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Religious Upbringing, Family, and Sexual Education: Exploring the Factors that Impact Sexual Decision-making among African American Emerging Adults Attending a Historically Black College

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An abstract of
A thesis submitted to the Faculty of the
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Abstract

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By Anne Marie Schipani

This qualitative study explored how religious upbringing and sexual education impacted sexual decision-making among African American college students. Participants included (N=19) African American females attending a historically Black college in the Southeastern United States. Because African American young women aged 18 to 24 have increased rates of STIs, HIV, and unintended pregnancy, it is important to understand the contextual factors that contribute to young Black women's sexual decision-making. The social ecological model was used as a theoretical framework to explore the determinants of sexual decision-making, particularly focusing on sexual education and religion. Unlike past research on religion and sexual health, this study sought to explore *religious upbringing* as an emergent construct in sexual decision-making, defined as familial religious values, religious importance, engagement in religious rituals, and religion from youth to the present. Based on semi structured in-depth interviews with participants about current sexual health attitudes and behaviors, analysis revealed that family was the most influential factor in sexual decision-making as well as in sexual education and religious upbringing. Findings demonstrate that religious upbringing, specifically religious values learned from family, impact current sexual decision-making. Also, sexual education messages learned from family during youth impact current sexual decisions more than sexual education messages learned in school. Overall, findings may potentially inform future HIV prevention interventions for young Black women that address the determinants of sexual decision-making.

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Chapter I. Introduction

Background

African Americans[1] are disproportionally impacted by human immunodeficiency virus (HIV) and sexually transmitted infections (STIs) in the United States. In 2009 African Americans represented only 14% of the total population but accounted for 44% of new HIV cases, making up the largest proportion of new HIV cases across races (CDC, 2011). Rates of STIs are significantly higher among African Americans compared to Whites (CDC, 2011). Black women make up a subgroup of women vulnerable to HIV and STIs. African American women make up one of the largest subpopulations affected by HIV in the U.S. (CDC, 2011). In 2010, African American females made up only 14% of the total female population but roughly 66% of new HIV cases (CDC, 2011). Among females in 2010, rates of STIs were highest among African American women across all racial groups (CDC, 2011).

In the United States, young African American women are disproportionately affected by STI and HIV transmission (CDC, 2011). Young adults aged 18 to 25 comprise a period in development known as emerging adulthood (Arnett, 2000). Emerging adulthood is characterized by independence and noteworthy life choices, thus it is a time in life when decision-making is key (Arnett, 2000). It is also a time in which risky sexual behaviors frequently occur (Arnett, 2000; Braithwaite et al., 1998; CDC, 2011). According to surveillance data from the Centers for Disease Control and Prevention (CDC), emerging adults are at increased risk of HIV, STIs, and unintended

[1] Due to variations in the use of Black and African American in the literature, the terms Black and African American will be used interchangeably throughout this paper.

pregnancy (2011). HIV and STI transmission is especially high in African American young women. Compared to other ethnicities, African American young women aged 15 through 24 account for the highest rate of unintended pregnancy compared to other races at roughly 67% (CDC, 2011). The birth rate among African American females aged 15 through 19 is the second highest in the United States across races (CDC, 2012). Black female emerging adults are at high risk for STIs (CDC, 2011). In 2010 the highest rates of gonorrhea, syphilis, and chlamydia diagnoses among females occurred in Black females ages 15-19 and ages 20-24 (CDC, 2011). Black female emerging adults are also disproportionally affected by the HIV/AIDS epidemic. African Americans women accounted for roughly 67% of HIV diagnoses among 13-24 year olds (CDC, 2012).

Because college is a time in which emerging adults often engage in risk behaviors, Black college students are especially vulnerable to adverse outcomes in sexual health (Braithwaite et al., 1998; Davidson et al., 2008; Hayes et al., 2009). Evidence suggests that Black college students have increased susceptibility to sexually transmitted infections, HIV, and unintended pregnancy. Due to engaging in high-risk behaviors (i.e. unprotected sex and more sexual partners), African American college students are more likely to contract STIs than White college students (Braithwaite et al., 1998; Davidson et al., 2008). Thus, it is necessary to understand the factors that contribute to Black students' sexual decision-making in the college environment. Because African American females aged 18 through 24 have increased rates of HIV, sexually transmitted infections, and unintended pregnancy, it is of particular importance to understand the factors contributing to sexual decision-making among females at a historically Black college (HBC) (CDC, 2011; CDC, 2012).

Studies show that various factors contribute to sexual decision-making among college students, some of which include religion, parental upbringing, and sexual education (Haglund & Fehring, 2010; Lehr et al., 2005; Pingel et al. 2012). It has been shown that, among African American college students, higher levels of religion and spirituality are related to lower levels of sexual risk behavior such as engagement in premarital sex and unprotected sex (Boyd-Starke et al., 2011; Braithwaite et al., 1998; Thomas & Freeman, 2011). Some evidence shows that sexual education is related to decreased sexual risk behaviors among emerging adults, though little is known about sexual education in African American college students (Braithwaite, Taylor, & Braithwaite, 1998; Hayes et al., 2009; Thomas & Freeman, 2011 Haglund & Fehring, 2009; Walcott et al., 2011). Furthermore, parental sexual education during upbringing has been shown to play a role in sexual decision-making among emerging adults (Haglund & Fehring, 2010; Lehr et al., 2005; Pingel et al., 2012). This underscores the importance of understanding religion, sexual education, and family's role in sexual decision-making throughout development to better understand current sexual decision-making in college among Black college students.

However, incomplete knowledge exists on how these factors impact sexual decision-making throughout development. Research indicates that religion plays a role in college students' sexual attitudes, but only one qualitative study to date has explored the influential components of sexual decision-making in college student populations (Collins Fantasia, 2011). Furthermore, no qualitative studies have examined sexual decision-making in Black college students, underscoring the importance of understanding sexual decision-making among this population.

Problem Justification

Few studies have investigated the impact religion has on sexual decision-making within a Black college student population (Braithwaite, Taylor, & Braithwaite, 1998; Thomas & Freeman, 2011; Thompson Robinson et al., 2005). Faith-based communities play a major role in African American communities, particularly in shaping beliefs, practices, and outcomes related to health and wellbeing (Holt et al., 2012). Many HBCs were founded based on religious affiliations and still embody religious values on campus (Allen, 1992). For this reason it is important to understand how religion impacts sexual decision-making in Black college students attending HBCs, as faith-based communities play a key role in life. While various studies have examined the relationship between religiosity and spirituality and sexual decision-making, little is known about the role religiosity or spirituality during upbringing plays in current sexual decision-making.

Studies have shown that few differences exist between sexual education and current sexual attitudes and behavior in young adults, such as engagement in sexual intercourse (Haglund & Fehring, 2010; Walcott et al., 2011). While studies have addressed sexual education as a factor in sexual decision-making, little is known about the sources of sexual education that impact sexual decision-making in African American emerging adult populations (Haglund & Fehring, 2010; Jones & Biddlecom, 2011; Thomas & Freeman, 2011; Walcott et al., 2011). For this reason, insufficient understanding exists on sexual education during upbringing and its impact on current sexual decision-making in African American college students.

Many studies that examine African American college students are conducted at predominantly White institutions that have very small African American student

populations (Braithwaite, Taylor, & Braithwaite, 1998; Hayes et al., 2009; Thomas & Freeman, 2011). Studies have been conducted at HBCs examining religion and its relationship in sexual behaviors among young Black women attending a HBC though no studies to date have examined religion as a contributing factor in sexual decision-making in this population (Braithwaite, Taylor, & Braithwaite, 1998; Hayes et al., 2009; Thomas & Freeman, 2011). Additionally, little is known about religion, family, and sexual education during upbringing as factors that impact sexual decision-making among young Black women. Because they are at increased risk of unintended pregnancy, HIV, and sexually transmitted infections and college is a time in which students engage in sexual practices and explore their sexuality, it is particularly important to explore sexual decision-making among Black females attending a HBC.

Theoretical Framework

This study employs the social ecological model as a framework for understanding religious upbringing, sexual education, and familial upbringing as factors that impact sexual decision-making. The social ecological model is a multi-structural theory focusing on both individual and social environmental factors that contribute to health behaviors (CDC, 2011; Glanz, Rimer, & Viswanath, 2008; McLeroy, Bibeau, Steckler, & Glanz, 1988). These contributing factors include individual, interpersonal, institutional, community, and public policy (CDC, 2011; Glanz, Rimer, & Viswanath, 2008; McLeroy, Bibeau, Steckler, & Glanz, 1988). In this study, the social ecological model will guide understanding of the institutional and interpersonal factors, particularly focusing on religion, family, and sexual education, that impact individual level sexual decision-making.

Purpose

The purpose of this study is to explore the roles of religious upbringing, family, and sexual education during upbringing as factors impacting current sexual decision-making. Unlike past research on religion and sexual health, this study seeks to inform the definition of *religious upbringing* as a possibly important construct in sexual decision-making. Defined by familial religious values, religious importance, engagement in religious rituals, and religion from youth to the present, religious upbringing adds a developmental perspective to the frequently cited religious constructs religiosity and spirituality. This study intends to capture religion on the institutional, interpersonal, and individual levels from youth to the present to inform the concept, religious upbringing.

Specifically, this study seeks to understand how religious upbringing, family, and sexual education impact sexual decision-making among young Black women attending a historically Black college. This study aims to contribute to the growing body of religion and sexual health literature by providing understanding of factors that contribute to sexual decisions and risk behaviors. The larger goal is to contribute to the body of research on HIV-related health disparities as well as public health HIV prevention efforts to reduce disparities among the African American emerging adult population.

Research Questions

1. What is the role of religious upbringing in current sexual decision-making?
    a. How do institutional-level factors in religious upbringing (e.g. youth religion, religious description, youth spirituality, adult religion, adult spirituality, religious rituals, religious importance) impact current sexual decision-making?
    b. How do interpersonal-level factors in religious upbringing (e.g. religious upbringing, familial upbringing, religious rituals, religious importance, religious upbringing and sexual health, etc.) impact current sexual decision-making?
    c. How do individual-level factors in religious upbringing (e.g. religious autonomy, adult spirituality, etc.) impact current sexual decision-making?

2. What is the role of sexual education in current sexual decision-making?
    a. How do institutional-level factors in sexual education (e.g. youth sexual education, adult sexual education, etc.) impact current sexual decision-making?
    b. How do interpersonal-level factors in sexual education (e.g. youth sexual information from family, youth sexual information from peers) impact current sexual decision-making?
    c. How do individual-level factors in sexual education (e.g. information-seeking behavior) impact current sexual decision-making?

