Parenting Processes Related to Sexual Risk-Taking Behaviors of Adolescent Males and Females

This study extends current research on the relationship of parenting processes to adolescent sexual behavior by asking what parenting behaviors are related to sexual risk taking among sexually active adolescent males and females. Parenting behaviors considered were communication about sexual issues, support, and psychological and behavioral controls. Sexual risk taking was assessed by using a composite measure of the number of sexual partners, the consistency of contraceptive use, and the effectiveness of contraceptive method. The sample of 350 primarily White ninth- to 12th-grade students was drawn from a population of 2,257 junior and high school students who were surveyed as part of a larger study. Logistic regression analysis revealed gender differences in the effect of parents' behaviors on the sexual risk taking of their sons and daughters. An interaction effect was observed between parental communication about sexual issues and perceived parental support for males only. For females, parental psychological control increased the odds that a sexually active daughter would take more sexual risks. In addition, parental monitoring significantly decreased the odds that sexually active male and female adolescents would be high risk takers.

Key Words: adolescents, gender differences, parenting, sexual activity.

In the past two decades researchers have examined sexual behaviors and attitudes of adolescents from a variety of theoretical perspectives (Christopher & Roosa, 1991; Miller & Fox, 1987). They have considered biological, psychological, and social factors in an attempt to explain the initiation of coitus and the use or failure to use contraception in the adolescent population. A review of the literature on adolescent sexuality (Miller & Moore, 1990) uncovered few studies that have focused specifically on the relation between parenting behaviors and teen sexual behaviors and attitudes. Parent-child communication about sexuality has most commonly been examined as a possible cause of teen sexual initiation but with inconclusive results (Fisher, 1989; Fox & Inazu, 1980; Moore, Peterson, & Furstenberg, 1986; Newcomer & Udry, 1985). Parental control (Miller, McCoy, Olson, & Wallace, 1986) and parental attitudes about premarital sex (Herold, 1981; Nathanson & Becker, 1986; Zabin, Stark, & Emerson, 1991) also have been examined. Parental monitoring has been less frequently considered (Miller et al., 1986; Moore et al., 1986; Small & Luster, 1994), as has the overall quality of the parent-child relationship (Crouter, Carson, Vicary, & Butler, 1988; Fox, 1980; Weinstein & Thornton, 1989).

The consequences of high-risk sexual behavior undoubtedly can be negative and lifelong. Well documented are the economic and educational implications of adolescent parenting for both adolescent and offspring (Hofferth, 1987; Maynard, 1996). Increasingly liberal attitudes about premarital sex are reflected in the fact that teens are far
more likely to engage in sexual intercourse before finishing high school than they were a decade ago (Maticka-Tyndale, 1991). In fact, by the time they graduate from high school, the majority of American teens report that they are sexually experienced (Newcomer & Baldwin, 1992). Pregnancy rates have continued to grow steadily among teens since the late 1980s. Between 1986 and 1991 the rate of births among teens aged 15–19 rose 24% (Moore, the late 1980s. Between 1986 and 1991 the rate of births among teens aged 15–19 rose 24% (Moore, 1994). Nearly 1 in 12 teens will become pregnant each year, and half of these pregnancies will result in live births (Trussell, 1988). In addition, high levels of unprotected sexual activity put adolescents at risk of contracting AIDS or other sexually transmitted diseases (Bingham, 1989; Moore & Rosenthal, 1991; Newcomer & Baldwin, 1992).

Given these trends, it is time for researchers to reconsider the “problem” of adolescent sexual behavior. Rather than continue to examine factors associated with sexual initiation, perhaps the more urgent question is: What factors will help sexually active adolescents make responsible sexual choices? This study reframes the problem by changing the question from why adolescents become sexually active to why some sexually active teens demonstrate low-risk sexual behaviors and others do not. In pursuing this issue, I address parenting behaviors related to sexual risk-taking behavior among sexually active adolescents. Parenting processes of interest are communication about sexually related issues, perceived parental support, and behavioral and psychological controls, such as monitoring teens’ behavior and allowing teens independence and autonomy.

Research into adolescent sexuality has focused overwhelmingly on the mother-daughter relationship and has paid less attention to the practices of mothers and fathers or the attitudes and sexual behavior of adolescent males. Because the socialization processes for males and females differ, I consider the gender differences of adolescent males and females and the behaviors of mothers and fathers. Unlike other research, this study uses a composite measure of sexual risk taking that includes the measurement of the number of sexual partners and the frequency of use and type of contraceptive used for prevention of pregnancy or HIV or both. Researchers typically have not addressed sexual risk-taking behavior as it is conceptualized in this article. Luster and Small (1994) are one exception. Therefore, I draw the arguments presented here primarily from literature on parental influence on adolescent sexual initiation and contraceptive use.

