; Wingood & DiClemente, 1998). These findings suggest that girls who find it difficult to assert and communicate

their own authentic desires may sacrifice their sexual health in the service of preserving relationships and engage in more sexually risky behavior.

### *Body Objectification and Sexual Health*

A feminist developmental perspective also positions the negotiation of learning to live in a woman's body as a critical developmental task in adolescence. The meaning and experience of being in one's own body (i.e., experiencing one's physical and concomitant emotional feelings) changes as girls undergo puberty in a society that objectifies and commodifies women's physical appearance (Bordo, 1993; Brumberg, 1997; de Beauvoir, 1961). In response to societal objectification, girls learn to internalize and eventually embody objectified constructs of femininity (Fredrickson & Roberts, 1997; McKinley & Hyde, 1996). The embodiment of femininity includes dissociating from one's body, that is, losing awareness of one's own desires and hungers (i.e., for food, for sex) as well as training the body how to move (and not move) appropriately to conform to "ladylike" norms of physicality (Bartky, 1990; Tolman & Debold, 1993). As de Beauvoir (1961) articulated, this process involves internalizing a "male gaze" and turning it upon oneself and learning to evaluate and assess rather than to feel and experience one's own body. Thus, as girls begin to develop physically mature bodies in adolescence, many of them, to some degree or other, dissociate from their own bodily hungers and engage in the behaviors of constantly controlling and surveilling their own bodies (Fredrickson & Roberts, 1997).

Both of these aspects of body objectification—dissociating from one's own desire and constantly surveilling one's own body from another's perspective—may have negative consequences for female sexuality. A woman who is separated from her own feelings may find it difficult to assert (or even know) her own desires and instead act based on her partner's desires and interests (Tolman, 2002). In a study of college women, body image self-consciousness (i.e., being concerned with how one's body looks to a partner during sex) was negatively associated with sexual self-esteem and sexual assertiveness (Wiederman, 2000; see also Dove & Wiederman, 2000). In another study, college student women who reported feeling more body image self-consciousness and less comfort with their bodies had less overall sexual experience, but when they did engage in sexual intercourse, used condoms and contraception less frequently (Schooler, Ward, Merriwether, & Caruthers, 2005). Other research has shown that adolescent girls who

are less satisfied with their body image were less likely to negotiate condom use because they feared abandonment by their partners (Wingood, DiClemente, Harrington, & Davies, 2002). In short, girls who objectify their own bodies may not be able to act in accordance with, or even know their own desires and, as a result, may avoid wanted sexual activity or engage in risky behaviors that pose a serious threat to their sexual well-being.

### **The Mediating Role of Sexual Self-Efficacy**

Both theory and preliminary empirical evidence suggest that inauthenticity in relationships and body objectification may be associated with diminished sexual health among adolescent girls. The mechanisms of this association, however, remain to be established. We suggest that femininity may primarily inhibit girls' sexual self-efficacy, which we define as a girl's conviction that she can act upon her own sexual needs in a relationship, such as enjoying sex, refusing unwanted sex, and insisting on the use of protection (Levinson, 1986). The resulting decreased sexual self-efficacy may interfere with girls' abilities to engage in wanted sexual activity and to enact safer sex practices when they do (Schooler et al., 2005).

Previous empirical work supports such a premise. Girls who find it difficult to assert and communicate their own authentic desires and who objectify their own bodies may be less able to communicate their desires in sexual situations (Impett & Peplau, 2003). Further, research has also shown that sexual self-efficacy is associated with an increased likelihood of practicing safer sex (e.g., Goldman & Harlow, 1993; Parsons, Halkitis, Bimbi, & Borkowski, 2000). Taken together, these results suggest that sexual self-efficacy may mediate the associations between both inauthenticity in relationships and body objectification and sexual health.

### **Hypotheses and Overview of the Current Research**

In the current study, we tested the central hypothesis that the extent to which girls espouse traditional ideas about femininity (i.e., femininity ideology) would be associated with their sexual self-efficacy, and, in turn, with the extent to which they engage in sexual activity and protect themselves from STIs and unwanted pregnancy. This main hypothesis was composed of three specific predictions: First, we predicted that both components of femininity ideology (i.e., relationship inauthenticity and body objectification) will be associated with lower sexual self-efficacy, less sexual experience, and less protection

behavior (i.e., less use of condoms and contraception). Second, we predicted that lower sexual self-efficacy will be associated with less sexual experience and less protection behavior. Third, we expected that sexual self-efficacy will mediate the association between femininity ideology and both sexual experience and protection behavior. So, for example, one reason why girls who have internalized more conventional ideas about femininity may engage in more sexually risky behaviors is because buying into ideas about what it means to be appropriately feminine is at odds with sexual self-efficacy and thus may undermine girls' ability to negotiate and enact protection behaviors. Taken together, these specific predictions are depicted in a conceptual model (see Fig. 1).