Chapter II. Literature Review

Introduction

African American young women are at high risk of transmitting HIV and sexually transmitted infections and unintended pregnancy. African American college students specifically are at increased sexual risk. Various factors contribute to sexual decision-making among college students, some of which include religion, parental upbringing, and sexual education. It is of particular importance to understand the contributing factors to sexual decision-making among young Black women at a historically Black college. Thus, this study will explore the roles of religious upbringing, family, and sexual education in sexual decision-making among young Black women enrolled in an undergraduate Bachelor's degree program.

Background & Significance

Health disparities have dramatically impacted Blacks throughout history in the United States. Both HIV and sexually transmitted infections (STIs) are highly prevalent among African Americans. Blacks have experienced a severe burden of HIV since the beginning of the epidemic (CDC, 2012). The Black population accounts for a disproportionate share of new HIV cases relative to their representation in the overall U.S. population (CDC, 2012). In 2010 African Americans accounted for 46% of all HIV diagnoses (CDC, 2012). Blacks continue to represent the largest proportion of new HIV cases racial groups (CDC, 2012). From 2007 to 2010 African Americans represented roughly 62% of new HIV diagnoses, the highest proportion of new HIV cases across all

racial groups (CDC, 2012). Blacks also account for the lowest survival rate among those living with HIV and AIDS. In 2009, Blacks accounted for roughly 29% of deaths among individuals with HIV diagnoses and 23% of deaths among those with AIDS diagnoses (CDC, 2012).

Blacks are also disproportionately impacted by STIs. According to data released by the Centers for Disease Control and Prevention, racial inequities are highly prevalent in STI rates. In 2010, rates of chlamydia, gonorrhea, and syphilis were highest in Blacks across all ethnic and racial groups (CDC, 2011). Rates of sexually transmitted infections are several times higher in Blacks compared to Whites (CDC, 2011). From 2009 to 2010 the rate of chlamydia increased 4% among Blacks, widening the gap in sexual health between Blacks and Whites (2011).

Black women make up a subpopulation that is vulnerable to STI and HIV transmission. Among women, Blacks are most likely to be diagnosed with HIV compared to Hispanics and Whites (CDC, 2012). Although they represent a small percentage of the total U.S. population, African American women represent over half of new HIV cases (CDC, 2012). In 2009, Black heterosexual women represented the fourth largest subpopulation in the United States affected by HIV (CDC, 2012). In that same year, the rate of new HIV infections among African American women was triple the rate among Hispanic/Latina women and fifteen times the rate among White women (CDC, 2012). Black women also experience high rates of sexually transmitted infections compared to non-Black women (CDC, 2011). In 2010, the rate of chlamydia among Black women was seven times the rate among White women and the rate of syphilis was twenty-one times

the rate among White women (CDC, 2011). Black women's susceptibility to STI transmission is disconcerting to public health.

Black young women make up a highly vulnerable population to sexual health inequities. Emerging adulthood represents an age group at high risk of HIV and STI transmission and unintended pregnancy (CDC, 2012). The HIV/AIDS epidemic disproportionately impacts Black young women. In 2009 Blacks aged 13 through 24 accounted for 67% of all HIV diagnoses (CDC, 2012). Thus, the growing prevalence of HIV diagnoses among women puts Black young women at particularly high risk of transmission (CDC, 2012. In 2010, the highest rates of STI diagnoses among women occurred in Black young women aged 15 through 24. In that same year, the rate of chlamydia among Black young women aged 15 through 19 was roughly seven times the rate among White young women (CDC, 2011). Similarly, rates of gonorrhea and syphilis among Black young women aged 15 through 19 were roughly 19 times and 38 times the rates among White young women respectively (CDC, 2011).

Despite overall declines in pregnancy rates, African American young women ages 15 through 24 account for the highest rates of unintended pregnancy across all racial and ethnic groups (CDC, 2012). Among 18 and 19 year old women in 2008, the pregnancy rate among Blacks was over two times the rate among Whites (2012). Additionally, birth rate among Black young women is the second highest in the United States compared to White and Hispanic young women (CDC, 2012).

Emerging adulthood represents a time in development from the late teens through the early twenties ranging from age 18 through 25 (Arnett, 2000). This time marks a

period of profound change, independence, and importance in which individuals in which most undergo education and training that will impact the course of their lives (2000). In modern society, emerging adulthood is a time in which individuals formulate and take on long-term adult roles as they explore their independence and social roles (Arnett, 2000). College is a time in which emerging adults test their independence and establish relationships, however it is also a time in which individuals engage in risk behaviors (Arnett, 2000; as cited in Braithwaite, Stephens, Taylor, & Braithwaite, 1998).

For many, college represents a transition into adulthood. With newfound independence and increased decision-making, many college students engage in unplanned sexual encounters that increase the likelihood of risky sexual behavior, such as unprotected sex (as cited in Braithwaite, Stephens, Taylor, & Braithwaite, 1998). Among college students, African Americans are at the highest risk of pregnancy, STIs and HIV across racial groups (Boyd-Starke et al., 2011; Braithwaite et al., 1998; Luquis et al., 2011; Rostosky et al., 2003). Specifically, findings suggest that Black college students are more likely to contract STIs, to engage in unprotected sex, and to have more sexual partners than White college students (Braithwaite et al., 1998; Davidson et al., 2008). Thus, Black college students have increased susceptibility to HIV, STIs and pregnancy than White college students.

Historically Black colleges and universities were founded in the 1800s and remain notable institutions in higher education to the present (Allen, 1992). Within the HBC environment, institutional services promote students' leadership skills and autonomy through a focus on mission and service. Graduation rates are higher among Black college students who graduate from HBCs than those who graduate from predominantly White

institutions (PWIs) (Fleming, 1984; Hoffman & Llagas, 2003). However, Black college students attending HBCs are at risk of STIs and HIV transmission, posing challenges to students' sexual health and development as well as their greater health and success. Among students attending a HBC, findings support the notion that STI transmission is higher among Black college students than students of other races (Braithwaite et al., 1998). Compared to young women attending a Southern private university, Davidson and colleagues found that STI transmission was higher among young women attending a HBC in the South (2008). Inconsistencies exist in the rate of STI transmission among Black college students at HBCs (Hayes et al., 2009). Evidence suggests that Black male and female college students at a Historically Black Public University engaged in greater sexual risk behavior, such as more sexual intercourse, early sexual debut, more lifetime sexual partners and increased likelihood of previous STI diagnosis, than Black college students attending a Southern predominantly White institution with religious heritage, public Midwestern university, and a public Southwestern university (Davidson et al., 2008). This evidence posits that African American college students are at increased sexual risk at HBCs than at PWIs.

Limited studies have examined the current state of sexual health among college students attending HBCs. Many studies have been conducted on college students' sexual health, however there is a small body of research on sexual health among college students at HBCs specifically. Students at HBCs require different sexual health promotion strategies than college students at traditionally White institutions (TWIs) and PWIs (Hayes et al., 2009). This is because various challenges confront historically Black campuses regarding sexual health promotion that differ significantly from those faced in

PWIs such as the disproportionately high risk of sexually transmitted infections and HIV among Black young adults (CDC, 2009). Additionally, a gender ratio imbalance exists on HBC campuses, creating small and, often overlapping, sexual networks (Ferguson, Quinn, Eng, and Sandelowski, 2006).

Barriers to condom use among Black college students include negative perceptions of condom use, living in the moment, trust, invincibility beliefs, and lack of self-control (Duncan et al., 2002). Through qualitative focus groups, Ferguson and researchers (2006) found that participants discussed the issue of sex ratio imbalance in all four focus groups conducted. The sex ratio imbalance referred to a greater proportion of female students than male students on HBC campuses. The focus group participants explained that the sex ratio imbalance creates the issues of males having more sexual partners and females agreeing with the male's condom use (or non-use) preferences, posing threats to Black young women's sexual health decisions (Ferguson et al., 2006).

However, evidence shows that Black college students attending HBCs engage in protective sexual practices (Hayes et al., 2009; Hou, 2009; Valentine, Wright, & Henley, 2003). Black college students attending HBCs had the highest rate of consistent condom use (72.4%, n=247) when compared to White college students (36.3%, n=41) and all other ethnic groups (Valentine, Wright, & Henley, 2003). Black males were more likely to use condoms than their female counterparts (2003). Additionally, studies show that college students at HBCs are more likely to use condoms during oral sex than those at PWIs (Hou, 2009). Despite safer sex behaviors among Black college students, STIs and HIV continue to disproportionately impact the Black college student population. This suggests that that sexual risk behavior may not be the sole reason for increased

susceptibility to STIs; sexual networks may heavily contribute to the disproportionate STI rate at HBCs (Hayes et al., 2009; Hou, 2009; Valentine, Wright, & Henley, 2003).

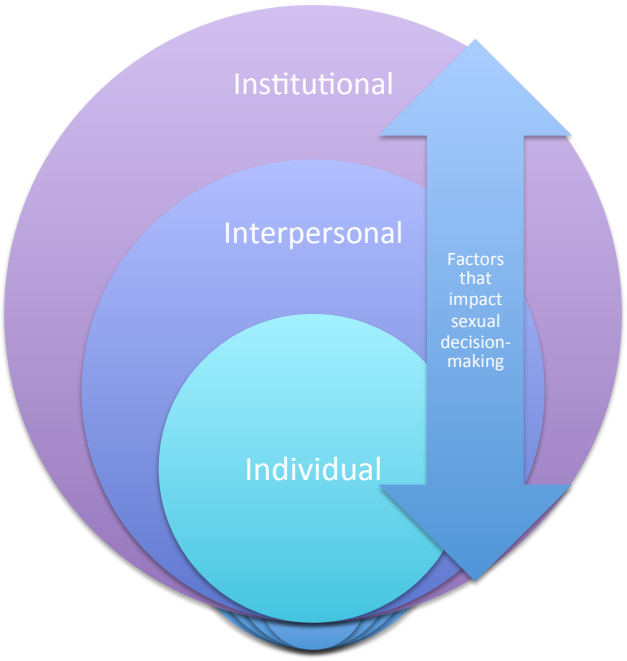
Findings indicate that Black college students attending a HBC were 4.4 times more likely to have had STIs in comparison to White PWI college students despite similar rates of condom use during vaginal and anal sex (Hou, 2009). Black women (9.4%, n=326) were more likely to report having an STI compared to men (4.3%, n=77) in the past year (Thomas & Freeman, 2011). Studies indicate that the average age of sexual debut is 16 years old among Black males (Hou, 2009; Valentine, 2003). However, Brown and researchers (2009) found that 33% of male students reported sexual debut before the age of 13. On average, women were 2.37 years older than men at age of sexual debut (Valentine et al., 2003). However, various factors have been found to contribute to sexual behavior among Black emerging adults. Specifically, religion and spirituality play a major role in current sexual behavior and attitudes among emerging adults, and more narrowly, Black college students (Boyd-Starke et al., 2011; Braithwaite et al., 1998, Thomas & Freeman, 2011).

