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**Narrative Sense-making and Time Lapse:
Interviews with Low-income Women about Sex-Education**

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Abstract

Secondary-school students in the United States score notoriously low on tests of their reproductive and sexual knowledge despite attempts by educators and legislators to provide them with informative sex-education courses. In this paper, we built from narrative theory to explore how low-income women perceived their formal sex-education experiences and how they connected those experiences to their sexual-health knowledge, beliefs, and behaviors. Drawing from interviews with 30 low-income women, we identified and developed a typology of sex-education narratives: narratives of regret, narratives of satisfaction, and narratives of uncertainty. We also investigated existing theoretical claims that lapses in time between lived events and the narration of those events connect to sense-making efforts. We found that younger women in the sample were more likely to tell narratives of uncertainty than were older women. These results have implications for the study of narrative theory, sexual-health communication, and the discourse of public sex education.

Narrative Sense-Making and Time Lapse:

Interviews with Low-Income Women about Sex Education

Schools generally offer sex-education lessons in an effort to provide young people with the information and decision-making skills they need to lead healthy, productive, and happy lives. Almost 90% of public secondary school students in the United States receive some sort of formal sex education, and the U.S. government spends roughly 175 million dollars per year subsidizing such programs (Guttmacher Institute, 2006; Kaiser Family Foundation, 2000). Unfortunately, recent research on individuals' knowledge of sexually transmitted infections (STIs), pregnancy, and general sexual health has reported disappointing results. For instance, the Kaiser Family Foundation (2003) found that approximately 20% of U.S. adolescents do not know that STIs can be transmitted via oral sex, 10% believe that only individuals with "a lot" of sexual partners have to worry about contracting an STI, and 30% are unaware that oral contraceptives do not protect against HIV/AIDS and other STIs (p. 23). And this lack of knowledge among adolescents seems to follow them into adulthood, as Weinstein, Walsh, and Ward (2008) concluded that many college undergraduates "demonstrated a fairly poor understanding of sexual health issues" (p. 212). Perhaps not surprisingly, this gap in sexual-health knowledge functions to exacerbate already high rates of STIs (many of which are undiagnosed), unintended pregnancies, and sexual violence in the United States (Satcher, 2001).

In attempts to ascertain why formal sex-education programs seem to be having so little influence on Americans' knowledge, attitudes, and behaviors, researchers have studied the content of existing programs and policies (Bandiera, et al., 2008; Santelli, et al., 2006), the effectiveness of various curricula (Dodge, Reece, & Herbenick, 2009; Kohler, Manhart, & Lafferty, 2008; Milhausen, et al., 2008; Pinkleton, et al., 2008), and media coverage of sex-

education courses (Jensen, 2007; Mebane, Yam, & Rimer, 2006). What research has not explored fully and what we investigate in the present article, is how individuals narrate and thereby make sense of their own experiences with sex education. A number of scholars (e.g., Charon 2009, 2006; Frank, 1995, Harter, Japp, and Beck, 2005; Sharf & Vanderford, 2003) have championed narrative as an indispensable theoretical and methodological guide for understanding and then addressing health-related problems. The practice of narrative inquiry, for scholars, research participants, and even medical professionals, is predicated on the importance of gathering and listening to individuals' stories before attempting to address, describe, or theorize unique health experiences. Scholars have typically employed narrative sensibilities to explore and understand the disruption of illness (e.g., Charmaz, 1999; Frank, 1995; Sharf & Vanderford, 2003; Vanderford & Smith, 1996) and more recently have applied narrative assumptions to the context of patient-provider relationships (e.g., Charon, 2006; Harter 2009, Rawlins, 2009). In this essay, we draw from and theorize about narrative theory in the process of exploring another important health context: educational experiences related to issues of health. Specifically, we argue that identifying and analyzing how individuals construct narratives of their formal sex education offers a lens into the lived, subjective experience of learning about sex in school and, correspondingly, new insight into the widespread lack of sexual-health knowledge. Such inquiry also provides us with the opportunity to examine existing claims about the importance of a lapse in time between lived events and their narration in the process of narrative sense-making (Brody, 2002; Vanderford & Smith, 2003).

Our research draws from semi-structured interviews ($N = 30$) with low-income women in a midwestern U.S. state about their formal sex-education experiences (e.g., school-based programs). We focused on low-income women in particular because access to and experiences

with formal sex education may be especially important for individuals with limited or intermittent access to adequate health information from other sources. In the following sections, we provide an overview of narrative theory—focusing specifically on its application in health-related contexts and its claims about the importance of elapsed time between lived events and their narration, outline our methodological and analytical choices, and describe the three major narrative themes that emerged from the interviews related to sex-education experiences. We conclude this essay by considering our findings in light of the larger sex-education context in the United States and delineating implications for scholars of sex education, public health advocates, and narrative theorists.

Theoretical Approach

In taking a narrative theoretical approach, we invoked Fisher's (1984) assumption that human beings are natural storytellers, as well as his description of narration as "symbolic actions—words and/or deeds—that have sequence and meaning for those who live, create, or interpret them" (p. 2). Narratives, in this sense, are framed as the primary means through which symbol-users account for their experiences and behaviors (Czarniawska-Joerges, 1991). We agree with Sharf (2009) that narrative competence—one's ability to make sense of and connect experiences through narratives—includes "storied exchanges about health, illness, and mortality in a multitude of contexts" (p. 133), exchanges that medical professionals, researchers, and educators must successfully negotiate and interpret when interacting with individuals seeking information and care (Charon, 2006). In particular, we focused on storied recollections of women's sexual-health education experiences. In doing so, we sought to provide a new perspective on the sex-education conundrum in the United States while providing participants the opportunity to articulate their own sex-education narratives.

