

Late Adolescents' Perceptions Of Factors That Influenced Their Sexual Decision Making: A Narrative Inquiry

Author: Heidi Collins Fantasia

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Boston College

William F. Connell School of Nursing

LATE ADOLESCENTS' PERCEPTIONS OF FACTORS THAT INFLUENCED
THEIR SEXUAL DECISION MAKING:
A NARRATIVE INQUIRY

a dissertation

by

HEIDI COLLINS FANTASIA

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Abstract

LATE ADOLESCENTS' PERCEPTIONS OF FACTORS THAT INFLUENCED
THEIR SEXUAL DECISION MAKING:
A NARRATIVE INQUIRY

Heidi Collins Fantasia, PhD, RN, WHNP-BC

Sandra R. Mott, PhD, RN

Dissertation Committee Chair, William F. Connell School of Nursing

The purpose of this research was to address the gap in the literature regarding the lack of first hand accounts of the factors that influence adolescent sexual decision making. Using a narrative approach, I asked a cohort of late adolescent participants to tell their stories about the events surrounding their decision to become sexually active, and how this initial decision affected subsequent decision making. The specific research questions that guided the study were: 1) What are late adolescents' perspectives of the factors that influenced their decision to become and remain sexually active? and 2) What is the effect of sexual decision making regarding coital debut on subsequent sexual activity?

To accomplish my research aims I used narrative inquiry to elicit rich information, in the adolescents' own words, about what they perceive to be the most salient factors that contributed to their decisions to engage in sexual activity. I recruited a purposive sample of 11 late adolescents between the ages of 18 and 22 years from a series of family planning and sexually transmitted infection (STI) clinics in the

Northeastern United States. As their stories unfolded, four main components emerged. These components included the internal and external environmental context, expected social norms, implied sexual consent, and self-reflection and evaluation.

The results of this study provide evidence that adolescent sexual decision making is a complex process with multiple layers of influence. Through the stories of my participants, I have constructed a more comprehensive conceptualization of adolescent sexual decision making and related sexual behaviors. This will guide the development of possible interventions to improve health care for this population. These interventions include expanding nursing knowledge to inform the development of theories, practice innovations, research, sexual health education, and policies for addressing adolescents' needs across the continuum of the adolescents' development from childhood to adulthood.

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CHAPTER 1

Impetus for the Study: Adolescent Sexual Activity

Introduction

A critical issue for today's youth is developing a healthy understanding of their sexuality. The United States Surgeon General labeled this challenge as one of the nation's leading public health concerns (Office of the Surgeon General, 2001). Sexual socialization is considered to be a process by which knowledge, attitudes, values, beliefs, and societal norms about sexuality are acquired. Knowledge that is acquired and processed in the formative years of adolescence provides the foundation for values and beliefs about sexual activity and sexual norms that extends far into adulthood and shapes life long health behavior.

The study of adolescent sexual behavior has been motivated by public health concerns such as the prevention of pregnancy and sexually transmitted infections (STIs). There has been a strong focus on epidemiology and the related consequences and health risks of engaging in sexual behavior. Despite attention in the literature, there is still a limited understanding of adolescent sexuality. One reason for this is that for theoretical, practical, and political reasons, most researchers have focused on examining correlates of early sexual debut and condom use, rather than looking for a deeper understanding of adolescents' sexual decisions and experiences (Whitaker, Miller, & Clark, 2000). As a consequence, sexual decision making has been narrowly viewed in terms of either good or bad decisions, with an inadequate focus on how adolescents actually made decisions about sexual behavior. Dichotomous views of adolescent sexual decision making fail to

acknowledge that overall decision making patterns and the influence of social context are important components that affect individual decisions.

As a women's health nurse practitioner, I educate my adolescent patients about sexual risks, and they verbalize that they understand the risks and possible consequences of their actions. I have learned that education and stated awareness do not necessarily lead to a risk reduction behavior change. In my clinical practice I observe repeated patterns of risky sexual decision making among my adolescent patients such as unprotected intercourse, absent or inadequate contraception, one-time anonymous sexual encounters, and sexual activity under the influence of drugs or alcohol. I realize that as a clinician, just being able to recognize factors associated with risky sexual decision making is inadequate. I need a greater understanding of how adolescents formulate their decisions to become and remain sexually active.

Authors of existing research on adolescent sexual decision making have largely focused on risk and protective factors for coital debut. When dealing with the concept of adolescent sexual decision making and the potential factors that may influence behavior, researchers have produced correlation data with significant limits. These researchers create self-report questionnaires designed from to reflect their interests and not those of the study participants. Thus, subjects are limited to picking from a range of answers already selected by the researcher, which may not match with the concerns of these respondents. This methodological approach does not consider the sociological and psychological context in which sexual behavior occurs, thus limiting understanding by categorizing behavior into preset groups.

