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# YOUNG WOMEN'S HEALTH CONCERNS: REVEALING PARADOX

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Because of the numerous physical, psychological, and social changes that take place for adolescents, the risk of engaging in life-threatening behavior is greater than at any other time in their life-span. Community workers identified the invisibility of adolescent women (ages 16–24) in their health-related programs and sought to rectify this. To discover the unmet health concerns of adolescent women, eight focus groups were held with a diverse group of adolescent women. Forty-two adolescent women, including adolescent mothers, women of color, attendees at a drop-in youth center, high school and university students, and employed persons participated. While most women attended one focus group, some participants attended two. Using Spradley's ethnographic method, we identified two overarching themes shared by the adolescent women. These themes included feeling invisible and struggling with independence. Our findings underscore the invisibility of adolescent women's lived experiences and concerns within most research agendas.

In 1996, workers at a community health center in a small Western Canadian city noticed that adolescent women appeared to be underrepre-

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sented in attending various programs for youth. For this reason, a preliminary research study was undertaken to address the following question: "What are the health related concerns of women aged 16–24?" Rather than relying solely on previous work, we aimed to identify adolescent women's health-related concerns from their perspective.

## CONCERNS OF CANADIAN YOUNG WOMEN

Because of the numerous physical, psychological, and social changes that take place for adolescents, the risk of engaging in life-threatening behavior is greater than at any other time in their life-span (Foxcroft, 1997). For example, a recent international study of adolescents' drinking and smoking habits demonstrated that Canadian teenagers rank among the highest users; 21% of 15-year-old Canadian women smoke daily (King, Boyce & King, 1999). Relationships with self and others are also problematic. In a survey of Canadian youth, Bibby and Posterski (1992) concluded that, although adolescent women place high value on relationships, these relationships do not promote self-worth in the adolescent women. Further, the researchers found the self-esteem of adolescent women appears to be significantly lower than that of adolescent males; 53% of the adolescent women surveyed were very concerned about their weight and appearance (Bibby & Posterski, 1992).

Young women demonstrate a variety of other health threatening behaviors. For example, while 85% of youth in the Bibby and Posterski (1992) study indicated they were well-informed on sexuality issues, adolescent women in Canada continue to have the highest rates of sexually transmitted diseases (STDs) of any age group. Statistics Canada (1995) shows that Canadian young women are more likely than young men to be the victims of a personal crime, such as sexual assault—23% of women aged 18–24 were assaulted by a date, boyfriend, acquaintance, or stranger. Furthermore, in their study of sexual decision-making, Rosenthal, Lewis, and Cohen (1996) found that adolescent women experience multiple pressures to engage in sexual activity at a young age. Holland, Ramazanoglu, Scott, Sharpe, and Thompson (1990) argue that conflicting social pressures affect young women's abilities to make decisions about contraceptive use and safe sex, which contributes to risk-taking behaviors in their sexual relationships with men. These statistics, along with the invisibility of adolescent women in health promotion programs provided the initial impetus for this study.

As researchers, we recognized that such epidemiological research, although valuable in itself, is limited in what it can reveal about the population of this study. Such studies, which focus on behaviors at the expense of adolescent women's experience, impose external categories on that ex-

perience rather than reflect it as it is lived, that is, continuous and evolving (Levinson, 1996). In addition, although there has been increased interest in examining gender, race, sexual orientation, and culture as significant variables, the use of survey data is limited in terms of what it can illuminate about our increasingly diverse society (Barbee, 1992; Yoder & Kahn, 1993). Research framed from a postpositivist perspective diverts attention away from understanding women's experience as they live it (Josselson, 1987).

Our purpose in conducting this study was to provide young women the opportunity to share their health concerns and to articulate their experiences. It was hoped that results from this study could provide a basis for community development and program planning to address the young women's health-related concerns. The research question that guided this study was, "What are the concerns of young women as they negotiate the transition from adolescence to young adulthood?"

## STUDY DESIGN

We used an ethnographic approach (Atkinson & Hammersley, 1994; Spradley, 1979) for data collection and analysis, employing group interviewing (Morgan, 1984) and participant observation (Spradley, 1980). Particular analytic attention was given to understanding young women's health related concerns within the social context. Ethical approval was obtained in accordance with the requirements of the university's Human Ethics Committee.