Our approach in this study assumes that narrative work is purposeful (see Gubrium & Holstein, 2009) and builds from three key elements of narrative theorizing: the sense-making function of narratives (focusing specifically on the role of time lapse between lived events and their narration), individuals' efforts to attribute meaning to decisions and behaviors, and the place of individuals' stories in a particular historical moment. First, the sense-making function of stories is an assumption that recognizes that narratives allow people to create meaning from seemingly chaotic or arbitrary encounters (Sharf & Vanderford, 2003). In this respect, "stories tell us how random facts and events are ordered and given significance by the storyteller" (Vanderford & Smith, 1996, p. 21). Such sense-making is an emergent process in which individuals seek to understand lived experiences in light of their present situations (Becker, 1999; Harter, Japp, & Beck; 2005). Sharf and Vandeford (2003) noted that "critical to this sense-making activity is the distance in time between the actions in the story and the 'telling' of it in retrospect" (p. 17). Recalling events in hindsight enables the narrator to assume a stance that is not possible when individuals are in the midst of living those same events (Brody, 2002; Sharf & Vanderford, 2003). As such, focusing on narratives as a sense-making tool encouraged us to explore women's retrospective accounts, allowing them to reflect on their sex-education experiences and to make sense of those experiences within the broader context of their lives (Gubrium & Holstein, 2009). We aimed to make claims about the connections women drew between their education about sex (or lack thereof) and lived events. As Gubrium and Holstein noted, "In practice, no item of experience is meaningful in its own right. It is made meaningful through the particular ways it is linked to other items" (p. 55). Thus, we paid close attention to individuals' discussion of not only their sex-education experiences but also their decisions and experiences with sexual behaviors and the concomitant consequences of those behaviors.

In focusing on the process of narrative sense-making, we paid specific attention to the process and potential importance of time lapse between lived events and their narration. We aimed to gain insight into the claim that, because “the narrator is separated from the narrated events in time and thus can assume a reflective, observant posture toward those events” (Brody, 2002, p. 25), a certain distance in time between the event and its narration is central to the process of narrative sense-making. To date, scholars have explored the narration of temporality and the structure of narrative in relation to time (e.g., Bruner, 1990; Burke, 1984; Ricoeur, 1990, Mishler, 2006), but few explorations have focused on the role that time plays in one’s ability or willingness to narrate a lived event. Much of what is known about this topic emerges out of research on narrative and loss. For instance, Moules and Amundson (1997) found that individuals’ narrative voices change over time following a grief-inducing event (see also Moules, Simonson, Prins, Angus, & Bell, 2004). Correspondingly, Neimeyer (2005) maintained that the narratives individuals tell over time necessarily incorporate the changing circumstances of their lived experiences. Thus, an early narrative of a grief-inducing event will differ from a later narrative of the same event simply because the narrator will need to account for (either explicitly or implicitly) more lived experience. These studies reiterated the idea that narratives are fluid productions of experience in which meaning-making unfolds over time, and they provide a fruitful starting point to explore more closely the role of time lapse in narrative creation. In the present study, we reasoned that exploring the time between lived events and the narration of those events would enlarge our understanding of women’s encounters with formal sex education.

Second, the theoretical lens guiding this study includes the recognition that, as sense-making accounts unfold, they often include efforts to assign responsibility, place blame, and “provide a rationale for decision and action” in the future (Fisher, 1985, p. 364). These

attributions can provide clues about the process of individuals' health-related decision-making. Vanderford and Smith (1996) noted: "as sense-making accounts, stories serve as important reasons for the decisions individuals make in their lives, including decisions about health" (p. 22). Stories, therefore, reflect individuals' ongoing efforts to construct understandings of self in concert with certain experiences (e.g., taking a sex-education course in school) that enable, constrain, or guide behaviors. Charmaz (1999) maintained that "the self in process emerges continually in response to events and experiences, other people, social roles, cultural constraints and imperatives, and subjective appraisals of them" (p. 227). We sought to identify and understand women's subjective appraisals of their own formal education about sex and whether and how those educational experiences shaped their behaviors and current understandings of health.

Third, our approach to narrative inquiry is based on the assumption that narratives take shape in particular historical moments across time, space, and subjective positioning; thus, we sought to account for the ways in which women drew on "cultural stocks of meaning" (Harter et al., 2005) as they narrated their understandings of sex education. Acknowledging the broader social and political context in which women told their narratives meant connecting the personal with the cultural. In the case of sex education, for instance, attention to individual stories cannot occur in isolation from the broader debates and controversies surrounding who should teach young people about sex, what sex-education curricula should include, and how sex-education programs should be funded. In addition, although researchers have noted the population-level benefits of formal sex-education courses for adolescents (Espey, Cosgrove, & Ogburn, 2007; Kirby, 2002a; Kirby, Laris, & Rolleri, 2007), not all students find themselves situated in ways that allow them to make use of such programs' lessons. For example, Kirby (2002b) found that

in schools that were impoverished and/or disorganized, students were more likely to become pregnant, regardless of the formal sex education available to them. Correspondingly, low-income women, in particular, have been found to face barriers that might limit their sexual agency and ability to choose whether and how to engage in sexual activity (Jensen & Bute, 2010). In this respect, the ways that low-income women experience formal sex-education courses will necessarily be connected to contextual barriers such as insufficient school resources, lack of access to healthcare, and controlling relational dynamics. Low-income women represent an important and under-studied perspective on the experience of formal sex education that plays a role in the comprehensive picture of sexual health in the twenty-first century United States.

In the following section, we articulate our methodological decisions and how they interacted with our narrative sensibilities in the process of exploring the following research questions:

RQ1: How do low-income women narrate and make sense of their formal sex-education experiences in the context of happenings and behaviors that have shaped their sexual lives?

RQ2: How does a lapse in time between lived events and their narration play out in terms of women's ability to make sense of their experiences through narrative?

Methods

Recruitment

We recruited participants for this study after receiving Institutional Review Board approval. Recruitment took place in conjunction with a different study on health literacy in low-income populations. Both studies targeted participants from three low-income communities who qualified for and participated in state-wide university extension programs. To be eligible for

these programs, individuals' income levels had to be at 200% of the poverty level or below. Staff members from these programs, who were members of the target populations (i.e., they received services from the extension programs), asked women in their programs if they were interested in participating in a research study on topics related to sexual health and education. Those women who were interested in participating completed a contact sheet and were then contacted by a research team member via U.S. mail, phone, or email (depending on the individual's preference) to schedule an interview.

Data Collection

We gathered women's storied recollections of their sex-education experiences using qualitative, semi-structured telephone interviews. Semi-structured interviews functioned as a fitting and useful method for exploring the lives of low-income women, many of whom have had limited educational opportunities and thus may not feel comfortable filling out a survey or answering questions in larger groups (Collins, 1990; Madiz, 2001; Muturi, 2005). Moreover, because semi-structured interviews allow participants to shape the research interaction according to their own experiences and expectations, the interviews worked well to uncover the complex nature of participants' lives without overwhelming participants with the potentially discomfiting nature of the study's topic—sexual health and education. Our decision to use telephone interviews, rather than face-to-face interviews, was based on several key considerations. First, we wanted to accommodate the complicated circumstances many of our participants faced in their daily lives. For instance, some women were living in temporary or transitional housing or were sharing a relative's home for several weeks. Many women had limited access to transportation and child care. However, all women in our study had telephone access. The majority of women had their own cellular telephones, even in cases where they did

not have a permanent residence. Thus, it made sense for us to call women at the numbers they provided on their contact sheets and to do so at their convenience to minimize the problems they might encounter from participating in a face-to-face interview. While this meant that a number of the interviews were conducted while women were also watching their children or otherwise multitasking, the majority of women in this sample would not have been able to participate in this study without the flexibility that a telephone interview afforded them.

