

UNH Center on Adolescence – University of New Hampshire

Girls Speak Up!

Conversations with Young Women About
Critical Issues in Their Lives



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The UNH Center on Adolescence

The UNH Center on Adolescence was launched in October 2002 as a university/state collaborative committed to fostering alliances that benefit youth and providing research capacity, education, and state of the art information that support the health and well-being of adolescents in New Hampshire. The Center is located in the School of Health and Human Services at the University of New Hampshire. The Center is directed by Kristine Baber, Ph.D. Gretchen Bean, M.A., is the Program Coordinator and Special Projects Director.

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Introduction

Adolescence is a critical period in the development of attitudes, behaviors, and life-style choices that can enhance health and well-being among young people (Call et al., 2002). It is also a time of unique vulnerabilities, health issues, and real and perceived barriers to accessing health care (Ozer, Macdonald, & Irwin, 2002). Although it is important to address social-cultural barriers to health for all youth, girls show different epidemiological patterns, tend to use more services, and exhibit different developmental patterns than boys (Dougherty, 1999). Early adolescence can be a particularly difficult time for girls who are more likely than boys to show increased signs of stress and depression, exhibit greater distress over appearance, experience eating disorders, experience unplanned pregnancies, suffer relationship violence, inflict self harm, run away, and attempt suicide (Debold, Brown, Weseen, & Brookins, 1999; Laye-Gindhu & Schonert-Reichl, 2005; Sanchez, Waller, & Greene, 2006). Persistent gender inequities, differences in health needs among boys and girls, and differential care utilization underscore the importance of focused attention on the needs of girls and young women. In addition, specific segments of the population of adolescent girls require specially tailored efforts by the health care system to reach them and meet their needs (Brindis, 2002).

Much of the information we have on national utilization of care by youth is based on data from someone other than the adolescents receiving services (Irwin & Duncan, 2002; Ozer et al., 2002). In a review of research on the health of adolescent girls, Dougherty (1999) pointed out the importance of identifying the efficacy and effectiveness of services that are now, or that could be, provided to girls. She argued that we need to know what works, for whom, and under what conditions, ideally getting information from girls themselves to supplement the existing data that usually comes from parents and care providers.



In New Hampshire, other than the Youth Risk Behavior Survey (YRBS), we have a paucity of data collected directly from young women. Even this data is limited because the YRBS includes only youth in the school system and

reports on this data usually provide only frequencies of behaviors. Therefore, we have little real understanding about the details of young women's health issues, why they make the decisions they do, the barriers they perceive in getting the help they need, and how adults can assist them. The Girls Speak Up! Project, funded by the Endowment for Health, addresses this gap in our knowledge by providing a forum where the voices and ideas of diverse girls and young women from New Hampshire are heard.

The purpose of the project, which is part of the Girls' Health Initiative, is to compile valid, useful information that will:

- Help professionals and parents better understand what girls and young women see to be the most important issues in their lives,
- Identify the needs of girls and young women in the state,
- Encourage development of effective strategies for reducing the social-cultural barriers young women face in accessing services and maintaining health, and
- Provide recommendations for care providers and other caring adults about assisting girls and young women.

An important aspect of the Girls' Health Initiative was ascertaining not just what girls and young women do in regard to health-related behaviors, but more important, how they think about the choices they make and the meaning of their behaviors. In this report, our analyses integrate the voices of young women and the research scholarship with the goal of developing approaches to health prevention and positive development of youth that will be "palatable, feasible, durable, affordable, and sustainable in real-world settings" (Lerner, Fisher, & Weinberg, 2000).

We included a broad age range of girls and young women in the study, and we felt it was particularly important to include young women just transitioning into adulthood. Youth aged 18-24 have been largely ignored by researchers, policy makers, and professionals, even though they fare worse than adolescents in many health areas, have the lowest insurance rate of any age group from 0 to 64 years, report high use of emergency room care, and lack a common entry point into the health care system (Park, Mulye, Adams, Brindis, & Irwin, 2006).

Although the primary reason to improve adolescents' access to care is to enhance their health and well-being, it also is fiscally prudent to do so. Nationally, adolescents, especially those without insurance, rely heavily on emergency services for primary care needs, even though half of these visits are for non-urgent situations (Ozer, Macdonald, & Irwin, 2002). Understanding the reasons female adolescents forgo or delay care can help policy makers develop better systems of care. Ozer and colleagues (2002) note that even limited success in improving youths' risk behaviors would have a significant effect on both teens' health and on health care costs. For example, it is estimated that 75% of the \$1.5 billion in costs for Chlamydia results from complications that could be prevented with early detection and treatment (Brindis, 2002).

What We Did

Methods

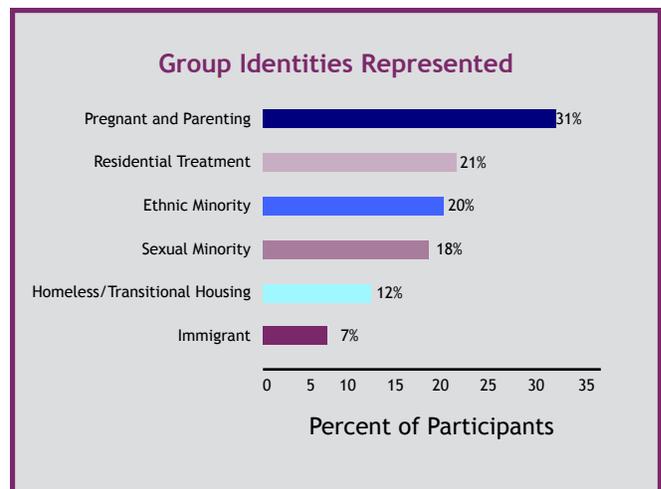
The UNH Center on Adolescence conducted fourteen "listening sessions" around New Hampshire to learn directly from girls and young women about the most important issues they face today, as well as what they need to be healthy. We focused our attention on those young women whose experiences are often missing from other existing research. These missing voices include those who are pregnant or parenting, out-of-school, homeless, who identify as immigrant/refugee or lesbian/bisexual/transgender, or who are living in treatment or transitional housing programs. Community collaborators such as Child and Family Services; Division for Children, Youth, and Families; Maternal and Child Health; Outright programs; after school and treatment programs; and the YWCA assisted us in reaching girls interested in participating.

We distributed invitations to the sessions through community programs that serve young women who might be more vulnerable and whose experiences might not be routinely included in other research. We conducted the sessions, which lasted approximately two hours each, with existing groups from these programs. We tape recorded the listening sessions and then content analyzed the data. We supplemented this data with brief pencil-and-paper surveys to provide an opportunity for the young women to share information they might be uncomfortable talking about in the group. Participants received \$10 to defray transportation costs and to acknowledge the contribution of their time and information. The Institutional Review Board at the University of New Hampshire approved the proce-

dures used to collect information from young women in the study.

Participants

Ninety-two girls and young women participated in the listening sessions. The average age of the participants was 17.6 years (SD = 2.8) with a range of 12 to 24 years. Seventy-six percent of the participants identified as white, 9% as Black, 7% as Hispanic, 6% as multiracial, 1% as Native American, and 1% as other. Approximately half of the sample described their families as having a hard time covering basic living costs (18%) or having just enough money to cover those costs (30%). The rest thought their families had few problems buying what they needed (19%) or could buy what was needed and buy special things (33%). Groups represented by the participants are young women who are homeless, pregnant and parenting, in residential treatment settings, in programs for "at risk" youth, immigrants or refugees, and sexual minority youth. Approximately 60% of the participants were attending school at the time of the listening sessions.



What We Learned

The listening sessions provided rich data about issues that are of greatest importance to the participants and other young women like them. Participants were articulate about their experiences, their interactions with adults and care providers, reasons why they don't get help when they really need it, and their views on how caring adults can help. In this report, we provide a summary of the data collected from these young women and interpreted in the context of other existing research and data. Wherever possible, we use quotes from the young women themselves that exemplify what we heard in the listening sessions. To provide as much confidentiality as possible for the young women who often shared sensitive and personal material with us, we identify the speakers only by their group membership, such as "a young mother" or "a sexual minority youth," when such an identification clarifies a comment.

The range of issues that participants identified as critical factors demonstrated the complexity of the lives of these young women. The salience of some topics differed across the groups. For example, among adolescent mothers, ensuring food, shelter, and medical care for their children was paramount, while they scarcely mentioned body image concerns or cutting. Issues related to discrimination and stigma were more frequently mentioned in sessions with homeless or lesbian, bisexual, and transgender young women than in sessions with any other group.

condoms; violence, especially sexual violence; family relationships; and barriers the girls face in getting the various types of help they need. Extensive intersections exist among these themes. For example, some young women do not receive information about sexuality from their school or their parents, are unable to easily access or effectively use contraceptive methods, and find themselves pregnant. As young mothers, some then find themselves homeless and in abusive relationships.

**Topics Girls Want to Discuss
But Are Too Embarrassed to Bring Up**

Topics Offered	% Mentioned
Reproductive Health Issues	31
Sexual Activity	21
Mental Health Issues	17
Weight/Body Image	15
Pregnancy	11

Unfortunately, the topics that the girls identified as most critical in their lives were among those that they said they wanted to discuss with caring adults, but were too embarrassed to bring up. These topics included: depression, sexuality, family problems, reproductive health issues, rape or sexual assault, suicide attempts, drug use, and physical abuse. Most of these topics emerged as dominant themes in our analysis of the data and we use the general categories of sexuality and reproductive health, relationships with adults, violence and safety concerns, mental health issues, and barriers to care to organize the presentation of the results.

We also provide sections specifically focused on young women who are pregnant or parenting, homeless, or identify as sexual minority youth. Below we present a summary of our findings, as well as representative quotes from the participants so that the young women's voices are as present as possible in this report on the research. The report concludes with recommendations for reducing barriers to care and better supporting the healthy development of girls and young women.

