The Role of Religiosity in Adolescent and Young Adult Sexual Behavior

Adolescence is a period of different transitions accompanied by many challenges. In addition to physical, cognitive and emotional changes in development, one of the greatest challenges adolescents face is dealing with their sexuality (Ozer et al., 2003). As adolescents develop into young adulthood, there are new developmental goals associated with sexual maturity including learning how to communicate with partners and developing the ability to make informed decisions about sexual health (DeLamater & Friedrich, 2002). Successfully navigating through these stages is essential to the attainment and maintenance of sexual health.

Over the past decade, the trends in adolescent sexual behavior have been improving, with increased abstinence and condom use; and fewer adolescents having sex, contracting Sexually Transmitted Infections (STIs), getting pregnant and giving birth (Irwin, Burg & Cart, 2002). Similar trends are also occurring among young adults.

Adolescence and young adulthood is the period when religious conversion is most likely to take place (Smith, Faris, Denton & Regnerus, 2003) and potentially the time that desirable sexual health patterns can be established. Many religions have tenets that provide guidelines for sexual behavior. Religiosity has been identified as a protective factor against some sexual risk behaviors among adolescents and young adults. The most common finding is that religious affiliation and high church attendance negatively correlates with age of first intercourse, and number of partners (Brewster et al, 1998; O'Connor, 1998). However, little is known about the role of religion at various stages of development (Mattis & Jagers, 2001) and how religiosity

influences sexual behavior in the transition from adolescence to young adulthood. Few researchers have examined the effect of religiosity on sexual behavior over time.

The purpose of this study is to examine the role of religiosity in sexual behavior, using longitudinal data. Studies on religiosity and sexual behavior have primarily been cross-sectional studies but longitudinal studies are needed to examine the impact of religiosity and previous behavior on the promotion of future well-being, which would allow tracking of behavior and making comparisons over time (Bridges & Moore, 2002).

The primary public health prevention strategies for addressing sexual and reproductive health include practicing abstinence (primary or secondary) or limiting the number of sexual partners, using contraceptives to prevent unintended pregnancies and using condoms to prevent STIs, recommendations which are not in conflict with most religious traditions. It is hypothesized that religiosity will promote responsible sexual behavior during adolescence and young adulthood and that there will be differences by race and gender.

This study is a secondary analysis of the public use data collected from the National Longitudinal Study of Adolescent Health (Add Health). Add Health is a nationally representative, probability-based, longitudinal, school-based study of American adolescents in 7th-12th grades. The Add Health data were collected during three waves: Wave I (September 1994 through December 1995), Wave II (April 1996 through August 1996) and Wave III (August 2001 through April 2002). Waves I and II of Add Health data examine the forces that influence adolescent's behavior and Wave III explores the transition between adolescence and young adulthood.

The sample includes unmarried, sexually active respondents who were at least 15 years old at Wave I and participated in all three waves of the survey. Selected independent variables include religiosity, sexual psychosocial factors and demographic variables such as age, race, gender, family structure, and socioeconomic status. The key independent variable, religiosity, will be measured as religious affiliation, religious salience and religious participation. The dependent variable is sexual behavior, measured as number of sexual partners, contraceptive use and condom use. The relationship between age, race, gender, family structure, and socioeconomic status and sexual behavior will also be examined. In addition to descriptive statistics and bivariate analysis, multivariate logistic regression will be used to examine the relationship between religiosity and sexual behavior.