Social Ecological Model

Borrowing from Broffenbrenner's model, the social ecological model used for health promotion is a multi-level theory that captures the individual, interpersonal, institutional, community, and public policy determinants of health behaviors (CDC, 2011; McLeroy et al., 1988). This framework provides a lens into understanding the environmental influences on health decisions (McLeroy et al., 1988). This study employs

the social ecological model to guide understanding of the institutional, interpersonal, and individual level factors that contribute to sexual decision-making.

Institutional factors include social institutions with organizational characteristics as well as both formal and informal rules and regulations (McLeroy et al., 1988). In this study, institutional level factors include church, school, and college because all are factors that college students are exposed to throughout development and in their current lives. Interpersonal factors include social networks and social support systems. Interpersonal level factors in this study include family and peers because both are primary sources of influence throughout development and during college. Individual level factors include personal characteristics such as attitudes, knowledge, beliefs, behavior, and self-concept as well as the individual's developmental history (McLeroy et al., 1988). In this study the outcome variable, sexual decision-making, exists on the individual level of the social ecological model.



The social ecological model has been used in public health research as a framework for understanding the factors that contribute to sexual health behaviors among emerging adult populations (Hayes et al., 2009; Kastner, 1984; McLeroy et al., 1989; Stevens, 2001). Studies examining factors in sexual decision-making have employed individual level theories to understand behavioral determinants of sexual decision-

making (Collins Fantasia, 2011). However, no recent qualitative studies have utilized the social ecological model to understand sexual decision-making in college students. The social ecological model's use in public health research informs multi-level sexual health promotion interventions targeted at emerging adults, which include health communication, self-efficacy and HIV prevention interventions (DiIorio et al., 2000; Haglund & Fehring, 2009; Kastner, 1984; McLeroy et al., 1989). For this reason, the social ecological model is a useful framework in this study because findings can be translated into multi-level public health interventions and health promotion programs. In its innovation, qualitative methodology is used in this study to obtain a thorough understanding of the multi-level factors that impact sexual decision-making.

Unlike previous studies, this study utilizes the social ecological model to hone in on religious upbringing, family, and sexual education as contributing factors in sexual decision-making. No studies to date have employed the social ecological model to understand the impact of religious upbringing, family, and sexual education on sexual decision-making among Black females attending a HBC. In examining the literature, individual-level factors are embedded within institutional and interpersonal factors in religious upbringing and sexual education. Therefore, individual-level factors that impact sexual decision-making are integrated into the institutional and interpersonal level sections in this review of the literature.

Institutional Level

Religion and Spirituality

Definitions of religious influence vary throughout the literature. The most commonly used indication of religion is *religiosity*, which varies in definition across studies. Haglund & Fehring (2010) refer to religiosity as a set of ethical standards on how to live a good life, institutional beliefs, and doctrines and rituals, while McCree et al. (2003) define religiosity based on religious involvement and practice. Spirituality has also been used as an indication of religion in the *Expressions of Spirituality Inventory*, defined as cognitive orientation towards spirituality, existential well-being, paranormal beliefs, experiential/phenomenological dimensions of spirituality and religiousness (from Boyd-Starke et al, 2011). Yet another term used in the literature is religious orientation, which Sanchez and Carter (2005) define as an individual's psychological attitude towards one's particular religious or spiritual beliefs.

Religiosity has been found to be a protective factor against sexual risk behavior among emerging adults (Haglund & Fehring, 2009; McCree et al., 2003; Lefkowitz, Gillen, Shearer, & Boone, 2004; Rostosky et al., 2003). Having strong religious beliefs is related to protective sexual attitudes and behavior, suggesting that religion plays a role in sexual decision-making (Boyd-Starke, Hill, Fife, & Whittington, 2011; Lefkowitz et al., 2004; Davidson, Moore, Earl, & Davis, 2008).

Religious values are deeply rooted in traditional African American culture. Findings show that religion is a dominant source of influence among many African Americans, especially in the South (Thomas & Freeman, 2011). Compared to their White

and Latino counterparts, findings from one study indicate that African American youth have reported being significantly more involved in and influenced by religion (McCree et al., 2003). Thus, it is necessary to understand how religion impacts sexual decision-making among African American emerging adults.

Emerging adulthood is a time in which both individuals' sexuality and religiosity are particularly impressionable. Findings indicate that religious adolescents and young adults are less likely to engage in sexual risk behavior than non-religious emerging adults (Lefkowitz et al., 2004). Among adolescents, lower levels of sexual involvement are related to religious service attendance, importance of religion, and denominational affiliation. Highly religious adolescents have been found to initiate sex later, have fewer sexual partners, and have sex less often than less religious adolescents (Haglund & Fehring, 2010; McCree et al., 2003; Rostosky, Regnerus, & Wright, 2003).

Religiosity has been found to be protective against sexual risk behaviors among African American emerging adults. McCree et al. (2003) found that greater religious involvement among African American adolescent females is a protective factor against HIV and STI risk behaviors and an indicator of increased self-efficacy in communicating with partners about sex. Further, research indicates that religiosity plays a role in college students' sexual behavior (Luquis, Brelsford, & Rojas-Guyler, 2011). Among African American college students, higher levels of religion and spirituality are related to lower levels of sexual risk behavior, which include premarital sex, fewer sexual partners, and less unprotected sex (Boyd-Starke et al., 2011; Braithwaite et al., 1998, Thomas & Freeman, 2011). Although findings suggest that religiosity is related to sexual behavior,

there is a gap in the literature regarding *religious upbringing* as a construct of religion and its impact on sexual behavior.

Individuals' religious practice and religious norms prior to entering college may impact sexual behavior during college. Additionally, previous religious practice and religious norms inform the construct of religious upbringing. Religious upbringing may be defined as previous religious practices, familial religious values and religious norms during childhood and adolescence. Although the literature does not define it explicitly, evidence from various studies on religion support that religious upbringing may play a role in sexual decision-making (Davidson et al., 2008; Haglund & Fehring, 2010; McCree et al., 2003; Romer et al., 1998; Rostosky, Regnerus, & Wright, 2003). Religious upbringing may impact individuals differently – direct religious influence may include current strong religious values while indirect religious influence may still influence personal morals and values. Both direct and indirect religious values may influence decision-making and behavior, however this warrants further exploration.

There is a gap in the literature with regard to the religion construct *religious upbringing*. Defined by familial religious values, religious importance, engagement in religious rituals, and religion from youth to the present, religious upbringing adds a developmental perspective to the frequently cited religious constructs religiosity and spirituality. There is a wide body of literature on the relationship between religiosity and spirituality and sexual attitudes and behavior, yet none have investigated the role religious upbringing plays in sexual decision-making.

Sexual Education

Literature suggests that sexual education is related to decreased sexual risk behaviors among emerging adults (Haglund & Fehring, 2009). Findings indicate that few differences exist between the type of sexual education (abstinence-only v. comprehensive sex-ed) received and young adults' current sexual attitudes and sexual activity, i.e. sexual intercourse (Haglund & Fehring, 2009; Walcott, Chenneville, & Tarquini, 2011). However, sexual education teaching peer negotiation has a longstanding impact on college students' sexual behavior (Haglund & Fehring, 2009; Walcott et al., 2011). College students who were taught peer negotiation skills during sex education were more likely to use condoms with non-steady sexual partners (Walcott et al., 2011). Likewise, emerging adults who had been taught how to say no during sex education were less likely to have had sex and had fewer sexual partners than those who had not learned how to say no (Haglund & Fehring, 2009).

Contrary to findings that show that few differences exist between type of sexual education received and current sexual attitudes and behavior, one study found that learned safer sex messages from comprehensive sex education related to long-term sexual attitudes and behavior, including positive recall of their sexual education experience and feeling that they had received a more comprehensive picture of sexuality (Walcott et al., 2011). Additionally, this study also found that students who had received comprehensive sex education had higher HIV knowledge compared to those who had received abstinence-only education (Walcott et al., 2011). Thus, discrepancies exist in the literature between types of sexual education and current sexual attitudes and behavior.

The literature indicates that most college students are knowledgeable about HIV transmission and prevention methods but that the knowledge rarely deters them from engaging in risky sexual practices, such as unprotected sex (from Opt, Loffredo, Knowles, & Fletcher, 2007). However, many studies that examine African American college students are conducted at predominantly White institutions and have very small African American student populations (Braithwaite, Taylor, & Braithwaite, 1998; Hayes et al., 2009; Thomas & Freeman, 2011). In one study Davidson and colleagues found that Black female college students received sexual education at a later time during middle school when compared to Black male and White male and female college students (Davidson et al., 2008). Black female college students were more likely to have sexual intercourse, more lifetime sexual partners and had been diagnosed with an STI than White college students (2008). Late exposure to sexual education may explain why individuals engage in various sexual risk behaviors, such as earlier sexual debut and unsafe sexual practices.

Among a sample of African American emerging adults living in the rural South, most had received abstinence-only or no school-based sexual education at all (Akers et al., 2010). Akers and colleagues also found that a sample of college students coming from a rural community with low socioeconomic status lacked exposure to sexual knowledge regarding safer sex behaviors and peer negotiation, putting them at higher risk of HIV, STIs, and pregnancy (2010). The culmination of factors including coming from a low socioeconomic background, lack of school-based sexual education and limited sexual communication skills may indicate that some Black emerging adults go on to college without knowledge to make informed sexual decisions (Akers, 2010). Findings also

reveal that sexual education messages that targeted older youth were ineffective because early sexual debut occurred during adolescence, indicating that sexual education should occur prior to sexual debut (Akers et al., 2010). However, contradicting messages in the literature on sexual education indicate that it is necessary to further explore sexual education in African American emerging adults.