**Reasons Girls Do Not Get Help
When They Need It**

Reasons Offered	% Mentioned
Fear	26
Cost	24
Reluctance	22
Stigma	15
Transportation	10

However, several major themes threaded through the dialogue of almost all groups. These themes included: mental health issues, including mental health care; sexuality and the importance of sexuality education; reproductive health care, including access to contraceptives and

Sexuality and Reproductive Health

Sexuality and reproductive health are salient factors in the lives of young women. According to 2005 YRBS data, by the time female adolescents in New Hampshire are seniors in high school, two thirds have experienced sexual intercourse. Adolescents participate in sexual activity for a variety of reasons, including sexual desire, curiosity, to enhance emotional intimacy, to be seen as popular or even “normal,” or because of coercion or force (Savin-Williams & Diamond, 2004). Discussions about sexuality and related topics came up in every listening group. Participants shared their observations about girls’ experiences with sexuality, their frustrations with the lack of useful information on sexuality and reproductive health, and their recommendations to improve the sexual health of younger girls.

The participants were much more likely to talk about sexual exploitation and problems than they were to talk about sexual desire and positive sexual identity. Many of the participants spontaneously shared their sexual experiences, often with a critical eye toward what they wished they had done differently or information they believe they should have received from adults. Some of the participants suffered sexual abuse early in their lives, but sexual exploitation in their current lives was also a frequent theme.

Need for Additional Information

Some of the girls interviewed indicated that they didn’t really know how their reproductive system functioned and had misinformation about their menstrual cycle. The need for earlier, accurate information was evident.

I just heard that, like in a month for a woman ... the day you got your period, I don't know, like a couple days after, that's like the day that, umm, what do you call it, the egg, whatever that is, comes out. That's when you get pregnant. I have a friend ... that's how she plan her thing, like she just knows.

A year or so I hid my period from my mom, 'cause I didn't know what was going on, and I was scared ... I thought I hurt myself, and it just started happening. My mom brought me to the nurse, but I didn't want to talk to the nurse about it. And then I was brought to a male doctor, and I didn't like that either ... My mom was scared to talk to me about it, and my mom was freaking out.

The participants wanted more information about sexuality in general and thought sexuality education in schools should begin earlier and be more comprehensive. As one girl explained, “I never had a health class that talked about sex until the 10th grade—when I was already having sex.” These young women believed that sexuality education could effectively reduce teen pregnancies and help young people have safer sexual activity.

It's like you wonder. They don't want to teach sex ed, but all these girls are pregnant, and it kinda shows there is less of a pregnancy rate at schools that are teaching it.

I came from a religious school before this, and they are just like, 'Well, don't have sex.' People are going to have sex whether you want them to or not. And they didn't even talk about like safe sex or anything. And I think it's really cool how some schools like distribute condoms and stuff.

Many participants specifically mentioned the importance of having valid information about sexually transmitted infections (STIs). Several of them already had concerns about the effect of STIs on their health and well-being. They wanted to know more about the various STIs, how to recognize the symptoms, and how to protect themselves. “Like STD’s, I don’t know how many STDs are out there. All I know is AIDS and herpes. That’s all I know, but I think there is more than that.” Others talked about how frightened they were of being diagnosed with, and treated for, sexually transmitted infections.

It was really scary you know to sit there and wait and be like, 'Oh my God. Do I have AIDS? Do I have HIV? Do I have syphilis? Do I have this? Do I have that?' It is scarier than hell to, you know, really think about. I've screwed up this much, that I have to worry about this.

I got a pap smear last summer, and it came back that I had such bad precancerous cells that I had to have a section of my cervix cut off. And like, if I'd learned about like all the different sexual things that could go wrong, I don't think I'd be as sexually active as I am ... My whole life is ruined. If I get more of those cells again, I have to get a hysterectomy, and I'm only 17.

Few of the young women felt they could rely on their parents for sexuality information. One said, “You can’t just rely on your parents for like the sex talk and stuff, because I never got it.” Another commented, “For me, my parents were like ‘Yeah, don’t have sex.’ Like, there’s no questions, just don’t do it.” Even for participants who were close to their mothers, sexuality was a difficult topic, as demonstrated by one girl’s comment: “Sex is the only thing I don’t talk to my mom about. I figured that out myself.” This is unfortunate because recent research suggests that if parents have the knowledge and communication skills they need to talk comfortably with their children about sexuality, they can buffer the effects of sexually active peers and help support their daughters to delay first sexual intercourse (Fasula & Miller, 2006).

Listening group participants wanted information and access to contraception and condoms, but wanted to receive them in a comfortable, non-judgmental way. They appeared to know that young women need information to make good decisions and stay healthy. One participant voiced this belief saying, “It hurts people if they don’t know what’s really going on, so I think that’s a big issue.” Another young woman, talking about her lack of knowledge about HIV/AIDS said, “I never learn anything, I hear it around, like how you just mention it ... but I definitely want to read a book or something.” Although the desire for more information exists, young women may not follow through on their intentions to seek information and care if they feel uncomfortable with the services or the provider.

I’d rather go to someone I know ... I went to Planned Parenthood. It was, like, degrading. I felt like, you know, they were judging me because they asked so many questions about, like, my sex life. I was, like, ‘look, I’m not having sex yet, but you know I want to, and I don’t feel comfortable answering these questions. If I want birth control, I want you to give it to me, and I don’t want to have to answer your questions.’

Other Barriers to Sexual Health

Stigma, embarrassment, and concerns about confidentiality were barriers to accessing the information and services these young women need, as well as factors that kept them from talking with adults who might assist them in developing an effective approach to sexual health. These young women often were too embarrassed to talk about their concerns with parents or care providers and worried how

information they shared might be handled and whether confidentiality would be breached.

My whole family goes to like the same doctor so like I don’t want to tell them ‘cause it’s just weird ... I know so many people that go to this one doctor, and you’re like, I don’t want to say anything to her ... who knows what’s going to come out if you’re having a conversation about me you know? No way.

My family all goes to the same doctor and like my doctor is a guy so I don’t really want to talk to him about ... questions that I have ‘cause I don’t really feel comfortable talking to my guy doctor about it.

I went to an appointment for a physical and ... I get bad cramps and they said birth control will help it. My mom was in the room with me. She heard birth control, and she went crazy. She was like ‘birth control, she’s not gonna have no birth control. She’s not taking birth control,’ yadda yadda. And they go like ‘No, it’s not ‘cause she’s having sex or anything. it’s for her cramps. It will stop it.’ My mom was like, ‘no, no, no, you’re not going to be taking birth control.’ Well, I’m having unprotected sex.

These barriers contribute to missed opportunities for communication and sharing of information with adolescent females. These barriers also emphasize the need for teen-friendly care providers and better approaches to educating parents on how best to support their daughters, particularly when these young women are attempting to secure information so they can make healthy sexual decisions.

Listening group participants seemed quite aware that they should be using condoms and contraceptives to prevent sexually transmitted infections and unwanted pregnancies, but a variety of factors prevented them from putting that knowledge into practice. For some, embarrassment and concerns about parents finding out interfered with accessing condoms and other forms of contraception.

Maybe they’re embarrassed and they don’t want their parents to find out. Like, if they are on birth control or whatever, or they don’t want their parents to know they are having sex, ‘cause that’s a topic people don’t want to talk about with parents. It’s kinda embarrassing.

Talking about other barriers for young people in accessing condoms, one woman said, “They cannot just go up to

the store, because they are going to feel embarrassed. So you could have it sitting in the corner, have it available.” Another said younger teens might be “even more embarrassed to ask for money to buy something like that.” A third added, “So the kids will get STDs and HIV at 11 years old.” A young woman in one group noted, “They did it when I was young. I wish they did it more. I wish they actually gave you the condoms instead of ‘Now we are talking about sex ed. Go out and buy yourself some.’” A few of the young women with latex allergies identified a related barrier, pointing out that non-latex condoms are expensive and rarely available for free. As a result, these young women may end up using no condom at all.

A participant who lived in a residential program identified another type of barrier related to preventing pregnancy and STIs. One of the rules of the house prohibited sexual activity. However, the residents talked about being sexually active. When asked what they do to protect themselves, one girl responded that she had some condoms found on her and had gotten in trouble. “I don’t think that it is right that we get in trouble for protecting ourselves,” she added.

Supporting Young Women’s Sexual Health

Young women who did have information about sexuality were proud of what they knew and tried to make sexually responsible decisions. One said, “I get tested for like STDs once a year.” Another talked about making sure both she and her partner had no STIs. “When we first got together, we both went to the doctor and did a check up to show each other.” Programs that provide accurate information about sexuality help young women make good choices and also encourage them to help one another.

Being around the Y [YWCA] so much, I learned a lot and I feel like I knew so much. And then I would go places and meet with people my age ... who had no clue, and it would surprise me every time. I would be shocked about what I could tell them that they didn’t know. And it is so important for people to know the truth about everything, – you know the right things – not just what they hear from other people.

Listening to the girls and young women in the groups talk about sexuality and their reproductive health issues, we were struck by the fact that these young women consistently

expressed the desire to make good decisions and protect their sexual health. They believed that they lacked 1) information that they needed about sexuality, 2) easy access to contraceptives and condoms, and 3) caring adults with whom they felt comfortable talking about sexual issues.

“I don’t think that it is right that we get in trouble for protecting ourselves..”

The results of this study provide support for the importance of comprehensive sexuality education that

begins prior to the time that youth become involved in sexual activity. Involving parents in sexuality education programs is critical, and providing them with information that can help them become as comfortable as possible talking with their children about sexuality could make them another important resource for adolescents. Young women also need access to care providers who are knowledgeable about adolescents and can attend to their particular sexual and reproductive health care needs.

The qualitative information from this study suggests that these young women became aware of their sexual feelings and anticipated becoming sexually active before they were. Additional research on the sexual transition process among adolescents could provide information regarding how teens process their feelings and experiences. This would help us better tailor programs and interventions to be effective in delaying sexual initiation, reducing unplanned pregnancies, and preventing STIs (Fasula & Miller, 2006). We would be better prepared to provide the knowledge and resources that young people need, at the time they will be most helpful, and in a manner that takes best advantage of adolescents’ interest in learning about their bodies and understanding the pleasure and risks associated with sexual activity. Youth who have valid information about sexuality, who have access to reproductive health care, and who have adults with whom they can discuss sexual topics are more likely to develop their own moral framework about sexuality and be prepared to make healthy sexual decisions.