### Parental Communication

Research that has examined the relation between parent-child communication and adolescent sexual behavior has revealed inconsistent findings (Furstenberg, Herceg-Baron, Shea, & Webb, 1984; Newcomer & Udry, 1985). Newcomer and Udry found that neither mothers’ communication nor their attitudes about premarital sex and birth control were significantly related to their daughters’ use of contraception. In contrast, Fox and Inazu (1980) found that daughters who communicated with their mothers about sexual matters were also more likely than nondiscussants to delay their sexual experimentation and reported that they would use birth control, would know what to say to their date about contraception if they decided to engage in sexual intercourse, and were less likely to view contraception as the male’s responsibility. Other research suggests that increased mother-daughter communication may follow contraceptive behavior (Furstenberg et al., 1984). More recent research has found a relation between mother-daughter discussion about contraception and the likelihood that a sexually active adolescent female would have one partner only with whom she consistently used contraception (Luster & Small, 1994).

These findings are consistent with sexual socialization theory, which suggests that adolescents who talk with their parents about sexual issues will be able to form judgments about their sexual behavior. Teens who communicate with their parents about sexual issues are likely to know parental expectations regarding sexual responsibility, as well as specific ways to minimize sexual risks (e.g., contraception, monogamy).

Hypothesis 1: Sexually active teens who talk with their parents about sexually related issues are less likely to demonstrate high-risk sexual behavior, compared with teens who do not communicate with their parents about such issues.

### Parental Support

Research suggests that parental support plays a role in the sexual risk-taking behaviors of adolescent females. An open and supportive mother-daughter relationship has been found to predict the delay of coitus, the likelihood that an adolescent female will not experience multiple pregnancies, and the likelihood that daughters will discuss
sexual matters with their mother (Fox, 1980; Fox & Inazu, 1980; Gispert, Brinich, Wheeler, & Krieger, 1984). Thus, the mother-daughter bond may moderate the effect of communication on sexually risky behaviors. Other research has found that sexually active male and female adolescents who took risks (i.e., had multiple partners and failed to use contraception consistently) perceived their parents as less supportive than their lower-risk peers who consistently used birth control within a monogamous relationship (Luster & Small, 1994).

The research findings on parental support and sexual behavior fit with Hirshi’s (1969) control theory. Applied to this context, control theory suggests that the parent-child bond creates an atmosphere in which parents’ views of adolescent sexual behavior, expressed directly or indirectly, may be internalized by the adolescent and may, therefore, play a protective role by encouraging sexually active teens to minimize their sexual risk. Empirical research and sexual socialization and control theories suggest the following hypotheses:

Hypothesis 2: Sexually active teens who have a supportive parental relationship are less likely to demonstrate high-risk sexual behavior, compared with teens who perceive the relationship with their parents as non-supportive.

Hypothesis 3: Having a supportive parent-child relationship will enhance the effect of communication on low-risk sexual behavior.

PARENTAL BEHAVIORAL CONTROL

Several studies have considered the relation of parental monitoring and adolescent sexual intercourse but with contradictory findings. Moore et al. (1986) found no significant relation between parental monitoring and adolescent sexual activity for males or females. Parental monitoring was determined by the proportion of the adolescent’s friends whom parents knew. Miller et al. (1986) found a curvilinear relation between perceived parental strictness about dating behaviors and adolescent sexual involvement. Two studies using a more inclusive parental monitoring scale revealed a strong relation between parents’ knowledge of their teens’ whereabouts (reported by teens) and adolescent sexual initiation and lower risk-taking behavior of sexually active females (Luster & Small, 1994; Small & Luster, 1994). Females who were less closely monitored by their parents were significantly more likely to have multiple sexual partners and to use contraception inconsistently. Among Black adolescent males, perceived parental strictness was associated with less frequent sexual intercourse, fewer sexual partners, and more consistent condom use. Males who perceived that their mother was stricter had sexual intercourse less often and had fewer sexual partners. This relationship held, even when religiosity and socioeconomic status were controlled (Jemmott & Jemmott, 1992).