Furthermore, because we conceptualized girls' protection behavior as multifaceted, additional questions guided our investigation. First, we considered the use of hormonal contraception (i.e., the pill or Depo), which protects against pregnancy, as potentially different from the use of condoms, which protects against both pregnancy and STIs. In addition to this difference in function, hormonal contraception and condoms also differ in their method of use. Specifically, the use of hormonal contraception often involves extensive advanced planning in expectation of sexual activity; an adolescent girl wishing to "go on the pill" might need to consult with her parents, or at the very least, obtain a prescription from a physician. Condom use, on the other hand, requires less advanced planning, but requires more negotiation with a partner once sexual activity is initiated. As such, although both require asserting oneself, the behaviors involved can look quite different. Because of the somewhat different functions and methods of these two forms of protection, we chose to evaluate whether femininity ideology was differentially associated with the use of hormonal contraception and condoms. Second, because the use and

meaning of contraception may change as girls develop and as their relationships become more committed and long lasting (e.g., Reisen & Poppen, 1995; Rosenthal & Shepherd, 1993), we chose to distinguish between protection behaviors at first intercourse, protection behaviors at last intercourse, and the general frequency of protection behaviors across all sexual encounters.

In addition, we assessed two demographic factors that have been associated with sexual behaviors and sexual risk taking in adolescence: socioeconomic status (e.g., Crosby, Holtgrave, DiClemente, Wingood, & Gayle, 2003) and religiosity (e.g., McCree, Wingood, DiClemente, Davies, & Harrington, 2003). We controlled for these two demographic factors in the analyses if appropriate.

## METHOD

### Participants

The entire 12th grade in a northeastern urban school district was recruited as part of a longitudinal study of adolescent sexual health (our collaboration with administrators and teachers produced 93% compliance for the district; see Tolman & Porche, 2000). A total of 116 girls aged 16–19 ( $M = 17.3$ ) participated in this panel of data collection. The sample was ethnically diverse: 59.5% were white, 27.6% were Latina, 6.9% were multiethnic, 2.6% were African-American, 1.7% were Asian or Pacific Islander, and 1.7% did not provide a description of their ethnicity. The sample was also diverse in terms of socioeconomic status: 23% reported that their mothers did not finish high school, 30% reported that their mothers finished high school, and 47% reported their mother's education as college or better. Sixteen (14%) of

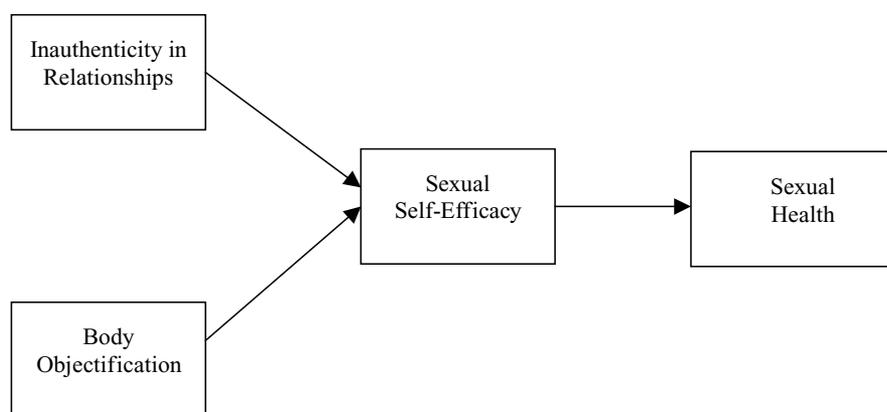


Fig. 1. Conceptual model of femininity ideology and sexual health.

**Table I.** Mean and SDs for Items in the Adolescent Femininity Ideology Scale

Item	<i>M</i>	<i>SD</i>
Inauthentic Self in Relationships Subscale.		
1. I would tell a friend I think she looks nice, even if I think she shouldn't go out of the house dressed like that.	2.33	1.16
2. I worry that I make others feel bad if I am successful.	2.25	1.21
3. I would not change the way I do things in order to please someone else. <sup>a</sup>	4.41	1.26
4. I tell my friends what I honestly think even when it is an unpopular idea. <sup>a</sup>	4.66	0.99
5. Often I look happy on the outside in order to please others, even if I don't feel happy on the inside.	3.25	1.40
6. I wish I could say what I feel more often than I do.	3.48	1.48
7. I feel like it's my fault when I have disagreements with my friends.	2.65	1.18
8. When my friends ignore my feelings, I think that my feelings weren't very important anyway.	2.44	1.41
9. I usually tell my friends when they hurt my feelings. <sup>a</sup>	4.10	1.28
Objectified Relationship with Body Subscale.		
1. The way I can tell that I am at a good weight is when I fit into a small size.	3.09	1.58
2. I often wish my body were different.	3.67	1.51
3. I think that a girl has to be thin to feel beautiful.	2.25	1.32
4. I think a girl has to have a light complexion and delicate features to be thought of as beautiful.	2.07	1.28
5. I am more concerned about how my body looks than how my body feels.	2.73	1.36
6. I often feel uncomfortable in my body.	3.18	1.46
7. There are times when I have really good feelings in my body. <sup>a</sup>	4.66	1.09
8. The way I decide I am at a good weight is when I feel healthy. <sup>a</sup>	4.46	1.23

<sup>a</sup>Item is reversed for coding.