All interviews were conducted by one of the study's authors. At the interview's start, the researcher carefully previewed and explained the informed consent process with the goal of allowing women to ask questions about the study and feel comfortable with what the study would ask of them. All interested volunteers consented to participate in the study after going through the informed-consent process and were subsequently asked several short questions about their demographic information (e.g., age, marital status, education). Then, the interviewer inquired about the participants' experiences related to sexual health and education and encouraged them to respond to specific questions with storied recollections of those experiences. Interviewers followed a semi-structured interview protocol, but each interview was enacted according to tenets of conversational interaction and thus was customized to correspond with participant response, experience, and interest (Corey, 1996; Langellier, 1989). For example, if a participant did not receive any formal sex education in secondary school, the interviewer encouraged her to discuss her informal sex-education experiences or to offer stories that she found relevant to the inquiry. In this respect, interviews and the storied recollections that emerged therein were co-constructed by interviewers and participants and frequently incorporated spontaneous discussions initiated by interviewees concerning related current events, cultural controversies, and a range of other topics. We recognized that, with this interviewing

method, participants could offer only impromptu narratives of their experiences rather than narratives that emerged naturally and had been crafted over time. However, we reasoned that our dedication to interview co-construction and conversational interaction would help to elicit organic, authentic, and detail-oriented narratives from participants.

The interview protocol guiding this study asked women to recall and then describe the lessons about sex they had in secondary school, as well as any informal sex education they received at that time (e.g., from friends, parents, relatives, the media). Interviewers prompted participants to continue explaining their stories and offer more information by asking them relevant follow-up questions using a conversational approach. Interviewers asked explicit questions that encouraged participants to consider whether they felt there were connections between their formal sex-education experiences and their subsequent behaviors. More specifically, they inquired as to whether participants' sex-education lessons might have changed how they behaved and to narrate how and why participants believed that to be the case. Interviewers also encouraged participants to talk about whether they still, as adults, believed what they learned in school about sex, and how, in retrospect, their formal sex education could have been more helpful to them. In addition, interviewees were also encouraged to engage in recollections about their access to sexual-health information, their interpersonal interactions concerning sexual-health-related issues, and societal and individual expectations about sexuality and pregnancy. Although the focus of the present study was not on these final inquiries, participants' responses to these questions were analyzed and considered part of their over-all narratives of sex education.

Each woman who participated in the study received a \$30 retail gift certificate.

Interviews ranged from 20 to 90 minutes in length. They were audio recorded and transcribed

verbatim, at which point the authors checked each transcript against the original interview recording to assure the transcript's accuracy.

Participants

Thirty women with an income at 200% of the poverty level or below participated in the study. They ranged in age from 18 to 48 years, with an average age of 29 years. Fifteen women were single at the time of the interview (although three of those women were engaged to be married), six women were married, and nine were divorced. All but one participant was either pregnant or had one or more child, and ten of the interviewees had given birth as a teenager. The Guttmacher Institute (2010) reported that the pregnancy rate for 15- to 19-year-olds in the United States is only 7% (as opposed to 30% in the present sample). In terms of racial/ethnic background, seventeen women identified themselves as white or Caucasian, eight as black or African American, two as Hispanic, and three reported a mixed heritage (e.g., half Jamaican and half Norwegian). Three women had completed either an associate's or bachelor's degree, twelve had completed some college, nine had completed high school, and six had not finished high school. Fifteen of the women were employed outside the home either full- or part-time, seven described themselves as stay-at-home moms or family caregivers, three women were students, and five women described themselves as disabled or unemployed at the time of the interview. Finally, in terms of health insurance and coverage, fifteen women were on Medicaid, six women had no access to health insurance, eight women had employer-based health insurance, and one woman reported that she was unsure about her health insurance status. Almost all of the women had experienced intermittent health-insurance coverage at some point in their lives.

Data Analysis

We used thematic narrative analysis to assess the resulting interview data. Rather than analyzing interview fragments in isolation, we attempted to “preserve sequences” of individual interviews and assess participants’ recollections to individual inquiries in relationship to their interviews as a whole (Reissman, 2008, p. 74). Each individual interview functioned as an overarching narrative and the primary unit of analysis, and the data were interpreted according to the investigators’ research interests concerning sex education and narrative theory. We conducted multiple rounds of constant-comparative analysis to engage in an ongoing, iterative process of qualitative data analysis (Corbin & Strauss, 2008). After each interview, we recorded and exchanged field notes and discussed theoretical possibilities and methodological adjustments (e.g., rewording particular interview questions). As we double-checked the interview transcripts for accuracy, we gained a holistic sense of the data, and we independently recorded notes about recurrent narrative themes. We then met to discuss those themes, as well as our commitment in this study to “case-centered” theory building (Reissman, 2008, p. 74). Based on our theoretical sensibilities, we focused on women’s efforts at sense-making as we revisited and took extensive notes on all 30 transcripts according to emergent narrative patterns. Although our interview protocol included specific questions related to sex education, we discovered that women discussed their sex-education experiences at a number of different points in the interviews. Therefore, rather than exclusively focusing on responses to one or two questions, we analyzed the entirety of each interview transcript, a move that is in line with research on narrative inquiry as holistic rather than fragmented (Webster & Mertova, 2007).

After getting a sense of women’s individual stories, we then identified dominant, recurrent themes among the narratives and used processes of constant comparison to develop categories describing individual participants’ experiences. Grappling with the tension between

commonality and idiosyncrasy in health experiences is a hallmark of theorizing about health communication (Babrow & Mattson, 2003). Following the lead of Vanderford and Smith (1996), we attempted to “maintain the uniqueness of individual experience while presenting the integrating concepts, or common themes” (p. 24) among the narratives. Throughout the process of data analysis, we created an audit trail (Lincoln & Guba, 1985) consisting of field notes, interview transcripts, and research memos. We used these notes and memos to generate working definitions for each narrative theme. Each author independently coded all 30 interviews according to the resulting definitions, and then we met to discuss and resolve discrepancies in our analysis.