Purpose of the Study

The purpose of this study was to address the gap in the literature regarding the lack of first hand accounts of the factors that influence adolescent sexual decision making. Using a narrative approach, I asked a cohort of 11 late adolescent participants to tell their stories about the events surrounding their decision to become sexually active, and how this initial decision affected subsequent decision making. Going directly to the adolescents who were experiencing the phenomenon of concern not only gave voice to this population by acknowledging interest in their stories, but also allowed me to gain a much deeper understanding of the complexities of sexual decision making. The following research questions guided the study:

1. What are late adolescents' perspectives of the factors that influenced their decision to become and remain sexually active?
2. What is the effect of sexual decision making regarding coital debut on subsequent sexual activity?

Data from narrative stories obtained by individual interviews with 11 late adolescents (ages 18-22) who agreed to participate in this research study were used to address the above questions. The narratives provided rich information and detail, in the adolescents' own words, about what they perceived to be the most salient factors that contributed to their decisions to engage in sexual activity. The story of adolescent sexual decision making formed around these factors, and main topics of the story emerged. These included the immediate environmental context, expected social norms, implied sexual consent, and self-reflection and evaluation.

Nurses who interact with the adolescent population are in a position to affect significant change regarding unhealthy and potentially dangerous sexual decisions and behavior. Adolescent sexual activity, and its potential consequences of STIs and unplanned pregnancy, has a significant impact on the lives of those involved, society, and the health care system. Holistic nursing care incorporates not only individual patient factors, but also the context in which the behaviors occur. The participants in this study spoke at length about the influence of context, and how that context set the stage for their decision making process.

The narratives of the adolescent participants provided valuable insight into a very complicated and poorly understood phenomenon. A lack of first hand accounts from individual adolescents was a contributing factor to incomplete knowledge about adolescent sexual decision making. The results of this study began the first steps toward a more comprehensive conceptualization of adolescent sexual decision making and related sexual behaviors. This will improve understanding of adolescent sexual activity and provide clinicians with significant information directly from adolescents who are involved in the decision making process. This will allow clinicians to tailor health care, education, and interventions to capture the issues that adolescents have identified as the most salient for them.

In the following chapter, I will present the significance of the problem related to adolescent sexual decision making and sexual activity. Theories of adolescent growth and development as well as decision making are reviewed. An overview of these theories provides a reference point for understanding how adolescents formulate their decisions based upon their stage of cognitive and psychosocial development. In the third chapter, I

will detail the study design, research methodology, ethical considerations, data analysis, and rigor. Research findings and interpretation will be included in the fourth chapter. Implications for future research, theory development, education, clinical practice, and policy will be discussed in Chapter Five.

CHAPTER 2

Background for the Study: What We Know and What We Need to Know About

Adolescent Sexual Debut and Decision Making

Review of the Literature

Adolescence is the longest developmental stage, often seen as beginning with the onset of puberty and extending through the college years into the early twenties (James & Mott, 1988). Adolescence precludes absolute characterization, as no single event heralds its beginning or end. It can be viewed as the period between sexual maturation and the attainment of adult roles and responsibilities (Dahl, 2004). Therefore, adolescence cannot be understood only on the basis of physical changes or chronological age. This broader and more fluid definition extends beyond the numeric span typically thought of as the teenage years and acknowledges an increase in length of secondary schooling and thus a delay in attainment of adult roles. Characterized by rapid physical growth, reproductive maturity, and psychosocial expectations, this stage is often the most tumultuous to navigate.

American youth are faced with many issues during adolescence, and one topic of significant concern within this population is the onset of sexual activity and the potential consequences. Due to puberty occurring at a younger age and marriage delayed until later in life, today's 21st century adolescents are sexually at risk for unplanned pregnancy and sexually transmitted infections (STIs) for a longer period of time than any preceding generation (Sutton, Brown, Wilson, & Klein, 2002).

One of the most important implications for this group is the ever-growing rates of STIs. The statistics are overwhelming. According to the Youth Risk Behavior

Surveillance of 2005, approximately 47% of high school students (grades 9-12) nationwide reported being sexually active and over 14% reported already having more than four lifetime partners (CDC, 2006). Each year it has been estimated that of the 19 million new STIs in this country, almost half occur among mid to late adolescents between the ages of 15 and 24 (Weinstock, Berman, & Cates, 2004). One in two sexually active adolescents and young adults will contract an STI by age 25, and half of all new HIV infections occur among adolescents (American Social Health Association, 2005).