Interpersonal Level

Familial Influence

Findings show that parents may exert a protective impact on sexual risk behavior among adolescents and young adults (Haglund & Fehring, 2010). Living in a two-parent household and discussions about how to say no to sex were found to be protective factors against sexual onset and having multiple sexual partners (2010). Sexual information learned from parents contributes to current sexual decisions among young adults (Haglund & Fehring, 2010; Rostosky, Regnerus, & Wright, 2003; Sanchez & Carter, 2005). Particularly, communication with mothers about sexual topics was significantly related to the belief that teens should not have sex until marriage and virginity among emerging adults (Haglund & Fehring, 2010).

Like religion, familial influence is a major source of influence in African American culture (Sanchez & Carter, 2005). African American mothers have been found to communicate more with their children about sexuality topics than fathers (Cornelius, 2009). In African American culture, religious beliefs are integrated into familial structure, guiding values, lifestyle behaviors, and practices (Sanchez & Carter, 2005). Thus, religious beliefs play a major role in African American family structure and in their

overall upbringing (2005). Thus, familial upbringing, along with religion, plays a role in sexual decision-making. Although mixed evidence exists regarding familial sexual education's impact on emerging adults' sexual behavior, some literature suggests that it may be protective against risky sexual behavior such as early sexual debut (Haglund & Fehring, 2010). Similarly, formal school-based sexual education may have an influence on emerging adults' sexual behavior (Haglund & Fehring, 2009; Walcott, Chenneville, & Tarquini, 2011).

Conclusion

Studies suggest that educational institutions, religion and family are important sources of influence on individuals' sexual behavior (as cited in Davidson, Moore, Earl & Davis, 2008). However, a gap in the literature exists regarding *religious upbringing* as a construct of religion. Little is known about how religious upbringing and sexual education together impact Black emerging adults' sexual decision-making.

Because religious values are deeply rooted in African American culture, it is particularly necessary to explore how religious upbringing specifically has influenced sexual decision-making. Various studies define religion by religiosity, spirituality and religious orientation (Boyd-Starke et al., 2011; Haglund & Fehring, 2010; McCree et al, 2003; Sanchez & Carter, 2005).

Very few studies have examined sexual education specifically within a Black college student population, thus little is known about how sexual education impacts Black college students' sexual decision-making (Haglund & Fehring, 2009; Walcott et al., 2011). While many studies have examined risky sexual behavior among African

American college students, the majority are conducted on predominantly White campuses and have small African American student populations (Braithwaite et al., 1998; Hayes et al, 2009). Because many engage in sexual practices and explore their sexuality during college and Black young women are at higher risk of STIs, HIV and pregnancy, it is crucial to investigate Black young women's sexual decision-making in the college setting. Exploring how religious upbringing and sexual education impact Black college students' sexual decision-making can provide greater insight into HIV, STI and pregnancy prevention for this population.

Thus, I have employed qualitative methods to gain insight into how religious upbringing and sexual education impact sexual decision-making among Black college students at HBCs. Gaining insight into African American college students' sexual health is essential to help college health educators facilitate preventative sexual practices, such as condom use and STI/HIV testing, among young women at HBCs. Greater understanding of Black college students' sexual decision-making can add depth to the current body of knowledge on African Americans' sexual health. Thus, this research has implications for public health professionals to develop and implement STI, HIV and pregnancy prevention efforts on HBC campuses.

Chapter III. Methodology

Research Design

This study is a secondary analysis of a larger qualitative study examining college students' sexual health attitudes and behavior at a HBC. Data for the current qualitative study were collected from 19 semi-structured, individual interviews. The study aims to inform future sexual health interventions on college campuses.

Participants

The larger qualitative study utilized purposive sampling to select a sample of Black female college students as their study population. This study used the same sampling methodology and selection criteria as that in the original study. Eligible study participants consisted of Black female full-time college students ages 18 through 24. The study was conducted at a HBC in the South. Selection criteria for the original study included the following: 1) Participants must be over the age of eighteen; 2) Participants must self identify as female; 3) Participants must self identify as Black or African American; 4) Participants must be enrolled in a Bachelor's degree program.

Thirty eligible participants were recruited for participation in the larger study. Participants were recruited through list-servs, posters, and flyers and in person on campus. The recruitment material contained the basic eligibility criteria and contact information for further screening. Potential participants were instructed to contact staff via e-mail, phone, or in-person to make an appointment to be screened for participation in the study. Of the thirty eligible participants, twenty (63.7%) were selected to participate

in the study on a first-come-first-serve basis. The other ten young women who expressed interest were not selected to participate based on time restrictions and scheduling conflicts. Additionally, saturation was reached at 19 interviews so it was not necessary to interview the other ten potential participants. Young women who agreed to participate in the study contacted the primary investigator in person or via email. The primary investigator confirmed the selection of eligible participants via email or in person. Research assistants then reached out to participants via phone or email to schedule interviews. One participant did not undergo an interview, thus study data consists of nineteen in-depth interviews with nineteen participants.

Data Collection and Management

This study utilized a qualitative methodology to collect nineteen individual semi-structured interviews. Two female graduate students, one White and one African American, who were employed as research assistants conducted the interviews. Both interviewers were trained by study staff and are CITI certified. Each interview lasted approximately forty minutes to two hours in length and was held in a private room on the college campus near the primary investigator's office. Signs reading "Do Not Disturb: Interview in Progress" were posted outside the interview rooms during the duration of the interview to prevent interruptions. The interviews explored dating, sexual, and non-sexual behaviors of students within the context of a HBC.

At the start of each interview, the research assistant greeted the participant and read the consent form aloud. The research assistant then provided details about the purpose and procedure of the study. Participants were informed that their participation

was completely voluntary and that they may feel free to withdraw at any time. They were also informed that the interview would be digitally audio recorded for data analysis purposes. The researcher acknowledged the personal nature of many of the questions. Participants were informed that their information would be kept confidential and anonymous. After the participant read and signed the researcher's copy of the consent form, she was given a copy for her personal records.

The research assistants then distributed an anonymous, brief screening tool that assessed the participant's demographic characteristics, such as age, classification (i.e. Freshman, Sophomore), and sexual behaviors. The screening instrument was administered via pen and paper. After the participant completed the survey, the survey was kept in a manila envelope and stored in the primary investigator's private office.

The participants were reminded that the interview would be digitally audio recorded before beginning the interview. Then, the research assistant turned on the audio recorder and engaged in an individual in-depth semi-structured interview with the participant. The interviews, on average, lasted 90 minutes. The interview structure consisted of guided conversations with the participant, allowing the participant to provide personal narratives and the interviewer to ask specific questions including probes. Interviewers used an interview protocol to guide the interviews. The interview protocol included questions pertaining to religious upbringing, sexual education, and sexual decisions and behaviors (see Appendix A). Regarding religious upbringing, participants were asked to describe the role religion played in their lives growing up until the present and how it impacts their current sexual decisions. To address sexual education, participants were asked to discuss the sexual information they received during youth and

to compare their different sources of sexual information. Silent probes and follow-up questions were also used to ensure that in-depth responses were obtained from participants. Upon completion of the interview, the participant signed (an alias is acceptable) and dated the provided incentive receipt and received $20 cash compensation for her participation.

Given the sensitive nature of the topics, a list of mental health resources was provided in the interview materials. If a participant was upset during the interview, the research assistant gave the participant the list of resources and encouraged her to leave and seek mental health care. Upon completion of the interviews, the audio recordings were uploaded to a secure, password-protected Netbook laptop. The laptop, screening instruments and interviewer notes were stored and locked in a file cabinet located in the primary investigator's office.

Interviews were transcribed verbatim and all interview notes, transcriptions, and screening tools were stored in the primary investigator's office for data management and analysis. After two pilot interviews were completed, the research team reviewed the protocol to ensure that all items accurately assess the intended research questions and to ensure that there was no repetition in the interview questions. After the protocol was finalized, the rest of the interviews began.

Reliability and Validity

To enhance rigor in this study, researchers addressed reliability and validity in a qualitative context (Maxwell, 2005; Morse & Field, 1995). To maintain reliability in data collection, interviewers conducted interviews in the same setting, a private room on

campus, for all 19 interviews (Morse & Field, 1995). Additionally, the interviewers were of the same status, age, and gender, as they were both young women employed as Graduate Research Assistants (1995). They followed the same interview protocol asking the same questions to enhance reliability. This ensured that the social context in data collection was the same during every interview (Morse & Field, 1995).

To address validity, researchers remained neutral while conducting the interviews to prevent reactivity and interviewer bias (Maxwell, 2005). The in-depth nature of the interviews enhanced validity because it resulted in rich, descriptive data. Analysis of verbatim transcripts rather than just interviewer notes provided a detailed foundation for, and test of, conclusions (Maxwell, 2005). Also, researchers examined and analyzed all data, including both supporting and discrepant evidence, to provide a thorough and accurate account of the results (2005). This prevented bias in the interpretation. Researchers prevented threats to external validity by confirming participants' evidence and emergent findings with outside sources, including informants and the literature (Morse & Field, 1995). This ensured that the data was credible and confirmable (Maxwell, 2005; Morse & Field, 1995). Thus, researchers addressed potential threats to the rigor of this study by working to enhance reliability and validity.

Data Analysis

The research assistants independently read two transcripts and created a list of codes to begin the coding process. The research assistants met to compare and review codes for agreement and developed a codebook for data analysis. Using the codebook, the two research assistants coded each transcript. The codebook includes codes based

upon the social ecological model as well as other codes developed by the research assistants. If research assistants discovered new codes during coding, they discussed the additional codes and added them to the codebook. The research assistants communicated about additional codes that emerged throughout the entire coding process. The project investigator resolved any discrepancies in coding. This process was repeated until the code list was exhaustive and saturation was reached.

Chapter IV. Results

Introduction

Results are organized by each research question and, further, by the institutional, interpersonal, and individual level factors that correspond to religious upbringing and sexual education. Within these levels, subsections (e.g. familial upbringing and religious upbringing) represent emergent themes. In some cases, sub-subsections exist under the subsections to indicate emergent themes within the larger emergent themes.

Sample Description

The mean age of participants in this study was 20.1 years. All participants in this sample (N=19) were female. Some (26.3%) participants were in their junior year of college, 31.6% of participants were in their sophomore year, and an equal number of participants were in their freshman (21.1%) and senior years of college (21.1%). Participants identified as Black (57.9%), African American (26.3%), or both Black and African American (15.8%). Many participants were dating and in committed relationships (47.4%), others were dating and in non-committed relationships (21.1%), and 31.6% were not currently dating. Among this sample, 84.2% of participants had engaged in oral sex, 78.9% had engaged in sexual intercourse, and 68.4% were currently sexually active at the time of the study. Among sexually active participants, 52.6% reported using condoms every time engaging in sex, 26.3% reported using condoms most of the time, and an equal number of participants reported never (5.3%) and sometimes using condoms (5.3%). The majority of participants (84.2%) had been tested for a

sexually transmitted infection (STI), including HIV/AIDS. Most participants (84.2%) felt that sexually transmitted infections were a major problem on campus, 10.5% felt it was a minor problem, and only 5.3% felt it was not a problem at all.