In the following section we offer a set of plausible knowledge claims about women’s perceptions of and experiences with sex education. We offer these claims with the qualification that all narratives are inherently incomplete and indeterminate (Harter et al, 2005). As Harter (2009) noted, “from a dialogic standpoint, meaning does not reside in the mind or words of any single participant but rather emerges in the interfaces between stories, people, and contexts” (p. 142). In this respect, we invite readers to engage in the ongoing co-construction of meaning about sex education as they encounter women’s stories. Throughout the manuscript, we use pseudonyms to protect participants’ anonymity.

Results

Our constant-comparative methodology (Corbin & Strauss, 2008) led us to group the interviews into one or more of three major narrative themes: the narrative of regret, the narrative of sex-education satisfaction, and the narrative of uncertainty. We then used those findings to examine the theoretical claim that time lapsed between the lived event and its narration is a central element of the sense-making process.

Narratives of Regret

Narratives of regret involved a discussion about the inadequacy or complete absence of formal sex education in school and the belief that access to an adequate sex-education class would have facilitated healthier choices and different, more positive outcomes. Individuals who communicated narratives of regret demonstrated a willingness and/or ability to make sense of their decisions and behaviors in light of their exposure to formal sex education (or lack thereof). Six individuals in our sample noted that they had no formal sex-education course in school and regretted that this had been the case. Shelby—a 28-year-old engaged, Caucasian mother of two—noted that in school “all they did was go over female, what’s it called, hygiene” in which “they talked about how to use a tampon or a pad, and when Mother Nature comes, and all that stuff, but they didn’t really talk about sex ed.” When Shelby found out she was pregnant with her first child several years later, her doctor diagnosed her with human papillomavirus (HPV), a condition that compromised both her and her future child’s health. Shelby explained that if she had had more information about STIs, including HPV, “I probably wouldn’t have been as promiscuous as I was.” In this way, she explicitly connected the lack of information she received in school about sex with a negative health outcome and regretted that she had never learned how to protect herself from this pervasive STI.

Unlike Shelby, Alex—a 33-year-old, divorced, mixed-race mother of one with a history of pelvic inflammatory disease—received no lessons about “female hygiene” while enrolled in a Department of Defense secondary school. Alex recalled that, after being molested by a step-parent at the age of five, she developed dysfunctional ideas about sex and began engaging in high-risk sexual relationships as a young teenager. Given that she had no access to information about sex in school, and her parents were equally silent on the issue, Alex had no idea how to

protect herself from pregnancy, STIs, or further abuse. She believed that if a teacher in the school “would’ve come in and said, ‘This is what a healthy relationship looks like. This is what healthy boundaries look like,’ it would’ve had some impact.” Alex noted that her mother had also been a victim of sexual abuse as a child and yet she “didn’t want to see it for what it was.” Thus, Alex was left to seek out information about what had happened to her from an anatomy book she found on her parents’ bookshelf. As Alex narrated her experiences, she connected the lack of explicit discussion about healthy relationships to the sexual abuse she endured and the unhealthy behavior she patterned after her initial molestation as a child.

Nine other participants regretted the gaps in their formal sex education (three of whom also communicated narratives of uncertainty), and they ended up either going without information entirely or seeking/receiving information elsewhere. Sally—a 40-year-old, divorced, African American mother of three—reported that she did not remember receiving much sex education in school, and she did not feel she was very affected by what she did receive. After she became pregnant as a teenager, Sally wished that she had learned in school about the importance of abstinence until marriage, as well as different contraceptive methods. But she faulted not her teachers or sex-education classes for her lack of knowledge, and instead faulted the lack of basic knowledge about such things at the time: “I feel like back then, I don’t think that there was a lotta information about what to use. They may have said some stuff that you’re supposed to use—they may have mentioned condoms and birth control back then,” but now, she noted, “they’ve got different things for women to use, like the shot and then the patch.” So, although Sally regretted that her sex-education classes had not given her more information, she did not believe that much of that information was publicly available at the time. As an exceptionally private person, Sally did not talk with her friends about sex—even when she became sexually

active—and was not willing to seek out information from other sources. While raising her own children, she worked to overcome her natural shyness about sexual issues (and take advantage of the era’s diversity of safe-sex information and choices) to make sure that her children knew what she did not: “I started talking to them early about it—just warned them to use protection. I talked to my son about using condoms. And, like I said, I talked to my daughter about using birth control and condoms, too.” Sally hoped to save them from the regret that she felt as a sexually active young person without adequate formal or informal sex-education resources.

While Sally, Shelby, and Alex were entirely disappointed by the sex education they received in school, Lacy—a 20-year-old, single Caucasian mother of a three-month-old—liked what she learned about sex in school but regretted that she had not learned more. In particular, Lacy found the “Baby Think It Over” assignment especially informative. This project was intended to teach students about the consequences of teenage pregnancy by requiring them to care for a doll designed to simulate a real infant. Lacy explained, “we had to carry around those babies [dolls] that, I guess, if you had sex and had babies, you would know what it was like at a young age.” She thought the information she learned in school “was pretty good information” and that it probably encouraged her to put off engaging in sex for longer than she might have otherwise. However, Lacy also wished that she had learned about birth control in school because she was forced to depend on Internet searches and information from her friends when she started having sex at age 16. At the time of the interview, she was still struggling with information about birth control and noted that her recent pregnancy had been unplanned. On a similar note, Darla—a 38-year-old, Caucasian mother of two—also enjoyed her sex-education class in eighth grade but wished, in retrospect, that it would have included more information about birth control. In particular, she wished that the class had talked:

more about the birth control and the antibiotics to make it not work well. I mean, things like that would've been very helpful to know—that yes, it's not 100% effective and that you might also want to use condoms or other means of birth control along with that if you're wanting to be 100% effective.

She became pregnant for the first time because she had never learned that antibiotics could interfere with the effectiveness of her oral contraceptives. She recalled that her “biggest thing was I didn't ever want to be pregnant until I was ready, and funny thing was I ended up getting pregnant two months after I got married while on birth control. I'd been sick, taking antibiotics.” Her daughter was born 9 weeks early after an extremely difficult labor that damaged her uterus. Although Darla was grateful for her daughter, her reflection on what the school's sex-education courses had not included made it clear that she connected that lack of information with her unintended pregnancy, a pregnancy for which she was neither physically nor emotionally prepared. Although one might assume that women who offered narratives of regret were also the women who had the most negative health outcomes or the fewest resources to deal with the hardships they faced, this was not necessarily the case in the present sample. Women who offered such narratives were no more likely than the other women in the sample to have experienced, for example, a miscarriage, an STI, or sexual abuse. In this respect, their narratives seem to be a product of how women processed their experiences and connected them to each other rather than an objective difference in their lives.