A Focus On: Pregnant and Parenting Young Women

Listening group participants identified pregnancy and not knowing what to do if they become pregnant as one of the most important issues facing girls and young women today. One young woman who was not pregnant or parenting herself indicated that she knew of at least twenty-five girls who were pregnant in her school at the time of our discussion. “I swear being pregnant is a disease. Everybody has it,” observed one young woman. Another added,

I know even with my own friends, I have five friends that are pregnant right now. And you know, three of them are all from the same guy, all from the same guy who claimed to be 20 and was 26.

It was rare for the young women who had been pregnant or who currently had children to have planned the pregnancy. Some expressed that pregnancy just happened or that they were surprised by it. One participant explained that, “my first pregnancy, I didn’t plan it. It wasn’t planned. It just came up. It just happened.” A woman in another group who had become pregnant said, “This was a shock for me, and it still is.” A young mother explained, “I wasn’t really planning on getting close to him ... We got pregnant eleven days after he got out of [correctional facility]. Yeah, he got out of jail.”

Others knew the importance of contraception to prevent unplanned pregnancies, but encountered difficulties using it effectively. One girl said, “I got pregnant on birth control ... I was taking the pill every day and I still got pregnant.” Another said,

We talked about getting pregnant and then I was going to go on birth control. Like I had it, and it was on top of my refrigerator. But just because we were talking about it, we didn’t really think it was going to happen. And then it did.

When asked why they think so many girls become pregnant, several participants shared their theories about this, as well as the consequences for the relationship with their male partners.

They fall in love. Almost like they sit there, and they kind of just, they get like involved, and they think they’re in love, and they think that just



everything is okay. And like the guy is really nice or whatever, and it’s okay, and that’s what guys want. Guys want sex. When you’re a teenager, that’s what guys are all about, pretty much. That’s what they do. And they leave after.

It’s like they make up like this whole entire story about how much supposedly they care about you, and they love you so much that they want to marry you. But then, after you end up having sex for the first time and he gets that girl pregnant, and then he’s like ‘Oh well, I’m going to decide to be an asshole and say, well I’m not going to help you take care of the kid.’ And then, that makes the girl wanna break up with him. So that happens, and then, poof, the father’s gone.

The theme of uninvolved fathers was pervasive among the young mothers. When young women learned they were pregnant, they had concerns about how the fathers would react and whether they would leave.

I could be afraid of telling my partner, because I’m not sure if he wanted a child or not, you know? I don’t know if he’s like, if I do tell him, you know, he’s gonna walk out on me or, you know, stay with me. That’s a lot of fear for girls nowadays.

Young mothers critiqued the responses the fathers of their children had when they received the news. One said that, “90% of the guys I hear, they always say ‘oh, that’s not my kid.’”

Another woman observed that, “They don’t think, like, they think that we just like climbed up on ourselves and got ourselves pregnant.”

Even when the men acknowledged fatherhood, many young mothers did not feel they could depend on these fathers. “I swear, guys, like right before you are about to have the baby, they deliberately sabotage the relationship to try to get out of it.” One young mother said, “It’s a fight to have them watch their kids when you just want to go for a night with the girls. It’s a huge fight.” Another mother voiced concerns about the quality of care her child received when his father cared for him. “It is stressful to deal with, you know. Like not trusting a father after they’ve done like drugs. Like, my husband did drugs while he was supposed to be watching my son. He was like snorting coke.”

Young mothers talked about the challenges they faced being poor and trying to secure the basic necessities for themselves and their children. “Most of the places us young people can get have slum lords. They don’t care about you. They don’t care if something breaks. They take you because they think you don’t know your rights.” Another talked about the vicious cycle that keeps her from being able to finish her education or spend the time she would like with her child. “They jack up the rent to where you can’t afford it, and then you have to get another job. And then you have no time with your children, because you are paying off day care and working.”

Although the young mothers took pride in their children and tried to do their best to care for them, participants discussed the stigma they felt associated with pregnancy and early child bearing. The young mothers voiced reluctance to ask for “welfare,” but said, “You have no other choice.” One young woman talked about, “When I was younger, 17, and just after having the baby, going to ask for formula and going to ask for diapers, it’s kind of embarrassing, but you have to do it.” Some of the young mothers talked about how their experiences were influenced by the responses of people in their communities.

When I was pregnant, I cried through my whole pregnancy because of the looks people gave me ... I couldn’t go anywhere and not have people look at me ... I wasn’t ashamed, but I felt awful, and I cried every five seconds.

Supportive programs and caring adults were particularly important to the young mothers participating in the listening groups. The young women attended programs for teen mothers to meet others like themselves because, as one participant explained, “Usually when you have children, your friends disappear.” The young women supported one another, both in and outside the programs they attended. For example, one mother had a baby who was still in the hospital in Boston. She had no transportation and was only able to see her baby once a week when another group member transported her to the hospital. “It is kind of hard. He is all the way in Boston, and I don’t have a car. So it is really difficult to see him ... It feels real weird, and it is really hard.” The woman providing the transportation added, “I give her a break and she gives me a break.”



Adults who show by their actions that they care, who are accessible, and who maintain confidentiality are important supports for these young mothers. One woman said about her social worker, “She’s on your side—about everything. She brings you the information to help you take care of your kid. When anything goes wrong, you can call in to talk to her ... You can trust her. She keeps confidentiality.” Adults who provide information are particularly valued. As one participant said, “There’s something you don’t even think about, and then you find out about it and you’re like, ‘Wow, I could have gotten help with that.’”

Relationships With Adults

Relationships—both positive and negative—played a key role in the narratives the girls and young women in the listening groups shared about their lives. Participants talked about parents and other family members, care providers, and other adults who influenced their lives and well-being. Generally, parents are the preferred source of information among teens, with more teens turning to mothers and fathers than to any other source for information and advice (Steinberg, 2005). Parents have direct influences on the physical and mental health of their teens by providing guidance about health-related matters and by helping youth access health care information and services (Steinberg & Duncan, 2002). Therefore, frequent and effective parent/teen communication can support healthy development. For example, teens whose parents communicate their values and expectations regarding sexual activity not only delay intercourse longer than peers whose parents do not openly discuss sex, they also engage in fewer risky sexual activities (Steinberg, 2005). In addition, parents who have open lines of communication with their teens raise adolescents who achieve more in school, score higher on self-esteem, and report less depression and anxiety (Steinberg, 2001).

The influence of parents and other caring adults was a major theme that emerged during our listening groups. Some of the young women talked about the importance of supportive and nurturing families. Mothers were much more likely to be mentioned than were fathers, who generally seemed to be invisible in the lives of these young women.

My mom understands most everything that I talk to her about ... I talk to her about everything, and in fact, sometimes it's helped. When my friend, he is a big cutter ... she had notified the therapist the next day and he stopped for awhile.

My mom tends to be more open-minded, and she's a good listener, and so I think it's great.

I lived with a guardian in Manchester for a while, and it was like the best time ever 'cause someone was always home. There was never an empty house.

Although some of the participants experienced healthy parent-child communication, many of the girls and young women expressed feelings of alienation from their parents

and other adults in their community. One young woman explained:

If I do have sex, my mom won't accept me, and so that makes me not trust her and not want to be open with her. But it also makes me fear her, and I don't think any of that is healthy to have in a mother-daughter relationship.

Some of the young women described their relationships with their mothers as close, but they critiqued the lack of appropriate boundaries in the relationships. One participant said, "Your mom needs to be your mom and not your friend." A young woman in another group offered her perception of her relationship with her mother.

My mom and I are pretty close, and I could tell her anything without her judging me or getting mad and that sort of thing. But then again, I feel like she never did her job all that well. She was more like my friend.

Research indicates that adolescents who lack positive role models are more likely to experience mental health and behavioral problems than their peers. Research also indicates that adolescents are more likely to use substances when one or more family members use substances (Arnett, 2007; Steinberg, 2005). Many of the young women we talked with, particularly those in treatment programs, discussed how their parents' actions influenced their behaviors and beliefs.

My dad, when I was like really, really little, he used to give us alcohol and stuff like that. And whenever he was having a drink, he let us have some. He'd get shot glasses and fill them with stuff.

One young woman identified her family as one of the major stresses in her life. She said, "My stress is my family ... my whole family pretty much is either drinking, or smoking, or doing some kinda drug." Family substance abuse normalized such activities for some of the young women, such as one who pointed out that, "Everyone in my family smokes pot. Just seeing someone you like and care about doing it puts in your mind that it is okay."

Another however said, "I have a lot of people in my family who have done drugs and I see how crazy they are when



they are drunk or—so it really made me say, ‘No, I’m not doing that.’

Connections to other caring adults also can improve the health and well-being of young people. For example, youth who have important relationships with non-parental adults experience better social-emotional well-being and academic success and engage in less risky behaviors than youth without long-term relationships with adults (Grossman & Bulle, 2006). The daily contexts where adolescents spend time, such as schools, programs, and supportive services, and the relationships they develop, contribute to overall health and well-being. However, the importance of these relationships and the benefits of participating in organized programs differ for boys and girls. For example, boys and young men are more motivated to participate in programs when they receive personal affirmations about their competencies. Girls and young women, on the other hand, are more likely to participate in programs if they experience important personal relationships with program staff and other adults (Denner & Griffin, 2003).

Nearly every listening session in our study was able to identify at least one non-family adult who has positively influenced their health and well-being. Many of these adults were helping professionals (social workers, nurse practitioners) who connected the young women with resources and information. Youth leaders were also frequently cited as important and supportive relationships.

“A lot of people are supportive, but a lot of people are judgmental”

She’s good with helping you find solutions rather than patting you on the back and sending you off.

There’s a teacher like that at my school ... she worked really hard with me ... I just found out, I didn’t even know that she was a lesbian and she’s worked really hard ‘cause I was really wanting to get a GSA started and ... we talked to our principal and we’re going to get one started.

Although nearly all participants in our study could identify at least one helpful adult, many talked about people who had let them down, sometimes parents, sometimes other adults. One young woman in a residential program talked about being raped and going to the hospital.

I couldn’t stop crying because my mom wasn’t there. My mom used to drink and my mom was at the bar. I was so scared inside. I had no way to get a hold of my mom. I had no way to tell her what happened. Finally I had a note left on the table, ‘Ma, this and this happened, and I am at the hospital.’ That’s how she found out I was raped.

