ADOLESCENT DATING RELATIONSHIPS AND THE MANAGEMENT OF SEXUAL RISK

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Abstract

Adolescent sexual behavior typically occurs within a relationship context, but we know more about parent and peer effects than about how specific features of romantic relationships influence sexual decision-making. A basic premise of this research is that decisions about sexual risk-taking are relational as well as "health" decisions. We draw on data from the Toledo Adolescent Relationships Study to explore the role of communication and emotional processes, asymmetries (demographic and relational) and levels of commitment that characterize adolescent romantic relationships. We evaluate how these relationship qualities influence the management of risk within the relationship, defined as communication about partner's past risk behavior, condom use and sexual exclusivity. Results provide support for a relationship focus. For example, scales measuring communication awkwardness and intimate self-disclosure are significantly related to the likelihood of relationship non-exclusivity. In addition, demographic and relational asymmetries were linked to a decreased likelihood of current and/or consistent condom use.

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Adolescents have recently become the focus of work on sexually transmitted infection prevention and research, and it is recognized increasingly that this age group deserves greater attention (e.g., DiClemente 1997; Eng and Butler 1997; Evans 2001; Kirby 1997; NICHD 2000; Santelli, DiClemente, Miller, and Kirby 1999; Sherr 1997). Increased research interest in the high risk sexual behaviors of adolescents and young adults reflects: (1) the growth of HIV and other STI cases resulting from heterosexual contacts, (2) recognition that young people engage in high risk activities with a greater sense of invulnerability and without the level of maturity that characterizes later, more cautious phases of the life course, and (3) concerns that adolescents may not know their HIV or STI status because sexually active teens often are reluctant or may be unable to obtain health services (Eng and Butler 1997). Recent Centers for Disease Control and Prevention (CDC) (2002) data show that while incidence rates are declining generally, new cases of HIV among youth are not declining. Further, the high incidence of death from HIV infection in the age range 25-44 likely reflects the reality that many young adults were exposed to HIV while in their teens.

Behaviors that put individuals at risk for exposure to sexually transmitted infections (i.e., inconsistent condom use, multiple and concurrent sexual partners) necessarily occur within relationship contexts. The importance of the relationship context cannot be over-stated because sexually transmitted infections are by definition transmitted interpersonally through relationship involvement (Iskovics, Thayaparan, and Ethier 2001; Santelli et al. 1996; Soler et al. 2000). Yet we know more about individual, family, peer and even neighborhood level effects on adolescent

and young adult involvement in high-risk sexual activities than about the influence of relationship dynamics on sexual risk-taking and the management of STI risk.

Relationship qualities and dynamics have been investigated infrequently or only superficially. Kotchick, Shaffer and Forehand (2001), for example, recently reviewed the existing research on adolescent sexual risk behavior, stressing the utility of a multisystemic perspective. Their review of social influences beyond the family, that is, "extra-familial systems," included attention to peer effects, but ignored romantic relationships entirely. Certainly family and peer processes are critical to consider, but the social context of sexual decision-making is distinct from choices relating to other life domains (including other high risk problem behaviors). Moreover, sexual behavior occurs outside the purview of parents and peers. The dyadic character of sexual relations highlights that the partner as reference other, and qualities of the relationship, are central to a comprehensive understanding of the likelihood and manner in which sexual behavior and in turn sexual risk occurs (Giordano, Longmore, and Manning 2001). It is critical to consider relationship processes because they play an important but not well understood role, and they represent a relatively more fruitful and malleable arena (relative to individual, peer, family or demographic factors) around which to build prevention/intervention efforts.

We draw on recently collected data from the Toledo Adolescent Relationships Study explore the role of the following relationship dynamics: perceived awkwardness communicating with the partner, heightened emotionality (love), balance/asymmetries within the relationship (both demographic and relational), and level of commitment to the partner and to the relationship. We evaluate how these relationship qualities influence the management of risk within the relationship. The management of sexual risk encompasses the following domains:

communication about partner experiences that place the adolescent at risk, condom use (current, consistent), and sexual exclusivity or cheating behavior within the context of the focal relationship.

