RISKY SEXUAL BEHAVIORS IN ADOLESCENTS:
THE IMPACT OF SOCIAL AND CULTURAL CAPITAL

Jessica Anne Hayes
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THE IMPACT OF SOCIAL AND CULTURAL CAPITAL  

A Thesis  

by  

Jessica Anne Hayes

Approved by:

________________________________, Committee Chair
Amy Qiaoming Liu Ph.D.

________________________________, Second Reader
Jacqueline Carrigan Ph.D.

Date
Student: Jessica Anne Hayes

I certify that this student has met the requirements for format contained in the University format manual, and that this thesis is suitable for shelving in the Library and credit is to be awarded for the thesis.

__________________________, Graduate Coordinator
Amy Qiaoming Liu, Ph.D.                     Date

Department of Sociology
Abstract

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Adolescents’ risky sexual behaviors are a serious public health concern in the United States. This study used the Center for Disease Control’s 2007 Youth Risk Behavior Survey to examine the complex relationships among social capital, cultural capital, and adolescents’ risky sexual behaviors. Analysis of the data revealed statistically significant relationships between social and cultural capital and risky sexual behaviors. The effect of social capital was stronger than the effect of cultural capital, even though both were weak predictors. Moreover, the impacts of social and cultural capital differ for males and females, resulting in contrasting outcomes in sexual behaviors. For example, females with higher levels of social and cultural capital were more likely to resist engaging in risky sexual behaviors, while the opposite was true for males. This indicates that social institutions in the United States continue to reproduce traditional gender ideologies, even when attempting to educate young people about the risks associated with sexual activities. Therefore social scientists need to continuously re-evaluate the effects and potential benefits associated with social and cultural capital and the ways in which both forms of capital produce differential effects in actual female and male sexual behaviors.
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Chapter 1

STATEMENT OF PROBLEM

The prevalence of adolescents’ risky sexual behaviors is a major concern in the United States. Trends in adolescents’ sexual behaviors from 1991 to 2005 show that nearly half of young people studied engaged in sexual intercourse during high school (Center for Disease Control (CDC) 2008). A report in 2007 from the CDC indicated that teen pregnancy rates were up for the first time in 14 years. The current rate is 42 births per 1,000 females ages 15 to 17. These findings vary among ethnicities, with African American females having the highest teen pregnancy rate at 83 births per 1,000 teens, Hispanic females at 64 births per 1,000, and non-Hispanic white females at 27 births per 1,000 teens. In addition, the rates of drug and alcohol use during adolescents’ last sexual encounter have also increased (CDC 2008). Equally disturbing is the trend in which more young people are engaging in oral and anal sex with the impression that these activities carry a lower health risk than actual intercourse (Hollander 2005). Of course, such behavior prevents pregnancy, which is generally more feared than sexually transmitted diseases (STDs). Conversely, other studies have indicated that contraceptive use at last sexual encounter has increased and that more young people were waiting longer to engage in sexual activity (Franzetta, Terry-Humen, Manlove, and Ikramullah 2006; Manlove, Ryan, and Franzetta 2004).

Another crucial global public health concern with adolescents’ risky sexual behaviors is the spread of STDs. Compared to other western nations, the United States
has the highest STD rate among adolescents aged 15 to 19 (CDC 2008; Kids Count 2006). The gonorrhea rate among American teens was 74 times higher than in the Netherlands and the chlamydia rate was over 20 times higher than in France (Feijoo 2001). Racial and gender differences were evident in the distribution of STDs among young people in the United States. Non-Hispanic black females had a disproportionately higher rate of chlamydia and gonorrhea than any other racial or ethnic groups. In addition, females had higher rates of all STDs combined compared to males (Mackay and Duran 2007).

Teen pregnancy, STDs, and other serious consequences of adolescents’ risky sexual behaviors have long-term and often devastating effects on the individual as well as society. Female adolescents bear the brunt of the repercussions of risky sexual behaviors. Teen motherhood frequently limits educational and employment opportunities and they are generally left raising the child alone. Many teen mothers do not finish high school and end up collecting welfare to provide for their child. The existence of various health problems in infants has also been linked to being born to teenage mothers (Hamilton, Martin, and Ventura 2007; Kids Count 2006). The social and health consequences stemming from adolescents’ risky sexual behaviors are an increasing dilemma for social institutions, including families, educational institutions and public health agencies (CDC 2008; Kids Count 2006; Feijoo 2001). These institutions are constantly trying to find more effective ways to deter and prevent sexual risk-taking among adolescents.

In the United States, significant efforts are underway at local, state, and national levels to promote positive health behaviors among teens. These efforts include mandatory
health classes and the availability of sex education in schools, providing greater access to family planning clinics, and the implementation of youth development programs (Grignon 2008; Mauro and Joffe 2007; Rose 2006; Moore, Lippman, and Brown 2004; Park 2004a; 2004b; Kirby 2002; Wilson 2000). Unfortunately, these preventative interventions designed to decrease adolescents’ risky sexual behaviors have met with very limited success. This is evident from the current high rates of teen pregnancy and STDs that persist in our adolescent population. If these measures were more effective, we would see a decrease in adolescents’ risky sexual behaviors.

A recent social policy to teach abstinence-only sex education has not produced the outcomes policy makers intended and many states are returning to a more comprehensive approach to sex education (Mauro and Joffe 2007; Rose 2005). For many in the United States, there has existed a fundamental discrepancy between the limited information some think should be available to teens about sexual health versus the outcomes desired. How much and what type of sexual information should be distributed to young people is a current and active social debate with much controversy and numerous differing viewpoints. Some policies prohibit providing direct information on different kinds of contraception and access to family planning services. However, most research on sex education shows clear evidence that having access to sex information does not increase the likeliness of adolescents engaging in sexual activity (Mauro and Joffe 2007; Rose 2006; U.S. Congress 2004; Perrin and Dejoy 2003; Kirby 2002; Wilson 2000; Zelnik and Kim 1982). This lack of consistency regarding the provision of comprehensive sexual health information to young people has had negative
consequences, which could directly connect to our current high rates of teenage pregnancy and STDs. It is unlikely that Americans will agree on sex education any time in the near future. Therefore it is imperative to search for alternative ways of educating young people about responsible health choices.

Unlike the disagreements in the debate about sex education, health knowledge about nutrition and physical activity has a solid foundation as a value within our major social institutions. If a family eats a balanced diet, it is more likely that the child will adopt that value and eat accordingly (Hamilton, Martin, and Ventura 2007; Kids Count 2006). This could also be true for physical activity: if children grow up in an active family they will be more prone to continue being active in adulthood. Health education is another socialization tool. Classes in which children are taught the importance of the four food groups, essential vitamins and minerals, and regular exercise may affect their health behavior.

The majority of the research about nutrition is based in studies of biological development, academic performance, parental controls, and childhood obesity (Cohen, Finch, Bower, and Sastry 2006; Bruckner, Martin, and Bearman 2004; Carmona 2004; Frelut and Flodmark 1995). It would be deficient for any study that investigates exercise and a nutritional diet to not mention obesity. This is another common health problem for teens in the United States. In this research, obesity will not be studied directly. It does constitute another health concern that could benefit from the scientific examination of how young people internalize health knowledge and apply that knowledge when making decisions that affect their health.
Adolescent obesity has significantly increased in recent years. The National Institute of Health (2004) reported that the leading causes of obesity in children and adolescents were genetics, lack of physical activity, unhealthy eating patterns, or a combination of these factors. According to the CDC (2008), nearly one-fifth of our nation’s youth was overweight or obese which puts them at a significantly higher risk for health problems in adulthood. Overweight children were more likely to become overweight adults resulting in health issues including diabetes, heart disease, and psychosocial problems such as low self-esteem and stigmatization (CDC 2008; Cohen et al. 2006; Office of the Surgeon General 2004; Frelut and Flodmark 2002; Hill and Lissau 2002; Kirkcaldy, Shephard, and Siefen 2002; Garcia, Broda, Frenn, Coviak, Pender, and Ronis 1995). As with participation in risky sexual behaviors, lack of regular exercise and a healthy diet create barriers in an individual’s social life and economic advancement.

Responding to this social dilemma, the CDC launched The School Health Policies and Program Study (SHIPPS) to evaluate whether additional funding has increased the amount of knowledge young people receive about nutrition and physical activity (CDC 2008). The SHIPPS report indicated that over three-quarters of middle schools and over 90 percent of high schools offer interscholastic sports to their students. However, many school sports programs are now charging higher fees, making it more difficult for children from low-income families to participate (Carmona 2004). Other social policies have been created to deal with the new health epidemic of obesity such as the Healthy Children through Better Nutrition Act of 2003, in which the Federal Institute of Medicine set standards for school nutrition. The Women, Infant, and Children Program (WIC)
subsidizes food costs through vouchers for specific nutritional foods to women with families living below the poverty threshold (Richardson 2004).

Parents also play an active role in the transfer of knowledge about proper diet and the importance of regular physical activity. Variyam’s (2004) research maintained that parental perception of their own weight status was a factor in predicting the likeliness of their children becoming overweight. Nevertheless, society attaches a negative stigma to obesity that can lower individuals’ self-esteem, decreasing their likeliness of participating in social organizations, and even reducing their ability to find employment (Hill and Lissau 2002). There is agreement among public health officials that preventing obesity is a necessity, and the importance of a balanced diet and regular physical activity should be taught to all children. As seen above, public health institutions have made significant progress in creating policies to try and deter obesity among young people. The same attention needs to be paid to other health risk behaviors such as risky sexual behaviors.

Traditionally, research on risky sexual behaviors among teens has focused on their damaging health choices such as alcohol and drug use (CDC 2008; Bruckner et al. 2004; Manlove et al. 2004; Luster and Small 1994). Little attention has been paid to the relationships between positive health choices (e.g. diet and exercise) and adolescents’ sexual activity. Theoretical concepts such as cultural and social capital may impact adolescents’ sexual behaviors, yet these constructs have yet to be empirically investigated in relation to patterns of adolescents’ risky sexual behaviors. This study contributes to our body of knowledge by investigating the relationships between adolescents’ risky sexual behaviors and their social and cultural capital. Understanding how these constructs
affects teens’ sexual choices is essential for creating more effective preventive measures, particularly education.