Another area of concern for the adolescent population is the potential for unintended pregnancy. The social and financial consequences of adolescent parenting are significant for both the individual and society as a whole. The adolescent pregnancy rate rose 3% among 15-19 year old females for the years 2005-2006. This represents the first increase in fourteen years (Hamilton, Martin, & Ventura, 2007). Approximately 750,000 adolescents become pregnant each year in the United States. This is the highest teenage pregnancy rate of any developed country (Alan Guttmacher Institute, 2006). The current pregnancy rate is concerning given the fact that contraception use by adolescents is at an all time high. According to Abma, Mosher, Martinez, and Dawson (2004), among teenagers who reported being sexually active (had intercourse within the past 3 months), 83% of females and 91% of males reported using a contraceptive method at last intercourse.

Adolescents are particularly vulnerable for negative and unintended outcomes of sexual activity for a number of behavioral, biological, cognitive, and cultural reasons (CDC, 2005). First and foremost, many adolescents, as well as young adults, have difficulty predicting the consequences of their actions, and therefore frequently

underestimate their risk for adverse events (Hall, Holmqvist, & Sherry, 2004). Authors of recent studies involving condom use (Lescano, Vazquez, Brown, Litvin, & Pugatch, 2006) and “hooking up”, or the phenomenon of adolescent sexual activity outside of a traditional dating relationship (Manning, Giordano, & Longmore, 2006), have suggested that adolescents may underestimate risk with certain partners. Also, adolescent women may be physiologically more susceptible to certain STIs, especially *Chlamydia trachomatis*, due to increased cervical ectopy of puberty (CDC, 2005).

It is well known that the potential consequences of adolescent sexual activity can cause repercussions far into adulthood. Making intelligent decisions and responsible choices about sexual activity during adolescence has both immediate and long term implications. A thorough discussion of adolescent decision making must occur within the framework of adolescent psychosocial and cognitive development. Understanding of the differences between adolescent and adult decision making processes is integral for effective implementation of interventions.

Developmental Theories

According to Jean Piaget’s cognitive-developmental model (Inhelder & Piaget, 1958), adolescence is marked by a transition of thinking in which the individual moves from the cognitive stage of concrete operations of late childhood to formal operational thinking of adulthood. It is during the period of formal operations that adolescents develop the ability to think abstractly and futuristically. Full transition into this stage results in the ability to draw conclusions from available information and predict possible outcomes, reason theoretically, and understand more abstract concepts such as love and fidelity. The implicit presumption in this model is that advances in cognition enable the

individual to act in a more thoughtful, mature manner (Steinberg & Cauffman, 1996). Although cognitive development seems to follow a clear progressive pattern, Inhelder and Piaget (1958) stated that adolescents may not be able to reason as adults until at least the age of fifteen, and may never fully operationalize all the components of formal thinking. Therefore, many adolescents and adults continue to utilize a more concrete thought process throughout their lives. Tending to remain a concrete thinker results in the adolescents' dominant orientation to the present, motivation to meet immediate desires, and little consideration of future consequences. Participation in risky sexual behaviors, including multiple partners, non-use of birth control methods, and inconsistent condom use are some examples of a present-oriented thinking (CDC, 2006).

Child psychologist David Elkind (1967) built on Piaget's theory of cognitive development, identifying egocentrism as a central feature of maturation as the individual moves from one cognitive stage to another. Egocentrism is seen as a negative but necessary by-product of cognitive development (Muuss, 1982), encompassing a dynamic interplay of the social and emotional components that accompany an individual's cognitive development. According to Elkind (1967), adolescent egocentrism begins at age eleven and continues until adulthood. Elkind described the adolescent as not only adapting his/her ego to the social environment, but also attempting to adjust the environment to the ego. Adolescents script their own personal fable through imagery and believe themselves to be both unique and invulnerable to negative evaluation of their actions and consequences of risky behaviors. Adolescents (particularly those in early and middle adolescence) believe that others are preoccupied with the adolescent's appearance, constituting the adolescent's egocentrism and explaining the power of the

peer group. Adolescent egocentrism and the influence of peers are displayed in risk taking behaviors in which adolescents feel personal invincibility to harm or negative consequences.