Note. *n* = 116.

the girls reported that Spanish was the primary language used at home. A substantial number of girls (21.6%) were born outside of the United States. Sixty-nine percent of the girls identified their religious affiliation as Catholic; a little more than a quarter of the girls (28.5%) described religion as "important" or "very important" in their lives.

## Procedure

Participants completed a survey that included questions about femininity ideology, sexual experiences, sexual self-efficacy, protection behavior, and demographic characteristics. Written permission was obtained from each child's parent or guardian. Bilingual students and mainstreamed Latinas were offered the option of completing the survey in Spanish (translated and back-translated) with a Spanish-speaking researcher present. Permission slips were translated into Spanish for this group. Students completed the surveys in school either in health education or in physical education class.

## Measures

### Femininity Ideology

The 20-item version of the Adolescent Femininity Ideology Scale (AFIS; Tolman & Porche, 2000) measured the extent to which girls have internalized two negative

conventions of femininity: inauthenticity in relationships with others and objectification of one's own body (see Table I). The AFIS was developed with and for girls of varied ages in adolescence, anchored largely in items constructed out of focus groups.

Based on the results of confirmatory factor analyses of data provided by early adolescent girls in another study (Tolman et al., *in press*), we dropped 3 of the 20 original items to increase the reliability of each subscale. Girls responded to such statements as "I wish I could say what I feel more often than I do" (Inauthentic Self in Relationships Subscale, ISR) and "I am more concerned about how my body looks than how my body feels" (Objectified Relationship with Body Subscale, ORB) on 6-point scales (1 = *strongly disagree* to 6 = *strongly agree*). Several items were reverse-scored and mean scores for each subscale were computed, with higher scores reflecting greater conventionality (i.e., more inauthentic in relationships, more self-objectifying). The Cronbach alphas for the two subscales were adequate ( $\alpha_{ISR} = 0.77$ ,  $\alpha_{ORB} = 0.81$ ).

### Sexual Experiences

Participants indicated whether or not they had engaged in each of the following sexual activities: (1) kissing on the mouth, (2) touching another person under their clothing or with no clothes on, (3) being touched under

their clothing or with no clothes on, (4) performing oral sex, (5) receiving oral sex, and (6) engaging in sexual intercourse. We summed their responses to each of these questions to create an index of sexual experiences (0 = *none of these behaviors* to 6 = *all of these behaviors*). Those girls who had engaged in sexual intercourse also indicated the number of partners with whom they had engaged in sexual intercourse on a 6-point scale (1 = *1 person*, 2 = *2 people*, etc., to 6 = *6 or more people*).

### *Sexual Self-Efficacy*

A modified version of Levinson's (1986) Contraceptive Self-Efficacy Scale assessed the strength of a girl's conviction that she can act upon her own sexual needs in a relationship, such as enjoying sex, refusing unwanted sex, and insisting on the use of protection. Girls responded to 16 statements such as "When I am with a partner, I feel that I can always be responsible for what happens sexually" and "I could stop things before intercourse if I couldn't bring up the subject of protection" on 5-point scales (1 = *not at all true* to 5 = *completely true*). Because we were interested in girls' use of condoms in addition to contraception, items that originally referred only to contraception were reworded to refer to protection more generally. For example, in one item, the original statement "even if I wasn't using a form of birth control" was changed to "even if I weren't protected." Several items were reverse-scored and a mean scale was computed with higher scores reflecting stronger beliefs that a girl could protect herself from pregnancy and STIs. The Cronbach alpha for this measure was adequate ( $\alpha = 0.73$ ).

### *Protection Behavior*

Girls who reported that they had engaged in sexual intercourse answered questions adopted from the National Longitudinal Study of Adolescent Health about: (1) *general frequency of protection*, (2) *protection at first intercourse*, and (3) *protection at last intercourse*. The first measure, general frequency of protection, was assessed with two questions. Girls indicated (1) how often they used protection to prevent pregnancy and (2) how often they used protection to prevent STIs on 4-point scales (0 = *never*, 1 = *sometimes*, 2 = *usually*, 3 = *always*). For the second and third measures, girls indicated whether or not they used each of the following forms of protection the first time and the last time they engaged in sexual intercourse: condoms, the pill, "the shot" (Depo), a diaphragm, or other. From their responses to these questions, girls were assigned a hormonal contraception score (i.e., protection

from pregnancy; 0 = *no*, 1 = *yes*) and a condom score (i.e., protection from pregnancy and STDs; 0 = *no*, 1 = *yes*) for both first and last intercourse.

### *Socioeconomic Status*

Each girl's mother/mother figure's education was included as a proxy for socioeconomic status. Girls reported to the best of their ability the highest level of formal education achieved by their mother or female guardian (1 = *did not finish high school*, 2 = *finished high school/obtained GED*, 3 = *completed some college*, 4 = *finished college*, 5 = *attended school beyond college*). Maternal education has been shown to be an adequate general index of socioeconomic status (Entwisle & Astone, 1994).