BACKGROUND

Social scientists have used demographic approaches to understand populations at risk for sexually transmitted infections including HIV, as well as to determine who is likely to engage in preventive measures such as using condoms. Using national, regional, and clinical samples of adolescents, scholars have examined the influence of age, gender, race/ethnicity, religion/religiosity, parents' education, and parental approval of sexual activity on condom use (e.g., Darroch and Singh 1999; Forrest and Singh 1990; Glei 1999; Katz et al. 2000; Longmore, Manning, Giordano and Rudolph forthcoming; Lowenstein and Furstenberg 1991; Mosher 1990; Sonenstein et al. 1989). Evidence suggests that younger adolescents who are sexually inexperienced, who report higher religiosity, whose parents report lower educational attainment, and whose parents are perceived to approve of premarital sexual activity are more often inconsistent or ineffective condom users or non-users. While very useful in providing a descriptive portrait, a particular theoretical framework has not often guided this work, nor has it highlighted the unique social emphases/concerns that characterize the adolescent period.

A common approach to understand high-risk sexual behavior is to view it as part of a broader problem behavior syndrome (Jessor and Jessor 1977; Ketterlinus, Lamb, Nitz, and Elster 1992; Luster and Small 1994; Rodgers and Row 1990). For example, drug and alcohol use are associated with earlier sexual onset, greater numbers of sexual partners, and more instances of unprotected sex (Santelli et al. 1999). Additionally, drug-using males often introduce adolescent women to drugs (Amaro 1995). Increased attention to the linkages between various risk

behaviors such as alcohol and drug abuse and early sexual onset has been helpful, particularly with understanding that the knowledge, motivation, and skills of adolescents are quite distinct from those of adults, especially with regard to attitudes of invulnerability associated with high risk behaviors. However, the overall effect of this approach has been to overstate the utility of a common conceptual toolkit to explain all of these behaviors (Giordano 1989). Across the adolescent period, sexual activity becomes increasingly normative, and unlike drug, cigarette, and alcohol use, can be developmentally appropriate (Longmore, Giordano, and Manning 1999; Harris, Ducan, and Biosjoly. 2002). Thus a more multifaceted approach to adolescent sexual risk-taking is required -- one that recognizes that romantic and other sexual relationships can be rewarding and status enhancing social experiences even as they can amplify the level of sexual risk-taking.

Another theoretically informed perspective within the sexual research/prevention arena is the Health Belief Model (Becker 1988). This social psychological perspective focuses on the individual's desire to avoid illness, and attempts to strengthen the belief that specific health behaviors will prevent illness. This approach has been useful, but a limitation of this and related approaches such as Fishbein and Azjen's Theory of Planned Behavior (Azjen and Fishbein 1980; Fishbein et al. 2001) is that the emphasis is individualistic and assumes that the behavior in question is entirely volitional. Thus interpersonal and situational processes are ignored including issues surrounding the negotiation of condom use, power dynamics, and variations in the type of relationship in which sexual activity occurs (casual or primary). A basic premise of our research is that these programs will be more effective if relationship issues are a key, even central, component. We agree with Eyre, Auerswald, Hoffman, and Millstein's (1998) conclusion that

youths themselves are far more focused on relationships than health issues and beliefs (see also Mahoney, Thombs, and Ford 1995).

Our conceptual framework and associated measurement emphasis reflects the notion that youthful relationships are complex social bonds that will likely always be incompletely described with regard to any one construct -- such as duration, frequency of interaction, or type of sexual relationship (e.g., primary or casual). Our multidimensional approach derives from a symbolic interactionist view of exchange (e.g., Giordano, Cernkovich, and Pugh 1986; McCall and Simmons 1978). As Burgess and Huston (1979, p. 9) note, "an explicit look at exchange processes sets the stage for considering the relationship itself -- rather than the individuals or the larger system as a unit of analysis." The symbolic interactionist lens underscores the need to capture and describe these relationships as the actors , themselves, experience them. We draw from and continually integrate the relationship-focused developmental and high-risk literature traditions.