Few, if any, studies that have examined the relation between parental behavioral control and adolescent sexual behavior have considered the moderating effect of the closeness of the parent-child relationship. Adolescents with a close relationship characterized by support, warmth, trust, and respect may be more likely than their peers with distant parental relationships to internalize their parents’ concerns and control efforts (Hirschi, 1969) and may view parental monitoring (behavioral control) as an act of caring, rather than an act of distrust or intrusiveness. A close parent-child relationship may foster adolescents’ willingness to consider parental wishes and concerns when they begin to make decisions and choices about their sexual behavior.

Hypothesis 4: Adolescents who are not closely monitored by their parents will be more likely to demonstrate high-risk sexual behaviors than teens who are closely monitored.

Hypothesis 5: A supportive parent-child relationship will enhance the effect of monitoring on risky sexual behavior.

PARENTAL PSYCHOLOGICAL CONTROL

A large body of literature suggests that children whose parents encourage autonomous thinking and self-discovery are more likely to develop psychological and social competence (Baumrind 1975, 1989; Maccoby & Martin, 1983). In contrast, excessive psychological control or lack of psychological autonomy may stifle the processes of social and psychological maturation that are necessary for adolescents to make responsible choices about their behaviors. Thus, adolescents whose parents use excessive psychological control may be less likely to demonstrate internalized moral reasoning (Hoffman, 1970, 1975).
Socialization theory suggests that allowing autonomy can promote responsible and moral decision making, whereas psychological control—such as instilling anxiety, controlling through guilt, or withdrawing love—fails to promote maturity or responsibility for one’s actions. It can be argued that the decision to become involved in a monogamous relationship and to use consistent and effective contraception indicates psychosocial maturity or the ability to foresee the potential consequences of one’s behavior and an adherence to a moral decision (i.e., to behave in a sexually responsible manner). Adolescents whose parents use excessive psychological control may be less likely to demonstrate internalized moral reasoning and, as a consequence, may fail to consider the consequences of their sexual choices and behaviors for themselves and their sexual partner. In contrast, teens whose parents have allowed them psychological autonomy may be more likely to demonstrate responsible sexual behaviors (i.e., to commit to a monogamous relationship and to use consistent and effective contraception).

Barber (1992) has proposed that specific types of parental control more strongly relate to particular types of adolescent problem behaviors. He distinguished internalized behavior problems (e.g., psychological problems like depression) from externalized behavior problems (e.g., substance abuse, sexual precocity) and linked them with Steinberg’s (1990) classification of behavioral control and psychological autonomy. Both psychological and behavioral control are likely to be related to internalized and externalized problem behaviors, but Barber posited that psychological control is most strongly related to internalized behaviors such as depression, suicide, or low self-esteem. This proposition may fit the simple behavioral outcome of sexual initiation, but it may be less true when considering the more complex construct of sexual responsibility. I argue here that teens who are allowed psychological autonomy develop the psychological maturity and moral internalization necessary to make mature sexual decisions and to demonstrate low-risk sexual behavior. This argument suggests that parents’ psychological control may be a factor equal to, if not stronger than, behavioral control in predicting sexual risk-taking behavior among adolescents. These arguments lead to the following hypotheses:

Hypothesis 6: Adolescents whose parents use a high degree of psychological control are more likely to demonstrate sexual risk-taking behaviors than teens whose parents utilize a low degree of psychological control.

Hypothesis 7: Parental psychological control will be equally or more strongly related to adolescent sexual risk-taking behavior than parental behavioral control.

METHODS

Population and Sample

The data were derived from a larger community-based research project that assessed the needs, attitudes, and behaviors of adolescents. Seven schools in two counties in a northern Midwestern state participated in the study, representing 94% of all teens enrolled in these schools. Ninety-nine percent of all students present on the day the survey was administered are included in the sample. During a standard classroom period, trained data collectors surveyed 2,257 students in grades 6–12. A sample of 375 students in grades 9–12, who reported that they voluntarily had had sexual intercourse and that they resided with two parents (either biological, adoptive, or in a blended family) was selected for the study presented here.

The sample was fairly evenly divided by gender (49% male, 51% female). The majority of teens lived with two parents (74%, i.e., either biological or adoptive) or in a blended family (26%, i.e., with a parent and stepparent). The sample was primarily White (93%). Thirty-eight percent of the parents had obtained a high school degree as their highest level of education, and 3% had advanced only as far as elementary or junior high school. Twenty-three percent of the parents had some schooling after high school but did not earn a degree, 11% had graduated from a 2-year technical college, 13% had earned a degree from a 4-year university, and 9% had some postgraduate schooling or had earned postgraduate degrees. Three percent of the students responded that they did not know their parents’ highest level of education.