### *Religiosity*

Religiosity was measured with a single item: "How important is religion in your life?" (1 = *not at all* to 4 = *very*).

## **Data Analyses**

In this article, we tested three separate models in which sexual self-efficacy mediated the association between both components of femininity ideology and sexual health. First, we tested a model linking femininity ideology with girls' overall level of sexual experience. Second, we tested a model linking femininity ideology with frequency of protection. Third, we tested a model linking femininity ideology with protection at first and last intercourse.

Structural equation modeling estimated with the EQS computer program (Bentler, 1995) was used to test the models linking femininity ideology to sexual experience and frequency of protection. For the first model linking femininity ideology to sexual experience, we assess the significance of the relevant paths and present information regarding model fit. Model fit was assessed with three different indices. First, we report the likelihood ratio chi-square statistic, an index that quantifies the degree of "model misfit" (i.e., a composite of the discrepancies between the obtained data and their model-implied values). Second, because the chi-square is dependent on the assumption of multivariate normality and can be inflated in models with strong associations (Kline, 2005), we report three other fit indices. We will report the Comparative Fit Index (CFI; Bentler, 1990), a common

**Table II.** Intercorrelations, Means, and SDs for all Measured Variables

Measured variable	1	2	3	4	5	6	7	8	9
1. ISR	—								
2. ORB	0.45**	—							
3. Sexual self-efficacy	-0.49**	-0.49**	—						
4. Sexual experience	-0.15*	-0.17*	0.30*	—					
5. Number of partners	0.08	0.19	-0.34**	0.23	—				
6. Contraception frequency	-0.29*	-0.17	0.35**	0.20	0.02	—			
7. Condom use frequency	-0.18	-0.26*	0.15	0.08	-0.14	0.65**	—		
8. Religiosity	-0.01	-0.05	0.08	-0.12	-0.06	-0.10	-0.02	—	
9. Socioeconomic status	-0.02	-0.19	0.11	0.04	-0.05	0.21	0.20	0.14	—
Mean	2.62	2.60	4.23	4.36	2.52	2.39	2.07	1.93	2.65
SD	0.77	0.79	0.50	1.97	1.75	0.95	1.11	0.96	1.28

Note. *n* = 70–116.

\**p* < .05.

\*\**p* < .01.

model fit index that is forced to vary between 0 and 1. The root mean square error of approximation (RMSEA) is an index which represents a population-based assessment of the amount of model misfit (less dependent on the sample size and distributional properties of the sample) and which compensates for the effect of model complexity. Browne and Cudeck (1993) recommended that an RMSEA of 0.05 or lower indicates that the model provides a good fit to the data. Finally, we will report the standardized root mean square residual (SRMR), a standardized measure of the average difference between the observed and the modeled covariances among the variables. Hu and Bentler (1999) recommended that an SRMR of 0.08 or lower indicates good fit.

The second set of models linking femininity ideology to frequency of protection (hormonal contraception and condoms) was “just identified” (i.e., we estimated as many paths as there were unique elements in the variance/covariance matrix). In these models, all possible paths were included, resulting in a perfect fit, and, accordingly, the purpose of model testing was to evaluate the significance of the paths between variables. Finally, the third models linking femininity ideology to protection at first and last intercourse were tested using logistic regression because the protection variables were dichotomous.

**RESULTS**

We present three models, those pertaining to sexual experience, those pertaining to frequency of protection, and those pertaining to protection at first and last intercourse. Table II lists the intercorrelations among all variables to be included in the models. Because neither socioeconomic status nor religiosity was significantly

associated with any of the other variables to be included in the models, they were dropped from the analyses.

Before we test the models, we present descriptive data regarding girls' sexual experiences and protection behavior.

**Sexual Experiences and Protection Behavior**

Girls reported engaging in a range of sexual experiences from kissing to sexual intercourse. Ninety-two percent of girls had kissed on the mouth, 85% reported touching someone or being touched under their clothing, 66% had either performed or received oral sex, and 60% reported that they had engaged in sexual intercourse. Among girls who had engaged in sexual intercourse, 41% had engaged in sex with one partner, 17% had two partners, 20% had three partners, 3% had four partners, 6% had five partners, and 13% had six or more partners.

Table III lists the percentages of participants who used hormonal contraception and condoms at varying frequencies. Table IV depicts the percentages of girls

**Table III.** Descriptive Statistics for Hormonal Contraception and Condom Use Frequency

	Hormonal contraception frequency (%)	Condom use frequency (%)
Never	9	14
Sometimes	7	14
Usually	21	21
Always	63	50

Note. *n* = 70.

**Table IV.** Descriptive Statistics for Hormonal Contraception and Condom Use at First and Most Recent Intercourse

	First intercourse (%)	Most recent intercourse (%)
Nothing	12.7	21.4
Hormonal contraception only	1.4	17.1
Condoms only	77.5	52.9
Dual methods	8.5	8.6

Note.  $n = 70$ .

who used different forms of protection at first and last intercourse.