One young woman solved the problem of finding people on whom she could depend and who would not be judgmental by feigning illness so she could go to the hospital. She explained:

I used to say I was sick so that I could go to the hospital, because I felt more comfortable there than being anyplace else, ‘cause like at the hospital they care about you, make you comfortable. There are people who basically care about you. They talk to you and they don’t judge you. They offer you their resources and care. They also offer you a shoulder to lean on. They have a strict rule to be supportive. They can not deceive your trust. There is a level of trust that you can confide in them.

Participants also shared negative experiences with community members passing judgment against them. This general concern of being judged by people in the community was a recurrent theme addressed by most of the focus groups, although the specific manners in which judgments were being manifested differed among the groups. For example, the judgments perceived by the GLBTQ population were vastly different than those perceived by the pregnant and parenting teens. As a result, many of the girls talked about a need to feel “on guard” all the time.

I think a lot of it depends. A lot of people are supportive, but a lot of people are judgmental. I mean, like, a lot of people judge you for being pregnant at a young age because, you know, it is looked down on for young people.

Supportive Relationships with Adults

Supportive relationships with caring adults are important for healthy adolescent development. Without these relationships, adolescents are at increased risk for a variety of problems. Parents generally are seen to be the most important adults in the lives of their children and need to be assisted so they can be the source of knowledge, caring, and encouragement for girls and young women. Parenting adolescents in contemporary society can be challenging for the most attentive and nurturing parents. In the NH strategic plan for adolescent health (Wood et al., 2004), we recommended for the increased availability of information on normative adolescent development, youth risk and protective factors, and parenting resources for all parents. We also need to help families find help for their own problems so that parental difficulties are not perpetuated in the lives of their children. If a family is dysfunctional or disorganized with ineffective parenting, high conflict, parental depression or substance abuse, and/or a lack of parent-child bonding, adolescents are vulnerable to health compromising behaviors and depression (Kumpfer & Adler, 2003; McWhirter, McWhirter, McWhirter, & McWhirter, 2007).

A range of effective family-strengthening approaches are available that can reduce adolescent problems. These include behavioral parent training which focuses on cognitive, affective, and behavioral changes in parents;



“Your mom needs to be your mom and not your friend”

family skills training; and family therapy (Kumpfer & Adler, 2003). Adding family interventions such as these to community or school programs increases the program’s overall effectiveness. Low cost family therapy is available in some parts of New Hampshire, but many families may be reluctant to take advantage of available resources because of stigma associated with therapy. Normalizing parental help seeking and consultation with experts may encourage better use of family support services.

If young women are unable to find the support they need from their own parents, caring adults can help youth develop interpersonal skills and can connect youth with resources and information that may be beyond the youths’ own reach (Villarruel, Perkins, Border, & Keith, 2003; Grossman & Bulle, 2006). Even when parents have the information or resources needed, young people may feel more comfortable, at times, seeking information and asking for help from non-family members. Youth programs can be an important venue where girls and young women may feel safe and supported to take age-appropriate, positive risks (Denner & Griffin, 2003). These programs also provide a context for girls to develop and sustain supportive relationships with caring adults. Professionals and adult volunteers in youth programs are in a unique position to role model adaptive and healthy behaviors – behaviors which may be lacking in the young women’s home environments.

A Focus On: Homeless Young Women

At least eleven of the participants in this study were homeless or living in transitional housing arrangements. Usually their situations were related to lack of money to pay for housing or problems with family or partners. Although fewer NH youth are living in poverty than anywhere else in the country (Annie E Casey Foundation, 2006), local homeless shelters provide housing for homeless youth and young families each night. Despite popular stereotypes about who constitutes the homeless, research indicates that families with children account for 40% of the homeless population (McWhirter, McWhirter, McWhirter, & McWhirter, 2007). These families are disproportionately young with limited social supports. One of the young women in this study challenged the existing stereotype of the homeless:

When you say homeless person, [people] see, in their mind, a guy sitting out on the street in raggedy old clothes and a bottle of booze. No one realizes that there is like young people, people with kids, just people who have gotten a bad shake in life and are looking for a second chance—a hand up, not a hand out.

Homeless families are also more likely to be composed of parents with histories of sexual abuse and domestic violence (McWhirter et al., 2007), factors which may actually increase a women's vulnerability to homelessness (Wenzel, Hambarsoomian, D'Amico, Ellison, & Tucker, 2006). Furthermore, for many homeless girls and young women, violence has been an integral part of their life histories (Reid, Berman, & Forchuk, 2005). We saw some evidence of this in our study. All but two of the women we spoke with who were living in shelters and transitional housing programs were mothers of young children, and half of the women disclosed histories of abuse and domestic violence. One young mother spoke of her difficulties trying to find a safe place to stay:

It's always full. They've told me, 'Keep calling, keep calling.' I said, 'Listen. I'm in a domestic violence situation I need to get out of here,' I said, 'Or I'm going to be killed.' [They told me] 'Call this.' I called everyday for like six months. 'We're full, we're full, we're full, we're full.' What would you like me

to do, you know? And the person that I was in a domestic violence situation with knew where I was staying, so they would come to the house and harass us. It's like, 'call the cops.' We do call the cops. The cops won't do anything. 'Put a restraining order on him.' We do all that. They don't care. They'll still get to you either way.

Being homeless affects every aspect of well-being. Munoz, Crespo, & Perez-Santos, (2005) report that homeless people are more likely than the non-homeless people to experience severe health problems and contract infectious diseases such as tuberculosis and pneumonia. They also have limited access to health care services and often only seek care when conditions become unbearable (Reid et al., 2005). Numerous barriers, including discrimination, and lack of transportation and health insurance, increase the likelihood that people who are homeless may delay seeking care (Hwang, 2001; Reid et al., 2005). In addition, their illnesses may be prolonged because they do not have prescription drug insurance and cannot afford medication (Hwang, 2001).

Stress was identified by the women in our study as an important factor influencing health, with many of the homeless young women discussing the connections between stress and illness. "you don't want to be homeless in the first place ... a lot of what makes you sick here is stress, because you get so stressed out and then you get ... pneumonia, strep throat, colds, and flu." In addition to physical health conditions, the women also talked about how homelessness contributes to depression and self-harming behaviors.

Depression, that's a big factor in my health. I know my emotions rule my health...and when I am depressed, like, I don't take care of myself as well as I should ... I end up not caring. And it's really hard in a place like this, it's hard NOT to be depressed.

I used to be bulimic and it's hard not to go back to that, because I am so depressed, I just want to eat. And I know if I do that, I will go back to bingeing and purging.

The young women we interviewed talked with us about how stigma and misconceptions about homelessness contribute to depression and low self esteem. The women at one homeless shelter indicated that they find themselves lying to others about where they live, because they don't want to admit they are homeless. For example, one young mother talked about how she tells people only the general vicinity in which she lives, hoping that they will assume she lives in the low-income apartments nearby. She offers this analogy to justify her actions: " [telling someone you are homeless] is like going out and telling someone you have AIDS, will you sleep with me? That's the effect it has on people when you say ... I'm a shelter resident." Another woman adds, "you could have a doctorate, but as soon as you are homeless, your self-worth, as far as other people look at you, goes right down the toilet." And the physical conditions of the shelter also influence feelings of self-worth among the residents.

And people drive by this place and it looks like crap-for lack of a better word ... It's hard to convince people you are worth a grain of salt, let alone anything else, when you live here...and that takes its toll on you, too. Especially when you've been here for a while, and you start thinking, 'Maybe they are right. Maybe it is my fault ... What if maybe I tried a little harder. Then I wouldn't have lost my job, and I wouldn't have lost my house.'

Stigma and discriminatory attitudes about homelessness have economic implications, as well. Securing employment while homeless and living in a shelter can be difficult. One young woman explained, "I've been looking for a job for [three months], and I've only had one person interview me. And that was because a person I went to church with put in an awesome reference for me." Stigma associated with homelessness also may contribute to employers' reluctance to hire homeless men and women. "My husband had to go out of [city] to find a job. He had to go all the way to [20 miles away]. And, just so people wouldn't see [shelter address] and know you're homeless."

Social supports do make a difference in the lives of these young women. All of the women interviewed in the homeless shelter and in the transitional housing

programs talked about the importance of friends in helping create a more positive disposition.

It sucks that I am here. But [friends] make it better for me.

That's another thing I found being here. If you don't have any friends, you're not going to get through.

I started doing a lot better when I found people who I considered not just friends but family. And those people made my world go from feeling nothing and depressed and not wanting to be on this earth anymore ... to, maybe it's not so bad. Maybe I can get through.

The experience of homelessness not only affects the health of mothers, it also has a profound impact on the health of their children. Homeless children are exposed to more adverse health conditions than children with homes. Homeless children also experience more chronic daily stressors, such as hunger, fears about safety, and concerns about future living arrangements, which affect long-term emotional and physical well-being (American Academy of Pediatrics, 2005). For the children of young mothers in this study, homelessness may perpetuate problems related to health and well-being into the next generation.



Violence and Safety Issues

Violence emerged as one of the critical themes in this study, with every listening group engaging in discussions about their own experiences and violence they had observed. The girls and young women openly talked about their experiences with sexual violence, dating and domestic violence, and physical abuse.

Nationally, young women aged 16-24 are at the greatest risk of experiencing physical or sexual violence (Wenzel et al., 2006) and females are over thirteen times more likely to be a victim of sexual assault than are males (Park et al., 2006). Women with lower incomes are more likely than women with higher incomes to be victimized (Wenzel, et al., 2006). Our study involved some of the most vulnerable populations of young women in New Hampshire, and half of the participants described financial difficulties in meeting basic needs. Therefore, it is not surprising that violence and safety issues permeated the discussions with these girls and young women.

Sexual minority youth and youth residing in residential programs frequently discussed experiences with sexual exploitation, sometimes perpetrated by family members.

My grandfather raped my cousin, which started a huge chain of rape in my family.

I was sexually assaulted by my dad and now it's hard for me to be able to- I have still have mixed feelings ... I love him because he is my dad, but I don't 'cause of what he did to me and my brother and my sister.

'Cause he raped my sister, and he did other things to my brother when he was younger.