Narratives of Sex-Education Satisfaction

Narratives of sex-education satisfaction involved a discussion about how one's formal sex education in school was informative and useful, and how it functioned as a guide toward positive experiences and health outcomes. Like those who told narratives of regret, individuals

who communicated narratives of satisfaction demonstrated a willingness and/or ability to make sense of their decisions and behaviors in light of their exposure to formal sex education (or lack thereof). Seven of the eight participants who spoke using a narrative of sex-education satisfaction expressed a feeling that they could ask questions freely in their sex-education classes and that they could apply what they learned outside the classroom. Brandie—a 22-year-old, single African American woman pregnant with her first child—described her formal sex-education classes as “very complete,” noting:

Brandie (B): They basically showed us about the different forms of birth control. They showed us how abortions are done.

Interviewer (I): Oh, they did? Wow.

B: Yes, that’s the most horrible thing. I won’t recommend anyone to get that.

I: Oh yeah, it’s surprising they showed you—the abortion.

B: Yes. They showed us the abortion, they showed us if someone has herpes—they showed us everything. They just gave it to us and it was the most horrible thing.

I: Oh, now, did they talk to you a little bit about your ability to get pregnant?

B: Yes. They also talked to us about the condoms, the Depo-Provera, the IUV—all of those—the patch, all of those sorts of things.

Although Brandie disliked witnessing the abortion and hearing about various STIs, and she referred to them with what some might consider surprising nonchalance, she felt that she needed to learn about those issues and that learning about them encouraged her to put off having sex until she was ready to do so responsibly and safely:

I: Do you think that maybe made you wait longer?

B: Yeah, ‘cause I was like 15 or 16 when we had the sex education. I was a sophomore.

She also noted that “everybody had questions,” and even though she did not ask any questions herself, she learned from the teacher’s responses to other students’ inquiries.

Two narratives of sex-education satisfaction emphasized the role of an especially dedicated or memorable sex-education teacher who was willing to answer questions and speak about a range of topics without squeamishness or unnecessary abstraction. Rose—a 38-year-old, divorced African American mother of three—reported that she learned all about “the different diseases” in her high-school sex-education class and noted, “I needed that. Yeah, I didn’t hold out [on having sex] ‘til marriage, but I held out longer than what I probably would have [if not for those lessons].” Her teacher seemed to be the variable that really made the class content something she could apply to her day-to-day life. Rose’s teacher worked to provide students with vivid, easy-to-remember examples:

He was talkin’ about the partners, and that’s somethin’ that they talked about. If you slept around with this person—I only sleep with one person—but then their partner might be sleepin’ with two people, and their partner might be sleepin’ with two people, so before you know it, you’re sleepin’ with the whole school! So he made that very clear to us as well.

Rose felt very lucky that her sex-education was guided by a person who spoke candidly with his students and did so in an unpretentious, relatable style.

Marge—a 43-year-old, single Caucasian mother of two—was especially impressed with her high-school sex-education teacher who was straightforward and refused to let students act immaturely during her lectures. Marge explained:

The teacher we had, she was an older teacher, but she didn’t play around the bush, beating about anything. She was direct on everything. She said, “You have sex, you do

this.” It was a co-ed room. We had boys and girls both in the same room. If the boys laughed for something she said, she is on them like I don’t know what. She would go off on them. She would directly tell you, “You need to use rubbers, you need to use birth control, you need to do this.”

Marge found the teacher’s willingness to discuss details about how a person might become pregnant and how to prevent pregnancy helpful because her parents would ask if she had questions about sex but only provide her with the vague admonition that “you better not come up pregnant.” Ultimately, Marge felt satisfied with the sex education she received in school and was encouraged by her teacher to wait to have sex until she felt she was ready to have a baby:

Marge (M): Everything I was told, I kept that in the back of my mind. If I have it before then, even though I'm using protection or not, or he's using it too, there's still a slight chance that we could still come up pregnant. There's that one little bitty percent chance there. I'm not going to take that precaution and not...

Interviewer (I): Right, so that lesson made a big impression on you.

M: Yeah. And that's why I said, I was 21 when I had my first one, and 23 when I had my second one. I was an adult. I didn't miss out on my childhood, I didn't miss out on anything when I had my kids. I didn't miss hanging with my friends. I didn't miss none of that stuff.

Marge connected her teacher’s lessons with her decision to wait until she was an adult to have sex and become a mother.

Beyond the seven participants who communicated a narrative of sex-education satisfaction and felt they could speak openly about sex in their sex-education courses, one woman also claimed to be satisfied with her formal sex-education experiences, but for different

reasons. Geanie—a 38-year-old, married Caucasian mother of three—claimed that she was satisfied because she did not receive information about sex in school. Outside of learning about menstruation in the fifth grade, the only sex education she encountered came from her parents. Guided by her religious beliefs, Geanie felt that any lessons the school would have provided her about sex would have “counteract[ed] everything my parents would have told me.” Although Geanie’s narrative of sex education satisfaction was unique in the present sample, her perspective that the most helpful sex education she received in school was no sex education is one that must not be overlooked.

Narratives of Uncertainty

In contrast to narratives of regret and satisfaction, narratives of uncertainty were marked by expressions of doubt about one’s experiences with formal sex education. Individuals who communicated narratives of uncertainty did not clearly connect their experience with formal sex education to their broader life experiences, decisions, and behaviors. Ten women in our sample narrated stories of uncertainty (three of whom also narrated stories of regret), and the majority of them were quite literally uncertain about what they learned in their school’s sex-education courses. For instance, Lauren—a 22-year-old married, Caucasian mother of one—expressed a great deal of doubt about what her sex-education lessons taught her. After noting that she did not know what she learned in school about sex, she posited, “I guess it didn’t take no more than one time to mess up, you know? I guess.” Then she added that, “I don’t really remember those [lessons] too much.” Lauren made claims about what she learned with tentative qualifications and a great deal of reservation.