On the whole, the girls in this sample used a great deal of protection, especially at first intercourse. For example, less than 13% of girls used no form of protection at first intercourse, and 86% used either condoms only or dual methods of protection. Only one girl reported the use of hormonal contraception only. By most recent intercourse, fewer girls reported the use of condoms or dual methods of protection (62%) whereas more girls reported using hormonal contraception only (17%).

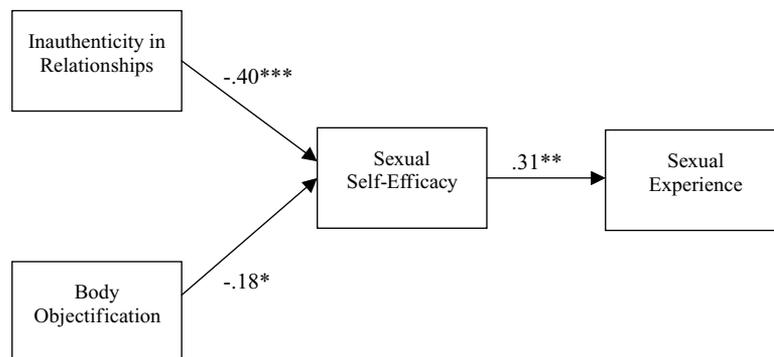
### Femininity Ideology and Sexual Experience

Our first model tested predictions linking femininity ideology to girls' overall level of sexual experience. As shown in Table IV, both ISR and ORB were associated with girls' overall level of sexual experience, but not with the number of partners that she reported over her lifetime. Accordingly, we tested one model that included both components of femininity ideology predicting sexual experience (see Fig. 2). This model provided a good fit to the data,  $\chi^2(2) = 0.46$ ,  $p = .80$ , CFI = 1.00, RMSEA

< 0.001, SRMR = 0.02. The Lagrange Multiplier test indicated that no additional paths could be added to improve the fit of the model. All of the hypothesized paths in the model were significant. As hypothesized, both ISR and ORB predicted sexual self-efficacy. Together, these two components of femininity ideology accounted for 26% of the variance in sexual self-efficacy. In turn, sexual self-efficacy predicted overall sexual experience, accounting for 10% of the variance in this variable. Finally, the indirect effect (equivalent to a Sobel [1982] test) of ISR on sexual experience was significant ( $z = -2.71$ ,  $p < .05$ ), providing evidence for mediation. However, the indirect effect of ORB on sexual experience was not significant ( $z = -1.73$ ,  $p > .05$ ). Thus, the association between femininity ideology and sexual experience may be partially explained by the fact that girls who were less authentic in relationships were also lower in sexual self-efficacy.

### Femininity Ideology and Frequency of Protection

Our second model tested predictions linking femininity ideology with the frequency with which girls used hormonal contraception and condoms. These analyses were conducted with the subsample of girls who had engaged in sexual intercourse ( $N = 70$ ). As seen in Table IV, whereas inauthenticity in relationships (ISR) was associated with less frequent use of hormonal contraception, body objectification (ORB) was associated with less frequent use of condoms. Results of multiple regression analyses in which ISR and ORB were entered simultaneously further support these differential findings. Whereas ISR ( $\beta = -0.27$ ,  $p < .05$ ) but not ORB ( $\beta = -0.04$ ,  $p = .74$ ) predicted frequency of hormonal



**Fig. 2.** Model with sexual self-efficacy mediating the association between femininity ideology and sexual experience. Note.  $n = 70$ .  $\chi^2(2) = .46$ ,  $p = .80$ , CFI = 1.00, RMSEA < .001, SRMR = .02. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

contraception, ORB ( $\beta = -0.22, p = .09$ ) but not ISR ( $\beta = -0.08, p = .56$ ) marginally predicted frequency of condom use. Because ISR and ORB were associated with different outcomes, we tested two separate mediational models, one linking ISR with contraception frequency and one linking ORB with condom use frequency. As explained above, because both of these models were saturated, we only report the significance of paths rather than the fit of the models. Further, tests for mediation were conducted according to the principles of Baron and Kenny (1986).

*ISR and Hormonal Contraception Frequency*

The first requirement in demonstrating mediation is that the predictor variable be associated with the outcome variable. As shown above, ISR was significantly associated with frequency of hormonal contraception. The second requirement is to show that the predictor variable is associated with the putative mediator, sexual self-efficacy. As shown in Table IV, ISR was significantly associated with sexual self-efficacy. The final requirement is that the mediator predicts the outcome variable and that these effects account for the direct effect between the predictor and the outcome variable. Results showed that sexual self-efficacy significantly predicted hormonal contraception frequency ( $\beta = 0.27, p < .05$ ), and the direct effect from ISR to hormonal contraception frequency dropped to nonsignificance ( $\beta = -0.17, p = .21$ ). The Sobel (1982) test indicated that the drop in the value of the betas was marginally significant ( $z = 1.89, p = .06$ ), suggesting possible, but not strong mediation. Figure 3 depicts this mediational model.