I've been molested three times and orally raped once.

Nearly all of the participants in our study who were living in homeless shelters or residing in transitional living programs reported histories of rape or sexual abuse. In addition,

the young women in shelters and transitional housing programs talked about their experiences with violent and controlling partners and their difficulties in finding assistance to leave an abusive situation.

And it was a pattern. Slowly I stopped using my cell phone. I had one with him so he could keep track of me at all times. Just kinda was a pattern. Slowly, you know that started happening. Then I was unable to work, and then my family kind of ... I used to go see them every weekend. Then it was like every couple months, and slowly then, I just didn't talk to them.

High-school girls in our study also talked about dating violence and emotionally abusive relationships.

I think verbal abuse is so huge because noone can see the marks on you, and it is harder to detect...

My first pregnancy was when I was fifteen. And the father and I did not last whatsoever. He beat it out of me, basically. He smacked me on the ground and kicked me a few times.

In my situation I was date raped, so the fact that I started the cycle with umm drinking and falling into peer pressure and going with people who I didn't know that well and everything, that played into being in the situation that I was in at the time. You know, I think that girls these days, they just kind of, they do whatever it takes ... if it was not that cool to party, then, like how many girls would be going out and getting drunk and getting abused?

Sexual abuse can have lasting effects on health and well-being. In a recent research study, Noll, Horowitz, Bonanno, Trickett, & Putnam (2003) found that sexually abused participants experienced significantly higher rates of physical abuse, including domestic violence. They were also twice as likely to experience subsequent sexual violence and four times as likely to engage in self-harming behaviors.

"I was sexually assaulted by my dad."



The association between abuse or assault and health can be extensive. In addition to increasing the likelihood that a woman will experience future sexual and physical violence, victimization adversely influences both physical and behavioral health in a number of ways. Women who have reported abuse in their lifetime experience more frequent headaches, sexually-transmitted infections, pelvic and back pain, digestive problems, and vaginal bleeding than non-abused women (Wenzel et al., 2006). Victimization also places girls and young women at increased risks of developing depression and other mental health problems, including suicidal ideation and behaviors (Arnett, 2007). One high-school student in our study explained the consequences of sexual violence for her life.

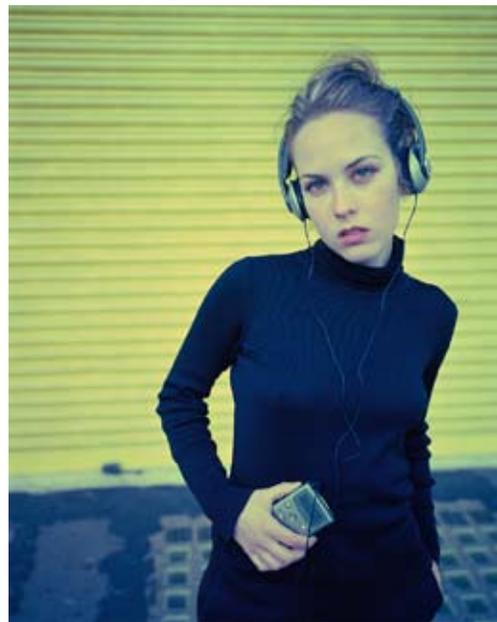
I don't feel safe a lot. I was raped in my school bathroom two years ago, and ever since then I didn't leave my house and refused to go to school. I just wouldn't leave the house. I would sit in the house all day ... I wouldn't answer the door. I wouldn't use the phone ... I'd be scared sitting in a car alone in broad daylight with the doors locked. I would freak out ... At one point I was locking myself in my room and just like staring at the ceiling. I just didn't go anywhere. It was really sad.

Feeling Unsafe

Witnessing violence and perceiving violence in the community also affects health and well-being. In a review article, Kuther (1999) reported that witnessing violence, sometimes referred to as co-victimization, has cognitive, emotional, and behavioral consequences. These include limiting neighborhood activities of children, poor school attendance, increased likelihood of dropping out of school, and increased likelihood of smoking. The accounts of some of the young mothers with whom we talked reflected these effects. For example, the young women in transitional housing programs talked with us about the different ways they altered their daily activities in response to perceived safety concerns about their neighborhood environments.

You don't take your kids out of the car until you've got all your stuff together to go to the door, because you don't know what's going to happen. At least they're in the car, and it's locked, and they are safe.

"I don't feel safe a lot."



So, when you are getting stuff out of the trunk, you know they're at least okay.

We live in a part of town that has like fifty-nine sex offenders within two blocks. There's like fifteen or sixteen right across the street from us. So it's like, who wants to go outside and play?

If you go out in the night, you are always scared. Like running with your kids fast, close the door fast, and do everything fast.

I worry about myself and my baby. I read the news and there are kidnappings around [city] – that's why I am scared all the time when I go out at night.

Feeling unsafe in their communities was not limited to young mothers in precarious living situations. High school students in our study also talked about feeling afraid and unsafe in their community.

When I get out of work, I have no ride, so I run all the way home.

I can't really go outside when I'm at home. I'm just kinda stuck inside. Like, we have no yard. Our house is in the middle of the city, and we can't really go outside and ride our bikes because we're afraid the cars are going to come and hit us or something. And it's just like, it gets annoying after a while, because I just want a way out.

Although concerns of violence and safety were woven throughout discussions in all listening groups, only among

sexual minority youth did the violence seem to take the form of hate crimes.

I was the only out person in my school and it was pretty dangerous sometimes. So things like uh, my prom, I was the first girl to ever take another person, well, a first person in general to take someone of the same sex to prom. And ... I got beat up pretty badly later on that night, but it was worth it.

“I was the only out person in my school, and it was pretty dangerous sometimes.”

The 2005 GLSEN Report on National School Climate is consistent with the experiences of violence and harassment disclosed by the young women with whom we spoke. For example, 75% of lesbian, gay, bisexual and transgender (LGBT) students surveyed by GLSEN reported hearing derogatory remarks such as “faggot” or “dyke” frequently at school. Nearly two-thirds (64%) reported feeling unsafe at school because of their sexual orientation, 64% reported that they had been verbally harassed in school in the past year, and over a third (38%) experienced physical harassment at school.

Helping Young Women Stay Safe

Narratives about sexual and physical violence were pervasive in the information participants shared. Abuse and sexual exploitation occurred at the hands of family members, partners, and strangers with whom girls participated in sexual activity. Some girls also voiced concern about younger siblings who may have experienced sexual abuse. Participants in this study who had experienced sexual violence worried about not being believed if they sought assistance or feared they would be judged or “looked at differently.” It is important that parents and other caring adults take reports of sexual and physical violence seriously and assist girls in connecting with available services.

In order to effectively assist girls and young women, caring adults need knowledge about services available to those who experience physical or sexual violence. According to a recent report issued by the NH Governor’s Commission on Domestic and Sexual Violence (Meridian Consulting, 2006) based on data from 204 representatives of state and local agencies, 39% of respondents could not identify a shelter for victims of sexual violence and 45% were not aware of hospital accompaniment programs. Becoming aware of the resources in the community is the first step in helping connect girls and young women with the assistance they may need.

Knowledge and awareness is important, but factors such as gender inequality, economic inequity, homophobia, and ageism that contribute to violence in the lives of the young women in this study require socio-political solutions. Therefore, helping young women stay safe requires

that caring adults work to reduce inequalities in our society that perpetuate sexual and physical violence. At the same time, it is important to support

programs that address violence and to provide shelter for those whose lives are affected by it.

In addition, our community programs, schools, and institutions need to educate children and adolescents about violence, need a zero-tolerance policy regarding violence, and need to make help easily accessible to young people who need to escape violence in their lives.



Mental Health Concerns

Participants in every listening group identified mental health issues as critical concerns in their lives. The young women talked about their own stress, anxiety, and depression, as well as that of their peers. They voiced concern about access to mental health care, taking medication, and the quality of care they received. They also spoke about other barriers to receiving care and the strategies, such as cutting, substance use, and induced vomiting, that they used to try to reduce their own stress.

Although historically depression in adolescents has been under-diagnosed and under-treated, youth in the United States increasingly are being seen and diagnosed with depressive disorders (Ma, Lee, & Stafford, 2005). The Commission on Adolescent Depression and Bipolar Disorder (2005) reported that rates of depressive disorders are twice as high for females as they are for male adolescents, that the first onset of major depressive disorders is frequently in adolescence, that the rates of major depressive disorder have been increasing in recent cohorts of youth, and that over 50% of depressed adolescents suffer a recurrence within five years.

Depression can have extensive effects on a young person's physical health, school experiences, interpersonal relationships, and plans for the future. Depression is also highly correlated with suicide-related behaviors. Although there is evidence that the youth suicide rate in New Hampshire is decreasing, eleven young women between ages 13 and 24 died by suicide in New Hampshire between January 1, 2003 and March 31, 2006 (Fenner-Lukaitis, 2006). Although male adolescents are more likely to die by suicide, female adolescents are more likely to experience depression and make suicidal attempts.

Data from the 2005 NH Youth Risk Behavior Survey indicated that 36% of the female participants had felt so sad or hopeless almost everyday for two weeks or more in a row that they had stopped doing some of their usual activities. Twice as many girls (23%) as boys (11%) had seriously considered attempting suicide in the last twelve months. Sixteen percent of girls (9% of males) had actually made a plan about how they would attempt suicide; 12% of girls and 5% of boys reported at least one suicide attempt.

We ran analyses to look at actual numbers reflected in the percentages, and it is most alarming. Nine hundred and fifty girls in the state reported at least one suicide attempt in the last year, with 466 girls reporting two or more suicide attempts during that period. Two hundred and forty-six girls indicated that an attempt in the last year resulted in injury, poisoning, or overdose that required medical care (NH Department of Education, 2005).

Reducing Anxiety, Seeking Control

The young women in our study reported using a variety of strategies including cutting, self-induced vomiting, and substance abuse—self-injurious behaviors—to address their anxiety and depression and gain some control in their lives. Most previous research on self-injurious behaviors does not include the adolescents' perspectives. However, a

recent study (Laye-Gindhu & Schonert-Reichl, 2004) asked a community sample of youth about self harm and found that 20% of

girls reported harming themselves, with cutting behaviors being the most frequent type of self harm. This cutting was generally non-suicidal self harm motivated by deep despair, anger, depression, loneliness, and frustration.