Over half (63%) of mothers held full-time jobs outside of the home, 17% worked part-time, and 13% were homemakers. Seven percent of mothers were either unemployed, retired or disabled, or full-time students. The majority (81%) of fathers held full-time jobs, 6% worked part-time, and 2% were unemployed. Ten percent of the fathers were either homemakers, retired or disabled, or full-time students.
**Measurement**

Ideally, the most responsible behavior of a sexually active adolescent would include the consistent use of an effective form of contraception within the context of a monogamous or committed relationship. The outcome measure, sexual risk taking, is operationalized as a composite of several behaviors associated with adolescent sexual intercourse: the number of sexual partners, the type of contraception used, and the frequency of contraceptive use. Sexually active teens are classified into two groups, low risk and high risk, based on the following measurement criteria.

**Monogamy.** Monogamy is assessed by a one-item measure that asks participants how many different sexual partners they had in the past year. Responses range from 1 *I have not had sexual intercourse in the past year* to 6 *sexual partners*. Participants who had one or fewer sexual partners in the past year were classified in the low-risk group. This classification is based on the knowledge that the risk of contracting a sexually transmitted disease, including AIDS or HIV, increases substantially with more sexual partners (Centers for Disease Control, 1991).

**Contraceptive use.** Studies of adolescent contraceptive use typically measure either the consistency of contraceptive use or the type of contraceptive method used (Whitely & Schofield, 1985–1986). Measurement of the consistency of contraceptive use alone does not take into consideration a particular method’s probability of failing to prevent pregnancy or sexually transmitted diseases. Likewise, the measurement of method effectiveness alone does not provide information about the consistency of use. In an attempt to overcome these methodological shortcomings, this study separately operationalizes both consistent and effective use of contraception. In addition, a distinction is made between the use of contraception for preventing pregnancy and for preventing HIV.

To assess the consistent use of contraception, participants were asked, “If you have had sexual intercourse, how often do you and/or your partner use some form of birth control?” Responses range from *always* (0) to *never* (5). Students who answered that they were in a monogamous relationship, were using an effective contraceptive method to prevent pregnancy, were using this contraception always or most of the time, or were using a condom to prevent AIDS, HIV, or other sexually transmitted diseases. Members of this group were given a score of 0. Teens who did not meet these criteria were classified as high risk takers and were given a score of 1.

**Parental support.** Parental support is assessed by a six-item measure of adolescents’ perception of their relationship with each parent (e.g., “my mother is there when I need her,” “my father respects me and what I have to say”). Responses ranged from 0 (*never*) to 4 (*always*) and are summed to create a continuous score for mothers and fathers separately. The measure is adapted from Armsden and Greenberg’s (1987) Parent-Adolescent Attachment Inventory and has been employed successfully by Small and Luster (1994). Higher scores represent a higher level of perceived parental support (Cronbach’s alpha = .93 for mothers and fathers together, .89 for mothers only, .93 for fathers only).

**Parent-child communication.** Communication is measured with several items that ascertain the frequency with which teens have had a “good” talk in the past year with each parent about sexually related issues. Items relevant to this analysis are: discussions about whether or not it’s okay for teenagers to have sex, birth control, and the dangers or risks of getting AIDS, HIV, or other sexually transmitted diseases. Responses ranged from the respondents (Pollack, 1992; Trussell, Hatcher, Cates, Stewart, & Kost, 1990).

Contraception effectiveness was assessed with two single-item measures. The first measure asked respondents, “The last time you had sexual intercourse, what did you use to prevent pregnancy?” Students who answered that they used birth control pills, condoms, condoms and another type of contraception, Norplant, or Depo-Provera were classified in the low-risk group. Students who answered that they used no method, withdrawal, or other were classified in the high-risk group. The second measure of contraceptive effectiveness specifically asked if participants or their partners used a condom to prevent the contraction of AIDS, HIV, or other sexually transmitted diseases the last time they had sexual intercourse. Positive responses were classified in the low-risk group. Thus, the low-risk group comprises teens who reported that they were in a monogamous relationship, were using an effective contraceptive method to prevent pregnancy, were using this contraception always or most of the time, or were using a condom to prevent AIDS, HIV, or other sexually transmitted diseases. Members of this group were given a score of 0. Teens who did not meet these criteria were classified as high risk takers and were given a score of 1.
0 (never) to 4 (very often) and are summed for mothers and fathers separately. Higher scores indicate more frequent discussions about these issues (Cronbach’s alpha = .84 for mothers and fathers together, .83 for mothers only, .87 for fathers only).