James Marcia (1989) discussed adolescent identity in the context of exploration, crisis and commitment. Marcia defined exploration as serious consideration of both cognitive and behavioral alternative actions, and stated that adolescent identity exploration sets the demarcation point between the adolescent just having an experience and the ability to make the experience personally meaningful. Crisis occurs when the adolescent is in the process of deciding on a commitment or unable to choose among an array of options. Commitment results when the adolescent is able to refuse any potential alternate actions. Successful commitment occurs in an environment of high support from family, peer, and social groups. Marcia (1989) viewed the combination of these factors as “developmentally crucial” (p. 405) in adolescence and stated that adolescents are better able to make a commitment if they know that failures occur in a safe context and they will find encouragement to try again. His theory has implications for adolescent decision making regarding the onset of sexual activity and risk behavior. Many adolescents function outside a supportive environment, which according to Marcia may affect their ability to fully consider options for their behavior.

Erik Erikson’s psychosocial theory of development (1980) is unique in the fact that it covers the whole lifespan, birth through older age, and recognizes the contribution of not only biologic factors to the developmental process, but also cultural, societal, historical, and environmental influences. Although he acknowledged that development occurs on a continuum, he also postulated that there are eight distinct stages characterized

by different conflicts that must be resolved by the individual. The developmental crises, which occur during each stage, must be resolved successfully before the individual can effectively move forward in life. Unsuccessful resolution of a crisis will lead to frustration and difficulty in dealing with the same crisis later in life (Erikson, 1980).

For Erikson, adolescence (12-18 years) is the fifth stage. It is characterized by the search for identity that is seen as the hallmark of transition into adulthood. As adolescents set themselves apart from their parents and peer relations become a central focal point in their lives, they form their own unique identity of self and are able to make deliberate choices and decisions. Experimentation with different social groups, behaviors, and attitudes is common as adolescents begin to define who they are. Rebellious behavior that purposely opposes parental wishes can be viewed as a desire to prove they are capable of having a unique and separate identity from that of their parents. Successful navigation of Erikson's stage of adolescence allows for a smooth transition into young adulthood, which Erikson defined as beginning at age 18 and lasting until age 40. In this stage a strong sense of identity is the most important component for the development of intimacy, personal commitment, and the ability to relate to others on a deeply personal level (Erikson, 1980).

William Perry (1999) provided a more detailed account of post-adolescent development than Piaget or Elkind, and extended his research to include older adolescents and college-aged young adults. Although he agreed with Piaget that individuals adapt and develop by assimilating new information, Perry placed greater emphasis on the idea that learners approach knowledge from a variety of individual standpoints. Perry also described stages, or positions, that outline cognitive development.

He labeled the most basic position duality. In this position knowledge, morality, and the world as a whole have a dualistic structure: either right or wrong, true or false, good or bad. The position of multiplicity occurs next, where there is no single right or wrong answer and many opinions may be equally valid. Further cognitive development transpires during the next stage of relativism. More complicated issues such as world knowledge, truth, and morality are seen as relative to a frame of reference rather than absolute. Concepts of right and wrong occur within a specific context, and peers are accepted as legitimate sources of learning. Commitment is the final, most fully developed position of cognition. In this stage, all knowledge is relative. There is a realization that identity is constantly evolving and each person partly determines his or her own fate. Although the process of cognitive development is clearly described, the rate, timing, and age at which adolescents attain these levels varies, as each individual processes information differently based on their personality and experiences. Also, according to Perry's theory, there is no set time or age at which individual adolescents progress from a lower to a higher stage, as illustrated by the great variation in adolescent behavior.

Adolescent Neurological Development

In addition to the developmental theories that focus on psychosocial aspects of development, neuroscience researchers contribute critical data related to brain development and the process of decision-making. Baird, Gruber, Fein, Maas, Steingard, & Renshaw et al. (1999) reported that as adolescents grow older and mature, brain activity shifts to the frontal lobe, leading to more reasoned perceptions and improved performance on emotional tasks. Sowell, Thompson, Holms, Jernigan, and Toga (1999) corroborated this statement with their research demonstrating that increased myelination

in the frontal cortex occurs during adolescence to enhance the efficiency of information processing. There is growing evidence supporting continued maturation of brain processes and activity throughout adolescence, including significant changes occurring well into the late adolescent years, thus demonstrating that frontal lobes of the brain are not fully matured until young adulthood (Giedd, Blumenthal, Jeffries, Castellanos, Liu, Zijdenbos et al., 1999; Paus, 2005; Sowell, Delis, Stiles, & Jernigan, 2001; Sowell, Trauner, Gamst, & Jernigan, 2002).

Because the brain, cognitive and behavioral systems all mature at different rates, adolescence is often a period of increased vulnerability and adjustment (Steinberg, 2005). Part of adolescent vulnerability may be linked to biological changes in neural systems that appear to increase tendencies toward risk-taking, sensation-seeking, and heightened emotional expression (Martin, Kelly, Rayners, Brogli, Brenzel, Smith et al., 2002).