Youth development programs are a significant contributor to instilling social and cultural norms to young people. These programs have a variety of objectives and strategies, but this research will focus on the role of youth development programs in the socialization of adolescents. Such programs are designed to give young people information about acceptable behaviors within various social structures. These acceptable behaviors in terms of health knowledge include healthy eating patterns and consistent physical activity, as well as teaching what is considered unacceptable behaviors including drug use and unprotected sex (Park 2004a; 2004b). This balanced perspective, addressing both the prevention of negative behaviors and the promotion of healthy behaviors, represents a comprehensive way of addressing these health issues.

Another important goal of youth development programs is to guide teenagers in developing judgment skills with the intention of promoting responsible decision-making and self-control (Durlak, Taylor, Kawashima, Pachan, DuPre, Celio, Berger, Dymnicki, and Weissberg 2007; Park 2004b). On a social and cultural level, it is imperative that teens internalize the values associated with making responsible decisions about their health. Cohen et al. (2005) found that the informal social control and social cohesion of a community has significant impact on youth health behaviors and can deter problem behaviors before they emerge. Problem behavior can be deterred through education, mentoring, or strengthening social networks, youth development programs are designed to intervene before negative consequences can occur (Durlak et al. 2007; Moore et al.
These programs act as a safeguard to lessen the likelihood of young people participating in risky health behaviors, including risky sexual behaviors.

Participation in sports is the most popular form of youth development programs and includes components of physical activity, learning to be a team member, and learning to set, work toward, and accomplish goals collectively. Roughly half of all adolescents in the United States participate in organized sports teams (Miller, Barnes, Melnick, Sabo, and Farrell 2002). These adolescents learn trust and reciprocity within their adult and peer-relationships, as well as benefiting from a healthier body image and higher self-esteem (Park 2004a: 2004b). Sports team membership can be an opportunity for teens to learn about acceptable health behaviors.

The following section of this paper explores how social capital (group membership through sports teams) and cultural capital (the value of a healthy diet and consistent physical activity) affect adolescents’ risky sexual behaviors by examining the following four general research questions:

Is there a relationship between social capital and participation in risky sexual behaviors (Question 1)?

To answer this question, the following specific research hypothesis is tested:

Those with sports team membership are less likely to engage in risky sexual behaviors (Hypothesis 1).

Is there a relationship between cultural capital and participation in risky sexual behaviors (Question 2)?

To answer this question, the following two specific research hypotheses are tested:

Those who exercise more are less likely to engage in risky sexual behaviors (Hypothesis 2A).
Those who eat a healthy diet on a regular basis are less likely to engage in risky sexual behaviors (Hypothesis 2B).

Of the two forms of capital (social or cultural), which one has more impact on adolescents’ risky sexual behaviors (Question 3)?

Do the relationships among social capital, cultural capital, and participation in risky sexual behaviors differ for boys and girls (Question 4)?
Chapter 2

LITERATURE REVIEW

This section contains a review of the relevant literature on the connection between social capital (team membership), cultural capital (teen’s exercise and diet), and adolescent risky sexual behaviors. Social capital will be examined first as a means of social cohesion (trust and reciprocity) within adolescent subculture. Youth development programs such as sports teams establish a form of social networks (social capital). These networks encourage young social actors to employ their agency in making positive health choices. Second, Bourdieu and Passeron’s (1977) cultural capital theory is used to explore the relationship between internalization of the cultural values of eating a well balanced diet and exercising regularly and how these values are incorporated into the decision making process concerning adolescents’ risky sexual behaviors. The focus will be on how adolescents learn health knowledge through social institutions and the degree to which they practice healthy behaviors.

Social Capital

*Conceptualizing social capital among adolescents.* Social capital as a sociological tool is difficult to conceptualize and define due to the lack of consensus among theorists about what the term means and how it should be used empirically. This is particularly true when considering the social capital of adolescents. Theorists often maintain that it encompasses resources made available to social actors through their group memberships. The following paragraphs will consider the different definitions of social capital as well as how researchers apply it in their studies.
Capital is generally viewed as an economic term to describe monetary revenue, such as the net worth of personal assets or stock holdings of a company. However, the word, “capital,” in the term, social capital, refers specifically to the resources available to actors through memberships in social organizations or groups and the impact these relationships have on their social lives (Halpern 2005; Marrow 2001; Putman 2000; Coleman 1988). Social capital differs from cultural capital. Cultural capital refers to social actors’ internalization of cultural values that are passed down through social and cultural institutions; this will be discussed later in this section (Bourdieu and Passeron 1977).

The conceptualization and definition of social capital is fluid and varies due to the diverse forms of social networks. Several researchers have recommended caution when investigating social capital due to its abstract nature, multiple definitions, and disparate metrics resulting in conflicting findings (Schaefer-Mc Daniel 2004; Liu and Besser 2003; Macinko and Starfield 2001; Marrow 2001).

Coleman (1988) suggested three forms of social capital: “1) obligations and expectations, which depend on trustworthiness within the social environment, 2) information flow capability of the social structures, and 3) norms accepted by sanctions” (p. S119). As a theoretical tool, social capital encompasses the various relationships social actors have and the impact of these relationships on their attitudes and behaviors. In The Adolescent Society, Coleman (1961) contended that adolescents seek approval from their peers and they also give and withhold approval for particular behaviors. Coleman was convinced that society needed to learn how to control teens through their
peer networks. His contention was that society needs to discover what values teens tend to mimic in their sub-cultures. As young actors become more embedded in youth society, established norms become the reference point for their decisions about health and well-being (Coleman 1988). Coleman’s recognition of the importance of peer acceptance still holds true. Whether it is positive reactions from peers for having a fit and attractive body or negative responses to the participation in risky sexual behaviors, gaining acceptance from peers is at the heart of adolescent society.

Social capital as a resource depends on the social actor’s ability to secure benefits through their group membership (Hawe and Shiell 2002). In these groups or networks, social actors share information, provide and receive support and work together to achieve collective goals. Social capital is acquired through acquaintances and recognition of productive activities within social networks (Macinko and Starfield 2001). It allows teens to perceive their behaviors within social contexts and to strengthen their ties to social institutions such as the family, school, and other group memberships. In Putman’s (2000) study on civic participation, he hypothesized that informal social connections facilitated cooperation for mutual benefit. Putman claimed that states that scored higher on the Social Capital Index had a lower incidence of teen parenthood, academic failure, and adolescent suicide. In this context, youth involvement in sports is a process in which teens build bonds with other like-minded teens that could lead to sharing the value of abstaining from risky sexual behaviors.

Wilson and Musick (1997) defined social capital in terms of group membership being a collaborative activity that creates an atmosphere where conformity in behaviors is
expected of participants. One requirement in sports is to attend both practices and games where the teens are working towards a collective goal of winning the game. This serves to limit the amount of leisure time available to participants thereby reducing their opportunities to participate in risky sexual activities (Kirkcaldy et al. 2002; Miller et al. 1998). In addition, individuals’ behaviors (on and off the team) affect the performance of the team as a whole. This often translates into consequences for those individuals whose adverse behaviors impact the team. All of the above factors indicate a higher level of individual responsibility resulting from adolescents’ membership on sports teams.

Sports team membership is a significant component of youth development programs and therefore a resource for adolescents’ social capital. Durlak et al. (2007) investigated the levels of change in adolescents’ behavior brought about by youth development programs. Their findings illustrated that many programs aimed at change on both micro and macro levels. Changes in individual behaviors were at the center of most programs, such as the deterrence of deviant behaviors. Changes within broader social structures were also a goal of these programs. Targets for macro changes were levels of parental involvement, social cohesiveness of the classroom, and particular social policies to induce modification in youth behaviors. This approach emphasized the importance of youth development programs to increase adolescents’ level of social capital and its relationship in preventing youth risk behaviors. Under this conceptualization, team membership categorized as a form of social capital should also aid in preventing risky sexual behaviors.
There appears to be disagreements among researchers as to whether we should examine the relationship between social capital and youth behaviors. Some researchers recommend approaching empirical inquiries of this nature with caution. Marrow (2001) maintained that when social capital is linked with health-related behaviors, research attempted to connect the micro-level behaviors with the macro-social structures. She argued that health behaviors are too individualistic to associate with major social policies. She also contended that most research on the social capital of teens looks at the implications of social lives on health and well-being, and does not explore their behaviors directly. Using Bourdeiu’s conceptualization of social capital, she explored the process teens utilize in internalizing their social world through their perceptions of their neighborhoods and towns. She focused on how they understand their social networks, local identity, sense of belonging, civil engagement, and attitudes towards community institutions. Marrow (2001) asserted “…we should move towards a view of children as active social agents who shape the structures and processes around them (at least on the micro-level)” (p. 42). Although there were significant differences among age, race, and gender, she found that teens do impact their communities and recognize their networks as a resource. This study demonstrates clearly that the utilization of social capital among teens is worthy of examination and may lead to insight into deterrents of adolescents’ risky sexual behaviors.

In Schaefer-Mc Daniel’s (2004) critique of the social capital theory, she argued that the majority of research on the social capital of youth was measured by adult reports, thereby failing to capture young people’s perceptions of their own relationships within
society. She maintained that there were conceptual differences as to how social capital was defined and measured, especially when studies focus on children and young adults. She claimed that while Bourdieu and Coleman view social capital as a private good, Putman sees it as a public good and in his research on civic engagement ignores young people as agents of social capital. Schaefer-Mc Daniel (2004) suggested that it was through adolescents’ own experiences and perceptions that we should measure the effects of social capital on their behaviors. Teens will increase their participation in formal and informal social groups such as sports teams and after school activities as they accumulate higher levels of social capital. Young people made decisions daily based on their perceptions and understanding of accepted social behaviors and they were active participants in the choices they make about their sexual health. With social capital as a resource, they may possess more bargaining power in negotiating sexual encounters.