**Behavioral control.** Behavioral control is assessed by Small’s (Small & Kern, 1993; Small & Luster, 1994) nine-item parental monitoring scale. This scale measures the degree to which parents know where their teens are and what they are doing (e.g., “I talk to my parents about the plans I have with my friends,” “if I’m going to be home late, I’m expected to call my parents and let them know”). Responses ranged from 0 (never) to 4 (always). Higher scores indicate a higher degree of parental monitoring (Cronbach’s alpha = .87).

**Psychological control.** Psychological control is assessed with a five-item subscale (control through guilt) of the Child’s Report of Parental Behavior Inventory (Schaefer, 1965), which assesses adolescents’ perception of their parents’ use of guilt as a controlling mechanism. Responses are reverse scored so that higher scores indicate higher psychological control (the absence of autonomy). Lower scores indicate lower psychological control and the allowance for autonomous thought and action (Cronbach’s alpha = .83 for mothers and fathers together, .71 for mothers only, .79 for fathers only).

**Age.** Student’s age has been associated with the use of contraception. Zabin, Kanter, and Zelnick (1979) found that younger teens who are sexually active are less likely than older teens to use contraception at sexual initiation. Age is also a factor that is likely to be associated with parental control. Because age has the potential of being associated with both the outcome variable and at least one predictor variable, it is controlled in the multivariate analyses.

**ANALYSES AND RESULTS**

**Sexual Risk Taking for Males and Females**

All teens in the sample reported having had sexual intercourse at least once. Most sexually active students in this study had sexual relations with one partner only (56%). Seven percent had five or more sexual partners. More than half of students reported they always use contraception (56%), and 12% use contraception most of the time. In contrast, about one in five (23%) teens reported they never or rarely use birth control. Use of condoms alone was the most common form of contraception for the prevention of pregnancy (47%), followed by oral contraceptives (14%). More females than males reported the use of oral contraceptives (20% females vs. 9% males). Nine percent of sexually active teens in the sample use withdrawal as their primary form of protection against pregnancy, and 18% use no method of contraception against pregnancy. More than half (57%) of sexually active teens in this sample reported that at last time of intercourse they used a condom for protection against AIDS, HIV, or other sexually transmitted diseases.

Forty percent of the sample (151 students) was classified in the low-risk group of teens who were in a monogamous relationship, who used an effective contraceptive method to prevent pregnancy, who used this contraception always or most of the time, or who used a condom to prevent AIDS, HIV, or other sexually transmitted diseases. (See Table 1.)

No teens met the most stringent criteria (i.e., were involved in a monogamous sexual relationship, used contraception consistently, used effective contraception to prevent pregnancy, and used a condom as protection from AIDS, HIV, or other sexually transmitted diseases). Low-risk teens

| TABLE 1. SEXUAL RISK-TAKING BEHAVIORS OF LOW- AND HIGH-RISK ADOLESCENTS (BY PERCENTAGE) |
|-------------------------------------------------|---------------------------------|---------------------------------|
| Risk-Taking Variable                          | Low Risk Takers (n = 151)       | High Risk Takers (n = 224)      |
| Number of sexual partners in past year        |                                  |                                 |
| One or fewer                                   | 100                             | 32                              |
| Multiple                                       | —                               | 68                              |
| Consistency of contraceptive use               |                                  |                                 |
| Always–most of time                            | 100                             | 47                              |
| Half the time–never                            | —                               | 53                              |
| Contraception for pregnancy prevention        |                                  |                                 |
| Effective method (Depo-Provera, Norplant, oral contraceptives, condoms alone or with other method) | 97                              | 56                              |
| No effective method (withdrawal, other, no method) | 3                               | 44                              |
| Condoms for HIV prevention                    |                                  |                                 |
| Yes                                            | 78                              | 42                              |
| No                                             | 22                              | 58                              |

This content downloaded from 134.121.167.110 on Wed, 13 Dec 2017 20:22:03 UTC
All use subject to http://about.jstor.org/terms
who were monogamous and consistently used contraception reported that they used either an effective method against pregnancy or a condom to prevent AIDS, HIV, or other sexually transmitted diseases. This suggests that teens in a monogamous or committed relationship may be reluctant to view their contraceptive methods as protection from AIDS, HIV, or sexually transmitted diseases. In a steady relationship, they do not appear to view AIDS, HIV, or sexually transmitted diseases as concerns. Mean scores of the independent variables are provided in Table 2.