In our listening groups, the young women talked about using cutting to reduce anxiety, depression, and emotional pain. Cutting, and related self-biting or gouging, served as strategies for trying to gain some control in their lives and to reduce their emotional pain.

And like people think you're trying to kill yourself when you cut yourself...most people who cut aren't trying to kill themselves. They are just trying to get the pain away. They're not trying to kill themselves, and that's what people automatically assume.

It kinda sucks when you are out of control and what you feel like you can do, like to make yourself feel real, is you have to shed some blood. It sucks, and I hated going through it.

At first it didn't start out as cutting. It's just gouging. Waiting for my nails to get long enough and using the ones that when they grew, came to like a rectangular

“Most people who cut aren't trying to kill themselves.”

tip and using the corner just gouging it into my arm as much as possible until it gouged so deep that I started bleeding. Just to take away emotional pain and put the pain somewhere else. And I started doing that after I was raped.

I used to cut myself and I didn't tell anyone except my best friend. Like, I couldn't. I did it because that's what made me feel better at the time. The drugs didn't...I tried doing drugs just to not like get that urge to cut myself, to make me feel better. Because like cutting yourself for me, like at least seeing the blood run down my arm, like I knew where the pain was coming from instead of like all the emotions jumbled up inside me.

Many of the young women who talked about cutting seemed to identify it as an undesirable, but dependable, way to reduce stress or emotional pain. When they talked about trying to stop cutting, they usually talked about turning to a friend or partner for help, rather than seeking help from an adult. One young woman talking about adults in her environment said, "They never comfort you, never talk about it. They just consequence you. They don't ask why." Another said, "I don't think people should be punished for it. They have a problem. You don't punish someone for it." When asked what adults could do to help, the first young woman responded:

If you cut yourself here, a staff should be with you at all times to make sure you are okay ... Their being with us and talking with us helps us. Having the staff talking with us gets it out of us, out of our system. It makes us so we're more aware of what we're doing.

The young women in this study talked also about self-induced vomiting as a stress reduction strategy. Health care providers and researchers frequently voice concern about girls' self-induced vomiting, but these discussions are usually related to body image and eating concerns. The comments of the young women in the listening groups suggested the importance of adults not making assumptions about the motivations for girls' self-injurious behaviors.

I know people who throw up to make themselves feel better, like not because they're fat, but I know people who like throw up because they need some kind of pain to make them feel better.

One time I got so depressed, and I used to get depressed all the time, that I would start making myself throw

up 'cause I felt like I was in control of something ... I knew that that was something I had control over, and that was something I would be able to like get my stress out, because I'd feel better for a little while afterward. But then it would get worse and worse.

There was surprisingly little discussion in the listening groups about alcohol and other substance use or abuse. We did not interpret this to mean that participants did not use alcohol or other drugs, but rather that other issues were more salient for them. When participants did discuss substance use, it tended to be in the context of self medicating or the management of stress. One girl talked about drugs as an alternative to cutting. "After like all these people make you stop doing drugs and that sort of thing, and then you have nothing else ...and it just makes you want to cut again." A homeless young woman explained how LSD could help her forget the realities of her life.

But for, for a long time, because I couldn't figure out how to kill myself, I went to drugs. Umm ... acid was my best friend, because when you're doing acid, nothing is that real. When you're not on it, it is real ... Everything that hurts, everything that you're afraid of, everything you're embarrassed by, it's just, it's all gone. It doesn't exist anymore ... Psychologically, I mean, the power of it, it's just, it's so seductive. And it's just so tempting, because you know that for the next...ten, twelve, thirty hours nothing matters anymore.

Mental Health Care

Many of the young women received mental health care, often facilitated through community programs in which they participated or the settings in which they lived. Others believed they needed some type of assistance, but identified a variety of barriers to seeking mental health care. Among these were fear, access issues, stigma and discrimination, and the difficulty of finding someone to whom they can relate. Participants voiced concerns about the consequences of being open about themselves and their experiences, fearing that their situation might get worse than it currently was.

"You can't tell a doctor or you're gonna go in the Pavilion."

I wouldn't go to people to talk about stuff like that, because I'd be too afraid. I wouldn't want to be sent like to a psych hospital or anything like that.

I know with my therapist...like when I was doing drugs and stuff like that, I was always really careful about what I told her and everything and what I wanted her to know. Like I didn't want her to tell anybody, and I didn't want her to know some stuff that might lead to me getting sent someplace, that sort of thing.

Young mothers were particularly fearful that they might reveal something that would result in their children being removed from their care. One homeless mother said, "You can't tell a doctor or you're gonna go in the Pavilion, if they know that you're doing it. I mean, I can't tell doctors about that. It's messed up." To which another in her group responded:

Yeah, they think you're total whack jobs, and they'll put you away. And they'll put you away for a long time, because they'll say 'Oh, she's not able to cope with everyday life.' For people like me, they take my kids away, even though it was in the past. And that's, that's not something I'm willing to risk.

Access to mental health care also was a barrier, particularly for those young women living on their own and for young mothers. One young mother in a transitional living situation identified as barriers both lack of knowledge and delays in getting services when she really needs them. "Not having enough resources to know who to go to. It's hard to get in those places. The waiting list is like 6-8 weeks." Others talked about the difficulties they encounter paying for mental health care and medication.

Depression medication is expensive, like Prozac and anxiety medication. I don't take it 'cause it's like \$120 for like fifteen pills. And that don't last very long. What if you have a bad month? You're screwed. So you know what they do? My doctor told me to do? Go to the ER if you have an anxiety attack, because then Medicaid has to pay for it. They'll give you a shot or a pill and then you go home. But that's a pain because you have to take your kids or my child and go to the hospital.

Or if you do have insurance, they'll give you a list of supposed people that take that insurance and that's a lie. Nobody takes insurance for anything these days...no professional takes Medicaid, nobody takes Medicaid. It's a lie. It's bogus. They just give it to you to shut you up when you're there, and then that's that. Basically they say 'Here you go, be quiet and don't, don't call us for any problems, 'cause we'll just send you another list of people that will accept.' And they don't.

A frequent complaint was the difficulty in relating to a mental health provider.

I don't like therapists 'cause it's like, I've had to go and do so much therapy and a lot of it is just them sitting there and nodding...but you could, you could feel it, that they didn't even care ...

Why am I even coming if you don't even understand, if you don't care, if you really don't want to be here anymore than I do? It's just pointless you know.

I don't feel like I should be talking about every part of my life to someone that I know nothing about [that] I only see once a week for an hour. Like I can't ask them personal questions, but they can do it to me. I don't like that idea at all. That's why the only person I ever talked to about it was my best friend.

And like, there is probably no one to turn to when you're really, really depressed. And I've had counselors and stuff like that and or therapists or whatever they were. But I've never been able to like really connect with them, and it's hard to find someone to talk to sometimes about things as far as depression goes.

Participants also complained about the quality of care they received or the difficulty in finding the expertise they needed.

I was trying to find someone who specialized in self-injury and borderline personality disorder and this was in Maine. There is no one who specializes in Maine.

For me, I need, I needed to see a psychiatrist. I needed to go to counseling, and I didn't have health care. And no place will take you in on like, you know, payment plans. And then you do get in there, and I think

"It's hard to find someone to talk to sometimes about things as far as depression goes."

in four months I changed psychiatrists three times, 'cause they all decided to move or decided not to, or to unload some of their clients, things like that.

Supporting Young Women's Mental Health

A recent review of the literature (Commission, 2005) indicated that mood disorders double in young women after puberty, probably due to hormonal changes. Among the factors identified as contributors to the onset and recurrence of depression disorders during adolescence for girls were family environments characterized by lack of supportive connections, poor parental bonding, harsh discipline, negative life events, and poverty. In addition, cumulative stressful life events and childhood abuse or mistreatment predicted depression for girls. The Commission also pointed out that individuals who are depressed can be more interpersonally difficult contributing to additional problems in their social interactions. This then can make relationships with parents, teachers, and other professionals more difficult and create additional barriers to receiving help. Many of these factors were pervasive in the lives of young women in our listening groups.

Lacking effective mental health care or assistance from knowledgeable adults, some of the young women in this study turned to self-injurious behaviors as a means of modulating their stress and emotional pain. Both the participants in this study and researchers in self-injurious behavior recommend that we



develop non-punitive, sensitive responses to behaviors such as cutting (Brumberg, 2006; Eells, 2006; Walsh, 2006). Eells emphasized the need to break the cycle through which emotions are manifested as self-injurious behaviors. Providing information and teaching coping skills to young women, both proactively and while they are receiving care, may be effective in helping them develop alternative non self-harming methods of relieving their emotional pain. Young women can be assisted in learning skills such as mindful breathing; visualization techniques; physical exercise; expression through writing, art, or music; and verbal communication skills to act as replacements for self-injurious behaviors (Walsh, 2006).

It appears that a multi-pronged approach to supporting young women's mental health would include providing services to parents that improve family life and parenting, early identification of mood disorders among young women, accessible and teen-friendly mental health services, and assistance that helps young women develop healthier strategies for dealing with stress. Because the chance of an adolescent having a treatable mental illness can be as high as 21%, some have called for voluntary screening of all teens by care providers to detect symptoms of mental health problems (Friedman, 2006). In addition, it seems particularly important for young women and adults who interact with them, including parents, to know the symptoms of depression and anxiety so that appropriate mental health services can be secured as early as possible.

Once we have identified young women who need mental health care, it is critical that services are available to provide the care that they need. For the most part, young women in this study did not perceive mental health care to be easily available or maintainable. They were skeptical about the effectiveness of care and had difficulty relating to care providers. Developing alternative delivery systems for mental health care through schools, after-school programs, support groups, or other places where young women congregate might be effective. Some of the homeless young women, for example, wished that a mental health provider would come to the homeless shelter and provide group therapy on site. There is a broad array of treatment approaches with demonstrated effectiveness including creative delivery models such as a peripatetic therapist-in-the-youth's environment and group sessions that build specific skills (Weisz, Sandler, Durlak, Anton, 2005).