Recruiting and gaining access to participants proved to be a significant challenge. Even though the women stated their interest in the project, frequently they failed to appear for the scheduled focus group meeting. We wondered if those who did not participate had difficulty acknowledging that they had something important to contribute, which was indicative of, and further contributed to, their invisibility. It was also possible that some women were shy and felt uncomfortable discussing their feelings with professional strangers (Schwartz & Jacobs, 1979).

With the help of a community health agency in a small city in Western Canada, we invited a diverse sample of women aged 16–24 to be interviewed using a focus group format (Morgan, 1984; Wilkinson, 1998). This age range was adapted from Levinson's (1996) definition of women's era of early adulthood, which begins with the "Early Adult Transition" (17–23 years) in his study of the human life course. Attempts were made to have the study sample as inclusive as possible to broaden the database and enrich the findings (Hall & Stevens, 1991; Lincoln & Guba, 1985). However, there were some marginal groups that were difficult to recruit. For example, although contacts were made with the lesbian and the street

youth communities, and in spite of expressed interest, members from these communities did not volunteer to participate in the study.

Despite the difficulty initially recruiting participants, 42 young women participated in the study, including women of color, adolescent mothers, employed women, mainstream and alternative students, and attendees at a youth drop-in center. While most women attended one focus group, some participants attended two. Eight focus groups were conducted between May and July 1997.

To establish rapport and trust within the group, participants were interviewed in settings that were familiar to them and refreshments were served (Agar, 1980; Spradley, 1979). At the beginning of each focus group, issues of confidentiality were discussed and written informed consent was obtained (Cottle, 1977; Hall & Stevens, 1991). In addition, we discussed the possibility of sensitive or painful subjects that might emerge. Participants were assured that they could choose the information that they wished to disclose. In addition, they were informed that support, and possible referral, was available for anyone who might need it. Demographic information was obtained at this time.

The group format encouraged participants to spark ideas, thoughts and feelings within the group (Nyamathi & Shuler, 1990). In addition, focus groups allowed the data collector to observe the interactions among participants, which added to the rich database (Seal, Bogart, & Ehrhardt, 1998; Wilkinson, 1998). Each focus group lasted approximately one and one-half hours. The focus groups were conducted using a global, open-ended question to initiate broad discussion of the women's concerns (Morgan, 1984). The question posed at the beginning of each group was: "What are some of your main concerns and issues that health providers need to know more about?" Data from all focus groups were audiotaped and transcribed without identifying information.

Through immersion in the data, categories and subsequent themes emerged, representing common threads of meaning among participants' narrative accounts (Fetterman, 1989; Spradley, 1979). The recursive process among data collection, analysis, and further questioning and observation continued until theoretical saturation had been reached (Lincoln & Guba, 1985). Prior to and during each interview, the emerging analysis from previous groups was discussed among group members for verification and any additional information (Lincoln & Guba, 1985).

## FINDINGS

Two major themes shared by all participants emerged from the data. These themes, representing the paradoxes of young womanhood, were Feeling Invisible and Struggling for Independence.

## Feeling Invisible

Participants in this study described a paradoxical experience of feeling invisible while at the same time being seen as highly visible in problematic ways. There were three components of this theme: feeling disrespected, experiencing violence, and being stereotyped. These components represent the contradictory nature of the young women's health related experiences and each is discussed below.

*Feeling Disrespected.* In this study, all of the participants experienced disrespectful treatment by authority figures and by their boyfriends. In some instance, this lack of respect was subtle, but nonetheless the women identified feeling unrecognized and insignificant. For example, many of the women recounted their school experiences as invalidating, and described teachers taking little interest in them as people. Many had specific comments about their relationships with teachers. For example, two participants[1] described such relationships. Katharine said, "The science teacher wouldn't listen to anything you would say. He wouldn't even acknowledge you, even when you told him the overhead was blurred." Sarah added her comments, "They don't pay attention and when you're not paying attention, they're yelling at you." These women's experiences in school did not enhance their self-esteem, but instead left them feeling disempowered and devalued. Although the women in such circumstances felt angry, there was no safe avenue for them to express their feelings without risking retribution. Being unable to express such feelings compounded their experience of disrespect, promoted their invisibility, and contributed to low self-esteem.