**Logistic Regression Analyses**

A logistic regression was run for males and females separately to assess the contribution of each of the four variables as predictors of sexual risk taking. Student's age was controlled for by entering it first in the logistic regression. This was followed by the main-effect predictor variables, which were entered as a block. The interaction variables, parental support by parental monitoring and parental support by parental communication, were entered in the third step of the regression analysis. The low-risk group was scored zero, and the high-risk group was scored 1. Because age was not significant for males or females, it was dropped from the model. The logistic regression analyses then were repeated, omitting age as a variable.

For males, a significant main effect was revealed for parental monitoring. (See Table 3.) Sexually active males who were closely monitored by their parents were more likely than their peers who were not well monitored by their parents to demonstrate low-risk sexual behaviors (i.e., be in a monogamous relationship, always use contraception, and use an effective method of contraception against pregnancy or disease). For each unit increase in parental monitoring, the odds of being classified in the low-risk group multiplied by .48. In other words, a sexually active adolescent male is nearly half as likely to exhibit high-risk sexual behavior for each unit increase in parental monitoring. The interaction of parental support by parental monitoring was not significant at the .05 level. However, the interaction of parental support and communication was significant, $p < .01$, $\chi^2 = 13.75$, $df = 4$, $p < .01$, $n = 185$.

To understand the interaction of parental support and communication with males’ sexual risks, I created four categories of parental support and communication using a median split: (a) high support-high communication, (b) high support-low communication, (c) low support-high communication, and (d) low support-low communication. A cross-tabulation of parents’ support-communication by risk group revealed that sexually active sons who perceived low parental support but who communicated about sexual issues with either parent

---

**Table 2. Mean Scores of Independent Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Females ($n = 189$)</th>
<th></th>
<th>Males ($n = 183$)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Minimum</td>
<td>Maximum</td>
</tr>
<tr>
<td>Age</td>
<td>16.13</td>
<td>1.04</td>
<td>13.00</td>
<td>18.00</td>
</tr>
<tr>
<td>Parental communication</td>
<td>5.69</td>
<td>4.83</td>
<td>.00</td>
<td>20.00</td>
</tr>
<tr>
<td>Parental monitoring</td>
<td>2.83</td>
<td>.65</td>
<td>.33</td>
<td>4.00</td>
</tr>
<tr>
<td>Parental psychological control</td>
<td>1.36</td>
<td>.92</td>
<td>.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Parental support</td>
<td>7.65</td>
<td>4.60</td>
<td>.00</td>
<td>16.00</td>
</tr>
</tbody>
</table>

---

**Table 3. Logistic Regression Model of the Probability of Adolescent Sexual Risk Taking**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>Exp (B)</td>
<td>B</td>
</tr>
<tr>
<td>Parental communication</td>
<td>.05</td>
<td>.03</td>
<td>1.05</td>
<td>-.04</td>
</tr>
<tr>
<td>Parental monitoring</td>
<td>-.73**</td>
<td>.24</td>
<td>.48</td>
<td>-.69**</td>
</tr>
<tr>
<td>Parental psychological control</td>
<td>.05</td>
<td>.18</td>
<td>1.05</td>
<td>.54**</td>
</tr>
<tr>
<td>Parental support</td>
<td>.03</td>
<td>.04</td>
<td>1.03</td>
<td>.00</td>
</tr>
<tr>
<td>Parental support $\times$ parental monitoring</td>
<td>.03</td>
<td>.04</td>
<td>1.03</td>
<td>.04</td>
</tr>
<tr>
<td>Parental support $\times$ parental communication</td>
<td>-.03**</td>
<td>.01</td>
<td>.97</td>
<td>.01</td>
</tr>
<tr>
<td>$-2$ log likelihood</td>
<td>230.70</td>
<td></td>
<td></td>
<td>239.21</td>
</tr>
<tr>
<td>Logistic regression $\chi^2$</td>
<td>13.75**</td>
<td></td>
<td></td>
<td>18.92***</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$. 

This content downloaded from 134.121.167.110 on Wed, 13 Dec 2017 20:22:03 UTC All use subject to http://about.jstor.org/terms
were most likely to report high-risk sexual behaviors (84%), compared with their peers who discussed sexual issues with their parents whom they perceived as supportive (55%) or who did not discuss sexual issues with parents whom they perceived as supportive (56%) or unsupportive (58%).