Relationships and Sexual Risk

Prior research focused on the relationship context has frequently emphasized characteristics of partners, and partner heterogamy. The research examining the effects of specific qualities of these relationships is rather limited, and results are sometimes contradictory. For example, some prior studies conclude that couples in closer relationships are more likely to use contraception than their counterparts in more casual relationships. Contraceptive use was found to be greater among a purposive sample of young adults in more committed couples (Inazu 1987) and among young adult men who had closer relationships with their first sexual partners (Pleck, Sonenstein, and Swain 1988). Other studies of low-income minority youth have reported more condom use with regular partners (Ford, Rubinstein, and Norris 1994). Focus group discussions indicate that

men in long-term stable relationships with strong emotional ties to their partners were more likely than those in casual relationships to discuss, support, and practice contraception (Landry and Camelo 1994). In particular, greater condom use is reported among young men (ages 17-21) who have closer relationships with their first sexual partner (Pleck, Sonenstein, and Swain 1988). Similarly, African-American women in a street survey reported more condom use when they felt emotionally close to their partners (Santelli et al. 1996). New evidence from the Add Health shows that condom use, and more generally contraceptive use, is greater among teens who are in romantic relationships and among those who have longer duration relationships (Ford, Sohn, and Lepkowski 2001).

Yet other evidence does not support the positive association between condom use and relationship closeness. For example, adolescent males' condom use with their most recent sexual partner was not related to duration of relationship with that partner (Ku et al. 1994). Among teenage girls who used contraception at first intercourse, those who were going steady shared similar levels of condom use as girls who just met or were just friends with their first sexual partner (Manning, Longmore, and Giordano 2000). A slightly different measure of contraceptive use, consistency of condom use with recent sexual partners, was not related to type of relationship in analyses of the National Survey of Adolescent Men, as well as in a clinical sample of adolescents (Pleck, Sonenstein, and Ku 1991; Weisman et al. 1991).

Some studies find a negative association between closeness with sexual partner and contraceptive use. Young men who later entered committed relationships with their sexual partners were less likely to use condoms at first intercourse with that partner (Ku, Sonenstein, and Pleck 1994). Adult men in more casual relationships (dating rather than cohabitation or marriage) are more likely to use protection against STDs (Forste and Morgan 1998). Similarly,

focus group discussions reveal that the more casual the relationship, the more likely men are to choose condoms as their method to protect themselves against STDs (Landry and Camelo 1994). Condoms are less likely to be used with regular partners in a sample of adolescents in family planning clinics (Plichta et al. 1992). Although referring to homosexual activity, Kippax and colleagues (Kippax et al. 1993; Kippax et al. 1997) refer to unprotected sexual intercourse in the context of certain relationships as "negotiated safety," a strategy based on trust, honesty, and accurate knowledge of both partners' HIV status. However, having unprotected sexual intercourse in a committed relationship may actually increase the risk of exposure to HIV, in part, because assessments of partner risk often are unknown or inaccurate (Ickovics et al. 2001).

Obviously non-exclusivity and condom use are interrelated in consequential ways. Among women with multiple partners who were at a STD clinic, condom use occurred more often with their casual than with their main partner (Lanskey, Thomas, and Earp 1998). Ellen, Cahn, Eyre, and Boyer (1996) report that teens use condoms less frequently with main partners than casual partners. Similarly, teens attending a STD clinic and HMO adolescent clinic more often used condoms with casual than main partners (Ott et al. 2002). However, the representativenss of such clinic samples is questionable. Even though concurrent sexual relationships are, perhaps, non-normative, condom use appears higher with casual partners than with primary sexual partners. Thus, we require more information about how main partners communicate and assess risk and sexual fidelity.