Participants also felt disrespected in their relationships with young men. This included feeling dismissed, as well as being called names such as "slut" or "bitch" when they made attempts to assert themselves. The women felt disrespected in negotiating sexual relations and spoke of feeling pressured to engage in sexual activities, particularly at an early age. Participants indicated they felt they should "please the man," putting his needs in front of their own. As Jude said, "Or, he's like, 'Or I'm leaving' and she's trying to please him. Or, 'You're my girlfriend, where else do you want me to get it? You want me to go out and look for it?' There's that threat there." In retrospect, some participants expressed regret at having succumbed to such pressure, interpreting the pressure as disrespectful of them, and they viewed their choices in hindsight as lacking self-respect. They wished they had waited to have sex until they felt ready.

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[1]Participants' names have been changed to ensure confidentiality.

The degree to which young women in this study felt disrespected by teachers and boyfriends, key relational figures in their lives, is significant. Participants interpreted these feelings as messages that their perspectives were not valued or welcomed, contributing to feelings of invisibility.

Women in this study also experienced invisibility in their relationships with physicians. In their dealings with physicians, participants expressed the belief that they were not valued as individual women with their own experiences and knowledge. They expressed frustration that the concerns they brought to physicians were often minimized or dismissed. This was compounded by the fact that they viewed their physicians as unapproachable and intimidating. As noted by others (Ussher, 1989), these women found that physicians' paternalistic attitudes prevented them from having their questions answered (Banister, 1999; Daniluk, 1993). Some women admitted that they avoided raising questions or consulting with their physicians because of such attitudes. The following quote is one example of the women's experiences:

> The very first time I went for mine [pap smear] the doctor was so intimidating. Like the way they questioned you whether you were [sexually] active or not, 'Are you using birth control?' and 'Well, you should.' It's very forceful. You may not believe in birth control, or you may not want to have weird stuff in your body. And he's like, 'You should think about it. You're being silly. You want to get pregnant? You're still too young.' Just the way they talk to you, I think it's very intimidating.

The women expressed anger and frustration that they could not trust physicians for timely, sensitive, and accurate information about their bodies. In particular, the women felt pressured to adopt particular methods of birth control ignoring their own knowledge and feelings of discomfort. Such polarization of complex issues and decision-making regarding sexuality and birth control not only disregards the array of birth control methods available, but reinforces the invisibility of the women's concerns. Such tight control of access to birth control information negates the work of feminists for 100 years, and renders invisible the lives of young women.

*Experiencing Violence.* Another serious form of disrespect was evident in the descriptions of emotional, physical, and sexual violence experienced by participants. Although participants described considerable violence in their lives, such experiences were not necessarily recognized by authority figures. For example, the school system seemed oblivious to this pervasive problem. The following conversation exemplifies this difficulty.

Catherine: Well they (school officials) have no idea how many girls get raped.

Liz: The schools think girls don't have sex. Then it hits them, "Oh my God, they're having sex!" as opposed to "Oh my God, they could be getting beaten by their boyfriends, or raped by their boyfriends!" They don't pay attention to that.

The lack of recognition of violence as a serious health concern in itself was a form of invalidation and disrespect for the women's experiences. In some instances the young women did not recognize the level of violence in their lives until reflecting upon it later.

It is worth mentioning that childhood sexual abuse was identified as a concern, but not discussed in any depth within the context of this study. It seemed that such a sensitive issue could not be fully explored within the confines of only one or two group interviews. Further, we decided it would be inappropriate to delve into these sensitive issues until further trust and rapport had been established among participants and the researcher.

All the women either experienced or had a close friend who experienced violence in a significant relationship. Participants described various forms of violence: physical, emotional, and sexual. Although violence against women is well recognized in all age groups, we were surprised at the prevalence and severity reported by participants (Sampselle, et. al., 1992; Walker, 1979). Most of the women in this study spoke about emotional abuse within their relationships. For these women, violence was described in tentative terms, and many had difficulty even identifying that the relationship was violent. For example, having recently completed training in a transition house, one woman shared her surprise at learning that her relationship was abusive by saying, "They told us about domestic violence, emotional abuse, and I'm thinking, 'I am being abused, and I don't even know it,' because it is maybe very minor, but it shouldn't be happening."