Although this is considered a normative process, some adolescents may be developmentally inclined to engage in more risky behavior if they are unable to mediate arousal, emotion, and new sensations. Steinberg (2004) stated there are two observations regarding adolescent brain development that are particularly important:

First, much brain development during adolescence is in the particular brain regions and systems that are key to the regulation of behavior and emotion and to the perception and evaluation of risk and reward. Second, it appears that changes in arousal and motivation brought on by pubertal maturation precede the development of regulatory competence in a manner that creates a disjunction between the adolescent's affective experience and his or her ability to regulate arousal and motivation. (p. 69)

This neurologic development can be linked to Elkind's theory of adolescent cognitive development (1967) in which adolescents express behaviors associated with egocentrism and invulnerability. The inability to regulate emotion and motivation may result in the inability to recognize the risk and potential harm associated with various behaviors. Acknowledging the existence of gaps between emotion, cognition, and behavior is fundamental to understanding the effect of development on difference in judgment, risk-taking, decision making, and sensation seeking behaviors (Steinberg, 2004). The impact of this continued cognitive maturation in the older adolescent population has yet to be fully explored, especially with regard to emotion regulation, inhibition, and risk versus reward behaviors (Steinberg, 2005).

Decision Making Theories

Cognitive Naturalistic Decision Making

Building on the above theories of adolescent cognitive development, a growing body of research is focusing on the role of cognition in the decision making processes of individuals (Falzer, 2004; Gutnik, Hakimzada, Yoskowitz, & Patel, 2006; Patel, Kaufman, & Arocha, 2002). Patel et al. (2002) reviewed new directions in decision making research, including a naturalistic method that enables researchers to investigate cognition in real-world environments. A naturalistic approach encompasses the ability to synthesize multiple sources of information and the ability to reason theoretically and abstractly to consider future outcomes in a thoughtful manner. For this approach, the researcher uses realistic settings and acknowledges that decision making cannot be studied in isolation from other processes, thereby necessitating an extended cognitive science framework that includes modulating variables such as age, stress, fatigue and

communication skills. It is important to consider decision making in relation to the evolving process of adolescent thinking. Since this process is not fully developed during adolescence, decision making outcomes may adversely affect the adolescent.

Falzer (2004) built upon findings from the research related to naturalistic decision making and proposed image theory as a naturalistic approach to cognitive schemata involved in the decision making process. The principles inherent in this theory comprise a collection of standards, principles, and norms that determine why decisions are made. According to Falzer (2004), these values are crucial in determining differences between the practitioner's goals and the patient's goals when attempting to formulate effective health care treatment plans. When dealing with an adolescent population, consideration must be given to the depth of principles and values the individual adolescent has to draw upon. These values and principles need to be explored on a case by case basis, and will vary by individual adolescent and be mediated by factors such as development, emotional maturity, coping ability, and parental and peer influence. More limited life experiences may potentially decrease the available resources adolescents have to consider when making decisions regarding sexual activity.

Classical Decision Theory

In contrast to a naturalistic approach, Classical Decision Theory (CDT) states the aim of making a decision is to maximize personal gains and use information to accomplish goals. This aim involves choosing among a fixed set of possibilities to reach a specific goal (Hastie & Dawes, 2001). A significant problem with CDT is the underlying assumption that individuals accurately process information and possess the ability to make logical and correct judgments. Also, CDT treats all decisions as

essentially the same, comparing them to a normative standard (Gutnick et al., 2006). This has significance for adolescents who think concretely and have not fully developed the ability for hypothetical and more abstract thought that would increase the chance for more reasoned judgments and the ability to predict the consequences of their decisions. Because individuals, especially adolescents, do not follow a normative model of standardized decision making, CDT has failed to explain human behavior and decision making in real world, everyday situations (Beach & Lipshitz, 1993).

Emotion and Decision Making

The role of emotion in decision making when experiencing risk, uncertainty, and ambiguity is the topic of concern by Gutnick et al. (2006). The authors described the neural architecture of the prefrontal cortex as highly complex and interconnected to several sub-cortical regions, all of which are involved in various aspects of decision-making. Gutnick et al. (2006) stressed the importance of environmental, social, and emotional factors on the decision making process, especially during situations involving risk and uncertainty. Emotions are seen as influencing attitudes and judgments, which can then negatively influence how decisions are made. The role of emotion becomes more pronounced during times of stress and uncertainty when individuals feel they have less control over a certain situation. Transition through adolescence involves physical, psychological, cognitive, and social changes that expose the adolescent to new situations and emotions, and it has been established that adolescents experience more intense and frequent emotions than other age groups (Larson, Csikszentmihalyi, & Graef, 1980; Larson & Lampman-Petratis, 1989). Also, the neural and cognitive systems that support the regulation of emotion are not fully mature during adolescence (Spear, 2000). The

combination of emotional lability and incomplete brain development must be considered as factors that may impact the quality of adolescent sexual decision making.