Another dimension of the relationship context is differences between the sexual partners or sociodemographic heterogamy. A central aim of prior work has been to test whether women who have sex with substantially older men (measured as age heterogamy) are less likely to use condoms. In a clinic sample of women, age heterogamy was not related to inconsistent condom

use (Weisman et al. 1991). Yet national data show that age heterogamy was associated with a greater level of risk-taking, especially a lower likelihood of using condoms (Darroch et al. 1999; Marin et al. 2000; Morris and Kretzschmar 1995). Heterogamy based on race was not associated with condom use among adolescent males (Ku et al. 1994). The analysis of the Add Health shows that partners with more asymmetries (school, neighborhood, age, and race) report lower odds of condom use and in some cases, depending on the relationship type, contraceptive use (Ford, Sohn, and Lepkowski 2001).

Research indicates that communication about condoms increases use (Catania et al. 1989; Shoop and Davidson 1994; Wingood and DiClemente 1996). Yet there is a need for more detailed study of communication processes among adolescent boys and girls, and for a more thorough investigation of other relationship-based influences on high-risk sexual behavior, including subjective processes. For example, researchers have conjectured but not tested directly the notion that power differentials flow from age disparities. A key strength of TARS is that we have developed an interview protocol that includes direct assessments of relational asymmetries within relationships, as well as measures of many other potentially important relationship qualities and dynamics.

CURRENT INVESTIGATION

The purpose of this study is to examine management of sexual risk within dating relationships. We provide a descriptive portrait of the strategies used to manage risk. Given that sexual intercourse is by definition dyadic, we evaluate how qualities of the relationship influence management of risk. We explore the role of communication and emotional processes, and basic "contours" of the relationship, such as asymmetries (demographic and relational) and the overall level of commitment that characterizes the relationship (for a more in-depth portrait

of these relationship features, see Giordano, Longmore and Manning, 2001). Within the realm of communication, we assess perceptions of *communication awkwardness*, a tendency to *monito*r or check one's communication, as well as levels of *intimate self-disclosure*. Emotional processes include feelings of *love and attraction* for the partner, as well as the experience of *jealousy*. Basic contours of the relationship are indexed by considering *demographic asymmetries* (whether respondent and partner are same race/ethnicity, similar in age, or different) as well as perceived *relational asym*metries (where one partner needs the other more). The *importance* of the relationship and levels of *mistrust* provide an overall measure of the state of the relationship, while *projected duration* indexes the level of commitment or future orientation that characterizes the relationship.

Hypotheses focus attention on the individual as a relatively conservative actor who wishes to avoid placing him/herself at risk, but who may be influenced by these relationship qualities (e.g., does not want to displease partner, does not believe there is another partner available). In general, higher levels of general communication and lower perceived awkwardness should be associated with more effective "risk-management," while heightened emotionality should be associated with less effective management. We hypothesize that more commitment and importance of the relationship should be associated with more effective management, but again, basic contours of the relationship (asymmetries) may complicate this effect—respondents involved in less balanced relationship situations should be less effective managers, as reflected by a lower rate of questioning partners, less consistent condom use, and a higher probability of partner cheating.

DATA

We draw on newly collected (wave 3) data from the Toledo Adolescent Relationships Study. The first-wave of completed in-home interviews were conducted with 1,316 adolescents. The initial sampling universe for TARS consisted of all students enrolled in Lucas County schools in grades seventh, ninth, and eleventh in the fall of 2000. Our sample represents a random sample of these students. The sociodemographic characteristics of Lucas County closely parallel the sociodemographic characteristics of the nation, especially with respect to race and ethnicity, median family income, educational levels and housing costs. For our study, African-American and Hispanic adolescents were over sampled. We have maintained a good response rate (84%) across interview waves. The respondents in wave 3 are 15-20 years old. This follow-up provides an opportunity to study teens as they experience a broader repertoire of relationships, navigate key life transitions, and enter an age range that typically involves greater potential exposure to sexually transmitted HIV/STI risk. Given that the purpose of latest data collection is to focus on HIV and sexual risk taking, we have developed and included extensive measurement of sexual risk taking. Our analytic sample is based on 599 respondents who have had sexual intercourse with their current or most recent boy/girlfriend.