When they did identify violence, the women felt ashamed to admit it, and were unsure of where to turn for help. Because the women were not in formalized relationships such as marriage, it was not clear to them that the existing supports would be available. Indeed, the women pointed out that because love relationships among young people are not socially sanctioned, they tend to be viewed as insignificant. As illustrated by the following discussion, violence within their love relationships was a major concern:

Kelly: In this society right now there's a lot of violence in relationships—especially teenage relationships. The girls, they don't know what to do or

who to go to. And if they say something, then they feel scared that the guy's going to beat them up anyway again, so what do you do?

Jamie: I think it's almost easier or safer to stay in the relationship.

As another source of disrespect in young women's lives, the issue of violence raises questions about the invisibility of this serious issue. As noted above, it was difficult for participants to talk about the violence in their own lives. Because their lived experiences were not seen or validated, their struggles were not recognized within the social context. Societal lack of recognition only added to the shame some experienced about this particular health concern. This in turn contributed to the women's sense of invisibility by keeping them silent. For some, this perpetuated a cycle of invisible violence, compounding their experience of invalidation and feelings of being disrespected.

*Being Stereotyped.* Another way the young women felt disrespected related to feeling stereotyped and stigmatized just because they were young (Goffman, 1963). Being stereotyped was paradoxically a form of societal invisibility. Instead of being seen as individuals, the women experienced themselves as highly visible representatives of a monolithic and stigmatized group. For example, some of the participants described being constantly watched when entering a department store, believing that the sales people did not trust them unattended. In particular, young mothers with baby carriages experienced this prejudice. As Jackie put it:

"I hate people watching me in the stores. I don't do it [enter stores] any more but I walk in and they start to follow me around. Even when I have D. (baby) with me, I'm still followed. I think they do it more because I have a diaper bag and stroller."

This mother felt that she was viewed as bad for several reasons: a) she was young; b) she was an unwed and therefore an incompetent mother; and c) she had the visible means to conceal stolen items. In these ways, Jackie expressed how she was seen only as representing a number of stigmatized groups and not as the individual she is.

Stereotyping was seen in various aspects of participants' lives. For example, a group of young women walking down the street felt they were being judged as "bad girls" whom others viewed as being involved in illegal activities, such as theft or drug use. Indeed, a common concern among the women was others' assumptions that participants were users of drugs and alcohol, as the following interchange illustrates:

Samantha: It's [being called "bad woman] like a label for being a teenager.

Jenn: It's weird to know that people think of you like that.

Brittany: It's a kind of prejudice.

Participants in this study were aware of the stigmatizing process, but this awareness did not diminish their feelings of invisibility.

The feelings of being stereotyped were profound for all participants, and an unexpected finding of this study. In fact, when preliminary findings were presented to the women themselves, they expressed surprise at the significance of the overarching stigma of being a young woman. The women identified that living within a context of stigmatization negatively influenced their self-esteem. For these women, daily reminders of disrespect were many. This finding of such disrespect and stereotyping of young women seems paradoxical to a societal dogma that canonizes youth and young women in particular (Freedman, 1986; Halprin, 1995; Wolf, 1990). It seems that in spite of the social dogma young women do not escape the societal devaluation of women.

## Struggling for Independence

The women expressed a desire for increased independence yet struggled with still needing adult support, particularly with issues around sexuality and body image. These struggles were significant in the degree to which the participants were aware of them, and the ways in which they moved toward resolution. In addition, the women identified the possibility that having a mentor with whom to speak about their struggles might help them. Struggling for independence includes three sub-themes: ambiguous dependency, struggling with body image, and dealing with sexual relationships.

*Ambiguous Dependency.* Participants expressed ambivalence about their own needs for autonomy, yet at the same time wanting support and guidance from older women. At the same time that they sought to establish themselves as separate beings from their parents, these women also expressed a desire to be cared for. Many participants expressed such paradoxical needs as illustrated in the following discussion.

> Nancy: If anybody tries to tell me what to do, I won't listen. I'll do it even more.
>
> Mary: I trust my mother, but I don't want to listen to her.
>
> Melissa: Yeah. I don't want somebody else taking care of me. So, at the same time, I'd love to sit there and say, "Yeah, totally take care of me."