We now need to direct effort and resources to making information about these evidence-based practices more widely known. In this way, we can reduce the gap between knowledge and practice.

Barriers to Receiving Care

An important purpose of this study was to better understand why young women may not get help when they really need it. Adolescents are the population group least likely to seek care through formal care providers, and nearly one in five report times when they have forgone medical care even though they thought they should see a care provider (Irwin, Burg, & Uhler Cart, 2002). Adolescents in general have identified a broad range of barriers to accessing health care which include pragmatic issues like transportation and inconvenient hours, as well as social-cultural barriers such as concerns about confidentiality, including the need for parental consent to secure care, language barriers, and the shortage of providers who are knowledgeable about adolescent health (Ozer, Macdonald, & Irwin, 2002). In addition, many of the most common problems experienced by adolescent girls have some stigma attached to them or can be embarrassing enough that girls will hesitate to seek assistance (Dougherty, 1999). For example, in the Commonwealth Fund study (Louis Harris Associates, 1997), 35% of girls who had received health care indicated that they had been too uncomfortable or embarrassed to talk about certain health issues; half of those identified as most in need of care indicated embarrassment or discomfort in sharing information. However, there is little research that captures young women's own thinking about this topic.

The young women participating in the listening groups identified a variety of barriers that prevented them from receiving the care and services they needed. Among these were fear, skepticism about effectiveness, lack of information, care-giver issues, access, stigma, and problems related to parents. Young women voiced concern about the consequences of help-seeking. In addition to the fears about what might happen if they sought mental health care discussed in the previous section of this report, the young women generally indicated skepticism that their attempts to seek care would be effective.

Health care like is hard, because you don't want to talk to your family physician about it, I don't think. But you're supposed to, you know. I mean, but you don't want to. So you go to a place like that hoping to find it (help). But then when they don't give it to you, you don't know what to do.

You just forget about it 'cause it's not going to get done. As much as you try and try and try to get something done, it doesn't happen. So you just say, 'Oh well, forget about it and move on.'

I usually go, 'I know you're probably not going to be able to help me but ... I'm just gonna say it, because at least I can't say I didn't ask. They usually come back with 'We don't know what to do.' Great 'cause I don't either. So, oh well.

Some of the young women did not think professionals took them seriously and did not feel that adults would help them. One young mother summed up her perceptions about the situation by saying, "Nobody helps you." The young woman quoted in the section on sexual minority youth, who had been hit by a car driven by adolescents who experienced no repercussions, talked about how that experience affected her expectation of getting help in a different situation. "So when I was abused during high school, I didn't go to law enforcement, 'cause I had kind of given up."

Another young woman with learning disabilities who dropped out of school talked about her frustration with getting help at school. She explained that, "Even if you are SPED, people don't sit down and help you with what you need. They'll only help with the things they think you need help with." Similarly, another participant talked about her frustration with a medical care provider, "She doesn't make me feel like I have anything valid to say about my own health ... I could understand if I was in there all the time like inventing these ailments, but that's not the case."

The cost of services, especially if a young woman is not covered by insurance, is a significant barrier to receiving needed care. Participants indicated that "Money is a huge factor." One participant noted that, "If you have limited resources, you're pretty much screwed." One young mother in transitional housing described the financial difficulties she encountered accessing services, even when they were provided on a sliding scale.

Okay, but you have all these other bills too and, like, they go by your income. They don't go by the fact that you have to pay rent, your kids have to have this and that like diapers and stuff. They don't do that. So it's

like, it goes by your income, and then you still can't afford to do it. You know, 'cause you have to pay day care. They don't take that into consideration.

Honestly, this is what I do after a while. You know what, I don't care anymore. Whatever. I won't go to a dentist. I won't get my teeth fixed. I'll deal with the pain, because I am just so sick of dealing with all these people. You get so mad when you're talking to them on the phone, you just hang up. Whatever, and you just hang up. What else can you do? You can't sit there and argue with them, 'cause they're not going to tell you anything different.

It's hard because sometimes my parents have rough, rough months or whatever. My stepfather's not working right now, 'cause he had surgery. So it's like they're scraping by, and you know my mom will go without something just to make sure I have the medication. Because I have to have it.

Discrimination and stigma also kept young women from seeking help they needed. When asked what might have helped her, one young woman who had experienced sexual abuse responded, “To know we have people there. There are not a lot of people girls can go to without people thinking they are lying, being considered a liar, or being judged. ‘Are they going to believe me?’

Sexual minority youth frequently talked about the discrimination they perceived in securing health care. Examples of the discrimination they perceived included comments from a young male-to-female transsexual talking about the experiences she had after sex reassignment surgery and the observation of a young woman who identifies as bisexual when she went for an examination.

Recently I've had surgery and I've had to go and have umm ... stitches removed for example, 'cause I was having complications with them and, uh, no one in the area where I lived would remove them- no medical personnel. Umm ... I got the like referral game. You know you go someplace, and they don't want to treat you, so they give you a BS excuse and a referral, so that way you can't file discrimination.

She was just telling me that I shouldn't be a lesbian or whatever, like I shouldn't be bisexual and all that stuff ... It was like way to tell me how to be like

you're supposed to be like caring and stuff and they weren't at all. I was mortified with them.

Reducing Barriers to Care

The barriers discussed in this and other sections of the report suggest the importance of professionals and other caring adults working to normalize discussions about sensitive issues girls and young women face in their everyday lives. Doing this, of course, assumes that these adults are in touch with their own values and understand how their individual biases may affect their interactions with diverse youth. Young women want to talk about the issues most salient to them. However, even recent research indicates that physicians are much more likely to talk with young women about diet or exercise than they are sexually transmitted infections or contraception (Rand, Auinger, Klein, & Weitzman, 2005). Rand and colleagues found that even at reproductive health visits, only 24% of providers reported providing family planning advice and 14% reported doing HIV/STD counseling.

The Society for Adolescent Medicine (SAM) issued a position paper outlining a range of policies and programs they recommended for implementation to ensure that adolescents have access to high quality, comprehensive health care (Morreale, Kapphahn, Elster, Juszczak, & Klein, 2004). In addition to affordable health care coverage for all youth through age 24, they recommended that adolescents be able to “receive confidential services based on their own consent whenever limitations on confidentiality would serve as an obstacle impeding their access to care.” (p. 343) The authors note that the existence of confidentiality protections for adolescents can actually help support voluntary communication with parents with the assistance of the health care professional. The SAM position paper also recommended that health care providers with expertise in adolescent and young adult health be available in all communities. Ideally, these youth-friendly providers, prepared culturally and linguistically to meet the needs of diverse youth, would be located at sites and during hours easily accessible to adolescents. If adults who are approachable, knowledgeable, and willing to assist are available to girls and young women, we may win back the confidence of the most vulnerable youth and encourage them to see adults as resources to help them access the help they need.

“I'll deal with the pain, because I am just so sick of dealing with all these people.”

A Focus On: Sexual Minority Youth

Lesbian, bisexual, and transgender (LBT) young women face a variety of challenges during adolescence. Many of these challenges are similar to those of their heterosexual peers (Savin-Williams, 2001). However, young lesbian and bisexual women experience higher rates of pregnancy, higher rates of HIV, earlier initiation of sexual activity, and a higher incidence of drug and alcohol use before last sex than their heterosexual peers (Blake, et. al., 2001; Goodenow, Netherland, & Szalacha, 2002; Saewyc, Bearinger, Blum, & Resnick, 1999). In addition, there are some issues that are unique to sexual minority girls, largely as a result of stigma and discrimination (Davis, 2003). For example, although participants in all of the Girls Speak Up! listening groups discussed issues pertaining to violence and safety, the violence experienced by minority youth participants frequently focused on their sexual orientation.

When I was younger, in the 7th grade I think ... I was hit by a car by 2 teenage boys ... for being gay. I didn't know I was gay yet, they did somehow. It was a scene and the cops were called and like I dislocated my shoulder and fun stuff... and I identified who it was, I knew who it was and the car was identified, but the boys just said no, we were in class. And nothing ever happened with it.

Much of the harassment discussed by sexual minority young women was compounded by teachers and other adults who failed to intervene on their behalf. One participant explained, "Pretty much in my town, it's uh, you don't tell anyone you're gay, you don't get the crap beaten out of you, and you don't have the teachers look the other way while it's happening." Although there were certainly some teachers and counselors in schools who were identified as supportive, even when they were willing to help, adults were more frequently perceived as ineffective. In one group, participants identified two teachers as being supportive, but when asked if they go to these teachers with concerns, one young woman responded:

I used to, but nothing ever gets done when it's taken to the administration or to the school resource officer or anything like that. So ... I gave up. I actually just

withdrew myself from the school, and I'm going to adult education instead, 'cause it'd be easier.

The perception that adults will not help has important implications for help seeking. Participants described prior experiences with ineffective adults as a powerful deterrent to seeking assistance from adults the next time they experienced violence or harassment. One young woman was so disenfranchised and felt so disconnected from, and distrustful of, adults, that she would not allow us to tape her voice during the listening session. She was alienated from her family and experienced long periods of homelessness. When we asked her how she got help when she needed it, she responded: "I don't. I find ways around it. I heal myself. It is not worth going to have someone ... treat you badly. My whole life has been like this. It's not safe."

Concerns about care providers' homophobia, confidentiality issues, and inadvertent disclosure of their sexual orientation to their parents contributed to lesbian, bisexual, and transgender participants' reluctance to seek care and information even when they needed it. Participants were particularly concerned when their health care provider also cared for the rest of their family. Many girls were similarly reluctant to disclose their sexual orientation to mental health professionals out of fear that they would be judged, devalued, and disregarded. Some that did feel comfortable to disclose their sexual or gender identity were met with an overall lack of specialized training and knowledge about gender and sexual orientation. Even well-intentioned counselors may have little education and training in how to effectively work with sexual minority youth. The young women we spoke with discussed how reproductive health professionals often assume heterosexuality and, therefore, do not provide important sexual health information. This may have potentially serious health consequences. For example, one young woman experienced direct discrimination when inquiring about bisexual-specific safer sex practices.

They completely discriminated against me because I was like bisexual. I was mortified by them, like I walked out ... I'm not doing this. Like you're not going to sit there and discriminate against me ...