Table 1.

Table 1. Sociodemographic characteristics of participants (N = 19)

	M	**SD**
Age	20.1	1.10
Number of Sexual Partners	1.47	2.22
	n	**%**
Classification		
Freshman	4	21.1
Sophomore	6	31.6
Junior	5	26.3
Senior	4	21.1
Race/Ethnicity		
Black	11	57.9
African American	5	26.3
Black/African American	3	15.8
Relationship Status		
Dating: non-committed relationship	4	21.1
Dating: committed relationship	9	47.4
Not currently dating	6	31.6
Sexual Activity		
Sexually Active	13	68.4
Oral Sex	16	84.2
Penetrative Sex	15	78.9
Protective Sexual Behaviors		
Condom Use – Every time	10	52.6
Condom Use – Most of the time	5	26.3
Condom Use – Sometimes	1	5.3
Condom Use – Never	1	5.3
STI Testing	16	84.2
Receipt of Test Results	16	84.2

Religious Upbringing

1. *What is the role of religious upbringing in current sexual decision-making?*
    a. *How do institutional-level factors in religious upbringing impact current sexual decision-making?*
    b. *How do interpersonal-level factors in religious upbringing impact current sexual decision-making?*
    c. *How do individual-level factors in religious upbringing impact current sexual decision-making?*

Institutional Level Factors

Youth Religion

Nearly all participants explained that religion had played a major role in their lives growing up throughout youth up until they left home for college. All described their religious affiliation as a form of Christianity. Many identified just as Christian, although most described their specific Christian denominations, which included Baptist, Southern Baptist, Apostolic, Roman Catholic, United Methodist, and Church of God of Christ. Some participants grew up in one Christian denomination, but then switched to another in their late teens or in college. One participant [ID #007] explains, "I'm Baptist now and when I was back home, it was a Church of God of Christ. So, I mean, the beliefs are basically the same for Christianity, but I feel as though now that I know it for myself, I can speak for a lot of things versus just doing it just because I'm doing it." Another participant [ID #015] grew up in the Baptist church but later switched to nondenominational Christianity when she was seventeen years old.

Religious Rituals

Nearly all participants participated in religious rituals growing up. For most, religious rituals during upbringing included weekly church attendance, prayer, often before meals, and reading the Bible. A few participants practiced fasting both during upbringing and in their current lives. One participant [ID #017] describes church-wide fasts that she participated in growing up. She says, "…if the church decides that you want to do a church-wide fast, then they might do the fast with the church." Many were also active in their church community growing up. Those who were active in their church explained that they attended church on Sundays and also engaged in church-based activities such as choir, praise dance, Bible study, Sunday school, youth ministry, and prayer groups. One young woman [ID #005] describes being very involved in the church growing up. She says,

> "I was on the Drama Ministry, the Praise Team Ministry, the choir, the Vandalism Ministry – just like every little ministry at my church, so I was big on helping out the church through community service; I was in the Youth Ministry and I was on there for six years, and I also volunteered at Sunday School classes. So it was just like I was really involved in the church, like I was driving there probably three times a week."

Religious Importance

Although some participants indicated that religion was somewhat important, most described religion as very important to them during upbringing. Very few participants felt that religion was not important at all during upbringing. One participant [ID #005] felt that religion was a very important part of her life growing up and referred to her church community as her "church family." She says, "Oh, well, back at home, my church was

actually like pretty small, and people knew each other for like many years, like I met my church family, I met the majority of people in my church when I was probably in like seventh grade, so I grew up with them…" On the contrary, other participants explained that church attendance was the extent of their religious involvement during youth. One young woman [ID #007] explained that she just went to church on Sundays "and that was it."

Interpersonal Level Factors

Religious Upbringing and Familial Upbringing

When asked to describe their religion growing up, all participants discussed their religion and family together. In addition to participating in religious rituals together, many young women described religion as an integral part of their family life and value system. Many explained that they attended church with their families growing up. Participants also explained that their families encouraged them to pray and some described praying as a family. Participants also described how religious values were "kept in the home." Demonstrating how religion was a major part of her upbringing, one young woman [ID #011] explained,

"…my family, we did go to church, um, I wouldn't say every Sunday, but we did, we kept our values of—Christian values in our home, um, growing up, um, we also held Bible study in our house on Thursdays, evening—every Thursday evening, um, my grandmother, she is a reverend, my grandfather, he's a pastor as well so it's kinda tight Christian family, Southern Baptist, yes."

Religious Rituals

It was common for participants to engage in religious rituals with family growing up. For most, familial religious rituals included church attendance and prayer. Almost all young women who described attending church growing up reported attending church with female family members, specifically a mother or grandmother or, in some cases, both. One young woman [ID #012] explains, "I went to a Baptist church every Sunday with my grandmother and mother."

Many participants describe engaging in religious rituals and activities, including church attendance, Bible study, choir, and praise dance, to please one or more family members. Some participants reported that they had participated in religious rituals, including religious education, Bible study, choir, and praise dance, to please a mother or grandmother. For example, one Roman Catholic young woman [ID #002] describes going to after-school religious education classes because her mother wanted her to go. A couple of participants reported that a grandmother is a church leader, which made participation in the church community very important to their families growing up. One young woman explained that her grandmother was a reverend and her a grandfather a pastor.

One young woman [ID #017] described her familial religious rituals, "Yeah, we prayed at home. We prayed every night, we tried to pray, and maybe in the morning on the way to school in the car, just to have a good day and things like that." She [ID #017] explains fasting with her family, "usually it's when something is not going right, like

when things just seem like they're crazy, that's when my family decides, okay, we need to fast until things are back on track."

Religious Importance to Family

Across interviews, the majority of participants indicated that religion was important to their families during youth. Typically, young women described religion as "very important" to their families growing up. Aside from one participant who indicated that religion was not important to her growing up and did not attend church regularly on Sundays, all others described church, prayer, and religious teachings as a part of their family's values. When asked if religion was important to her family growing up, one young woman [ID #001] said, "It was. My grandmother actually raised me, so she really made it very important for me and my brother to like pray every night, to go to church, to be sure to read the Bible. So, yes, it was very important."

Religious Autonomy

Some participants explained that their family did not push them to choose a certain religious affiliation during upbringing. Rather, some participants were given the freedom to choose which denomination they wanted to become a part of as well as freedom on how to practice their religion. One participant [ID #008] explained that her mother allowed her freedom to choose her religious affiliation, rather than become her mother's religion (i.e. Baptist) during upbringing: "She never forced me to have a religion, which I love about my mom." Another young woman grew up practicing the same religion as her grandparents (i.e. Apostolic), which differed from her parents' faith (i.e. Baptist): "I think what I love most about my religious background is that since my

parents were not a part of the apostolic church I never felt pressured to follow the rules at my church. Like, I knew it was my own desire. But like, if I wanted to put on a pair of jeans my family would be perfectly okay with that because they're not a part of that religion anyway."

Individual Level Factors

Adult Religion

Participants internalized religious teachings in different ways. Many participants describe their religious teachings as guiding principles for how to live their lives. This includes striving to live according to the Bible's teachings, being a good person, treating others kindly, and living according to Christ's will. Some even described specific Bible verses to explain how religion is a part of daily life, such as one young woman [ID #013] who says, "Um, I read a scripture to somethin' that's very inspiring to me such as, um, Hebrews 11 and 6, which talks about how important it is to have faith and how important it is to be diligent. Also, Proverbs – specifically the scripture that says, uh, "Trust in the Lord with all thy heart and lean not to my own understanding." Those are scriptures that I live by daily." One young woman [ID #009] explains that she finds her religion "confusing" and adds that she is "God-fearing," meaning that she is afraid to question her faith.

Adult Spirituality: "Relationship with Christ"

Most participants identified as more spiritual than religious in their current lives. Maintaining a "relationship with Christ" was a recurrent theme throughout all interviews. Many also disliked using the word religion and identifying as a specific denomination.

Rather than describing their religion as a specific affiliation, many participants described their religion as Christian and stated that they do not like religion. When asked to describe her religion, a young woman [ID #001] demonstrates how spirituality is more prominent than religion in her current life: “My religion, I really hate the word religion, but I would describe it as a relationship, as like I have a strong relationship with Christ, but I don’t feel like it’s a religion. Like I guess I don’t do all the rituals or whatever, but I do feel like I have a strong relationship with Christ.”

Spirituality vs. Religion

Distinguishing between religion and spirituality was normative among participants. Many explained that spirituality is related to your “relationship with Christ” and religion embodies a “set of rules.” A young woman summed up the difference between religion and spirituality this way: “I think the difference with me with religion and spirituality is religion is something that you kind of do at a set time and a set pace. I think of spirituality as always there. You can't really turn it off, if you're a truly spiritual person.” Young women also acknowledged that individuals might identify as both spiritual and religious. One young woman [ID #006] explained, “I mean, I’m not saying that spiritual people can’t be religious, but I’m just moving farther away from religion.” More so, some participants explained that they identify as both spiritual and religious in their current lives, but were more religious growing up.

Religious Autonomy

Religious autonomy emerged as a theme in the interviews. Many participants discussed having the freedom and independence to decide which religious affiliation,

church, and identification is right for them. A participant [ID #015] explained that she made the autonomous decision to change religious affiliation from her religion during upbringing, Baptist, to nondenominational Christian, in her late teens: “But when I became 17, I kind of ventured out on my own and got my own relationship with Christ and became nondenominational, so no religion, just Christianity. So, I kinda started my own tradition with being very spiritual.” Another young woman [ID #007] described choosing a church in college that she liked best:

> “Well, when I first came here, at first I didn't go to church. I just would sleep in on Sundays. And then I went to [a Baptist church] which is not far from here and I just really loved the pastor at first. I was like, "Wow. He really gives a good message." And then I would start going to Bible study which really helped because it would reinforce a lot of the things that I learned on Sunday and it helped me to keep my faith throughout the week and not just on Sunday.

It was also common for participants to describe that they missed their church back at home and the sense of “community” that they experienced within the church and their families. One participant [ID #005] even described her church community back at home as her “church family.” However, some described attending church with a boyfriend and friends in college to maintain a sense of religious community in the college environment.