As can be seen, these participants recognized the limits of their ability to be independent, even though independence was their desire. Despite the difficulty involved, the act of engaging in a struggle between dependence and independence appears to be a necessary development step toward reaching adulthood (Erikson, 1968; Josselson, 1987).

This struggle was also noticeable among the adolescent mothers. These young women identified that their pregnancies profoundly interrupted their relationships with friends and peers who could not relate to the women's experiences of motherhood. In spite of their own developmental needs to be cared for, such women now had the full responsibilities of adults. Many described losing friendships because, with the responsibility of caring for a child, they could no longer "just (get) up and go." They felt caught somewhere between the world of adults and that of adolescents, and were pulled in both directions by their own needs and those of their babies. As Amanda said:

> You don't fit in with your peers and adults don't accept you because you're a child having children, and they don't agree with that. And you don't get very much support or help from them, because they don't agree with anything that we do under-age.

In discussion, this young woman recognized that she needed support both for herself and for her role as a mother, and indicated that such support was unavailable outside her school/daycare program. In recognizing the loss of friendships, the women identified how lonely and isolated they would be were it not for their involvement in an alternative school program for adolescent mothers. Outside this program, the young mothers felt a lack of membership and subsequent invisibility in both the adolescent and the adult worlds. This invisibility sabotaged the young mothers' efforts to achieve independence and recognition within the adult world.

Recognizing their struggles with independence, the participants identified that a relationship with a woman older than themselves might help them develop the knowledge and skills they felt they needed for negotiating the transition to young adulthood. Connecting with an older woman was viewed as a potential resource to grapple with numerous health related concerns the young women faced, including body image issues, sexuality and birth control, and relationships.

*Struggling with Body Image.* As might be anticipated, a major component of participants' struggles with independence related to development of an acceptance of their own bodies (Bordo, 1997; Halprin, 1995; Wolf, 1990). However, cultural messages undermined the young women's efforts, as demonstrated in the following interaction.

> Amanda: Well, the image, like the body image now is like, you see all these posters with anorexic women standing . . .
>
> Kara: Gorgeous women. With beautiful faces, but really they're unhealthy because they probably weigh like 105 pounds and they're probably 6 foot, when they should be probably weighing 125 pounds instead of 105.

Participants recognized the sexism involved in such media portrayals of women's bodies and went on to discuss it further.

> Amanda: Body image affects women of all ages.
>
> Melissa: It bugs me women are subjected to that.
>
> Sarah: And men aren't.
>
> Jude: Yeah, big huge beer guts.

Cultural stereotyping and social pressures influenced young women's self-perceptions about physical features other than size. This was particularly apparent among women of color, who described their own differences in relation to dominant cultural values. In the following interaction, two women describe their understanding of this.

> Samantha: . . . and I'm not the ideal Barbie doll figure. A White guy has never asked me out. And I think it's my figure. They're not used to the big butt. They're scared of my figure.
>
> Josie: And hair is the other thing. Your hair's not straight or wavy—well, a White person's hair.
>
> Samantha: Not just White, but African. I get so much flak about my hair. I can't wear it how I want it.

As this interaction suggests, the women compared themselves unfavorably to the European norms. Nonetheless, all participants were concerned about various "defects" in their bodies when compared against such norms (Bordo, 1993; 1997), and described various ways they tried to hide or cover them. This hyperawareness of body "defects" was particularly emphasized when the women were discussing their relationships with men. The sensitivity about body image impacted on the women's self esteem, and has been noted by other researchers (Kaplan, 1997; Pipher, 1995; Usmiani & Daniluk, 1997).

Participants in this study struggled to accept their bodies in the face of sociocultural messages devaluing the ways in which their bodies deviated from the ideal. Even though they clearly identified that the media portrayal is of an idealized female, it was difficult for them to discredit, and separate themselves from such messages. This struggle with media images complicated the young women's efforts to move toward independent adulthood in which they could accept their bodies as just right for them.