Measures

<u>*Management of Sexual Risk*</u>. *Partner disclosure* is based on four questions that ask whether the respondent asked about their boy/girlfriends behavior before having sex. The behaviors include: sexually transmitted diseases or infection, intravenous (IV) drugs, previous sexual partners, and homosexual relations. The alpha reliability is .89. *Current condom use* is based on the question about the primary method of birth control. *Consistent condom use* is measured with a question that asks "How often do you and X use a condom now?" Respondents who did not reply "every we have had sex" are coded as not consistency using condoms. *Partner's cheating* behavior is

based on a question, "How often do you think X has gotten physically involved (had sex) with other guys/girls?" Respondents who reported never are coded as perceiving their partner never cheated.

Communication Processes. To measure *intimate self-disclosure* we rely on revised version of West and Zingle's (1969) self-disclosure scale. This four-item index asks respondents to report about how often they communicate with the partner about a range of topics, e.g., " your home life and family," "something really bad that happened, "your private thoughts and feelings." (alpha=.90). To measure *Communication Awkwardness* we use items drawn primarily from Powers and Hutchinson's (1979) personal report of spouse communication apprehension items, revised for the younger sample. These consist of five items, such as : "sometimes I don't know quite what to say with X," "I would be uncomfortable having intimate conversations with X," and "sometimes I find it hard to talk about my feelings with X." (alpha=.74). *Monitoring communication* is based on responses to the question, "Sometimes I feel I need to watch what I say to X. "

Emotional Processes. To measure *love*, we use items drawn from Hatfield and Sprecher's (1986) passionate love scale, including "I would rather be with X than anyone else," "I am very attracted to X," and "X always seems to be on my mind" (alpha=.87). *Jealousy* is measured by the single-item indicator, "when my partner is around other girls (boys), I get jealous.

Asymmetries . Demographic asymmetries are assessed via questions about the partner's age and race. Dummy variables were constructed to reflect a situation wherein the respondent is dating someone of a *different race* or *greater than two years older*. *Relational asymmetry* is based on the reply to the question "I need X more than she[he] needs me."

Commitment. The overall importance of the relationship is assessed by a question concerning the overall *importance of the relationship* to the respondent, *mistrust* of the boy/girlfriend (There are times when X cannot be trusted"), as well as an item indexing the *projected duration* (How long do you think that the relationship will last)?

We include additional variables that serve as control variables in our multivariate models. In addition to *gender* (female=1) and *age*, models include dummy variables for *race/ethnicity* (African American and Hispanic, and white were created). We also include dummy variables reflecting variations in *mother's education* (less than 12, greater than 12, where 12^{th} grade completion is the reference category), a strategy that allows for the observation of non-linear effects. This measure is derived from a questionnaire completed by parents, rather than from youth reports. *Family Structure* is represented in the models as a set of dummy variables (single parent, stepparent, other, where married biological is the reference category*). Parental Monitoring* is included, as most studies of the adolescent period have shown that girls are more closely supervised than adolescent boys of a similar age (Longmore, Manning and Giordano 2001). Monitoring is measured by a six item scale completed by the parent that includes items such as: "When my child is away from home, s/he is supposed to let me know where s/he is," "I call to check if my child is where s/he said," "My child has to be home at a specific time on the weekends" (alpha=.73). A measure of *peers' sexual involvement* is included that asks respondents: "How many of your friends do you think have had sex? Responses include none, one, a few, some, most of them or all of them (0-6). We will include a series of other covariates that have been found to be associated with sexual risk taking, such as prior sexual experience, alcohol and drug use, and HIV knowledge.