Schaefer-Mc Daniel (2004) also proposed that the measurement of social capital through group membership should concentrate on voluntary participation given that some teens are coerced by adults into church or volunteer activities. If young people are forced into group membership, they may not obtain the benefits conferred by their group membership. In Coleman’s (1988) definition of social capital, individuals must recognize and accept the group expectation of behavior, feel a level of trust within the group dynamic, and conform to the sanctioned behaviors.

The role of individual and family factors on adolescents’ sexuality has been thoroughly studied; however, the influence of community action is less established. Crosby, Holtgrave, DiClemente, Wingood, and Gayle (2003) evaluated the impact of
social capital on sexual risk, using Putman’s 2000 Social Capital Index. This index measured levels of political, religious, and civic participation within communities throughout the United States. The research was based on adult accounts, not on adolescents’ actual civic participation. Those states with higher participation rates had higher levels of social capital (Putman 2002). Additional results showed social capital was inversely associated with risky sexual behaviors and positively correlated with sexual protective behaviors. This was especially true for males. However, one major problem with this study was the limited ability to generalize findings from adults to adolescents, bolstering the Schaefer-Mc Daniel (2004) argument that we need to examine adolescent, not adult, social ties to study relationships between social capital and behaviors.

Another challenge to defining social capital is the overlap of principles with the paradigm of cultural capital as a theoretical tool in examining adolescents’ risky sexual behaviors. Cultural capital includes the norms and values of the larger social structures and how individuals gain and process knowledge passed down through social and cultural institutions. Social capital focuses on smaller group memberships and the relational aspects of social networks such as trust and conformity within the group. The prevention of adolescents’ risky sexual behaviors is an important societal goal. If group membership such as sports team membership can deter adolescents’ risky sexual behaviors, then the internalization of health knowledge may also curb such behaviors. In the following segment, past research on adolescents’ behavior and team membership (social capital) and its impact on adolescents’ sexual behaviors will be examined.
Social capital and adolescents’ behaviors. This section contains information on previous empirical inquiries into social capital and youth behaviors. The focus of these studies was concerned with how young people obtain and utilize social capital through group memberships. The research on the impact of sports team membership on adolescents’ risky sexual behaviors has focused mainly on gender diversity (in regards to self-image) and perspectives on scripted normative roles for gaining higher social status within peer groups (Miller et al. 2002; Tracy and Erut 2002; Elite and Elite 2002; Kirkcaldy et al. 2002; Miller et al. 1998). One major limitation to the empirical use of social capital is the lack of agreement on whether it is social ties within groups or the sanctioned cultural norms that affect behaviors. For example, scripted normative expectations of gender behavior in sports participation may be founded in the cultural norm of gendered behaviors rather than through group membership. It would certainly not be unusual to find that both affect behaviors to different extents at different times, depending on the individual and circumstances. Males are generally socialized to be sexually aggressive and females sexually passive. The fact that female athletes are less likely to conform to normative expectations and feel less emotionally dependent on male attention to establish their self-worth illustrates how their group membership impacts how they internalize societies’ expectation of gendered roles (Miller et al. 2002). One study found that participation in sports increased self-esteem, sense of physical well-being, and attachment to school (Tracy and Erut 2002). It was found that through the social networks of athletic involvement, both adolescent males and females gained more status and social capital.
Another study investigated the correlation between sports participation and status within peer groups. Eitle and Eitle (2002) asserted that adolescents who participate in sports possess a higher status within their peer groups, thus having a higher degree of social capital or resources. They examined sports participation as a mechanism to a higher status among teen males and found that sports were an avenue for disadvantaged youths to advance their social resources and attain higher status. High status signals (attitudes, behaviors, and preferences) were an instrument of social inclusions to and exclusions from social networks. This demonstrated the importance of adolescents’ involvement in social networks, particularly for those from lower income families, to gain more resources and access to more opportunities.

Miller and associates (2002; 1998) conducted two studies exploring the relationship between sports team membership and adolescents’ risky sexual behaviors. In the first study, Miller’s et al. (1998) used the theoretical lens of control theory, cultural processes, and engagement processes to examine the relationship between athletic males and females and the likelihood of their participation in risky sexual behaviors. They discovered that girls with athletic social status gained from sports participation had more bargaining power in resisting sexual pressures. In contrast, boys employed their athletic social status to engage in more risky sexual behaviors. They also investigated how teens utilized their social capital to create strong ties to coaches and other teammates. These ties are another deterring factor for risky sexual behaviors. It was found that male athletes internalized athletic prowess, which reinforced traditional male stereotypes whereas the opposite was true for females. Adolescent female athletes were less likely to participate
in sexual activity than female non-athletes, whereas the opposite was true for males. They concluded that although athletic participation operated differently on sexual risk behaviors of males and females, it did in fact enhance both male and female social status, granting them greater power to negotiate sexual outcomes.

Miller’s et al. (2002) second study expanded on the concept of adolescents’ athletic participation and its influence on risky sexual behaviors. Using the cultural resource theory, they investigated teens’ involvement in sports and exercise during leisure time and their likeliness of engaging in risky sexual behaviors. Sports involvement increased interaction with peers and adults (coaches and health professionals) thus boosting social capital for those participants. Leisure time physical activity could be accomplished in a social setting such as a gym or in isolation. According to their results, adolescents adhered to scripted normative gender roles consequently affecting their bargaining power in sexual situations. For a more in-depth analysis; see Miller et al. 2002. The findings of this research indicated that comparable to sports team membership, exercise was associated with a decreased likeliness of adolescents to engage in risky sexual behaviors compared to non-athletes and non-exercisers. However, they found little support for their hypothesis that athletic status would have a greater impact on sexual risk taking than exercise alone for both males and females. Even outside the formal bonds of organized sports, “physical exertion acts as a buffer against risky sexual behaviors” (Miller et al. 2002:446). Since the choice to exercise does not necessarily take place in a social setting, I propose that regular physical
activity is related more to teens’ accumulation of cultural capital (internalizing the cultural value of positive health behaviors) rather than social capital (team membership).

Social networks play a significant role in how young people view the world and their place in it. While there are many forms of social networking, all with varying degrees of resources, sports is one of the most common forms of social groups for teens. Using Coleman’s (1998) framework of social capital, sports team membership is an opportunity for young people to learn about the obligations and expectations of social behaviors as they enter adulthood. Social capital is a catalyst for young people to increase their social status and achieve more bargaining power within their relationships (Eitle and Eitle 2002; Miller et al. 2002). This growth in adolescents’ social resources influences the likelihood of not participating in negative behaviors. This study expands on the idea that social capital is gained through sports team membership and delineates its impact on risky sexual behaviors.

Another consideration is the blurred line between the effects of social ties versus the effects of cultural norms on adolescents’ behaviors. It is hard to measure quantitatively to determine if social or cultural capital has more impact on preventing risky sexual behavior. It might be wise for policies to take both into account when devising ways to encourage teens to choose positive sexual behaviors.

Hypothesizing social capital and adolescents’ sexual risk. Utilizing social capital as a theoretical tool to understand how young people behave within their social worlds can provide better insights into what factors deter risky sexual behaviors. Acceptance from peer groups is a powerful motivator in adolescent society and some group
memberships confer a higher status than others. Sports team membership is one of the most prevalent forms of youth development programs, which makes it a viable measure of social capital in adolescent research. Empirical inquiries into the relationship between sports involvement and risky sexual behaviors have ignored the role of social capital as a means of deterring sexual activities. Sports team membership is a social resource for adolescents. As team members young people learn important social expectations and ascribe to sanctioned behaviors and attitudes held by the group. This form of network can impact the sexual choices of athletes. Therefore the first research question is:

Is there a relationship between social capital and participation in risky sexual behaviors (Question 1)?

To answer this question, the following specific research hypothesis is tested:

Those with sports team membership are less likely to engage in risky sexual behaviors (Hypothesis 1).

Moreover, Miller et al. (1998) found significant differences in sexual risk taking between male and female athletes; male athletes were more likely to take sexual risks than their female counterparts. Therefore this study examines whether this gender difference also emerges. This leads to the following research question:

Does the relationship between social capital and participation in risky sexual behaviors differ for boys and girls (Question 4A)?

Cultural Capital

The following section explores the social construction of health knowledge in contemporary American society. Then, different definitions of cultural capital are examined. Finally, reviews of how other researchers use cultural capital as a theoretical tool to investigate adolescents’ risky sexual behaviors.
The social construction of health knowledge. To examine how young people gain access to important health knowledge, we must look at the social institutions in which they access and receive information. Basic health knowledge begins with the family. Family health knowledge is a child’s first resource for learning about hygiene, nutrition, and the importance of physical activity. Both the value and the degree of health knowledge taught vary from family to family. Adolescents raised in one-parent homes are at a disadvantage due to the lack of time the parent is able to commit to passing down health knowledge (Oman, Vesely, and Apsy 2005).

Educational institutions generally act as the next source of health knowledge. As a child continues to be socialized, health information comes from the media, peers, extended family, youth development programs, and other social institutions. In spite of the effort put into the distribution of health knowledge, the degree to which teens internalize health information from these outlets varies. Degrees of internalization are difficult to measure; consequently researchers commonly investigate the influences on an individual and the resulting behaviors. However, if we concentrate only on negative behaviors, we lack a comprehensive perspective that could demonstrate how teens internalize and utilize health knowledge in their sexual choices.

With the focus on the negative influences of adolescents’ choices, we ignore the obvious benefits of education. For society to be proactive, youth development programs need to grasp all the factors shaping how adolescents internalize its teachings and how they perceive their actions within social structures. Numerous researchers have found that children from one-parent homes, those who live in unsafe neighborhoods, and those who
lack peer or mentor relationships were more inclined to participate in risky health behaviors including unprotected sex (Oman et al. 2005; Coleman 1998; Furstenberg and Hughes 1995; Luster and Small 1994). However, the absence of research on adolescents who make responsible health decisions, such as eating a balanced diet and exercising regularly, creates a gap in our empirical understanding of adolescents’ health behaviors. By also examining responsible health behaviors, we gain a more thorough comprehension of factors associated with adolescents’ risky sexual behaviors.