Conflict Model of Decision Making

In the field of psychology, decision making has been explored in relation to stress response. In Janis and Mann's (1977) Conflict Model of Decision Making, these authors viewed decision making as a stressful process. The model includes the concept of risk appraisal relative to an assessment of success and the time involved to reach a decision. In this model, its creators assert that individuals weigh potential gains and losses, and consider others' approval or disapproval when they make personal decisions. In situations where individuals perceive their stress level to be very high, decisions may be made quickly without thoughtful consideration, or not made at all and deferred to a third party. Adolescence is an unusually stressful time. According to Janis and Mann (1977), the amount of perceived stress involved in each situation directly impacts the quality of the decision making process. Multiple sources of adolescent stress arise from developmental changes, complex and evolving social contexts, and the progression toward increasing independence. In addition to identifiable sources of stress, the perception of events as stressful is increased in adolescence relative to adulthood (Spear, 2000).

Prospect Theory

Decision making can also be examined in relation to prospect theory (Tversky & Kahneman, 1981). Originally developed in the context of gambling for money, the creators of prospect theory postulated that individuals typically avoid risk when a certain outcome is likely to result in a gain. Conversely, individuals will opt for a more risky choice to avoid a loss. Therefore, the framing of messages may influence how an

individual chooses to respond to the messages. Messages that are worded according to what a person has to lose by not performing a certain task or action are more influential in motivating performance than messages that emphasize potential gains (Abood, Coster, Mullis, & Black, 2002). Adolescents and adults may not view risky behavior the same way (Alexander, Kin, Ensminger, Johnson, Smith, & Dolan, 1990), and adolescents may inaccurately perceive that they have control over negative events (Moore & Rosenthal, 1992). When compared with adults, adolescents consider options differently by identifying fewer consequences and placing less value on consequences (Furby & Beyth-Marom, 1992). Adolescents feel unique and invulnerable to negative evaluation of their actions. In addition, adolescents may differ in motivational behavior and attribute-altered incentive value to motivationally relevant information (Spear, 2000). Therefore, prospect theory may have limited usefulness with the adolescent population.

Overall, decision making theories need to be filtered through the lens of adolescent growth and development. Increased levels of stress and emotion, limited life experiences, concrete thinking, and immature cognition all intersect to interfere with the decision making process. The disconnect between biological maturity and equivalent cognitive-emotional maturity in the complex setting of the adolescent social environment creates an atmosphere of great instability and vulnerability. Therefore, decision making theories may provide a useful framework from which to understand adult actions, but have significant limitations in the adolescent population.

Reflective Thinking

The ability of older adolescents to think reflectively and abstractly is directly related to increasing cognitive and neurological development during later adolescence.

The construct of reflective thinking in adolescence and adulthood was originally proposed by John Dewey (1933) for the field of education. Reflective thinking and reflective judgments occur when problems are unable to be addressed by formal logic alone. During a time of controversy, personal beliefs are explored and evidence is evaluated in each complex situation.

Reflective thinking occurs in a developmental progression, and is grounded in the cognitive-developmental tradition of Piaget (King & Kitchener, 2004). Prereflective thinking that begins to develop in younger adolescence is characterized by the belief that single correct answers exist for all questions, answers are known with absolute certainty, and are based upon information from authority figures (King & Kitchener, 2004). Prereflective thinkers rely on beliefs and personal opinions, not evidence, to reason toward conclusions.

Individuals who are able to reason reflectively have the ability to think abstractly, accept uncertainty in decision making based on their evaluation of available information, and believe that knowledge claims must be evaluated in relation to the context within which they were generated (King, 2000). As new data and/or perspectives emerge, knowledge is constructed and reconstructed and conclusions are reevaluated based on new information. The ability to think reflectively is influenced by changes in brain activity and reorganization of neural networks. The emergence of abstraction and reflective thinking appears to involve brain development that does not occur until late adolescence or early adulthood (King & Kitchener, 2004).

Adolescent Influences

An ecological perspective that includes family, peers, and environment will be used to examine the multiple factors that affect adolescent sexual decision making. An ecological approach considers varying levels of influence on behavior, and recognizes that decisions and behaviors are a result of the interaction among many factors that cannot be well understood without viewing the context in which the decisions and behaviors occur (Grzywacz & Fuqua, 2000). From an ecological standpoint, behavior is multifaceted, and this position considers the environment and its relation to individuals at numerous levels, including interpersonal, social, and cultural aspects as potential sources of influences on behavior and decision making (Glanz, Lewis, & Rimer, 1997).