Analytic Strategy

We begin by identifying the relationship qualities associated with management of sexual risk. Our analyses focus on the effects of relationship qualities of current or most recent dating relationship. We present bivariate relationships between relationship qualities and management of sexual risk. The next step is to estimate baseline models that include the effects of the relationship qualities on the dependent variables. We will then examine the effects of other variables found in other studies to be associated with sexual risk. These include the following factors: sociodemographic characteristics, prior sexual experience, duration of relationship, alcohol and drug use, HIV knowledge, identity, and parental and peer influences. Consistent with our developmental focus, we examine these models separately for the three age groups because we expect that the effects of the qualities might differ by age as respondents move closer to young adulthood. Furthermore, the gender scripts surrounding dating and sexual behavior suggest that we may observe that relationship processes operate differently for boys and girls. We examine interaction models as well as estimate separate models for boys and girls.

PRELIMINARY RESULTS

Table 1 presents the association between relationship qualities and management of sexual risk. We have not finalized our measurement of relationship qualities or management of sexual risk. These are illustrative findings and will be further refined as we progress further on the paper. We present the mean values of the relationship qualities and p values indicating statistical significance.

The first column of Table 1 focuses on levels of partner disclosure. This item is based on having asked the boy/girlfriend about sexually risky behaviors prior to having sex. Most (79%) of the respondents had inquired about their partners' prior behavior. However, it was relatively uncommon (38%) to ask about all four behaviors. Respondents who reported higher levels of

communication awkwardness were significantly less likely to have questioned partners about their prior actions. The indicator of monitoring or 'checking' one's talk when with the partner is not related to disclosure. The index of overall level of intimate self-disclosure that characterizes the relationship is significantly associated with this questioning process, however (respondents who had higher levels of intimacy also had greater disclosure about sexual risk). The emotionality processes and demographic/relational asymmetries are not linked to partner disclosure about sexual risk. We find that our indicators of relationship commitment are, however, associated with partner disclosure. Respondents who indicated that their partners were more trustworthy were nevertheless more likely to question these partners about prior potentially risky acts. In contrast, projected duration is inversely related to this questioning process-teens and young adults in relationships they expect to last a long time disclose less about their sexual risk than those in projected shorter term relationships. These results are potentially important, as they indicate that teens and young adults in relationships that are potentially more sexually risky (projected short term, high levels of mistrust, low communication) are less likely to question partners about behaviors that may place them at heightened risk for STIs.

The next two columns refer to condom use in the relationship. Almost all respondents reported using a condom with their boyfriend/girlfriend. However, there is variation in the percent who were using a condom at most recent intercourse and consistency of condom use. Two-fifths (40%) of respondents were using a condom during their most recent intercourse. Almost all of the relationship qualities assessed are associated with current condom use. Teens and young adults who have greater communication awkwardness, greater monitoring of communication, and less intimate self-disclosure with their boy/girlfriend were more likely to report that they currently use condoms. Respondents who report higher levels of love and

jealousy in their relationships less often use condoms. Similar to prior work, couples with a greater age gap less often use condoms. However, these results also document that relationships that are viewed as more important and that teens believe will last longer less often involve condom use. Overall, current condom use is associated with relationships that are not as far along in terms of the intimacy of communication, and love, while being characterized by greater jealousy, and less commitment. Further analyses (not shown) reveal that one-third of teens decrease condom use over the course of their relationship and direct questions about the reasons indicate that relationship shifts in the direction of more love, trust, and commitment are frequent motivations for these changes.

Only about one-third of respondents who used a condom reported using it consistently. The relationship qualities significantly associated with consistency are emotionality, commitment and the asymmetry measures. It is also interesting to note that while greater jealousy was associated with current use, higher scores on the jealousy index were associated with inconsistent use of condoms. Relationships characterized by greater asymmetries have less consistent condom use (racial and age heterogamy are associated with significantly lower levels of consistent condom use, and the measure of relational asymmetry is also tied to less consistent condom use). Finally, adolescents and young adults who score high on the relationship's importance have less consistent condom use than their counterparts involved in less important relationships. These results indicate that the relationships influence consistency of condom use in some unexpected ways. Teens who are in relationships that may be more risky (high jealousy, less important, and at least a two year age gap) are at greater risk of STIs via inconsistent condom use. Responses to direct questions about reasons for not being consistent in using

condoms suggest that these are often based on the couple's commitment and love (results not shown).