To utilize educational resources most effectively, it is essential for social agencies to examine the causes of risky sexual behaviors among adolescents. This examination will aid in the ultimate goal of finding preventative measures that avert negative outcomes, including teen pregnancy, STDs, and having multiple sexual partners. The lack of success of current programs in preventing negative outcomes associated with risky sexual behaviors suggests that efforts to deter these activities need to be restructured and reevaluated for their effectiveness. Moore, Lippman, and Brown (2004) argued that there are a minimal number of positive measures in national databases about adolescents’ behaviors and that this limits our understanding of the beneficial outcomes of positive activities. Effective education needs to include both positive and negative antecedents of adolescents’ sexual behaviors.

Social ideology regarding the promotion of healthy youth behaviors mostly concentrates on prevention. Prevention science focuses on measuring risk factors, yet it ignores the diverse reasons for particular dysfunctions or unhealthy behaviors (Coie, Watt, West, Hawkins, Asarnow, Markman, Ramey, Shure, and Long 1993). Public health
officials often concentrate on predictors of risk behaviors, and social scientists need to expand this scope to include the relationship between positive health choices and adolescents’ risky sexual behaviors. By exploring the connection between the internalization of positive health behaviors and likelihood of participation in risky sexual behaviors, we may be able to decrease the current high rates of teen pregnancy and STDs.

In addition to negative impacts on the teens themselves and their families, adolescents’ risky sexual behaviors have negative effects on society. Social service assistance for both STD treatment and family planning clinics are often publically subsidized. Many teens fear discussing their sexual behaviors with their parents or other authority figures and therefore end up utilizing free health services. If greater resources went into the development of programs that are more effective disseminators of information for adolescents; the costs to society on treating the consequences of risky sexual health behaviors would be lower. In short, the amount of health information internalized by young people has lasting effects on their health decisions whether it is partaking in regular physical activity, eating a healthy balanced diet, or abstaining from risky sexual behaviors. The consequences of their actions significantly impact the individual, the family and society as a whole.

*Conceptualizing health knowledge as cultural capital.* Through the theoretical framework of sociology, cultural capital refers to the resource of knowledge distributed to individuals within social institutions. Not only are social actors an asset to the labor market, they also are a resource on a cultural level. Bourdieu and Passeron (1977) defined cultural capital as cultural competencies of social actors, their perceptions of cultural
values and norms, their preferences and their use and understanding of language. Some theorists believe Bourdieu was interested in the attainment of cultural capital through cultural fields to find distinctions in individuals’ social class and status (Anheier, Gerhards, and Romo 1995). Cultural capital accounts for one’s cultural competencies in internalizing the knowledge acquired during childhood mainly through social institutions such as family and schools (Dumais 2002). Internalizing the cultural knowledge of positive health choices such as healthy eating and regular exercise is a characteristic of adolescents that possess cultural capital. This research expands on this idea and examines how these positive health choices affect the likeliness of participation in risky sexual behaviors.

Wilson and Musick (1997) conceptualized cultural capital as social profit, yielding both social and self-esteem, postulating that cultural values are a viable resource or capital. They maintained, “At the cultural level, capital consists of attitudes, knowledge, and preferences” (1997:696). They also argued that the distribution of knowledge is a resource, a ‘symbolic good’ that can be consumed and acquired through social interaction. This definition incorporates both cultural capital (symbolic good of health knowledge) and social capital (social interactions). Although they were measuring volunteer patterns of adults, the principle behind knowledge as a symbolic good can be utilized in examining the health choices of adolescents. If teens make responsible decisions about their health, there is a mutual benefit for the individual as well as society. For example, regular exercise and a healthy diet increase the well-being and quality of life of individuals as well as reducing the probability of becoming overweight or obese.
In addition, abstaining from risky sexual behaviors allows teens to avoid the negative consequences associated with pregnancy and STDs. Both teen pregnancy and adolescent obesity are serious public health issues in the United States. There is social profit in the cultural capital of health knowledge. If teens internalize the social value of a healthy lifestyle, this may also persuade them to not participate in risky sexual behaviors.

Grossman (1972) hypothesized health as a commodity that individuals demand; they invest their time in this non-market good, which has social profits such as a higher social status. He contended that the stock of health knowledge is capital and will depreciate with age; therefore the investment can be measured by medical care, diet, and exercise. The cultural capital of health behaviors could be considered an expressed value, where there is a greater return on investment such as a higher self-esteem or perceived quality of life. This suggests that adolescents who participate in positive health behaviors have a higher level of cultural capital. This research will elaborate on the concept that positive health choices are a cultural value based on quality of life rather than wealth.

Providing adolescents with the cultural knowledge of morals and values within a society is a form of social control. Teens that either abstain from sex or practice safe sex have endorsed, either implicitly or explicitly, the value of health knowledge and the risks associated with unprotected sex. Moreover, a young person who chooses to exercise in their leisure time or is mindful of their diet illustrates how health knowledge is incorporated into behaviors.

With respect to cultural capital and school success, Dumais (2002) theorized that in order to gain cultural capital, adolescents must possess the ability to receive and
internalize cultural values. This permits them to develop aspirations and practice responsible, beneficial activities within cultural constructs. A poor diet or lack of physical activity can have lasting negative consequences on the physical well-being of individuals as well as lower their self esteem (Tracy and Erkut 2002). The lower the cultural competencies adolescents have towards health knowledge, the more inclined they could be to engage in other risk behaviors.

Positive health behaviors are a resource for society. If the cultural value of positive health choices becomes a personal value, there is less chance adolescents will face barriers associated with poor health within social structures. Bhattacharya and Currie (2001) explored constraints to utilizing nutritional knowledge for teens by the amount of information available to them from their parents as well as the family budget. They concluded that American children are *mislabeled* rather than malnourished mainly due to the lack of correct information about the importance of a balanced diet and regular exercise. Furthermore, young people who embrace cultural capital by acting on their health knowledge may be more inclined towards safe sexual activity, including abstinence. If young people act out the cultural value of avoiding teen pregnancy, it is worth examining whether their cultural capital of positive health knowledge is a predictor of responsible sexual behaviors. During my review of literature about cultural capital and health, there were limited studies directly linking the two although, as stated above, it is worthy of consideration. The next section will explore cultural capital and its relationship to adolescents’ risky sexual behaviors.
Cultural capital and adolescents’ behaviors. Many researchers have considered the significance of cultural capital on youth behaviors including academic success, status positioning, participation in sports, and other extracurricular activities, as well as likelihood of participating in risky sexual behaviors (Carter 2003; Eitle and Eitle 2002; Dumais 2002; Kivisto 2001; DiMaggio 1982). The effectiveness of using cultural capital as the framework to investigate how cultural norms influence adolescents’ choices and actions enhances our understanding of variability in behavior among teens.

As a society, there is a structural approach to the knowledge passed down to younger generations. The social institutions of education and family are the foremost authorities over what information is distributed, typically through curriculum and rules. Schools are required to teach health classes in order to transmit the cultural value of health quality as well as to educate on the dangers of poor health behaviors. The shared consequences of teen parenthood and obesity are a liability to the collective whole, creating the need for more social services and subsidies and ultimately costing the state fiscal capital. The beneficial outcomes of adolescents who practice positive health choices include higher self-esteem, higher status within peer groups, and better health in adulthood (Garcia et al. 1995; Mechanic and Hansell 1987). Young people who have a more positive self-image are less likely to participate in risky behaviors like drug use, crime, and unprotected sex which are more likely to happen during teens’ leisure time (Kirkcaldy et al. 2002). If the teens are engaging in physical activity during their leisure time, then the opportunity to partake in deviant activities is reduced.
The genuine challenge revolves around developing a true understanding of why some teens choose to adopt cultural values, while other teens do not. Kivisto (2001) analyzed ‘risk’ as it pertains to individual behavior and ‘risk’ as a cultural norm. He wanted to know why some girls choose to use family planning services and others do not, considering the cultural value of either abstaining from sexual activity or practicing safe sex. He interviewed adolescent females who were already teen mothers and general clients at a family planning clinic. His findings indicated that the cultural morals concerned with sexual conduct do not have the power and authority that they once possessed. Also, females with more cultural capital in terms of more knowledge about and access to family planning services were less likely to be teen parents and engage in risky sexual behaviors. They also had fewer partners, were older when sexual activity began, and were more likely to use contraceptives at the last sexual encounter. They had higher aspirations for their future, and made decisions based on the perceived risk of sexual activity that can have detrimental social and cultural consequences. Kivisto (2001) concluded adolescent females needed more social and cultural resources to make responsible sexual choices in a risk society. It is possible that more knowledge about the consequences of an improper diet and lack of exercise would influence adolescents’ nutrition and physical activity patterns. This study illustrated how the accumulation of health knowledge as a form of cultural capital does indeed influence the health choices of young people.

Another pertinent study of cultural capital and adolescents’ academic success demonstrated that as young people accrue cultural capital by participating in cultural
activities, they utilize it in other areas of their lives. Dumais’ (2002) research recognized that adolescent females utilize cultural capital as a powerful resource for school success. The higher the level of cultural capital they achieved, the more successful they were both academically and socially. Using the framework of Bourdieus concept of habitus (one’s view of the world and one’s place in it), she measured cultural capital as the sum of activities the youth participated in focusing on gender differences. These activities included participation in art, music, and dance, visiting museums and public libraries, and going to concerts. Dumais (2002) concluded that cultural participation was at the heart of one’s cultural resources and girls’ participation outnumbered boys in every activity. If parents were willing and able to pay and make the time commitments, this would also increase the teen’s cultural capital. Her research also disputed the long-established claim that females use cultural capital to attract accomplished husbands. Due to this traditional gender ideology, however, she also concluded that females may need to possess more cultural capital to have equality with men (Dumais 2002). With her gendered ideology in mind, we must also consider whether the cultural value of health knowledge influences adolescent females more than males.