While Lauren did not remember the sex-education lessons themselves, Leigh—a 24-year-old married, Caucasian mother of two with a history of an STI—noted that she did not

understand the lessons she received about sex when she was in school. She did not express regret about the lack of clarity in the course content, and she was either not able or not willing to make sense of the lessons in relation to her broader life experiences, decisions, and behaviors. For instance, when asked if the lessons she received in school about sex changed what she believed or how she acted, Leigh responded, “I don’t think so, really. I was basically the same person before and after.” Lachelle—a 19-year-old engaged, mixed-race mother of one—was also largely unable to connect the lessons about sex she learned in school to her larger life story, which included becoming pregnant as a high school freshman and dropping out of school to care for her daughter. At times in her narrative she seemed uninterested in and/or neutral about her sex-education lessons. She noted that the lessons were probably “informative” but at that point in her life she was “too busy throwing paper balls at other students” to pay close attention to their content. But at other times, Lachelle implied that she was very much absorbed in the topic of the class, so much so that she supplemented the lessons with outside readings about “just basic stuff on human development of girls and boys, babies, and all that. Everything you basically need to know that doesn’t get too adult materialistic” (i.e., “like it wasn’t like a porn or anything”). So although Lachelle believed that the courses changed her behavior, “not a single bit,” she suggested otherwise by noting that she was inspired by the class to find out more about the topic outside of school. Overall, Lachelle did not seem to regret anything about the lessons’ content, but neither did she express satisfaction in what she learned. In this way, her narrative of sex education demonstrated a lack of coherence that made it difficult to follow her narrative of events and experiences and ultimately demonstrated that she had not yet seemed to process how her formal sex education connected to her larger narrative of self.

Unlike Leigh and to some extent Lachelle, not all individuals who told narratives of uncertainty claimed to have trouble remembering or even understanding their sex education lessons in school. For instance, Jessica—a 29-year-old Caucasian, married mother of three—remembered quite a bit about her sex-education lessons in school, explaining that her freshman-year health class included:

[An] open conversation about everything—about birth control, about all types; about problems that males experienced—physical body experiences and sexually transmitted diseases. There were slides. It showed pictures. It was open conversation about it. And then, of course, we also had right after that, in like a home-ec course, the baby, where we had to carry around the, I think it was like a bag of flour as the baby. So we had the two different classes back to back. And that was part of the health that year, the nine weeks.

But even though Jessica seemed to remember the course content, she did not connect that content to her other experiences. After listing the information that her health teacher conveyed to her class about sex, she noted that while the lessons “informed [her]” she did not believe that they affected her own decisions or behaviors.

Of the women who told narratives of uncertainty, three told stories that connected uncertainty with narratives of regret. They expressed significant doubt about what they learned in formal sex-education courses and/or what the course content meant, but they also showed signs that they were beginning to connect their experiences therein to their broader life stories.

Bettina—a 24-year-old single, African American mother of four and former teen mother—framed her narrative with the caveat that it was hard for her to remember what she had learned. But after listing several topics that she remembered the courses covering such as condoms, STIs,

and abstinence, Bettina briefly connected what she did not learn to her subsequent beliefs and behaviors:

Sometimes, really, I thought that if you just wore a condom, there's nothing else you had to worry about. Like, people think if you wear a condom that you still don't have to worry about diseases, when that's not true. That's not true at all. So they really didn't press that issue there, that just because you have a condom on don't mean that it isn't something that you shouldn't worry about.

Bettina recognized at this point in her narrative that she regretted not having had a more complete or clear lesson about condoms, and although this was not the focus of her discussion, she seemed to be starting to make sense of her experiences with sex education in light of her later experiences with teenage pregnancy.

Time Lapse

Of the 30 interviews in this study, all of them featured at least one of three central narrative themes (i.e., regret, satisfaction, and uncertainty) and three of them featured elements of two narrative themes (e.g., regret and uncertainty). Of the youngest half of the participants (aged 18-24; $n = 15$), four told narratives of regret, three told narratives of satisfaction, five told narratives of uncertainty, and three told narratives of regret and uncertainty. Of the oldest half of the participants (aged 25-48; $n = 15$), eight told narratives of regret, five told narratives of satisfaction, two told narratives of uncertainty, and none told narratives of regret and uncertainty. These findings seem to align with work on narrative inquiry that positions lapse in time between the lived event and its narration as an important factor in one's ability to make sense of life experiences (Brody, 2002; Vanderford & Sharf, 2003). Those who were the furthest removed from their sex-education lessons in school offered more narratives of either regret or satisfaction,

rather than uncertainty. Their narratives were less likely to include expressions of doubt and thus were more likely to demonstrate that they had made sense of their experiences within the larger narratives of their lives and in light of their lived experiences.

By contrast, those who had most recently completed their sex-education lessons in school offered narratives of uncertainty more often than they did narratives of regret or satisfaction (although three individuals combined narratives of uncertainty with regret, which may indicate that they were on their way toward making sense of their sex-education experiences in the context of their broader life experiences). While this could be related to the lack of confidence or maturity that comes with youth—especially because uncertainty was sometimes intertwined with inaccurate beliefs about sexual health, one could also argue that younger individuals should be more familiar with the lessons they learned and thus more able to integrate those lessons into their larger narratives of self. Narrative work on sense-making over time would suggest that the younger women in our sample might need more time to connect their formal education experiences with various lived events.

Discussion and Implications

Following in the tradition of scholars who have used narrative approaches to explore health and healing (e.g., Charon, 2006, Harter et al., 2005; Sharf & Vanderford, 2003), we built from tenets of narrative theory to explore the sex-education narratives of low-income women and shed light on the gap in sexual-health knowledge among U.S. adolescents and adults. Although each woman in our sample told a narrative informed by her own unique experiences, we noted common themes across the sample, which reiterates that encounters with formal lessons about sexual health are marked by both idiosyncrasy and commonality (Babrow & Mattson, 2003). Some women narrated tales of regret in which they lamented the absence of any sort of formal

education or regretted that the lessons they had were not more complete and informative. Other women described satisfying experiences as they told stories of their sex-education lessons, though not all women in the sample agreed that sex education should be the domain of the public school system. Finally, a number of women told stories characterized by uncertainty in which they expressed doubt about what they learned in sex-education courses, had trouble understanding what they learned, or struggled to connect their lessons to their own subsequent beliefs, decisions, and behaviors. In several cases, narratives of uncertainty also included a tone of regret that could indicate individuals' increasing willingness or ability to make sense of their formal sex-education experiences in the broader context of their lives.