Religious Importance

When asked if religion was important in their current lives, responses ranged. Some participants explained that religion is not very important to them at all. Many described that religion is still very important in their lives today, while others explained that spirituality is now more important to them than religion. Several young women

explained that religion was more important to them during youth than adulthood. Participants also explained that they found it easier to be more religious back at home than in the college environment. One young woman [ID #005] explained, "And I would say, back at home, I was more religious, just for the fact that it was with my family and my church family and, you know, there was always somebody, you know, there with you, but now it's kind of like you're on your own and you really have to develop and grow as a person to see how your spiritual life can change or how it has changed."

Religious Impact on Health Decisions

Many participants explained that religion impacts their health decisions today because their religion taught that the body is a temple. To live out this religious teaching, many described that they take care of their bodies by eating healthy foods and exercising. One young woman [ID #001] explained, I have always been taught that my body is a temple, so I've always been – I guess I've been more aware of who I'm with and who – I guess sexually, or what I do to my body like health wise. I try to work out, try to eat right as much as I can, so that's kind of helped me a little bit." One young woman also explained that exercising has become a way that she maintains her spirituality because it relaxes her mind. Other young women did not feel that religion impacted their health decisions at all.

Religious Impact on Sexual Health Decisions

Most participants described that religion plays a role in their sexual decision-making. Many participants described that religion impacted their morals in sexual decision-making. Several young women described that they will not engage in sex unless

in a committed relationship. One young woman [ID #003] summed up the norm this way: "Um, I think my religion impacts it in the sense that, um, that my religion has impacted my morals, of course and I'm just not gonna go have sex with anybody, um, and I think, for me I've always, if I have had sex with someone, I've been in a committed relationship with them."

Some young women practiced abstinence because they learned to do so from family, religious beliefs, and church teachings. Others explained that religion played more of a role in their sexual decision-making growing up than in their current lives. For many of these young women, this meant that they practiced abstinence before coming to college but became sexually active in college. Regarding religion's role in sexual decision-making, one sexually active participant [ID #001] said, "It did before I guess, before, you know, the whole no sex before marriage and stuff like that, but it definitely changed that with college I guess."

The ideology that it is a 'personal choice' to refrain from sex emerged among those who were abstinent. For many of these young women, religion helped shape their decision to abstain from sex. A young woman [ID #005] describing her personal choice to remain abstinent exemplified this theme: "…but I feel like more it's kind of like, Okay, I don't think of it as like, "I'm a Christian, I'm not going to do this." I think of it as, "I'm me. What do I want to do?" You know what I'm saying? So it's a little bit less than before, but it's just like I look at it more as like, you know, my own perspective of it and not just through the church's perspective."

Among participants, fear of negative religious consequences for engaging in premarital sex emerged as a reason to remain abstinent. A young woman explained that fear drives her decision to refrain from sex: “at first it was more of waiting [to have sex] for fear of all the—all the consequences of having, like, sex and not knowing what, you know, not knowing anything about it or what to do, or anything like that than more-so waiting [to have sex] because I feel like I’m going to go to Hell if I have sex.” Fear of negative religious consequences was also a reason why religion does not impact sexual decision-making. One young woman [ID #009] who described herself as “God-fearing” explained, “I try not to think about God and religion when I’m participating in whatever I’m doing cause I just feel like he’s looking down judging me so no, I don’t think it affects me at all.”

Spiritual Impact on Sexual Decision-Making

Spirituality emerged as a factor that is sometimes integrated with sex in current sexual decision-making. One young woman [ID #017] expressed that spirituality and sex are linked. It was not common for participants to discuss sex and spirituality together, but she explained that “sex is a spiritual experience.”

Sexual Education

2. *What is the role of sexual education in current sexual decision-making?*
    a. *How do institutional-level factors in sexual education impact current sexual decision-making?*
    b. *How do interpersonal-level factors in sexual education impact current sexual decision-making?*
    c. *How do individual-level factors in sexual education impact current sexual decision-making?*

Institutional Level Factors

Youth Sexual Education: Church

Aside from abstinence, sexual education learned in church was uncommon among participants. Many expressed that "church didn't really address it" where "it" is sex. One participant [ID #005] explained that sex and religion are kept separate in the church: "I feel like religion is not really the place where they address that kind of thing [sex education]." Generally, participants were in consensus that they did not learn much sexual information aside from the teaching of abstinence during youth from the church. One young woman who is currently sexually active [ID #007] described participating in chastity classes at her church growing up, explaining that she was angered that only females were required to take classes:

When I was younger, my church had a chastity vow where, basically, they have the women and we go through all these classes and you take a vow not to have sex until you get married. I think you sign a paper or something and you get a ring. So, I started taking the classes and then I started rebelling because they didn't have the guys taking the classes. It was only the females. So, I'm like, "Okay, what about the guys in the church? This is so sexist." And nobody really understood me so I just told my mom I had to work the day they had the actual chastity vow. I really didn't have to work. I just went into

work because I wanted to. But the truth was I didn't want to participate in it 'cause I felt like it was sexist.

However, in one case a young woman explained that her church held a lock-in that addressed healthy relationships and, in some cases, sex before marriage. She described this, “We did have a lock-in before when I was in high school out where we did bring things up and we’d try to talk about, um, people were talking about their experiences as far as being in relationships. And having sex, some people did talk about their experiences having sex before marriage.”

Youth Sexual Education: School

Many described receiving abstinence-only education during youth. Sexual education often addressed risk of pregnancy, but did not address HIV and STIs. One participant sums this up perfectly: “I don’t even think we really talked about sex in middle school. I don’t remember talking about sex health or how to prevent STDs or STIs. I do remember talking about pregnancy, but that was about it. And of course, in high school there’s no sex ed.” Like this participant mentions, it was uncommon for participants to receive sexual education past middle school. Some participants received sexual education in high school in health class, which was where they learned about sexually transmitted infections and condom use. One young woman said, “OK, so it was mostly abstinence, of course. Um, but you know you have to—you have to take health and all that type stuff in so many different years of school, um, which is basically where—how I learned about, like, all these different types of condoms, um, and all the different types of diseases…”

Youth Sexual Education: Physicians and Clinics

Some learned sexual health information from a primary care physician or at a clinic during upbringing. One young woman described her primary care physician as her main source of sexual education during youth. She described feeling more comfortable asking her doctor questions in one-on-one setting. Another young woman [ID #011] expressed, "And even going to your, um, your doctor and your physician personally on a one-on-one level you learn more, so." Others gained sexual health information from clinics in a one-on-one setting as well as pamphlets and brochures on sexual health. One young woman [ID #001] summed it up: "I did when I went to that clinic because I got the HPV shot. So they gave me some information there, but that's about it really. I mean, I know there's – I'll go to an event, and they'll have this information. But like I said, it would be like a brochure, and I'd like throw it away a few hours later type thing."

Adult Sexual Education: College

Many participants described learning sexual information during college. Many used their college health clinic as a source for STI and HIV testing, sexual health information, and counseling. Several participants addressed that their college held various formal speaker presentations related to sexual health. Various participants explained that they often received emails in college about getting tested, HIV awareness, and sexual health events on campus. It was common for young women to talk about residence halls distributing condoms. Many also described informal events on campus related to sexual health, including one event held in residence halls where students talk about sexual health in a private, anonymous atmosphere. One student [ID #005] explained, "And basically, you sit in a room, males and females, they turn off the lights and you can ask any

question that you want, and a lot of the time, it's about sexual health and sexual behavior…"

Interpersonal Level Factors

Youth Sexual Information: Family

All described family as a main source of sexual education during youth. For most, this included messages from their parents, sisters, and other family members about sex, what to do, what not to do, and, in some cases, stories about personal experiences. Many received abstinence-only education in the home environment, while others learned to practice safe sex.

Most abstinence-based messages from family surrounded the fear of getting pregnant. A young woman [ID #005] sums up this norm perfectly:

"My mom has always just been – you can always talk to me – and abstinence. School has always just been – you don't want to be that pregnant – . Well, my mom was also saying – you don't want to be that pregnant girl walking around in school. My mother even told me – if you were pregnant, you know [Indiscernible], if you ever got pregnant, you won't be staying in my house. So it was kind of like – I don't want to be kicked out of the house, I'm not going to do that."

Specifically, many young women described learning their sexual education from a mother or grandmother. One participant explained the sexual education she learned from her mother growing up, "…it's been what I've been taught since ever, like even when I was little and my Ma was just like – she just told me the importance of abstinence." Messages at home often included, "Don't get pregnant." One participant [ID #001] recalled sexual health information she received from her grandmother growing up: "But,

I mean, she always put it in my head because my mom had me really young at 16, so she was like just don't get pregnant, don't get pregnant, don't get pregnant. That's all that I really had from her really."

Some young women learned about sexual education through friends and family members' personal experiences about teen pregnancy and HIV transmission. One participant described learning about the importance of condom use from a cousin, who had gotten pregnant while using birth control. A few participants learned from family members that family or community members died of HIV transmission.

Others explained that family did not address sexual education at all. Aside from abstinence-only messages, several participants expressed that sex was "not addressed in the home." Among these participants, abstinence was taught as more of understanding than a conversation. One participant [ID #004] described that her parents never talked to her about sex saying, "they never really explained the whole birds and the bees talk to me."

Youth Sexual Information: Peers

Sexual information learned from peers also emerged as a form of sexual education during youth. Some participants explained that their peers taught them about sexual health and, in some cases, abstinence during upbringing. Often, participants learned about pregnancy from friends and pregnancies they witnessed in their peers during high school. One young woman [ID #013] recalled,

"…but growin' up a lot of it just came from my peers and, thankfully, it was, um, it was healthy if I had sex so, um, you know they told me, you know, be careful. Um, try to wait

until you're married but I know a lot of people from my community did not always have that advice. Some people had peers who told them, you know, havin' sex is great. Um, unfortunately when I was growin' up some of my friends did get pregnant when I graduated from high school a lot of the girls did get pregnant and, so, growin' up my peer group definitely played a role."

Individual Level Factors

Youth Sexual Education: Information-Seeking Behavior

Many obtained their sexual education during youth by finding it themselves. Sources of this information mainly included television shows and the Internet. Reasons why participants sought information themselves were because they did not learn much in school or at home. Some described learning about condoms and contraception from sexual education television shows on MTV and BET. One young woman explained, "I don't even think we really talked about sex in middle school. I don't remember talking about sex health or how to prevent STDs or STIs. I do remember talking about pregnancy, but that was about it. And of course, in high school there's no sex ed. The most that I got was watching *Sex with Mom and Dad* on *MTV*." Another recalled viewing a music video her mother had told her not to watch.