The review of literature demonstrated that some researchers measured adolescents’ quantity of health knowledge without referencing cultural capital. For instance, exercise among adolescents had lasting effects on many difference aspects of their adult lives. Garcia et al. (1995) used self-schemas to investigate how regular exercise influenced other behaviors and self-conceptions of adolescents. She defined self-schemas as “elaborate knowledge structures that reflect a person’s experience and
competence in specific behavioral domains” (p. 214). In a sense, this can be defined as the cultural capital of individuals and their ability to show competence in the cultural knowledge of healthy behaviors. She argued that perceived barriers and perceived benefits affect one’s decision to exercise. Females reported less regular exercise, lower self-esteem, and poorer perceived health than their male counterparts. She maintained that culturally, we encouraged boys more than girls to exercise and maintain a positive self image. There were fewer exercise role models for females and girls received less family support for leisure time physical activities. Garcia’s et al. (1995) findings implied that males received more cultural capital from exercise and sports involvement as adolescents than girls due to the cultural belief that males’ self-worth is based on their physical competency. This study will further explore male and female levels of cultural capital and the effect on their likelihood of engaging in risky sexual behaviors.

Kirkcaldy et al. (2002) examined the relationship between exercising, self-image, and problem behaviors among youth. He found that adolescents who exercised regularly had higher scores of physical and psychological well-being, and lower rates of smoking, drinking, and drug use. Although this study did not measure social or cultural capital directly, it did take into account how teens internalize the cultural knowledge of health behaviors, as well as the impact of sports team membership on youths’ negative health choices. A strong association was found between team membership and resistance to alcohol or drug use. Other findings indicated that adolescents who exercised regularly had elevated self-esteem, advanced levels of academic success, and a more positive view of their future.
Another study focused on the exercise patterns of female adolescents and its relationship to their age at first sexual experience (Brown, Ellis, Guerrina, Paxton, and Poleno 1997). Using the 1992 Youth Risk Behavior Survey, they found that the more days a week that young females exercise, the older they were when they first engaged in sexual activity. The results showed that three-quarters of adolescent girls who did not exercise have had sexual intercourse compared to only 50 percent of girls that exercised five to seven times a week. These implications suggest that more investment into health knowledge and increasing females’ cultural capital may help to decrease risky sexual behaviors.

Cultural capital may be an important resource for adolescents when making decisions about their sexual behaviors. Whether it is regular physical activity or eating a balanced diet, these choices have lasting positive outcomes in adulthood. Although the quantity and extent of health knowledge varies among individuals; there is also cultural value in a healthy society. As adolescents show proficiency in their use of cultural knowledge, they gain power and status among their peers and often make positive choices about their health and well-being (Dumais 2002; Kivisto 2002; Garcia’s et al. 1995). The cultural resources in this health knowledge may influence other health choices such as engaging in risky sexual behaviors.

_Hypothesizing cultural capital and adolescents’ sexual risk._ The framework of cultural capital enables us to investigate the health knowledge adolescents accumulate and the practical application of that knowledge on risky sexual behaviors. Living a healthy lifestyle is a cultural value that increases quality of life both physically and
psychologically. It is important to understand and strengthen teens’ commitment to good health as a value. Through the transfer of health knowledge, adolescents gain the resource of cultural capital that they can in turn use to make responsible health choices. Regular exercise and a balanced diet are examples of how young people utilize the cultural value of a healthy lifestyle and employ cultural capital to make positive health choices. These decisions may also give insight into the choices adolescents make about their sexual health. Therefore, this study explores the following research question:

Is there a relationship between cultural capital and participation in sexual risky behaviors (Question 2)?

To answer this question, the following two specific research hypotheses are tested:

Those who exercise more are less likely to engage in risky sexual behaviors (Hypothesis 2A).

Those who eat a healthy diet on a regular basis are less likely to engage in risky sexual behaviors (Hypothesis 2B).

Moreover, as indicated by Dumias’ (2002) research of females needing more cultural capital to be viewed as equal to their male counterparts and Garcia’s et al. (1995) suggestion that society tends to encourage males more than females to exercise, the gender differences in the attainment and utilization of cultural capital should be examined. Female adolescents who do exercise on a regular basis and incorporate healthy eating patterns may possess more cultural capital and therefore be less risky in their sexual choices. Consequently, the following questions are considered:

Does the relationship between consistent physical activity (the first measure of cultural capital) and risky sexual behaviors differ for boys and girls (Question 4B)?
Does the relationship between regular healthy diet (the second measure of cultural capital) and risky sexual behaviors differ for boys and girls (Question 4C)?

**Social and Cultural Capital and Adolescents’ Risky Sexual Behaviors**

Adolescents gain social and cultural competencies through a variety of social and cultural institutions and use these as they develop into adult social actors. Social and cultural capital can be used to study how individuals identify with socially and culturally accepted behaviors within the social contexts of their daily lives. For the purposes of this study, social capital will be measured by sports team membership and cultural capital by participation in regular physical activity and healthy eating patterns.

This study examines four main questions. First, is there a relationship between social capital and participation in sexual risky behaviors (Question 1: social capital and sexual risky behaviors)? To answer this question, the following specific research hypothesis is tested:

Those with sports team membership are less likely to engage in risky sexual behaviors (Hypothesis 1).

Second, this study explores whether there is a relationship between cultural capital and participation in risky sexual behaviors (Question 2). To answer this question, the following two specific research hypotheses are tested:

Those who exercise more are less likely to engage in risky sexual behaviors (Hypothesis 2A).

Those who eat a healthy diet on a regular basis are less likely to engage in risky sexual behaviors (Hypothesis 2B).

Due to the diverse conceptualization and definition of social and cultural capital, it is wise to examine which of these resources have a stronger relationship with the sexual
choices of teens. Sports team membership is a widely accepted youth social group that has benefits when their participants make responsible health choices. However, not all young people choose to join a sports team, thus reducing its influence over youth culture as a whole. On the other hand, all adolescents receive knowledge from social institutions, regardless whether they play sports or not. Cultural capital in the form of health knowledge is available to all young people and may have more of an impact on the sexual decisions of teens. Therefore, of the two forms of capital (social or cultural), which one has more impact on risky sexual behaviors (Question 3)?

The literature review has allowed a comprehensive understanding of cultural capital and its association with actual adolescents’ behaviors. The internalization of health knowledge by teens shows their cultural competencies regarding the cultural expectation of their health behaviors. Moreover, gender plays a significant role in how cultural capital is employed by young people. Does cultural capital influence females more than males? Cultural capital is divided into two measures: healthy eating patterns and regular physical activity. Therefore, the following research question is explored: Do the relationships among social capital, cultural capital, and participation in sexual risky behaviors differ for boys and girls (Question 4)? More specifically:

Does the relationship between sports team membership (a measure of social capital) and risky sexual behaviors differ for boys and girls (Question 4A)?

Does the relationship between consistent physical activity (the first measure of cultural capital) and risky sexual behaviors differ for boys and girls (Question 4B)?

Does the relationship between regular healthy diet (the second measure of cultural capital) and risky sexual behaviors differ for boys and girls (Question 4C)?
Chapter 3

RESEARCH METHODOLOGY

This section explains the quality of data used for measuring adolescents’ social and cultural capital and risky sexual behaviors and the methodology of both the independent and dependent variables. First will be a description of the national public health survey administered in high schools in the United. Next, the measurements of this study are outlined.

Data

The Youth Risk Behavior Survey (YRBS) is a national study conducted by the CDC to monitor adolescents’ most detrimental behaviors on their health status. The data is collected biannually from 9th to 12th graders in private and public high schools throughout the United States using a three-stage cluster sampling frame. The three stages consist of random sampling at the county, school, and classroom levels. Ethnic minorities were oversampled and results weighted to insure representativeness of the target population. Under the direction of professional researchers, students were asked to fill out anonymous questionnaires about the amount and frequency of health behaviors. This study used the 2007 YRBS database to detect current trends in the relationship between adolescents’ sexual risky behaviors and cultural and social capital. The sample size was 14,041 and the response rate was 68 percent based on an 81 percent school response rate and an 84 percent student response rate.
Measurement

The dependent variable in this study was participation in risky sexual behaviors. Utilizing Miller et al.’s (2002) sexual risk scale based on the 1997 YRBS, a similar scale was created based on the questions available in the 2007 YRBS. They used six dichotomous measures based on self reports of adolescents’ sexual behaviors. In the 2007 YRBS there were seven questions regarding adolescent risky sexual behaviors. The sexual risk scale in this study had seven dichotomous measures: 1) ever have sex 2) first intercourse while in high school, 3) failure to use birth control at last sex, 4) use of drugs and alcohol at last sex, 5) multiple partners within the last three months, 6) multiple partners throughout one’s lifetime, and 7) failure to use a condom at last sex. For each question, if the respondents indicated that they had participated in the sexual risk behavior, they were coded as affirmative “1”; if they specified they had not, they were coded as “0”. Responses to these questions were then added together on a scale of one to seven. The sexual risk scale was used for hypothesis testing for the bi-variant and multi-variant regression analysis. To facilitate chi-square significance testing, the sexual risk scale was recoded into four categories: “0” no sex risk behavior, “1” low sex risk (= participated in one or two sexual risk behaviors), “2” medium sex risk (= participated in three or four sexual risk behaviors), and “3” high sex risk (= participated in five, six, or seven sexual risk behaviors).

There were two independent variables in this study: social and cultural capital. For comparative purposes, sports team membership was used as a measure of social capital to evaluate the impact of group membership on adolescents’ risky sexual
behaviors. The following question was asked: “During the past 12 months, on how many sports teams did you play? (Include any teams run by your school or community groups.)” An affirmative answer to involvement in any sports teams was used to measure social capital. The response categories for social capital was recoded into “0” (= no sports team membership) and “1” (= at least one sports team membership). The social capital measurement was used in both regression and chi-square tests.