*Dealing with Sexual Relationships.* Another aspect of the struggle with independence involved developing healthy sexual relationships, in

which both parties feel equally respected. Participants identified that they struggled because they knew little about healthy sexual relationships, and how to end an unhappy one. They reported that they sometimes avoided ending unhappy relationships because of societal pressure to have a boyfriend. In fact, the women felt so pressurred, that some would lie about being partnered when in fact they were not. This form of pressure, discussed in most of the groups, is illustrated by one of the group conversations.

> Katy: I feel there's a lot of pressure in having a boyfriend. You're supposed to just dive into it and get into it. But then, dealing with relationship problems and stuff, there's nowhere to go to talk to somebody.
>
> Laurie: Yeah, it's culturally expected that you should have a boyfriend. I'm not quite confident in myself not having one. But still, I think there's a thing going through other peoples' heads, "Oh you don't have a boyfriend, you haven't had a boyfriend. Oh, you're not sexually active." They think there's something wrong with you.

For participants, the pressure to be in a relationship, whether or not it promoted their personal growth, complicated their desire for independence. Thus, participants reported they sometimes made choices about intimate relationships that compromised their sense of self.

Adding to their struggles with intimate relationships, participants consistently described what they perceived as a lack of reliable information about sexuality. This involved issues of STDs, birth control, reproduction, and basic human anatomy and physiology. They lacked knowledge of their own bodies as well as the bodies of men. Even when the women knew where to go for assistance with these issues, the information they found was seen as inadequate. The younger women in the group found birth control inaccessible in their own community and had to travel for assistance. For those who had access, this information was felt to be incomplete, as they believed they were not presented with the full picture of the possible choices, and the implications of the various methods. Animated conversations took place related to the issues of birth control information, as the following interchange illustrates.

> Connie: It's like, "take this pill," but they don't tell you what's in the pill, or tell you exactly what it's doing to your body.
>
> Melissa: The school nurse focused a lot more on the condoms and the spermicide foam you can use.

The women stressed that they would welcome more information, particularly on the effects of various birth control methods on their bod-

ies. Many voiced a preference for "more natural" choices, including the rhythm method or foam. In addition, they expressed a desire to have their boyfriends assume some of this responsibility, even if it meant accompanying them to the clinic. At the same time, the women were often intimidated about asking questions because of their discomfort with medical personnel and expressed a desire to have someone supportive to accompany them.

If a young woman became pregnant, she described being presented with limited choices regarding their pregnancy. Although information available focused on abortion or adoption, the women believed that keeping a child should also have been a possibility. It was frustrating for some that this choice was not included within the information they received. There was minimal support for those women who chose to raise their own babies. The issue of pregnancy was a flashpoint for many adolescent women struggling with issues of independence, and the young mothers in particular expressed a wish for someone to act as an advocate on their behalf. They saw their choice as a viable one and wanted support for their own perspective and growth.

## DISCUSSION AND IMPLICATIONS

As researchers, we were surprised that the participants in this study did not identify risk behaviors as a central concern. This contradicts the prevalent view that issues such as smoking and substance use are sufficiently distressing to merit educational interventions (McCreary Centre Society, 1993). These findings raise the question, "To whom are these issues distressing?" Perhaps the patriarchal focus on the health concerns of risk behaviors has diverted attention away from the lived concerns of adolescent women. In this way, attention to such behavioral issues seems to contribute to the invisibility of the women's lived experiences within the discourse on young women's health. From our findings, it seems that attention to these societal concerns may be masking more serious, core issues that young women themselves experience. Understanding the underlying meanings of risk behaviors may help to inform health and health care providers. This understanding might also decrease the invisibility of young women and their concerns within the health care arena.

Our findings have important implications for practice and research. From a practice perspective, this study emphasizes the need to seek out and attend to the stories and experiences of health and well being from young women themselves. Effective support and assistance that attends to these lived experiences could begin with what the women identify as salient. To do this, as researchers and practitioners we are challenged to put aside our own assumptions and listen (Capponi, 1992).

Research approaches that attend to the experiential world of adolescent women will broaden our understanding of the specific concerns of women in this developmental stage. Such research would provide a humanistic perspective to augment the current epidemiological understandings that frame the discourse on the health of young people. This humanistic perspective is congruent with the ecological view of health promotion, which encourages community building and participatory action (Purdey, Adhikari, Robinson& Cox, 1994). In the words of many of the participants, "Just listen to us!"

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