These young women appeared to be very discriminating about sharing information about their sexual orientation. When young women felt acceptance and trust from their care provider, they did seek assistance from that person.

I feel 100% comfortable talking to him, like, because he's just so laidback and amazing ... He knows I'm a lesbian. Like I told him that, but like my regular doctor doesn't know ... I could tell him anything, but I would never tell my primary care physician anything.

The role of parents, and mothers in particular, was an important topic when talking with lesbian, bisexual, and transgender girls. Many girls experienced difficult relationships with their parents. One girl said that her mother doesn't approve of her sexual identity and essentially ignores it. Another noted that her father was actually excited when she experienced an unwanted pregnancy earlier this year, because he thought it meant she was "turning straight." Another young woman shared that she has absolutely no relationship with her parents, indicating that she and her family have "disowned each other." Although many girls had strained relationships with their parents, others were quick to name their mothers and their families as important sources of support. For example, one young woman explained:

I love my family to death. They are so supportive of me in every way possible. I think it was just last week that my mom and I were talking about ... what my wedding was going to be like.

Another young woman talked about the reaction her mother had when she came out:

She did really well with it. She wasn't upset, she doesn't disown me or anything. She was like, 'If that's who you are, that's who you are. I can't make you change from what you want to be. That's who you are, and that's who you want to be. You stick with it.'

This young woman spoke with pride about her mother and the relationship they have. Parental reaction to a child's disclosure of sexual orientation can be a positive experience and may increase parent-child closeness (Mallon, 1998). The young

women in this study who were able to name their parents as a source of love and support were more self-confident and appeared to be more successful in school and work. Parents' acceptance and support can be important resources in the lives of their lesbian, bisexual, and transgender children who often get little acknowledgement or assistance from others in their day-to-day lives.

Sexual minority youth are often neglected by professionals who function as though these young people "do not or should not exist" (Prezbindowski & Prezbindowski, 2001 - p. 65), which may encourage escalation of violence toward lesbian, bisexual, or transgender young women and increase their feelings of hopelessness and isolation. Schools can be particularly difficult and unsafe for sexual minority youth. Not only are GLBT issues generally omitted from diversity, health education, and sexuality education curricula, but openly gay role models among teachers, counselors, and other school personnel are frequently nonexistent (Morrow, 2006). Support groups for sexual minority youth and gay/straight alliances are often a lifeline for these young people. Outright groups served such a purpose for girls and young women in this study.

I wasn't really sure about PACT or Outright for awhile ... when you have a group like PACT and then you have a group like Outright like it really helps. Going and sitting in a group ... every Tuesday night ... sitting there and playing games and laughing all night ... it gives you a night away from everything else in life and it just gives you a night to relax and you're around everybody else who doesn't care who you are or what you are and that just make sit so much easier. It really does. That one night out is just amazing.

Conclusions and Recommendations

This report presents results of the Girls Speak Up! Project conducted by the UNH Center on Adolescence. Each section of this report provides an overview of a major theme discussed, critical issues raised by the participants, and important considerations for parents, caring adults, care providers, and policy makers interested in supporting the healthy development of young women. Addressing some of the issues raised by the young women may be fairly easily accomplished by reflecting on routine practices or by training and educating for providers and other caregivers. Other issues involve socio-political challenges that require cross-system efforts and collaboration. The following recommendations are based on the comments and suggestions made by the participants in this study and reflect the research literature on best practices in adolescent development.

Listen to girls and demonstrate caring through actions as well as words. If girls believe that you really want to listen to them, and that you will do so without judging them, they will speak up. The young women in this study were looking for adults they could trust to listen to their perspectives and ideas and then help them solve the critical issues in their lives. They wanted to connect to caring adults, but indicated that the adults who were supposed to help them stay healthy and safe frequently let them down. These young women often had reasonable strategies for how to address the problems in their lives, but needed the help of adults to understand what resources were available and how best to access them.

Provide girls and young women with information about mental health issues, particularly depression, anxiety, and stress, and help them get care when necessary. Mental health disorders are the single leading cause of disabilities among adolescents; 21% of youth aged 9-17 have a diagnosable mental or addictive disorder (Ozer, Macdonald, & Irwin, 2002). By knowing how to identify indicators of mental health disorders, being aware of available mental health care resources, and being willing to talk with young women and their parents about these disorders and services, caring adults can improve the likelihood these young women will secure effective care. Hopefully, this will reduce the tendency of young women to turn to one another or to self-injurious behaviors to manage their problems and emotional pain.

Advocate for adequate mental health care services for adolescents and young adults. It is important that young women with even mild depression receive adequate treatment. Depression is linked to increased risk of suicide, lack of social development and skills, substance abuse, withdrawal from peers, poor school performance, and less than optimal career and relationship choices (Commission, 2005). The Academy of Child and Adolescent Psychiatry recommends that the first line of treatment of depression for adolescents should be psychotherapy—ideally cognitive behavioral therapy and/or interpersonal therapy—neither of which is widely available.

Take reports of sexual and physical violence seriously and assist girls in connecting with services. Narratives about sexual and physical violence were pervasive in the information participants shared. Young women in this study who had experienced sexual violence voiced concern about not being believed if they sought assistance or feared they would be judged or “looked at differently.” Professionals and other caring adults need knowledge about available services for those who are victims of violence, and also need to be actively involved in working to reduce the factors in our society that perpetuate violence.

Reflect on and address heterosexist assumptions and biases that may result in stigmatization and discrimination against girls and young women. Currently, services for sexual minority youth are minimal to non-existent. We need to advocate for services that include and respond to the needs of these young people. In a review of the social and developmental challenges facing gay and lesbian youth, Ryan and Futterman (2001) found that only about one in ten care providers ask about sexual orientation, so sexual minority youth may not get the most appropriate health care or risk-prevention information. In addition, negative experiences with care providers may result in lesbian and gay clients withholding important health information, avoiding preventive care, and delaying seeking care until a problem is far advanced. Sexual minority youth are often alienated from their families and thus may have no adult to provide information or help them secure the care they need. Schools also are frequently perceived as unsafe by sexual minority youth. School and care provider environments could be improved by educating everyone in them about GLBT youth and recognizing them as part

of a broad spectrum of people to be respected and valued, hiring adults who can be role models for sexual minority youth or who are GLBT friendly, and having information about appropriate resources easily available (Morrow, 2006; Prezbindowski & Prezbindowski, 2001).

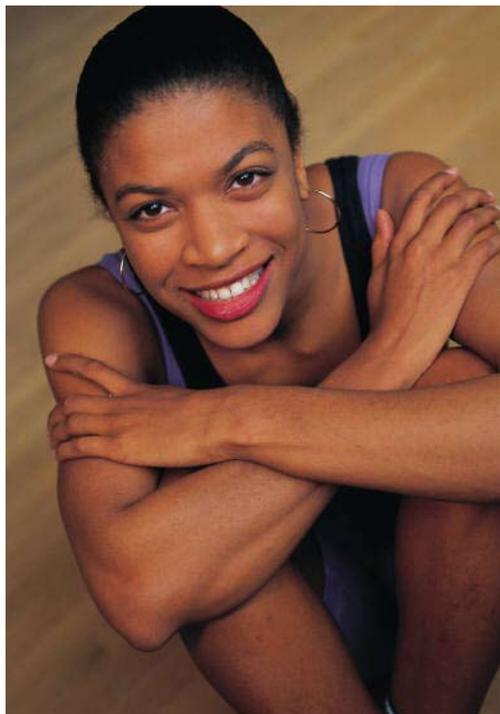
Advocate for and support sexuality education and easy access to reproductive health care for girls and young women. Sexuality and reproductive health care remain the most controversial aspect of adolescent health, with the general public and many care providers demonstrating ambivalence and uncertainty about how best to provide services that girls need. As a result, Brindis (2002) estimates that only 39% of all American teens who need reproductive care services are receiving them. The Society for Adolescent Medicine recently issued a position paper on educating adolescents about sexuality stating that, “It is unethical to provide misinformation or withhold information about sexual health that teens need in order to protect themselves from STIs and unintended pregnancy” (Santelli & Ott, 2006, p. 86). “SAM supports a comprehensive approach to sexual risk reduction including abstinence as well as correct and consistent use of condoms and contraception among teens who choose to be sexually active.” The young women in our study echoed this position and recommended more, and earlier, sexuality education with emphasis on access to a range of contraceptive methods. They wanted more information about sexually transmitted infections and how to protect themselves. They hoped that girls coming after them would not acquire this information the way many of them they had—after becoming pregnant or being diagnosed with precancerous cervical changes.

Don't make girls and young women ask for information and assistance. Many of the most common problems experienced by adolescent girls have some stigma attached to them or can be embarrassing enough that girls will hesitate to seek assistance (Dougherty, 1999). In the Girls Speak Up! Project, participants reported wanting to discuss critical issues with providers or other caring adults, but being too embarrassed to bring the issues up themselves. Caring adults should initiate discussions about these topics, knowing that girls may be relieved that someone is willing to talk with them about these difficult issues. We can further reduce stigma by educating the general public about the effectiveness of mental health care, talking openly about sensitive issues, and putting “resources within easy reach, or in the way of, adolescents” (Call et al., 2002).

Encourage help seeking. In addition to providing young women with information and helping them develop the

skills they need to maintain their health and well-being, caring adults can assist youth in understanding that asking for assistance when they need it is a very adult way of behaving. Many young people believe that they should handle their own problems, not upset their parents, and/or not reveal that they need help. If caring adults model help-seeking behaviors and act as though seeking help is a normal and expected way of responding to challenges, youth may integrate this into their strategies for dealing with problems. Young women's confidence and competence in seeking help might be further improved if they know what to expect when accessing services such as mental or reproductive health care.

Engage young women in their own care and help them find answers to their questions. Most young women, when given adequate information, are able to make responsible decisions about their health and well-being and should be included as full participants in the care they receive (Dickey & Deatrck, 2000). Engaging young women in enhancing and improving organizations and care-provider services contributes to creating youth friendly environments as well as increased competence for the young women involved. Working with youth to find sources of information and helping them to be critical consumers of that information can contribute to a respectful, caring relationship that should encourage teens to ask for assistance in the future when they need it.



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