The final indicator of management of sexual risk is exclusivity. The interview schedule includes measures of the respondent's sexual exclusivity, perceptions of boy/girlfriend's exclusivity, as well as whether either the respondent or their boy/girlfriend are sexually exclusive. As the results are similar for each measure, we present findings relating to whether the boy/girlfriend cheated. One-fifth (20%) of respondents report that they believe their boy/girlfriend was having sexual intercourse with someone else while they were dating. All of our relationship qualities are associated with this measure of exclusivity. Teens and young adults with greater communication more often report that they are in exclusive relationships. Relationships that include more love and less jealousy are associated with sexual exclusivity. Higher levels of demographic and relational asymmetries are significantly related to partner infidelity. Finally, higher levels of commitment (relationship importance, trust, and perceived longevity) exist in sexually exclusive relationships. It is important to note, however, that this measure is perceptual, and thus does not capture instances of infidelity that may be outside of the respondent's awareness.

These findings represent our first step in assessing how dating relationships influence the management of sexual risk. We will further refine our relationship processes measures and consider how these processes configure together. We will next estimate multivariate models predicting each indicator of sexual risk. We will examine how the management strategies work together. Gender interactions will be included to determine whether and how relationship processes influence management of sexual risk. Our results indicate that decisions about sexual

risk-taking are relational as well as “health” decisions, suggesting the need to incorporate these relationship features into prevention and intervention efforts.

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Table 1. Relationship Qualities and Management of Sexual Risk.

	Partner Disclosure		Current Condom		Consistent Condom		Partner Exclusivity	
	Yes (79%)	No (21%)	No (60%)	Yes (40%)	No (64%)	Yes (36%)	Yes (80%)	No 20%)
Communication Processes								
Communication awkwardness	10.4900	11.2110	10.1410	11.0050	10.3220	10.6430	10.9490	12.3480
	p=0.0518		p=0.0058		p=0.3327		p=<.0001	
'Monitoring' communication	1.9139	2.0060	1.8168	1.9985	1.8748	1.9035	2.0462	2.3963
	p=0.3559		p=0.0274		p=0.7426		p=<.0001	
Intimate self-disclosure	16.271	15.228	16.412	15.650	16.173	15.758	15.583	13.983
	p=0.0168		p=0.0200		p=0.2309		p=<.0001	
Emotional Processes								
Heightened emotionality (love)	19.269	19.453	19.836	18.464	19.431	19.050	18.621	17.218
	p=0.6499		p=<.0001		p=0.2936		p=<.0001	
Jealousy	2.9659	2.8767	3.0398	2.8127	3.1205	2.6227	2.7588	3.0963
	p=0.4675		p=0.0306		p=<.0001		p=0.0003	
Asymmetries								
Racial	0.2173	0.1942	0.1976	0.2215	0.2408	0.1549	0.1934	0.2679
	p=0.5899		p=0.5137		p=0.0197		p=0.0377	
Age	0.2559	0.1859	0.2806	0.1634	0.2576	0.1532	0.1777	0.2551
	p=0.1172		p=0.0013		p=0.0048		p=0.0262	
Relational (need)	2.4052	2.5460	2.4803	2.3352	2.4969	2.2619	2.3309	2.6406
	p=0.1643		p=0.0889		p=0.0084		p=0.0002	
Commitment								
Importance	4.2730	4.1686	4.4193	4.0272	4.3333	4.1394	4.0765	3.5472
	p=0.3235		p=<.0001		p=0.0476		p=<.0001	
Projected duration	7.5347	8.1189	7.8261	7.3072	7.7502	7.5817	7.1955	6.0471
	p=0.0510		p=0.0382		p=0.5059		p=0.0003	
Mistrust	2.2698	2.3090	2.1930	2.3174	2.3622	1.9865	2.0167	3.0542
	p=0.0452		p=0.2312		p=0.0005		p=<.0001	

N=599 Source: Toledo Adolescent Relationships Study