There were two different measures of cultural capital: healthy diet and regular physical exercise. Using three questions about the self report of engagement in physical activity, an index was created to determine the degree of commitment to the cultural value of regular physical activity. The questions were:

1. “During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spend in any kind of physical activity that increases your heart rate and makes you breathe hard some of the time.)”

2. “On how many of the past 7 days did you participate in physical activity for at least 30 minutes that did not make you sweat or breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?”

3. “On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activities?”

Adolescents who indicated they participated in these forms of physical activity three or more times a week were coded as affirmative “1” and those who indicated they did not participate or only participated one or two times a week were coded “0”. Responses to these questions were then added together to form a scale from one to three. This scale was recoded into “0” did not participate in regular physical
activity and “1” participated in at least one of the three forms of physical activity more than three days a week.

Using seven questions about food consumption, an index to measure the degree of commitment to the cultural value of a healthy diet was created. Each question began with “During the past 7 days,” and then named specific foods:

1. “How many times did you drink 100% fruit juices such as orange juice, apple juice, or grape juice? (Do not count punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)”

2. “How many times did you eat fruit? (Do not count fruit juice.)”

3. How many times did you eat potatoes? (Do not count French fries, fried potatoes, or potato chips.)”

4. “How many glasses of milk did you drink? (Include the milk you drank in a glass or cup, from a carton, or with cereal. Count the half pint of milk served at school as equal to one glass.)”

5. “How many times did you eat carrots?”

6. “How many times did you eat green salad?”

7. “How many times did you eat other vegetables? (Do not count green salad, potatoes, or carrots.)”

Teens who consumed the listed healthy food choices on a regular basis (four or more times a week) were coded as affirmative “1” and those who did not were coded as “0”. Responses to these questions were then added together for the scale of one to seven. The scale was then recoded into “0” did not eat any of the food four or more times a week (poor diet) and “1” ate at least one of the foods at least four times a week (good diet).

Gender was used as a control variable in this study. Gender was a dichotomous variable with one “1” for male and two “2” for female. Gender was recoded into “0” male
and “1” female. Data for this study was collected in high schools; therefore, age of
participants was used for a control variable. Age categories ranged from 12 and younger
to 18 years old. Age was recoded into under 14 years to 18 years old.

The majority of adolescents reported engaging in sex while in high school (52 percent). More than one-third (39 percent) indicated they have had multiple partners in
the last three months. In contrast, only 16 percent said they did not use some form of
birth control the last time they engaged in sexual activity. Overall, male adolescents
reported more risky sexual behaviors than female adolescents. They (13 percent) were
more likely to have used alcohol or drugs at last sexual experience than their female
counterparts (8 percent). The older the adolescent were the more likely they were to
participate in multiple risky sexual behaviors.
Chapter 4

RESULTS

This section describes the results of chi-square analysis, and bi-variant and multi-variant regression analyses of the research questions and hypotheses. First, the relationship between social capital (sports team membership), cultural capital (physical activity and diet) and risky sexual behaviors is discussed. Then an explanation is provided on how gender impacts the attainment of social and cultural capital and its influence on adolescents’ risky sexual behaviors.

Social Capital and Adolescents’ Risky Sexual Behaviors

In this study we examined whether there was a relationship between social capital and participation in sexual risky behaviors by testing the first hypothesis that those who participated on sports teams were less likely to engage in risky sexual behaviors (Hypothesis 1). Data from the chi-square test indicated this was true: 22 percent of those who were on a sports team engaged in high sexual risk behaviors, compared to 26 percent of those who did not belong to any sports team. Moreover, the relationship between social capital and risky sexual behaviors was statistically significant ($p<.05$); therefore we had the support for the hypothesis. See Table 1 for more details.
Table 1: Chi-Square Analysis of the Relationship between Social Capital and Sexual Risk*

<table>
<thead>
<tr>
<th></th>
<th>All Adolescents</th>
<th>Not on Any Sports Team</th>
<th>On Sports Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>No sex risk (0 sex risk behaviors)</td>
<td>48%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Low sex risk (1-2 sex risk behaviors)</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Medium sex risk (3-4 sex risk behaviors)</td>
<td>26 %</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>High sex risk (5-7 sex risk behaviors)</td>
<td>26%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

*<p><.05

A bi-variant regression analysis was used to expand on the nature of this relationship. Results showed that there was a negative relationship between social capital and risky sexual behaviors. Although the relationship was statistically significant at (p<.001), the variances in participation in risky sexual behaviors explained by social capital (sports membership) (R²=.006) was very low, only 0.6 percent. This suggested that there are other significant predictors of risky sexual behaviors. Adolescents with sports team membership were less likely to engage in risky sexual behaviors. See Table 2 for more details.

Table 2: Bi-Variant Regression Analysis of the Relationship between Social Capital and Sexual Risk

<table>
<thead>
<tr>
<th>Social Capital</th>
<th>Unstandardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sports team membership (1 = on sports team)</td>
<td>-.182***</td>
</tr>
<tr>
<td></td>
<td>(.028)</td>
</tr>
<tr>
<td>R²</td>
<td>.006</td>
</tr>
<tr>
<td>N</td>
<td>6,665</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

In order to provide more in-depth understanding of the impact of social capital on teens’ risky sexual behavior, a multi-variant analysis was performed. The findings
revealed the relationship between social capital and participation in risky sexual behaviors was still a negative association and statistically significant \((p<.001)\) after controlling for cultural capital, gender, and age. See Table 3 for more detail. However, the variance explained by all the five variables was modest \((R^2=.023)\). Moreover, according to the standardized regression coefficient, social capital was only the third most important predictor \((\beta_{social}=-.046)\). Therefore although this relationship was statistically important, the magnitude of its effect on preventing adolescents’ risky sexual behaviors was not extensive.

Table 3: Multi-Variant Analysis of the Relationship between Social Capital and Sexual Risk after Controlling for Cultural Capital, Gender, and Age

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Capital (sports team membership)</td>
<td>-.105***</td>
<td>-.046</td>
</tr>
<tr>
<td>(1= on sports team)</td>
<td>(.029)</td>
<td></td>
</tr>
<tr>
<td>Cultural Capital (physically active)</td>
<td>-.091**</td>
<td>-.040</td>
</tr>
<tr>
<td>(1= Active at least 3 days a week)</td>
<td>(.030)</td>
<td></td>
</tr>
<tr>
<td>Cultural Capital (diet)</td>
<td>-.038</td>
<td>-.012</td>
</tr>
<tr>
<td>(1= Eat well at least 4 days a week)</td>
<td>(.039)</td>
<td></td>
</tr>
<tr>
<td>Gender (1= female)</td>
<td>.137***</td>
<td>.061</td>
</tr>
<tr>
<td>(1= female)</td>
<td>(.030)</td>
<td></td>
</tr>
<tr>
<td>Age (14-18)</td>
<td>0.100***</td>
<td>.101</td>
</tr>
<tr>
<td></td>
<td>(.012)</td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>.023</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>6,609</td>
<td></td>
</tr>
</tbody>
</table>

\(*p<.05; **p<.01; ***p<.001\)

**Cultural Capital and Adolescents’ Risky Sexual Behaviors**

The next research question explored if there was a relationship between cultural capital and adolescents’ risky sexual behaviors by testing two hypotheses. The first hypothesis focused on whether those who exercised on a regular basis were less likely to engage in risky sexual behaviors (Hypothesis 2A). The chi-square analysis established
there was an association between physical activity and risky sexual behaviors. Only 22 percent of adolescents who were physically active engaged in high sex risk behaviors, compared to 26 percent of those who were not physically active. Moreover, the relationship between this form of cultural capital and risky sexual behaviors was statistically significant ($p<.05$); therefore we had the support for the hypothesis. See Table 4 for more details.

Table 4: Chi-Square Analysis of the Relationship between Cultural Capital (Physically Active) and Sexual Risk*

<table>
<thead>
<tr>
<th>All Adolescents</th>
<th>Not Physically Active</th>
<th>Physically Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>No sex risk (0 sex risk behaviors)</td>
<td>47%</td>
<td>48%</td>
</tr>
<tr>
<td>Low sex risk (1-2 sex risk behaviors)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Medium sex risk (3-4 sex risk behaviors)</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>High sex risk (5-7 sex risk behaviors)</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* $p<.05$

The strength of the relationship between exercise and risky sexual behaviors was tested with a bi-varient regression analysis. The results suggested that although the relationship between exercise and sexual risk was statistically significant ($p<.001$), the variances in participation in risky sexual behaviors explained by cultural capital (physically active) was only 0.5 percent of the variances ($R^2=.005$). This association was also negative; those who exercised more often were less likely to engage in risky sexual behaviors. However, even though the relationship was statistically significant, it was not substantively important. The level of change in risky sexual behaviors explained by physical activity was very limited. Various other factors may affect teens’ sexual choices. See Table 5 for more details.
 Adolescents’ healthy eating patterns were the second measure of cultural capital. The second hypothesis of cultural capital proposed that those who eat a healthy diet on a regular basis were less likely to participate in risky sexual behaviors (Hypothesis 2B). Results from the chi-square analysis signified this was true. Of all the adolescents in this study, only 23 percent of those with a healthy diet engaged in high sex risk behaviors, compared to 26 percent of those who had a poor diet. Moreover, the relationship between this form of cultural capital and risky sexual behaviors was statistically significant ($p<.05$); therefore, we also had the support for the hypothesis. See Table 6 for more details.