For females, significant main effects were revealed for parental monitoring and parental psychological control. (See Table 3.) Close parental monitoring of sexually active daughters significantly increased the odds that they would be classified in the low-risk group. A 1-unit decrease in parental monitoring for females multiplied the odds by .50 that a sexually active female would be classified in the high-risk group. Sexually active daughters who perceived their parents as more psychologically controlling were more likely to demonstrate high-risk sexual behavior than their counterparts who perceived their parents as less psychologically controlling. For each unit increase in parental psychological control, the odds of high-risk behavior are multiplied by about 1.5 times for sexually active females. None of the interactions was significant for females, $\chi^2 = 18.92$, $df = 4$, $p < .01$, $n = 189$.

Socialization literature suggests that mothers and fathers tend to use different parenting strategies with their offspring. Mothers are more likely than fathers to use an authoritative style of parenting, which includes support and the allowance of child autonomy. In contrast, fathers are more likely to take an authoritarian approach to childrearing (Maccoby & Martin, 1983). To understand the significant relation between daughters’ sexual risk taking and parental psychological control, the logistic regression model was repeated, but fathers’ and mothers’ psychological control were entered separately. This analysis was possible because the psychological control variable measured adolescent perceptions of mothers and fathers individually. The logistic regression model for mothers’ and fathers’ psychological control revealed a significant relation between daughters’ sexual risk taking and fathers’ psychological control, $p = .02$, $B = .86$, $SE = .36$, $Exp(B) = 2.36$, but not mothers’ psychological control, $B = .17$, $SE = .37$, $Exp(B) = 1.19$. Sexually active daughters who perceived their father to be more psychologically controlling were more likely to demonstrate high-risk sexual behavior than their counterparts who perceived their father as less psychologically controlling, $\chi^2 = 10.76$, $df = 2$, $p < .01$, $n = 189$.

**DISCUSSION**

Results of the logistic regression analyses supported, in part or wholly, four of the seven proposed hypotheses. Age was not significantly related to the outcome variable. This is most likely due to the low number of sexually active early adolescents in this sample. (Only 26 students were 14 years old or younger.)

Although parental communication about sexual matters and parental support were not directly associated with sexual risk taking, an interaction effect between parental support and communication was revealed for sexually active adolescent males. Closer examination of this interaction, however, indicates that the significant effect was due to the large proportion of high-risk sexually active males who discussed sexual issues with a parent whom they perceived as unsupportive (84%). This finding was contrary to what was expected. It is possible that the dynamics of a poor or nonsupportive parent-child relationship may inhibit the mutual exchange or understanding of ideas or concerns about sexuality. Sexually active sons who lack a supportive parental relationship may be more likely to reject or ignore information or concerns expressed by a parent.

Hypothesis 4 was supported. Sexually active adolescent males and females who have parents who monitor them (behavioral control) are more likely to minimize their sexual risks than their peers who have parents who monitor them less. This is consistent with the findings of Jemmott and Jemmott (1992) that sexually active Black males who reported high levels of behavioral control by their parents were more likely to use condoms consistently and have fewer sexual partners than their peers who reported low levels of behavioral control by their parents. This finding is an extension of Jemmott and Jemmott’s research.

Contrary to Hypothesis 5, parental support did not enhance the effect of monitoring in the logistic regression model. The findings indicate that parental monitoring can be a protective process, independent of parental support. It is possible that parental monitoring (e.g., knowing where and with whom your teen is and what he or she is doing) conveys to teens that parents care and are concerned. Sexually active teens who are closely monitored may reciprocate perceived caring and concern by behaving in ways that will minimize their sexual risk and their parents’ worries about their behavior. Alternatively, parental monitoring may prevent high-risk sexual behaviors by regul-
ing the number of suitors and potential sexual partners, as well as the number of situations that could lead to or facilitate sexual intercourse.

Hypothesis 6 was supported by the logistic regression for females only. A high degree of psychological control (control through guilt) by parents increases the odds that a sexually active daughter will demonstrate high-risk sexual behavior. In addition, fathers’ psychological control appears to be more important than mothers’ psychological control. The data suggest that daughters who have been given the opportunity for autonomous thought by parents have a higher likelihood of developing the psychological maturity and internalized moral reasoning necessary to make mature sexual decisions and to demonstrate low-risk sexual behavior. In contrast, sexually active daughters who are controlled by their parents through guilt may lack the moral internalization necessary for making sexually responsible decisions that will minimize their health risks and the health risks of their partner. The findings suggest that fathers, in particular, play an important and indirect role in helping their daughters make sound decisions about their bodies and their sexual involvement. By providing the opportunity for autonomous psychological development, fathers can help prepare their daughters for making good decisions about their sexuality and, potentially, their future.