*ORB and Condom Use Frequency*

As shown in Table IV, sexual self-efficacy was not associated with condom use frequency. Because the mediator (in this case, sexual self-efficacy) was not associated with the outcome variable (condom use frequency), one

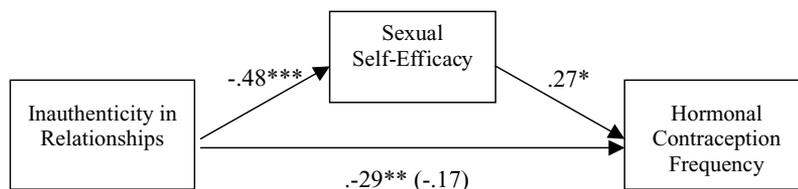
of the crucial requirements for mediation was not met. In short, the direct association between ORB and condom use was not mediated by sexual self-efficacy.

**Femininity Ideology and Protection at First and Last Intercourse**

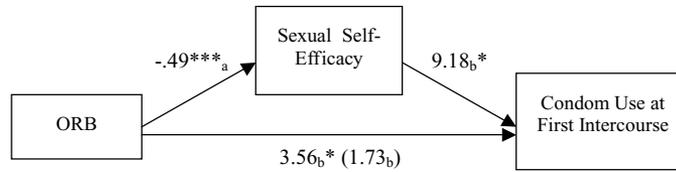
The analyses concerning frequency of protection suggested that ISR and ORB may be associated with different aspects of protection (i.e., protection from pregnancy vs. protection from STIs). Accordingly, we conducted analyses to see whether ISR and ORB predicted different aspects of protection at first and last intercourse. Because condom use and hormonal contraception use at first and last intercourse were dichotomous variables (0 = no, 1 = yes), we used logistic regression. ISR and ORB were entered into separate logistic regression equations to aid in interpretation, although we should point out that all effects remain significant when the two predictors are entered simultaneously.

Starting with first intercourse, ISR was marginally associated with the use of hormonal contraception (odds ratio [OR] = 2.89, 95% CI = 0.89, 9.42,  $p = .08$ ), but was not associated with the use of condoms (OR = 1.60, 95% CI = 0.67, 3.81,  $p = .29$ ). Specifically, for each unit increase in ISR, participants were almost three times as likely to fail to use hormonal contraception. For first intercourse, ORB was associated with the use of condoms (OR = 3.56, 95% CI = 1.36, 9.31,  $p = .01$ ), but was not associated with the use of hormonal contraception (OR = 1.32, 95% CI = 0.46, 3.77,  $p = .61$ ). Specifically, for each unit increase in ORB, participants were more than three times as likely to fail to use condoms. Thus, consistent with the findings regarding frequency of protection, different aspects of femininity ideology were associated with different aspects of protection at first intercourse.

Because ISR was only marginally associated with the use of hormonal contraception at first intercourse, we did not test the full model with sexual self-efficacy



**Fig. 3.** Model with sexual self-efficacy mediating the association between inauthenticity in relationships and hormonal contraception frequency. Note. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ . All paths are standardized regression coefficients.



**Fig. 4.** Model with sexual self-efficacy mediating the link between body objectification and condom use at first intercourse. Note. Path coefficients with an “a” subscript are standardized betas; path coefficients with a “b” subscript are exponentiated betas from logistic regression (condom use has been recoded so that all exponentiated betas are greater than one).  $^*p < .05$ ,  $^{***}p < .001$ .

as the mediator. Instead, we present only the results for the model linking ORB with condom use at first intercourse. As shown above, ORB was associated with condom use at first intercourse and with sexual self-efficacy. Further, sexual self-efficacy predicted condom use at first intercourse (OR = 9.18, 95% CI = 1.46, 57.76,  $p < .05$ ), and the direct effect from ORB to condom use dropped to nonsignificance (OR dropped to 1.73, 95% CI = 0.54, 5.53,  $p = .36$ ). A significant Sobel test indicated that the drop in value of the path coefficient from ORB to condom use was significant ( $z = 2.05$ ,  $p < .05$ ), providing evidence for mediation. This model is depicted in Fig. 4. In short, ORB may influence a girl’s use of condoms at first intercourse in part through its association with sexual self-efficacy.

Finally, turning to last intercourse, we found that neither ISR nor ORB was associated with the use of hormonal contraception or the use of condoms (all  $ps > .05$ ); therefore we could not determine whether sexual self-efficacy mediated any of these associations.