Adolescent Sexual Decision Making

Cognitive Ability, Problem Solving, and Self-Concept

The concept that positive self-esteem, problem solving, and reasoning skills serve as probable protective factors for a variety of adolescent risk behaviors, including sexual activity, has been reported (Goodson, Buhi, & Dunsmore, 2006). In addition, lower levels of problem solving skills, health promoting behaviors, and education were found as possible predictors of early intercourse (Felton & Bartoces, 2002). It has also been reported that high school students who expected to delay sexual activity reported higher self-esteem, less hopelessness, and greater school achievement than their peers who anticipated that they would engage in sexual activity soon (Whitaker, Miller, & Clark, 2000). Researchers studying a younger adolescent population (11-14) also support positive self-concept and self-efficacy as protective factors for remaining abstinent (DiIorio, Dudley, Soet, & McCarty, 2004). In addition, Paradise Cote, Minsky, Lourenco,

and Howland (2001) surveyed 197 African American adolescents who ranged in age from 14-25. Over 50% who reported being virgins and approximately 25% who had been abstinent in the past three months cited personal values and beliefs as the reason for not having intercourse.

Misperceived Risk

Many investigators have focused on decision making and its relationship to misperceived risk of sexual activity. Chapin (2001) examined the role of optimistic bias, or the suggestion that individuals underestimate their personal risk to health hazards in relation to their peers. Within a sample of African American youths under the age of 17, Chapin's findings indicated that respondents did not use condoms consistently, and believed they would not become pregnant or cause pregnancy to occur. This misperception that they were not personally susceptible to pregnancy or health risks was coupled with the erroneous belief that their peers were more sexually active than they really were.

Additional researchers studying younger adolescent females support the concept of misperceived risk. Their results indicated that approximately half the participants underestimated the risk of their behaviors; of those who engaged in high risk behavior (defined as unprotected sex with multiple partners), 65% believed that their behavior was only slightly risky or not risky at all (Kershaw, Eithier, Niccolai, Lewis, & Ickovics, 2003). The authors inferred that adolescents equated long-term relationships with trust and safety, even when the evidence did not support that assumption. This reflects adolescents' utopian view of life. Similar findings were also reported in a study by Johnson, McCaul, and Klein (2002). Their study was unique in the researchers compared

younger adolescents (16-18 years) to older adolescents (18-22 years). For both groups, the findings demonstrated that as involvement in risky sexual behavior increased, estimates of their risk decreased, indicating that the participants seemed not to recognize that their behavior was elevating their risk. Overall, the data suggested that age was not a factor and neither group had an adequate understanding of their exposure to harm.

The concept of underestimated or misperceived sexual risk has also been examined using an exclusively older adolescent population. Von Sadovszky, Keller, and McKinney (2002) interviewed college students between the ages of 18 and 20 and discovered that over half of the participants had inaccurate perceptions of safer sex. They believed they had practiced safe sex when they had not. Also, they reported that over half of the sexual encounters were unplanned, increasing the risk for unprotected sex. Reports of multiple partners, inconsistent condom use, and drug and alcohol use during sex were consistent findings among older adolescents. Nevertheless, the adolescents claimed that they felt assertive, in control of the sexual situation, and were aware of the risk of substance use causing impaired judgment (Roberts & Kennedy, 2006). In a study of older adolescents' risky sexual encounters, emotion was implicated as a contributing factor (Von Sadovszky, Vahey, McKinney, & Keller, 2006). Even after acknowledging risky sex (as defined in the study as intercourse without a condom), 55% of respondents reported positive emotions, which may suggest an underestimation of actual risk. Participants also did not overwhelmingly identify love as the emotion experienced with a partner. Rather, the most frequently reported emotion was gratification of sexual desire or attraction, even among those respondents with a steady partner. Considered together, although available research is limited, there is a consistent pattern, pervasive across age

groups, that suggests the inability to correctly assess risk in sexual situations is a potential contributor to the negative health outcomes of unplanned pregnancy and STIs.

Risk and Protective Factors

A large body of research in the area of adolescent sexual decision making has focused on risk factors and predictors for unsafe sexual behavior. Because the focus of the researchers was primarily on delaying sexual activity, younger adolescents were targeted as the sample populations. Results revealed multiple risk factors that included having intercourse with a partner to feel important or cared about, lack of parental supervision, and other multiple problem behaviors such as alcohol and marijuana use as well as smoking (Garwick, Nerdahl, Banken, Muenzenberger-Bretl, & Sieving, 2004; Howard & Wang, 2005; Wu et al., 2005). Additionally, researchers have linked sensation seeking behaviors with impulsive adolescent decision making (Donohew, Zimmerman, Cupp, Novak, Colon, & Abell, 2000). Among a large sample of almost 3000 9th grade high school students, high levels of sensation seeking activities (i.e. thrill seeking) were strongly correlated to impulsive sexual decision making, including having sex under pressure from a partner or under the impairment of drugs or alcohol.