Adult Sexual Education: Information-Seeking Behavior

Many described seeking sexual health information in college. Several participants turned to the Internet to look up information on sexual health. Some turned to friends and peers for discussions on sexual information. However, many also explained that they like to look up information on their own via the Internet rather than ask their friends and peers

because they wanted to keep their sexual health and questions private. It was common for participants to describe getting HIV tested on campus during campus-wide testing events. One young woman [ID #005] proudly said, "And like I had recently got tested, because there were just – they have a lot of opportunities for you to get tested for organisms; like I think there's something going on right now or later on today or tomorrow or yesterday or something." Many young women also described going to lectures and discussions on sexual health. A young woman described going to "sex sessions" at college about sex and spirituality with her peers and pastor.

Impact of Sexual Education Sources in Sexual Decision-Making

Family

When asked which sexual education source were most influential to them in current sexual decision-making, most said that sexual education messages from family are most useful to them. Stories they learned from family, usually from a mother or grandmother, about personal experiences with pregnancy, HIV, or STIs, resonated with them more than learning strictly sexual education facts. When asked to compare which sexual education source had the biggest impact on her, one participant [ID #005] provided a perfect example of the mother as the most influential source of sexual education growing up: "Home, because I mean, I'm with my mother 24-7 – well, not 24-7, but you know what I'm saying. Like I was always with my mother and if I needed to talk to her, she would be the first person I would go to, because I'm close with my mother and I don't really trust going to my sixth grade, you know, teacher about that – so my mom had a bigger influence than everybody else."

Many personal experiences about pregnancy were about a mother, cousin, or sister. Most felt that this type of information was also the most influential source of sexual education in their current sexual decision-making. One young woman [ID #019] summed up this norm perfectly:

"At home, hearing at a personal level and testimonies from people who experienced it before or knew someone who got pregnant at a really young age probably affected me more, because when you hear someone's testimony or a person's story that you could also see yourself being in one day, you start to listen more. It sounds kind of selfish that people only listen when they're going to be affected, but it's true. I feel like people at home definitely had a bigger influence on me."

School

It was uncommon for participants to describe school sexual education as their most influential source of sexual education. Most learned about abstinence and pregnancy only, although some described learning about condoms, contraception, STIs, and HIV. One young woman [ID #007], who received comprehensive sexual education in middle school, encapsulates the reason why sexual education during upbringing does not impact current sexual decision-making: "I didn't have sexual health in high school because I went to middle school and then one year of high school in Baltimore. So maybe they do it in the freshman year of high school or something, the first year, but I didn't receive it in North Carolina. So, I did get it in middle school but not in high school. So, by high school, I probably forgot."

College

Several participants explained that sexual education learned in college is currently their most influential source of information in sexual decision-making. The reason for

this was largely because they had received nothing but abstinence-only education growing up until coming to college. One young woman [ID #007] summed up this norm: "The only sexual education I really got was when I got to [college name]. Outside of [college name], I never really knew anything. I mean, I knew one lady, my godmother's cousin got HIV from her husband so, like, from there, I just like to read so I just started reading and I was so amazed and everything about the HIV disease. Outside of that, that was just on my own."

Church

Nearly all participants described church as the least influential source of sexual education in current sexual decision-making. It was common for participants to say that "they [church] didn't really address it." The church's abstinence-only teaching was a normative reason why participants explained that church did not impact sexual decision-making, especially among participants that are currently sexually active. One young woman [ID #014] sums this up, describing how sexual messages from church surrounded abstinence:

"Church did not talk about sex. They wouldn't do that. Well, in the church that we started going to when I was like in sixth or seventh grade, he would incorporate topics of sex into his sermon. So it wouldn't be a whole sermon about sex, but it would be something to the effect of maybe if the sermon was about decisions that you'd make, then maybe having sex with random guys maybe is a bad decision so something like that, but church not really too much sex conversation."

In some cases, young women expressed that church was a useful source of sexual education. One young woman [ID #013] described participating in an abstinence-based

workshop with her church that helped her practice abstinence in her life. She explained, "At my church, um, I went to a convention and one time we had a workshop and that was pretty much the only time we – we did talk about, um, sex and, um, we were encouraged to be abstinent."

Youth Sexual Education: Abstinence-Only Education

When comparing sexual education sources, many identified abstinence as the main teaching they learned in all sexual education during upbringing. A normative explanation of their sexual education during upbringing included testimonials like the following [ID #003]: "Um, so for the most part, my education, my family, my church, um was abstinence-only." While most felt that this was not useful to them, a handful of young women currently practice abstinence and found their abstinence-only education an influential ideology in their current sexual decisions. Specifically, one young woman [ID #013], who has chosen to remain abstinent until marriage, found her church's abstinence-only teachings very useful in current sexual decisions: "They [church], um, always instill abstinence in us. Oh, and growin' up I was actually in a abstinent group which also helps me to commit to not havin' sex."

Chapter V. Discussion

Introduction

Few studies have investigated the impact religion and sexual education has on sexual decision-making within a Black college student population. This study provides insight into religion and sexual education as determinants of current sexual decision-making among Black young women attending a HBC. Unlike past research on religion and sexual health, this study explored religious upbringing as an emergent construct in sexual decision-making. Using the social ecological model as a theoretical framework, this study examined the institutional, interpersonal, and individual –level factors within religious upbringing and sexual education to understand their impact on sexual decision-making. Use of the social ecological model allowed the researcher to examine multiple factors across levels (i.e. institutional, interpersonal, and individual) related to sexual education and religious upbringing that influence sexual decision-making among college students.

Findings suggest that religious upbringing played a role in sexual decision-making most notably on the interpersonal level. On the institutional level, religious upbringing shaped individuals' value systems. On the interpersonal level, family played the strongest role in religious upbringing, especially female family members holding mother-roles. Within the individual-level, religious autonomy played a large role in current religion and in sexual decision-making.

Regarding sexual education, findings show that formal sexual education received during youth had almost no impact on individuals' sexual decision-making. Sexual education messages in church were largely abstinence-only and school-based sexual education mainly focused on pregnancy and abstinence. However, college was found to be most influential institutional-level source of sexual education in participants' current sexual decision-making. On the interpersonal level, sexual health information learned from family, especially family members holding mother-roles, was the most influential source of sexual education throughout development. On the individual level, participants often sought out sexual information during youth and adulthood, which helped them make sexual decisions.

Positioning Findings in Theoretical Context

Religious Upbringing

Across the interviews, young women expressed their experiences in religion and sexual education growing up and in their current lives. Generally, religious upbringing impacted young women's sexual decision-making. Findings indicate that religious upbringing shapes the individual's values and morality despite current religion or spirituality. Within religious upbringing, institutional factors included church teachings, religious affiliation, and religious rituals growing up. Although institutional factors in religious upbringing did not have a direct impact on sexual decision-making, they were integrated into the individual's values, which therefore have an impact on overall decision-making. This often included religious teachings such as being forgiving, being kind to others, and being a good Christian among other things. For some, religion did not impact sexual decision-making at all and they treated sex and religion as disconnected

factors in sexual decision-making. However, these young women consciously disconnected religion and sex to avoid shame and guilt due to religious upbringing.

Religious upbringing and familial upbringing are presented together on the interpersonal level because participants' responses revealed that these factors are closely integrated. All young women described their familial and religious upbringing simultaneously. Interestingly, a commonality that emerged among participants was the dominant role of the mother and/or grandmother in their religious upbringing. Most said that, during youth, they attended church with a mother and grandmother or participated in church activities because a mother or grandmother wanted them to do so. In African American culture, strong, dominant women portraying the 'mother-role' play a significant role in the lives of their daughters and granddaughters, taking on a positive *matriarchal role* in the religious upbringing of their daughters. African American matriarchs are strong, dominant women who teach respect and set and enforce rules in the home. This is consistent with a study released over forty years ago, which suggested that matriarchs play a strong influential role in African American families and, more narrowly, in African American children's upbringing (Hyman & Reed, 1969). Therefore, it is not surprising that matriarchal roles have a major impact on religious upbringing among African American young women.

The individual-level factors in religious upbringing that emerged include religious autonomy, adult religion, and adult spirituality. *Religious autonomy* emerged as a construct in religious upbringing in educational literature (Gardner, 1988). Peter Gardner first theorized about the role religious autonomy plays in religious upbringing from an educational standpoint in 1988. However, this construct has not been examined in sexual

health and religion research. Religious autonomy emerged in this study as the freedom to make individual choices about religion, beliefs, spirituality, and church affiliation. Additionally, it meant being responsible and accountable for their religion, participation in religious rituals, morals, and beliefs. Consistent with literature on emerging adulthood, college is a time when many emerging adults explore their beliefs and make their own decisions (Arnett, 2000). As the young women in this study revealed, emerging adults therefore have religious autonomy in the college environment. Religious autonomy impacted sexual decision-making among participants because many adjusted their religious values in college with the start of a new relationship or increased freedom. Participants who were both abstinent and in a relationship found it very difficult to adhere to their moral code, while many others were abstinent until coming to college and began dating their current partner. Overall, religious autonomy played a role in individuals' current value system, which impacted their sexual decision-making.

Sexual Education

Sexual education during upbringing had somewhat of an impact on sexual decision-making among participants, although it depended greatly on the source of information. Institutional level factors regarding youth sexual education had almost no impact in current sexual decision-making. Formal sexual education during middle and high school had very little influence on sexual decision-making. Consistent with existing literature, this is largely due to participants receiving abstinence-only education during youth. However, formal sexual education had little impact on sexual decision-making even among participants who received comprehensive sexual education. Any sexual information learned at church, which was a very limited amount, had little to no influence

on individuals' sexual decision-making. Sexual education teachings from church included abstinence, which only participants who practice abstinence found helpful in current sexual decision-making.

Findings suggest that sexual education in college played a significant role in sexual decision-making among participants. Many utilized resources on-campus, such as testing, lectures, and peer discussion groups to help them make decisions about their sexual health. Compared to school or church during youth, college is a more comfortable environment to learn about sexual health and to explore options in sexual decision-making, such as contraception use.