The results of our analysis demonstrate the importance of retrospective sense-making (Sharf & Vanderford, 2003). More specifically, the narrative themes that emerged from our interview sample provide some evidence that individuals with the most distance from an event might be less likely to express doubt about their experiences and more likely to integrate those experiences into their broader stories of self. In this respect, our findings seemed to tentatively uphold the theoretical claim that a lapse in time between lived events and their narration is important to the process of sense-making. If, as our study suggests, a time lapse is an important element of one's ability to make sense of specific experiences through narratives, questions remain about, for instance, how much time is generally needed for sense-making and whether sense-making tends to decline after a certain amount of time passes. Thus, the present interpretive exploration functions as an invitation to researchers to continue to explore the potential role of time lapse in the ongoing process of narrative sense-making. Scholars could also explore the role of time lapse by devoting greater attention to in-depth analysis of specific cases. In the present study, we chose to look for common themes across the narratives of the 30 women

who shared their stories with us. As an alternative to this approach, future research could explore time lapse through longitudinal work that explores a smaller set of cases over time.

Regardless of whether a time lapse facilitates sense-making or not, the mere process of asking participants about their experiences with formal sex-education seemed to foster important self-reflection. As women narrated their stories over the course of the interview, many of them seemed to realize the significance of sex education, or the lack thereof, in guiding decisions and actions. Recall Marge, for instance, who explained that her teacher's admonitions encouraged her to wait until she was an adult to have sex and become pregnant. And while telling the interviewer about her first pregnancy, Darla realized that if she had learned about the effects of antibiotics on contraceptives, she might not have become pregnant before she was ready. These examples, and others like them, illustrate how women gave order and meaning to life events as they articulated their experiences with sex education. As Gubrium and Holstein (2009) argued, "narrative work entails constructing linkages between bits and pieces of experience" (p. 66). In the present study, we see these linkages occur as women engage in sense-making and connect lived events (e.g., unplanned pregnancies, STIs) and life choices with sex-education encounters.

Although we cannot make broad generalizations based on our qualitative narrative typology and analysis, the voices of women in our study offer a number of practical implications for the field of sex education that might be useful to scholars and educators alike. First, women's narratives suggest that a lack of formal sex education compels individuals to seek information elsewhere, which could result in incomplete or inaccurate information (e.g., learning that condom use is important but not learning the proper way to use a condom). A lack of comprehensive school-based lessons might also suggest a need for ongoing educational efforts, perhaps into adulthood, especially for those who might not have access to information from a

traditional health-care provider. Social service agencies and health-based organizations are known for providing sexual and reproductive health information to otherwise underserved individuals and might think creatively about outreach efforts that could fill the gaps in formal training about sexual-health topics.

Regarding school-based curricula, several narratives from our study suggest that the teacher's style and demeanor are particularly important, whether teachers are known for crafting memorable messages or for discouraging open dialogue in the classroom. Whatever the case, such narratives are consistent with Allen's (2009) argument that sex educators themselves are a critical part of the sex-education effectiveness equation. However, we must also consider the current cultural and political climate in making recommendations that teachers approach the classroom in a particular way. Cates (2008) found that the lack or inadequacy of sex education might be connected to teachers who "were afraid to bring up the subject in school or even to be open to questions from students" as a result of lack of support and information from administration (p. 137). In this respect, future research should explore the narratives of sex-education teachers to offer them opportunities for reflection, consider the sex-education debates from those at its center, and continue to theorize about narrative and health education. Finally, the retrospective sense-making that women engaged in during their interviews suggests that sex-education can influence individuals over the course of their lifetimes. Though many educators likely recognize that sexual behaviors can have lifelong consequences, they might not realize that early educational experiences can influence individuals in varying ways well into adulthood. As such, it would behoove educators to conceptualize sex-education courses as teaching life skills with potentially lasting effects as opposed to teaching skills intended to help students navigate their teenage years.

We conclude by noting that the stories of the women we interviewed are ever-evolving, partial, and unfinalizable (Harter et. al, 2005). Indeed, sense-making is an emergent process, and women's narratives of their sex-education experiences will most certainly change and shift over time as they incorporate their lived experiences into the narration of those same events (also see Moules & Amundson, 1997). As women are faced with ongoing decisions about their sexual and reproductive health, such decisions will continue to shape and be shaped by their unfolding stories.

References

- Allen, L. (2009). 'It's not *who* they are it's *what they are like*': Re-conceptualising sexuality education's 'best educator' debate. *Sex Education*, 9, 33-49.
- Babrow, A. S., & Mattson, M. (2003). Theorizing about health communication. In T. Thompson, A. Dorsey, K. Miller & R. Parrot (Eds.), *Handbook of Health Communication*. Hillsdale, NJ: Erlbaum.
- Becker, G. (1997). *Disrupted lives: How people create meaning in a chaotic world*. Berkley, CA: University of California Press.
- Brody, H. (2002). *Stories of sickness* (2nd ed.). New York: Oxford University Press.
- Bruner, J. (1990). *Acts of meaning: Four lectures on mind and culture*. Cambridge, Mass.: Harvard University Press.
- Burke, K. (1984). *Permanence and change: An anatomy of purpose* (3rd ed.). Berkeley: University of California Press.
- Cates, J. R. (2008). Education on sexually transmitted infections: Finding common ground among youth, parents, providers and policy advocates. *Sex Education*, 8, 129-143.
- Charmaz, K. (1999). From the "sick role" to stories of self: Understanding the self in illness. In R. J. Contrada & R. D. Ashmore (Eds.), *Self, social identity, and physical health* (pp. 209-239). New York: Oxford.
- Charon, R. (2006). *Narrative medicine: Honoring the stories of illness*. Oxford: Oxford University Press.
- Charon, R. (2009). Narrative medicine as witness for the self-telling body. *Journal of Applied Communication Research*, 37, 118-131.

- Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York: Routledge, Chapman & Hall.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research 3e*. Thousand Oaks, CA: Sage.
- Corey, F. C. (1996). Personal narratives and young men in prison: Labeling the outside inside. *Western Journal of Communication, 60*, 57-75.
- Czarniawska-Joerges, B. (1991). *Narrating the organization: Dramas of institutional identity*. Chicago: University of Chicago Press.
- Dodge, B., Reece, M., & Herbenick, D. (2009). School-based condom education and its relations with diagnoses of and testing for sexually transmitted infections among men in the United States. *American Journal of Public Health, 99*, 1-2.
- Espey, E., Cosgrove, E., & Ogburn, T. (2007). Family planning American style: Why it's so hard to control birth in the U.S. *Obstetrics and Gynecology Clinics of North America, 34*, 1-17.
- Fisher, W. R. (1984). Narration as human communication paradigm: The case of public moral argument. *Communication Monographs, 51*, 1-22.
- Fisher, W. R. (1985). The narrative paradigm: An elaboration. *Communication Monographs, 52*, 347-367.
- Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: University of Chicago Press.
- Gubrium, J. F., & Holstein, J. A. (2009). *Analyzing narrative reality*. Thousand Oaks, CA: Sage.
- Guttmacher Institute. (2006). *Facts on sex education in the United States*. New York: Author.
- Guttmacher Institute. (2010). *U.S. teenage pregnancies, births and abortions: National and state trends and trends by race and ethnicity*. New York: Author.