## DISCUSSION

In this study, we investigated the role of femininity ideology in understanding late adolescent girls’ abilities to make healthy sexual choices. In particular, both inauthenticity in relationships and body objectification were associated with poorer sexual self-efficacy. That is, girls who internalized messages that they should “be seen” (rather than feel their own embodied feelings) and “not heard” (by taking their own thoughts and desires out of relationships) had a diminished ability to act on their own desires in sexual relationships (i.e., enjoy sex, refuse unwanted sex, and insist on the use of protection). In turn, lower feelings of sexual self-efficacy predicted less sexual experience and less protection behavior. The negative associations between femininity ideology and sexual experience suggest that girls who internalize norms of traditional femininity may find it difficult to voice

their sexual desires and engage in wanted sexual behavior. Although we cannot determine from these data whether girls’ sexual experiences indeed represent *wanted* experiences, the mediating role of sexual self-efficacy supports this interpretation. The finding that sexual self-efficacy mediated associations between femininity ideology and protection behavior points to the specific importance of self-efficacy for adolescent girls’ sexuality. Being able to assert one’s sexual desires and needs may be a critical prerequisite for enacting safer sex practices. Consequently, the extent to which conventional femininity ideology inhibits this ability may present a threat to the sexual health of adolescent girls.

Our findings further indicate that femininity ideology was a complex and multifaceted construct. Inauthenticity in relationships and body objectification predicted different types of protection behavior. Specifically, whereas inauthenticity was associated with less frequent use of contraception, body objectification was associated with less frequent use of condoms. The results for protection behavior at first intercourse were similar, namely that inauthenticity in relationships predicted less use of the pill and body objectification predicted less use of condoms. Although both of these forms of protection prevent pregnancy, condom use has the added benefit of providing protection from STIs. Given the different processes involved in condom and contraceptive use, such differences are not surprising. Specifically, contraceptive use requires advanced planning and expectation of sexual activity but does not require further action once sexual activity is initiated. Conversely, condom use requires less advanced planning but involves enacting safer sex practices while in the midst of sexual activity. Girls who objectify their bodies may find it especially difficult to assert themselves *during* ongoing sexual activity, when bodies are exposed and vulnerable to evaluation. This heightened focus on the body may induce shame for girls prone to objectification (Fredrickson & Roberts, 1997), which may stall efforts to enact safer sex practices. Use of hormonal contraceptives is more removed from the

immediate context of sexual activity, and, accordingly, may not present the same challenge for girls high in body objectification. Use of oral contraceptives does require that participants are planning for and expecting to engage in sexual activity and that they acknowledge these intentions to a parent or physician. Girls who silence their own thoughts and desires may be less likely to negotiate the initiation of intercourse with a partner or discuss it with an adult. Indeed, a common theme among adolescent girls' stories of first intercourse is that of "it just happened" (Tolman, 2002). Girls who silence their true thoughts and desires may be less likely to experience sexuality with conscious intentions and may therefore be less likely to use hormonal contraception.

We should also note that neither of the femininity ideology factors predicted use of protection during the most recent intercourse experience. It is possible that girls' beliefs about femininity may play a greater role in the beginning of relationships when people rely on gender stereotypes and others' expectations to guide their actions. This explanation is consistent with research on stereotyping processes that shows that increasing familiarity decreases the use of stereotypes (e.g., Fiske, 1998). That is, in the beginning of a relationship, girls' beliefs about gender may influence their use of protection; later on, other concerns may take precedence. Indeed, previous research indicates that as relationships progress, the choice to use condoms as opposed to hormonal contraception becomes conflated with questions of trust and, consequently, many girls elect not to use condoms (e.g., Reisen & Poppen, 1995). Our data were consistent with this pattern; from first to last intercourse, there was a substantial drop in the number of participants who used only condoms (approximately 25%), and a roughly equivalent increase in the number of participants who used hormonal contraception only or no protection at all. For these girls, the lack of condom use may be predicated on other factors of their relationships, such as trust or familiarity. Even outside the context of a relationship, girls' increasing experience and familiarity with sexual activity may function to lessen the importance of gender ideology in sexual decision making. Internalizing ideas about femininity may be especially disadvantageous to adolescent girls who are just beginning to explore sexual activity, who, due to their lack of experience, may rely more heavily on gendered scripts.

Several limitations of this research deserve comment. First, although the sample included moderate numbers of both white and Latina (mostly Dominican) girls, girls from other ethnic groups (e.g., Asian-American, African-American) were underrepresented. Further, there were not sufficient numbers of Latina girls to permit comparisons

among ethnic groups. In some ethnic groups, women and girls are actively discouraged from asserting themselves sexually, particularly from initiating discussions about condom use (e.g., Gómez & Marín, 1996). In addition, this sample included a much higher proportion of Catholic girls than are included in the general population. Future research is needed to examine the potential ways in which ethnicity, race, class, religion, and other factors interact with femininity ideology during adolescence. A further limitation of this study is that it was restricted to heterosexual adolescent girls. Future studies should examine the ways in which femininity ideology is linked with sexual health for lesbian adolescent girls.

Second, the direction of causal relations remains to be determined. Feminist developmental theory predicts that lower sexual self-efficacy and riskier sex are liabilities of internalizing conventional aspects of femininity ideology, implying directionality. That is, if a girl suppresses her own wishes and desires and objectifies her own body, she will be more likely to engage in risky sex. It could also be, however, that the extent to which a girl suppresses her desires and objectifies her body is influenced and shaped by her sexual experiences. It is also possible that such a relationship eventually becomes reciprocal, in that internalizing conventional norms of femininity may lead to poorer sexual self-efficacy and more risky sex; subsequently, girls in their abilities to say no to unwanted sexual interactions or protect themselves in sexual situations, the more they may suppress their own bodily feelings and authentic voices.