### Table 6: Chi-Square Analysis of the Relationship between Cultural Capital (Diet) and Sexual Risk*

<table>
<thead>
<tr>
<th>All Adolescents</th>
<th>Poor Diet</th>
<th>Good Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>No sex risk (0 sex risk behaviors)</td>
<td>45%</td>
<td>48%</td>
</tr>
<tr>
<td>Low sex risk (1-2 sex risk behaviors)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Medium sex risk (3-4 sex risk behaviors)</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>High sex risk (5-7 sex risk behaviors)</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*p<.05*
A bi-variant regression analysis was used to determine the nature of the relationship between diet and risky sexual behaviors. The results indicated that diet and risky sexual behaviors had a negative relationship; teens with a consistent good diet were less likely to participate in risky sexual behaviors. This association was statistically significant \( p<.05 \). However, the variances explained by cultural capital (diet) \( (R^2=.001) \) was low, only 0.1 percent. Though the relationship was statistically significant, the substantive importance was small, indicating many other factors influence why young people engage in sexual activity. See Table 7 for more details.

### Table 7: Bi-Variant Regression Analysis of the Relationship between Cultural Capital (Diet) and Sexual Risk

<table>
<thead>
<tr>
<th>Cultural Capital</th>
<th>Unstandardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet (1=Eat well at least 4 days a week)</td>
<td>-.096*</td>
</tr>
<tr>
<td></td>
<td>(.038)</td>
</tr>
<tr>
<td>( R^2 )</td>
<td>.001</td>
</tr>
<tr>
<td>( N )</td>
<td>6,862</td>
</tr>
</tbody>
</table>

\*\( p<.05 \); **\( p<.01 \); ***\( p<.001 \)

A multi-variant regression analysis was used to establish how important cultural capital was as a predictor of risky sexual behaviors. The relationship between physically active (the first measure of cultural capital) \( (p<.001) \) and risky sexual behaviors was still significant, but diet (the second measure of cultural capital) was not, after controlling for social capital, gender, and age. According to the standardized regression coefficient, physically active \( (\beta_{\text{active}} = -.040) \) and diet \( (\beta_{\text{diet}} = -.012) \), cultural capital, were the least important predictors. Moreover, the variance explained by all these five variables was
very low ($R^2=.023$). This implied there are other factors also influencing adolescents’ participation in risky sexual behaviors. See Table 8 for more details.

Table 8: Multi-Variant Analysis of the Relationship between Cultural Capital (Active and Diet) and Sexual Risk after Controlling for Social Capital, Gender, and Age

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Capital (physically active)</td>
<td>-.091** (.030)</td>
<td>-.040 (.030)</td>
</tr>
<tr>
<td>(1= Active at least 3 days a week)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Capital (diet)</td>
<td>-.038 (.039)</td>
<td>-.012 (.039)</td>
</tr>
<tr>
<td>(1= Eat well at least 4 days a week)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Capital (sports team membership)</td>
<td>-.105*** (.029)</td>
<td>-.046 (.029)</td>
</tr>
<tr>
<td>(1= on sports team)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (1=female)</td>
<td>.137*** (.030)</td>
<td>.061 (.030)</td>
</tr>
<tr>
<td>Age (14-18)</td>
<td>0.100*** (.012)</td>
<td>.101 (.012)</td>
</tr>
<tr>
<td>$R^2$</td>
<td>.023 (.012)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>6,609</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001

Social Capital, Cultural Capital, and Adolescents’ Risky Sexual Behaviors

The third research question in this study was concerned with which type of capital had a larger impact on adolescents’ risky sexual behaviors. The standard coefficients specified that social capital ($\beta_{(social)} = -.046$) had a larger influence than either of the cultural capital measures ($\beta_{(active)} = -.040$) and ($\beta_{(diet)} = -.012$). See Table 8 for more details. The variance explained by all five variables was very low ($R^2 = .023$). According to the standard coefficients cultural capital (active) ($\beta_{(active)} = -.040$) was only the third most important predictor and diet ($\beta_{(diet)} = -.012$) was the least important. This implies teens’ social capital that they obtain through their social networks is a stronger deterrent to engaging in risky sexual behaviors than cultural capital.
Gender, Social and Cultural Capital, and Risky Sexual Behaviors

The last research question evaluated the relationship among gender, social capital, cultural capital and risky sexual behaviors. Specifically, this section answers the following research questions:

Is there a relationship between gender and participation in risky sexual behaviors (Question 4)?

Does the relationship between sports team membership (a measure of social capital) and risky sexual behaviors differ for boys and girls (Question 4A)?

Does the relationship between consistent physical activity (the first measure of cultural capital) and risky sexual behaviors differ for boys and girls (Question 4B)?

Does the relationship between regular healthy diet (the second measure of cultural capital) and risky sexual behaviors differ for boys and girls (Question 4C)?

Data from the chi-square test indicated there were some differences in the participation in risky sexual behaviors for males and females. Even though participation in high sex risk behaviors was almost the same for males (23 percent) and females (24 percent) and engagement in low sex risk behaviors was the same (0 percent for both boys and girls), there were noteworthy differences when looking at no and medium sex risk behaviors between males and females. In general, females (50 percent) were more likely to engage in no sex risk behaviors than males (45 percent). Nearly one-third of males (32 percent) participated in three or four sex risk behaviors compared to one-quarter of females (26 percent). Therefore, there were differences between gender and participation in risky sexual behaviors and it was statistically significant ($p<.05$). See Table 9 for more details.
Table 9: Chi-Square Analysis of the Relationship between Gender and Sexual Risk*

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>No sex risk (0 sex risk behaviors)</td>
<td>50%</td>
</tr>
<tr>
<td>Low sex risk (1-2 sex risk behaviors)</td>
<td>0%</td>
</tr>
<tr>
<td>Medium sex risk (3-4 sex risk behaviors)</td>
<td>26%</td>
</tr>
<tr>
<td>High sex risk (5-7 sex risk behaviors)</td>
<td>24%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

*p<.05

Gender, Social Capital, and Risky Sexual Behaviors

The relationship between social capital and risky sexual behaviors did differ for boys and girls. Sports team membership discouraged females from engaging in risky sexual behaviors. To the contrary, boys were more likely to participate in risky sexual behaviors when they had sports team membership. Over one-half of girls (54 percent) with sports team membership did not engage in any risky sexual behaviors compared to only 42 percent of males. Moreover, females with sports team membership were eight percent less likely to participate in high sex risk behaviors than females who were not on a sports team. Sports team membership had the opposite effect on males: over one-third (34 percent) of males on a sports team engaged in multiple risky sexual behaviors compared to males not on a sports team (28 percent). Therefore, the relationship between social capital and risky sexual behaviors did impact males and females differently and was statistically significant (p<.05). See table 10 for more details.
Table 10: Chi-square Analysis of the Relationship between Social Capital, Gender and Sexual Risk*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Not on Any Sports Team</th>
<th>On Sports Team</th>
<th>Not on Any Team</th>
<th>On Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>49%</td>
<td>42%</td>
<td>48%</td>
<td>54%</td>
</tr>
<tr>
<td>Females</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>No sex risk (0 sexual risk behaviors)</td>
<td>28%</td>
<td>34%</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>Low sex risk (1-2 sexual risk behaviors)</td>
<td>23%</td>
<td>23%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Medium sex risk (3-4 sexual risk behaviors)</td>
<td>23%</td>
<td>23%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>High sex risk (5-7 sexual risk behaviors)</td>
<td>23%</td>
<td>23%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*\(p < .05\)

*Gender, Physical Activity, and Risky Sexual Behaviors*

The relationship between physical activity and risky sexual behaviors did affect boys and girls differently and was statistically significant \((p < .05)\). The majority of females who were active (55 percent) did not engage in any sex risk behaviors compared to males (44 percent). Moreover, one-third of males (33 percent) who were active on a regular basis were more likely to participate in multiple sex risk behaviors compared to one-quarter of females (25 percent). Females who were physically active were seven percent less likely to engage in high sex risk behaviors than females who were not active.

The relationship between this measure of cultural capital and risky sexual behaviors did produce differences in males and females. Being physically active did deter females more than males from engaging in risky sexual behaviors. See Table 11 for more details.
Table 11: Chi-square Analysis of the Relationship between Cultural Capital (Physically Active), Gender, and Sexual Risk*

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Active</td>
<td>Active</td>
<td>Not Active</td>
<td>Active</td>
</tr>
<tr>
<td>No sex risk (0 sexual risk behaviors)</td>
<td>47%</td>
<td>44%</td>
<td>47%</td>
<td>55%</td>
</tr>
<tr>
<td>Low sex risk (1-2 sexual risk behaviors)</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Medium sex risk (3-4 sexual risk behaviors)</td>
<td>29%</td>
<td>33%</td>
<td>26%</td>
<td>25%</td>
</tr>
<tr>
<td>High sex risk (5-7 sexual risk behaviors)</td>
<td>23%</td>
<td>23%</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*p < .05

Gender, Diet, and Risky Sexual Behaviors

There were gender differences in the relationship between the second measure of cultural capital, diet, and risky sexual behaviors. Females with a good diet (51 percent) were more likely not to participate in risky sexual behaviors compared to males (45 percent). A good diet produced significant differences in the participation in medium sex risk behaviors for females (26 percent) and males (32 percent). There were no differences in high sex risk behaviors between females and males regardless of their diet (26 percent for poor diet and 23 percent for good diet). There are some differences in the relationship between gender, cultural capital (diet), and sexual risk behaviors. This relationship was statistically significant only for females (p < .05). See Table 12 for more details.
Table 12: Chi-square Analysis of the Relationship between Cultural Capital (Diet), Gender, and Sexual Risk

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Males</th>
<th>Females*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poor Diet</td>
<td>Good Diet</td>
<td>Poor Diet</td>
</tr>
<tr>
<td>No sex risk (0 sexual risk behaviors)</td>
<td>42%</td>
<td>45%</td>
<td>47%</td>
</tr>
<tr>
<td>Low sex risk (1-2 sexual risk behaviors)</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Medium sex risk (3-4 sexual risk behaviors)</td>
<td>31%</td>
<td>32%</td>
<td>27%</td>
</tr>
<tr>
<td>High sex risk (5-7 sexual risk behaviors)</td>
<td>26%</td>
<td>23%</td>
<td>26%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*p < .05
This section offers the conclusions and discusses how we can use social and cultural capital as tools for understanding and preventing adolescent actions and behaviors. It includes an explanation of advantages and limitations of this study, recommendations for future research, and the social and policy implications in finding deterrents for adolescents’ risky sexual behaviors.