- Harter, L. M. (2009). Narratives as dialogic, contested, and aesthetic performances. *Journal of Applied Communication Research*, 37, 140-150
- Harter, L. M., Japp, P. M., & Beck, C. S. (2005). Vital problematics of narrative theorizing about health and healing. In L. M. Harter, P. M. Japp & C. S. Beck (Eds.), *Narratives, health, and healing: Communication theory, research, and practice* (pp. 7-29). Mahwah, NJ: Erlbaum.
- Jensen, R. E. (2007). Using science to argue for sexual education in U.S. public schools: Dr. Ella Flagg Young and the 1913 "Chicago Experiment." *Science Communication*, 29, 217-241.
- Jensen, R.E. & Bute, J.J. (in press). Fertility and sexuality-related perceptions and behaviors among low-income women: Perceived injunctive norms, social sanctions, and the assumption of choice. *Qualitative Health Research*.
- Kaiser Family Foundation. (2003). *National survey of adolescents and young adults: Sexual health knowledge, attitudes and experiences*. Menlo Park, CA: Author.
- Kaiser Family Foundation. (2000). *Sex education in America: A series of national surveys of students, parents, teachers, and principals*. Menlo Park, CA: Author.
- Kirby, D. (2002a). Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. *Journal of Sex Research*, 39, 51-57.
- Kirby, D. (2002b). The impact of schools and school programs upon adolescent sexual behavior. *Journal of Sex Research*, 39, 27-33.
- Kirby, D. B., Laris, B. A., & Roller, L. A. (2007). Sex and HIV education programs: Their impact on sexual behaviors of young people throughout the world. *Journal of Adolescent Health*, 40, 206-217.

- Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health, 42*, 344-351.
- Langellier, K. M. (1989). Personal narratives: Perspectives on theory and research. *Text and Performance Quarterly, 9*, 243-276.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, Ca: Sage.
- Lupton, D. (1994, 2003). *Medicine as culture: Illness, disease, and the body in western society*. Thousand Oaks, CA: Sage Publications.
- Madriz, E. (2001). Focus groups in feminist research. In N.K. Denzin (Ed.), *Handbook of qualitative research* (2nd ed.), pp. 835-850. Thousand Oaks, CA: Sage.
- Mebane, F., Yam, E., & Rimer, B. (2006). Sex education and the news: Lessons from how journalists framed virginity pledges. *Journal of Health Communication, 11*, 583-606.
- Milhausen, R. R., DiClemente, R. J., Lang, D. L., Spitalnick, J. S., Sales, J. M., & Hardin, J. W. (2008). Frequency of sex after an intervention to decrease sexual risk-taking among African-American adolescent girls: Results of a randomized, controlled clinical trial. *Sex Education, 8*, 47-57.
- Mishler, E. (2006). Narrative and identity: The double arrow of time. In A. de Fina, D. Schiffrin, & M. Bamberg (Eds). *Discourse and identity*, pp. 30-47. Cambridge: Cambridge University Press.
- Moules, N. J., & Amundson, J. K. (1997). Grief-an invitation to inertia: A narrative approach to working with grief. *Journal of Family Nursing, 3*, 378-393.
- Moules, N. J., Simonson, K., Prins, M., Angus, P., & Bell, J. M. (2004). Making room for grief: Walking backwards and living forward. *Nursing Inquiry, 11*, 88-107.

- Muturi, N. W. (2005). Communication for HIV/AIDS prevention in Kenya: Social-cultural considerations. *Journal of Health Communication, 10*, 77-98.
- Neimeyer, R. A. (2005). Widowhood, grief, and the quest for meaning: A narrative perspective on resilience. In D. Carr, R. M. Nesse, & C. B. Wortman (Eds.), *Spousal bereavement in late life*. New York: Springer.
- Pinkleton, B. E., Austin, E. W., Cohen, M., Chen, Y. C., & Fitzgerald, E. (2008). Effects of a peer-led media literacy curriculum on adolescents' knowledge and attitudes toward sexual behavior and media portrayals of sex. *Health Communication, 23*, 462-472.
- Rawlins, W. K. (2009). Narrative medicine and the stories of friends. *Journal of Applied Communication Research, 37*, 167-173.
- Reymert, J., & Hunskaar, S. (1994). Why do only a minority of perimenopausal women with urinary incontinence consult a doctor? *Scandinavian Journal of Primary Health Care, 12*, 180-183.
- Ricoeur, P. (1990). *Time and narrative* (Vols. 1-3). Chicago: University of Chicago Press.
- Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage.
- Santelli, J., Ott, M. A., Lyon, M., Rogers, J., Summers, D., & Schleifer, R. (2006). Abstinence and abstinence-only education: A review of U.S. policies and programs. *Journal of Adolescent Health, 38*, 72-81.
- Satcher, D. (2001). *The Surgeon General's call to action to promote sexual health and responsible sexual behavior*. Washington, D.C.: Department of Health and Human Services.
- Sharf, B. F. (2009). Observations from the outside in: Narratives of illness, healing, and mortality in everyday life. *Journal of Applied Communication Research, 37*, 132-139.

Sharf, B. F., & Vandeford, M. L. (2003). Illness narratives and the social construction of health.

In T. L. Thompson, A. Dorsey, K. I. Miller & R. Parrott (Eds.), *Handbook of health communication*. Mahwah, NJ: Erlbaum.

Vandeford, M. L., & Smith, D. H. (1996). *The silicone breast implant story: Communication and uncertainty*. Mahwah, NJ: Erlbaum.

Webster, L., & Mertova, P. (2007). *Using narrative inquiry as a research method: An introduction to using critical event narrative analysis in research on learning and teaching*. New York: Routledge.

Weinstein, R. B., Walsh, J. L., & Ward, L. M. (2008). Testing a new measure of sexual health knowledge and its connections to students' sex education, communication, confidence, and condom use. *International Journal of Sexual Health*, 20, 212-221.

Zoller, H. M. (2005). Women caught in a multi-causal web: A gendered analysis of *Healthy People 2010*. *Communication Studies*, 56, 175-192.