Third, the measure of inauthenticity in relationships was not specific to romantic relationships, but instead, assessed a girl's tendency to silence her thoughts and feelings in relationships in general (i.e., with peers). It is not clear the extent to which a girl silences herself in peer relationships overlaps with the degree to which she silences her voice in romantic relationships (particularly in heterosexual relationships in which power differentials are embedded). We believe that had we measured inauthenticity in dating or sexual relationships more specifically, we may have found stronger associations between relationship inauthenticity and actual sexual behavior. Thus, the development of a comparable measure of inauthenticity in romantic relationships that can be used in adolescent samples may make a useful contribution to this line of investigation. Qualitative research would be an important first step in identifying which aspects of relationship authenticity are most salient for adolescent girls in romantic relationships.

Finally, questions can be raised about the validity of self-reports of sexual behavior (Catania, Gibson, Chitwood, & Coates, 1990). One barrier to valid reporting

is that participants may have provided socially desirable responses, such as by underreporting instances of sex or unprotected sex. While social desirability may have limited honest reporting, it is not clear how it would have specifically affected the theoretical link between femininity ideology and sexual risk taking. Another barrier concerns the retrospective nature of the data collection, as participants may have experienced difficulties in recalling events fully and accurately. Previous research suggests that first and most recent sexual experiences are highly memorable and salient (Hearn, O'Sullivan, & Dudley, 2003; Kauth, St. Lawrence, & Kelly, 1991). Nonetheless, future research could employ daily experience methods to collect sexual behavior data that minimizes retrospective bias (e.g., Impett, Peplau, & Gable, 2005).

This study suggests several important directions for future research. Our study provides a snapshot of girls at one time point in late adolescence. One future direction concerns the developmental trajectories of girls as they mature throughout adolescence and young adulthood. Do girls tend to internalize or become more resistant to femininity ideologies as they mature? Are possible changes in femininity ideology associated with changes in sexual health over time? Are such trajectories influenced by a girl's race, class, or social status? These questions seem especially important given our findings of differences between first and last intercourse. Longitudinal research designs that utilize latent growth curve methods would be ideal to answer such developmental questions and would enable us to examine more directly the causal association between femininity ideology and sexual health.

A second fruitful direction for future research would be to focus on the gender ideologies and sexual health of boys (Tolman, Spencer, Harmon, Rosen-Reynoso, & Striepe, 2004). Healthy heterosexual interactions require both girls *and* boys to communicate their desires for protection in clear ways. To what extent does internalizing traditional ideas about masculinity impact boys' sexual health? Such gendered ideas include concerns that boys should present themselves as tough and sexually active as well as hide feelings of vulnerability in relationships (Chu, Porche, & Tolman, 2005). Previous research with adolescent boys found that masculinity ideology defined in terms of social gender roles was associated with using condoms less consistently, viewing condoms as reducing male sexual pleasure, being less concerned with whether a partner wanted him to use a condom, believing that males are less responsible for preventing pregnancy and having greater beliefs that pregnancy validates masculinity (Pleck, Sonenstein, & Ku, 1993). The Pleck et al. study focused primarily on preventing pregnancy. It is possible that while boys high in masculinity ideology may not

view it as their responsibility to prevent pregnancy, they may take more seriously concerns about preventing the transmission of STIs. Future research could determine whether there are different dimensions of masculinity ideology that are associated with different forms of protection.

A third useful direction for future research would be to collect data from both partners in a romantic relationship. Previous research on married couples has documented moderate associations between spouses' scores on measures of sex role attitudes, with traditional men partnered with traditional women and less traditional men partnered with less traditional women (Peplau, Hill, & Rubin, 1993). Girls who espouse traditional ideas about femininity with partners who also espouse conventional conceptions of femininity (or masculinity) may be at heightened risk, especially given the unequal power dynamics in such relationships (Amaro, 1995). Future research should explore the ways in which both partners' ideas about gender interact to predict sexual health and risk. Although many adolescent relationships are relatively transient, particularly in early adolescence, relationships in middle to late adolescence tend to be more committed and long lasting (Carver, Joyner, & Udry, 2003) making such a developmental period in adolescents' lives ripe for dyadic research.

Given the noted limitations of this study, we developed and tested theoretical predictions from feminist developmental theory about how internalizing conventional ideologies about femininity is associated with adolescent girls' sexual self-efficacy and sexual protection behavior. This research provides the foundation for more expanded models of gender ideology and sexual health, including the experiences of adolescent boys and the role of masculinity ideology. Future research should examine the ways in which girls' and boys' beliefs about gender interact so that we may more fully understand the ways in which patriarchy as it is operationalized in both femininity and masculinity ideologies shapes the lives and sexual experiences of young people.

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