This study found that the relationship between risky sexual behaviors and social and cultural capital was statistically significant but weak, suggesting that other factors or variables maybe more important at affecting adolescents’ risky sexual behaviors. Social capital did have more of an impact on participation in risky sexual behaviors than cultural capital. The relationship between social and cultural capital and risky sexual behaviors varies for boys and girls.

Hypothesis one focused on social capital through adolescents’ sports team membership as a predictor of likelihood of participation in risky sexual behaviors. Though the chi-square test showed the relationship between social capital and risky sexual behaviors was statically significant, the regression analysis revealed social capital was a weak predictor of risky sexual behaviors. This suggests that other important factors, including different measures of social and cultural capital may influence teens’ likelihood of engaging in risky sexual behaviors. Deterring adolescents from making poor choices is a goal of not only sports teams but other types of youth development programs. There are many forms of social capital available to and utilized by adolescents and these
forms should also be empirically studied to see what indicators are working to reduce adolescents’ risk behaviors. Social capital does increase the social status of individuals providing more bargaining power in their relationships. This bargaining power allows teens to resist peer pressure and enhances their ability to make better choices; therefore it is a viable tool in adolescent research. Schaefer-McDaniel (2004) suggested we should measure adolescents’ social capital through their own experiences and perceptions. This study looked directly at teens’ behavior yet the results demonstrated the complexity of measuring social capital and its effect on behaviors.

Gender did have an impact on the relationship between sports team membership and risky sexual behaviors. Females utilize the resources associated with their sports team membership and were active social agents in their decisions about their sexual health. Past research on female athletes maintained they were less likely to conform to scripted normative gender roles, less likely to depend on male attention to establish their self worth, and gained higher social status within their peer groups (Miller et al. 2004; Tracy and Erut 2002). They had bargaining power to negotiate the outcome of the social interaction. The social capital obtained by females with sports team membership may also be true for other types of youth development programs. These programs may also promote healthy choices among females for all types of risky health behaviors.

The opposite was true for males; they actually participated in more risky sexual behaviors. The status gained through sports team membership encouraged them to conform to the gender ideology of males by displaying more sexually assertive behaviors which was demonstrated by taking multiple sexual risks. This exemplifies the different
ways male and female adolescents employ their social capital and how it impacts their sexual choices. Females resisted the pressure to have sex whereas males asserted their traditional gender role and took more risks. Youth development programs could benefit from understanding how traditional gender ideologies are reproduced through social networks and employ that knowledge to create innovative ways to encourage healthy behaviors in both males and females. Focus group interviews or in-depth interviews could be used to explore this subject in more depth.

The second intention of this study was to analyze cultural capital as the resource of health knowledge and its effect on teens’ risky sexual behaviors. Hypotheses 2A and 2B examined physical activity and diet as measures of cultural capital and its impact on risky sexual behaviors. Bourdieu and Passeron’s (1977) conceptualization of cultural capital defined it as one’s competence in internalizing the knowledge that is distributed through various social institutions. Learning how to encourage the practical application of health knowledge into actual behaviors is imperative for understanding how to decrease negative health choices. Again the results did verify the relationship between physical activity, diet, and risky sexual behaviors were statistically significant, yet cultural capital was an insubstantial indicator of engaging in sexual behavior. This suggests that there are many factors that influence adolescents’ likelihood of participation in risky sexual behaviors.

Gender was an important predictor of adolescents’ internalization of cultural capital and how they apply it to their daily lives. Females who exercised on a regular basis and had a healthy diet were less likely to participate in risky sexual behaviors.
Females have more social pressure to adhere to traditional gender roles and deny male advances. Participation in risky sexual behaviors does have more negative consequences for girls than boys. It could be the stigmas of terminating a pregnancy or becoming a teen mother that caused girls to refrain from risky sexual behaviors. When female adolescents maintain a healthy lifestyle, they also resist the pressure to have sex. Males, on the other hand, actually participated in more sexual risk when they were physically active on a regular basis. Males’ eating patterns were not statistically significant, nor did it reduce their likelihood of engaging in risky sexual behaviors. There is less pressure on males to resist sexual activity and they often have less social repercussions for engaging in risky sexual behaviors. Garcia et al. (1995) argued that males receive more cultural capital during adolescence due to the belief that males’ worth is based on their physical competency. This differs from females in that their worth is measured by resistance to sexual pressure. Social institutions should consider how the distribution of health knowledge influences males and females differently and modify the way health knowledge is dispensed to young people.

There are advantages to this study. The surveys and their instruments are well-established and psychometrically sound. The YRBS has been conducted every two years for over three decades and has been used by numerous public health officials to try and counter the negative outcomes associated with a variety of risk behaviors (CDC 2008). This study had a large sample size, with 14,041 high school students. The data was collected in private and public high schools throughout the United States using a three-stage cluster sampling frame. The three stages consisted of random sampling at the
county, school, and classroom levels. Additionally, the sample was regarded as representative of American high school students and was weighted to represent minority populations. Another important advantage to this study was that we not only used significance testing but also explored the strength of the relationship. The majority of past research on adolescents’ risky sexual behaviors focused on statistical significance of the relationship, ignoring the strength and substantive importance of the relationship (Kirkcaldy et al. 2002; Miller et al. 2002; Miller et al. 1998; Coie et al. 1993).

The bi-variant and multi-variant regression analysis provided an opportunity to study the complexity involved when determining the rationale behind adolescents’ behaviors. There are numerous causes and motivations for why teens participate in risky sexual behaviors. This study found considerable differences in the interaction between both forms of capital, gender, and risky sexual behaviors. Social institutions still reproduce traditional gender ideologies, including educating young people about the risks associated with sexual activity. The findings of this study indicated that the resources obtained through social and cultural capital produce contrasting outcomes in male and female sexual activities. Females were more likely to resist risky sexual behaviors compared to males. This illustrates the necessity for social scientists to consider the disparity between males and females perceptions of the benefits associated with the attainment of social and cultural capital and their actual behaviors and actions.

The key limitations in this study involve concerns with self-report data, causality, and the use of existing data sets. Self report data confines the researcher to depend on the trustworthiness of answers to behavioral questions. Particularly with questions about
personal health and sexual behaviors, respondents may be inclined to answer in socially desirable ways. However, the anonymity of the survey largely neutralizes the issue of social desirability. Second, measuring the association between naturally occurring variables does not permit causal inference. However, it is an important exploratory step in adolescent research which establishes a relationship between variables and therefore potential causality. While causality cannot be determined in the current study, whether one or more variables appear to be influencing other variables can be established. However, the large sample size is sensitive to significant testing, whereas small differences can be statistically significant yet weak at predicting how one variable is actually influencing another. Finally, using existing data restricts the variables available for analysis. The YRBS focuses on young people’s risk behaviors and is not interested in their attitudes and preferences about any of the topics. It would be of interest to enhance the quantitative results with additional qualitative follow up or to incorporate questions about attitudes towards different topics. This would provide for a more detailed interpretation of the data and greater understanding of the complexities underlying the relationships between social and cultural capital with adolescents’ risky sexual behaviors.

Future studies on the social and cultural capital of adolescents should focus not only on behaviors but include attitudes and perceptions of the benefits of social networks or the importance of the distribution of health knowledge. A qualitative methodological approach to understanding the impact of social and cultural capital on adolescents’ risky sexual behaviors would give insight into why teens internalize certain behaviors. How do
perceived positive and negative outcomes of particular behaviors influence the choices young people make about their health?

Participation in sports is only one outlet where adolescents conform to group perceptions. Sports team membership promotes healthy behaviors including exercise and a healthy diet. Expanding our study of social capital to include different types of teen social groups could increase our empirical knowledge of how young people implement social capital to gain status and more bargaining power in their social interactions. Do community groups such as, arts and theater groups produce the same increase in social status as sports? Studying and comparing the use of other outlets where adolescents obtain social capital could lead to a discourse into how society can better convince teens of the dangers and consequences associated with risky health behaviors. Moreover, learning how teens perceive and utilize the resources associated with social capital could be an advantage for creating better deterrents against risky sexual behaviors. Another important area to examine is how gender stereotypes are reproduced and internalized through social groups and the impact this has on their sexual health decisions. The results of this study illustrates sports team membership did not discourage risky sexual behaviors in males as it did with females. Future social policies should take this into consideration and design programs that address these differences. Males may need more direct information and support from their group network concerning the consequences of risky sexual behaviors.

Various social institutions contribute to the allocation of health knowledge accessible to young people. Future research should analyze these different institutions,
such as the family, education, and health care professionals, to gain insight into how this knowledge is presented and interpreted by teens. This information can be used by social policy makers to ensure future health education policies incorporate how positive health choices can discourage negative health choices. While the importance of a healthy diet and regular exercise seem self evident, the rise in obesity among teens is a contemporary major public health issue. It is imperative that social research incorporate all the major social institutions responsible for the distribution of health knowledge into future studies. Do family factors have more influence on the distribution of health knowledge than education or public health? If so, how can policies aid in the promotion of positive health behaviors and discourage negative behaviors like risky sexual behaviors?

Another key focal point for social institutions is the role of traditional gender ideology in the distribution of health knowledge. This study illustrated gender differences in the relationship between physical activity, diet, and risky sexual behaviors. Future research should focus on how males and females utilize cultural capital differently and its impact on adolescents’ behaviors. Expanding on Garcia’s et al. (1995) research about gender differences in the status gained from regular physical activity, social institutions should equally encourage both males and females to demonstrate competence in healthy behaviors. The underlying concept here is the need to expand research on how young people internalize the knowledge and turn it into actual behaviors. Social scientists are needed to provide studies, data, and insight to enable social policy makers to create and implement useful programs for deterring negative health choices, including sexual choices to the benefit of the individual, families, and the society as a whole. These studies
need to include working models on how adolescents incorporate knowledge about health, diet, and sexuality into their everyday lives.
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