On the interpersonal level, sexual education learned from family had the largest impact on current sexual decision-making. Family played a key role in sexual education during upbringing largely because this information consisted of stories about experiences (i.e. mother, cousin, family friend, church member, etc.) with pregnancy, HIV, and STIs. Consistent with literature on the importance of mothers in sexual education, the mother, or woman who took on a 'mother-role' during upbringing (i.e. grandmother, aunt, sister), played a critical role in sexual education among participants (Bacchus Cornelius, 2009). These stories resonated with participants more than their school sexual education classes during youth and influenced their current sexual decisions. For instance, in current sexual decisions many used birth control because a cousin or mother had a teenage pregnancy and others got tested every three months because they had a family member who died of HIV. Most participants did not consider this information sexual education, though it had the longest lasting impact on their sexual decision-making across all sexual education

factors. Thus, sexual education learned from family had a very strong, though indirect, impact on sexual decision-making among participants.

On the individual level, information-seeking behavior had a direct impact on sexual decision-making in participants. This is because participants sought sexual information that they were interested in learning or to help in their own sexual decision-making. During youth, information-seeking behavior helped participants to learn about sex, relationships, condom use, contraception, and other sexual health topics. In their current lives, information-seeking behavior helps them to make decisions in their sexual health that are most appropriate for them. While information-seeking behavior had a direct impact on individuals' sexual decision-making, sexual education learned from family had the most long-lasting impact.

Implications

The current study's findings suggest several implications for public health research and practice. The following sections will discuss public health implications as well as recommendations for future research.

Family was found to be the most influential factor throughout development in that it shaped individuals' values and decision-making. Family also shaped perceptions of both sexual education and religion during upbringing as well as adulthood. Because family played a major role in life, interventions should include family members in sexual health and HIV prevention interventions during adolescence to address factors such as value systems, sexual education, and religion that contribute to sexual decision-making. Sexual health messages from family was found to be most influential to young Black

women, however messages may differ from learned sexual education taught in religion. Thus, future research should investigate conflicting sexual health messages from family and religious institutions and how both family and the individual resolve differences in sexual health teachings.

Family members holding a 'mother-role' in young women's lives were the most influential source in development as well as in sexual decision-making among young Black women, suggesting that there is greater need to include these family members in sexual education interventions during adolescence. Sexual health education and HIV prevention interventions targeted at young Black women during adolescence should include family members holding a mother-role. Inclusion of these family members in sexual health interventions can help to shape healthy sexual decision-making during emerging adulthood. Additionally, family can help to integrate values kept in the home, which may include religion, into sexual education and decision-making in an intervention setting.

Colleges could also create interventions that integrate familial influence with sexual health messages to address family's impact on sexual decision-making during college. Sexual information regarding women's experiences with sexual health resonated with young Black women, suggesting that sexual education interventions targeted at young Black women in the college setting should include women's real-life stories about HIV, STIs, and pregnancy along with safer sex messages, HIV prevention, and college-level sexual education.

The fact that religion played a role in young women's value system suggests a need to address religion in sexual health interventions both during adolescence and in college. Faith-based HIV prevention interventions have been proven effective among young Black women (Wingood, 2011). Findings from the current study inform the development of faith-based interventions targeted at Black young women attending HBCs. The HBC in this study is a religious institution and was founded based on religious principles. This might suggest why participants' interviews indicate that chapel life and religious organizations are present on HBC campuses. Thus, a faith-based on-campus HIV intervention should be developed for young Black women at this HBC in partnership with the chapel or an on-campus religious organization. The faith-based HIV intervention should address religious teachings as they relates to sexual decision-making, sexual education messages, and safer sex behaviors.

The fact that college was a critical source of influence in current sexual decision-making among participants provides insight into the development of peer-led sexual health interventions on college campuses. Peer-led sexual health interventions should be held in residence halls in an informal setting and address topics related to healthy relationships, partner communication, safer sex behaviors, and sexual education. Additionally, the current study's findings should also encourage college campuses to take a more active role in college students' sexual health. This should be accomplished by expanding sexual health resources and awareness initiatives to educate and prevent sexual risk behavior among college students.

To do this, colleges should consider opening an on-campus student sexual information center that offers free and confidential sexual health counseling, STI and

HIV testing, condoms, information about contraceptives, and other sexual health items (i.e. toys, lubrication, etc.). The sexual information center should include students working as peer educators and counselors. Student volunteers from the sexual information center could then work in conjunction with the larger college campus to plan sexual health –based events and hold sexual education sessions in residence halls. The development of a sexual health center would create a safe and confidential place on campus where students can go to receive sexual health information and address sexual health concerns. The development of an on-campus sexual health center with profound emphasis on peer education would create a more open and inclusive sexual health environment on campus for college students.

Recommendations for future research

Based on this study's findings and limitations, there is need for further research to explore several themes that emerged in the current study. Firstly, there is a need for more qualitative research on religion and sexual health among Black college students specifically in Black males as well as in mixed-gender populations. The study's findings inform the definition of *religious upbringing* as a construct, a term that is new to the body of literature on religion and sexual health. This study suggests the need for further qualitative exploration of religious upbringing for future use as a measurable construct in quantitative research.

An emergent theme in this study included that of female family members portraying a 'mother-role' as a major source of influence in sexual decision-making, religious upbringing, and sexual education. Another important theme that emerged in this

study included that of young women experiencing religious autonomy during college. Both of these themes are new to the body of literature on sexual health and religion research as well as public health research and, therefore, warrant further qualitative exploration.

Because these findings provide insight into the structural components of Black female college students' sexual decision-making, future studies should be conducted with a Black male college student population and a mixed-gender college student population. This will provide more comprehensive knowledge for developing behavioral interventions targeted at students attending HBCs. Thus study's findings outlining the factors that influence sexual decision-making are limited to institutional, interpersonal, and individual level factors in sexual education and religious upbringing, suggesting the need to explore further factors that may impact sexual decision-making among college students.

Limitations

The exploratory nature of qualitative research provided depth and insight into religion, sexual education, and sexual decision-making in college students, in addition to the meaning of religious upbringing. However, limitations exist that must be addressed. Like all qualitative studies, findings cannot be generalized to the broader population level. A limitation of this study is that the sample of college students is limited to Black young women attending a HBC. This study therefore lacks generalizability. Additionally, findings may not inform a universal definition of religious upbringing because the

population is so specific. Therefore further exploration of religious upbringing is needed in order to establish a definition of religious upbringing.

However, this study allows researchers to gain insight into factors that impact sexual decision-making among Black young women in college. It also informed the definition of religious upbringing in public health research. The findings of this study will inform the implementation of appropriate on-campus student sexual health services and information available to students at HBCs.

Conclusion

Among college students, sexual decision-making derives from a multitude of factors in their lives. The integrative factors within religious upbringing and sexual education impact sexual decision-making among Black college students. More narrowly, the current study revealed that family's role in religious upbringing and sexual education had the most impact on sexual decision-making during college. However, sexual decision-making is complex and requires further understanding of all the integrative factors within. The examination of the combination of factors in this study provides a glimpse into the development of multi-level sexual health interventions with family as the main component to address both religion and sexual education. More broadly, family's powerful impact on college students' value systems and decision-making provides insight into the focus on family in multi-level public health interventions for emerging adults.

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Appendices

Appendix A

Interview Guide

Please describe the role that religion has played in your life while you were growing up.

Probes:

- *How would you describe your religion?*

- *Do you consider yourself a religious (or spiritual) person? Why or why not?*

- *Was religion important to your family (i.e. going to church, praying at home, meditating, religious values)?*

Next, please describe the religious rituals that you participated in growing up.

Probes:

- *(i.e. prayer, church attendance, etc.)*

- *Did you go to church when you were growing up? If yes, how often?*

- *What other things did you do to express your faith/religion/spirituality?*

How important is religion to you now? Are you a religious person? Do you consider yourself to be religious now?

Probes:

- *Explain how your religious upbringing has impacted your health decisions today.*

- *Does your religion or spiritual perspective influence your sexual decision making in any way?*

How did it influence your sexual decision making when you were younger?

How does it influence your sexual decision making today?

(E.g., abstinence, selection of sexual partners, condom usage, etc.)

Please tell me about the sexual health information (education) that you received while growing up.

Probes:

- Some people learn about sex and sex-related information from their schools, health clinics, or churches. Where did you receive sex education or information about sex when you were growing up?

- What type(s) of information did you learn from each setting?

- How does the sexual health information that you received in school/clinic/church compare to any sexual education or information you received at home (or elsewhere)? How were they the same, how did they differ?

- Did information you received in certain settings impact your health behavior more than information you received in other settings? Did information received in certain settings impact your health behavior less than information received from others?

- How has this health information impacted your health decisions today (for example, how do you protect your sexual health)?

Appendix B

Codebook

1. Religious Description: Description of religious denomination.
2. Familial Upbringing: family values, the role religion played in family life and rituals of the home
3. Youth Religion: Describing the role of religion in life as an adolescent
4. Adult Religion: Describing the role of religion in life as an adult
5. Religious Rituals: Activities and events that are associated with the church community (i.e. choir, praying, praise dance, youth groups, etc.)
6. Religious Importance
    a. Very Important: Praying often/regularly, active in the religious community, maintaining a spiritual relationship with God, and being mindful that God is part of their everyday lives.
    b. Somewhat Important: Spiritual relationship with God, although irregular; praying sometimes; somewhat mindful about God as a part of everyday life; somewhat connected to God.
    c. Not Important: Lack of praying, lack of connectedness to God, lack of spiritual relationship with God.
7. Youth Spirituality: Describing the role of spirituality in life as an adolescent.
8. Adult Spirituality: Describing the role of spirituality in life as an adult.
9. Spiritual Rituals: Maintaining relationship with God and/or having conversations with God

10. Spiritual Importance
    a. Very Important: Maintains relationship with God, has regular conversations with God, is kind to others, and is mindful about spirituality.
    b. Somewhat Important: Has some conversations with God, talks about relationship with god, may talk about the role of spirituality in lifestyle, and believes in a higher power.
    c. Not Important: Dos not at all feel that spirituality plays a role in life.
11. Religion and Health Decisions: Defining if and why religion influenced health decisions.
12. Religious Upbringing and Health: Describing how the religious values of one's family impact health.
13. Religion and Sexual Health Decisions: Describing the role religion has in sexual decision-making.
14. Youth Sex Information: Descriptions of sources of sexual information received during youth and how this information impacted health decisions.
    a. Source
        i. Family
        ii. Peers
        iii. School
        iv. Clinic
        v. Church
        vi. Information Seeking
    b. Age-appropriateness

c. Self-efficacy

15. Usefulness of Sex Information Sources: Identification of which sex information sources were most useful or least useful in decisions made about sexual health.