Hypothesis 7, the examination of the strength of association of psychological and behavioral control with sexual risk taking, was intended to test the proposal of Barber (1992) that behavioral parental controls are more strongly related to externalized behaviors of adolescents, such as sexual precocity or the use of alcohol. This hypothesis was supported for daughters only. The analysis revealed a stronger relation between daughters’ sexual risk taking and parents’ psychological control than between daughters’ sexual risk taking and parents’ behavioral control. In contrast, the sexual risk taking of sons was significantly related to behavioral control by parents (parental monitoring) but was not related to parents’ psychological control.

For sexually active females, sexual intimacy may be an internalized process. For males, the decision to engage in sexual relations may be more externalized. This is consistent with the literature that describes gender differences in sexual intention and intimacy. Females are more likely than males to equate emotional commitment or love to sexual intimacy and are less likely to have multiple sexual partners (Maticka-Tyndale, 1991; Miller & Simon, 1980). Females also are more likely than males to bear the financial or emotional costs of unintended pregnancies and may be more likely to view their sexual behavior in terms of the consequences for themselves and their future. Males, on the other hand, may be more influenced by external factors, such as peer pressure to engage in sexual intercourse. The prevalence of the sexual double standard also may contribute to the sexual behavior of males.

The distinction between male and female attitudes about sexual intimacy may help explain the findings regarding externalized and internalized parental controls (i.e., behavioral and psychological control). Because of the external factors of peer pressure or the sexual double standard, adolescent males may experience sexual involvement as more of an externalized event and may, therefore, be more receptive to behavioral control by their parents (external control). Females, on the other hand, are more likely to regard sexual and emotional intimacy as a form of caring that results in the integration of identity and intimacy (Gilligan, 1992). Consequently, females may be more affected by psychological control by their parents because sexual relations represent an emotional connection with others (i.e., sex is an internalized event). The results from this study indicate that parental monitoring, autonomy giving, and parental communication within the context of a supportive relationship can be positive forces in the lives of sexually active adolescent males and females. Parental monitoring is strongly associated with low-risk sexual behavior among sexually active teens. Parents who know where and with whom their adolescent is and what their adolescent is doing may be instrumental in helping their child avoid situations that could put them at sexual risk. Parental monitoring may also act as a protection against sexually risky behavior because parents have the power to limit the number of potential sexual partners.

Teaching parents about the importance of parental monitoring and how they can monitor without being intrusive is one way to ensure low-risk sexual behavior among sexually active teens. Communities also might assist families in this effort by providing places or organizations where teens can socialize and feel a part of the community while under adult supervision. Youth centers or clubs provide safe environments and opportunities to interact with peers and nonparental adults.
Mothers are most likely to provide direct sexual socialization through communication with their adolescent, but the study presented here indicates that both parents play an important, albeit indirect, role in the sexual socialization of their daughters. Future efforts to try to involve both parents in the sexual socialization of daughters should focus on helping fathers and mothers understand the importance of fostering psychological autonomy in their children and should provide concrete strategies for doing this. For example, educators working with parents might role play to emphasize the subtle difference between control through guilt and the use of other-oriented induction, which helps children understand the consequences of their behavior. Additionally, educators could provide strategies for effective communication that builds confidence and encourages problem solving.

This study examines several parenting processes associated with the sexual risk taking of adolescent males and females. It adds to the existing literature on parenting and adolescent sexual behaviors by examining both psychological and behavioral processes of control, by analyzing sons and daughters separately, and by reframing the problem of adolescent sexual behavior from factors related to sexual initiation to factors associated with reducing sexually risky behavior among sexually active teens.

This study is not without shortcomings. The sample of primarily White adolescents who reside in fairly well-educated two-parent families is limited in its generalizability. Socialization literature suggests that parenting strategies are likely to differ by social class and culture (Maccoby & Martin, 1983). Thus, it is reasonable to presume that the parental processes examined in this study might differ by socioeconomic status and race. Future research might expand on the findings by examining parental processes in ethnic minorities and low-income families and by examining the parenting behavior of mothers and fathers separately. Because the sample includes only sexually active adolescents, reported significant results may be spurious to the extent that unmeasured factors related to an adolescent having sex are also tied to risk taking. The limitations of the study do not negate the findings but, rather, are reminders to not overgeneralize the results. Within these parameters, the data have extended our understanding of the processes of parental control and gender differences for the sexual socialization of males and females, the role of parental support, and the relationship between communication about sexually related issues and sexual risk-taking behaviors among sexually active adolescents.

REFERENCES