Peer influence on risky sexual decision making was investigated by Gardner and Steinberg (2005). These authors found that adolescents tended to take more risks, make more risky decisions, and evaluate risk behavior more positively when they were with peers than when they were alone. Results also indicated that peer influence varied by age. Risky decision making was more pronounced in middle (13-16) to late (18-22) adolescence than in adulthood (24 and older) indicating that compared to adults, adolescents were more susceptible to peer influence regarding risky behaviors.

Protective factors for healthy decision making among younger adolescents included increased ability to recognize partner motives, better overall decision making skills, and increased expectations for healthy relationships (Garwick et al., 2004). Although these investigators identified protective factors, their work did not reveal how adolescents acquired these specific factors or how long they last. Given that adolescents are oriented to the present, it is possible that protective factors for healthy decision making may be a temporary phenomenon.

Although many investigators have found that there was a correlation between high sexual risk and other health risks for younger adolescents, older adolescents were not included, and therefore it is not known if risk or protective factors for younger adolescents can be extended to older adolescents. It is important to recognize that problem behaviors in younger adolescence may correlate with learned patterns of risky sexual activity that continue into later adolescence.

Perceived Relationship Safety

The concept of perceived relationship safety has also been examined as an influence on sexual decision making of younger adolescents. In a large sample of over 1,000 adolescents seventeen years old and younger, two fifths of the respondents reported initiating sex within one month of the dating relationship, and these relationships were not universally monogamous. Almost half of the participants reported seeing someone else in addition to their steady partner or reported that they believed their partner was seeing someone else. Reported condom use for this group was low, indicating that the youths may have believed they were in “safe” relationships because of a familiarity with their dating partners (Manning, Giordano, & Longmore, 2006). Adolescents who

presume they are in a mutually monogamous relationship often underestimate their own risk of STIs due to discrepancies between perceptions of sex partner concurrency and partner self-reports of behavior (Lenoir, Adler, Borzekowski, Tschann, & Ellen, 2006). The concept of relationship safety as a determinate of condom use with both casual and main partners has also been investigated, revealing that adolescents used condoms only half of the time with casual partners and only one third of the time with main partners, indicating that the teens may have overestimated the safety of the relationship (Lescano, Vazquez, Brown, Litvin, & Pugatch, 2006), or possibly had a false sense of invulnerability that is typical of this developmental level in adolescence.

Related Findings

Other researchers studying adolescent sexual decision making have revealed a variety of different findings. Zwane, Mngadi, and Nxumalo (2004) involved adolescents between the ages of 13 and 19 in focus group discussions to examine sexual decision making within this population. Findings indicated that individual decision making was swayed in the direction of the social norm, with adolescents indicating that they were influenced by peers to engage in sexual activity. Decision making regarding initiating early sexual activity was the focus of research by Michels, Kropp, Eyre, and Halpern-Felsher (2005). Using a grounded theory design, they interviewed a sample of 42 9th graders. Participants reported that relationship quality and personal characteristics of their partner coupled with opportunity to engage in intercourse (unsupervised time alone) primarily influenced their decisions. This type of response is consistent with concrete thinking of early adolescence. Additional evidence of the present-focused, concrete thinking of adolescence, Cohen, Farley, Taylor, Martin, and Schuster (2002) reported that

opportunity for intercourse was a significant determinant of the decision to engage in sexual activity. In their study, sexual activity in younger adolescents took place after school in their own homes, prior to parents returning home from work. Adolescents with less parental supervision and significant periods of unregulated time alone with partners were more likely to be sexually active and have a greater number of sexual partners.

Differing results from investigators reporting on studies examining adolescents' decision making to engage in sexual activity have been reported with older adolescents. College age females reported that perceived behavioral control and positive past sexual experience were the most important predictors of decision making about whether or not to engage in sexual behaviors (McCabe & Killackey, 2004). These results would seem to indicate a progression toward more formal, abstract thinking. However, these findings were not universal, as other investigators reported opposite results from studies with college age adolescents. Von Sadovszky, Keller, Vahey, McKinney, Powwattana, and Pornchiakate (2003) discovered that among a small sample of 18-20 year old adolescents, the factors most associated with riskier sexual behaviors included a physically attractive partner, a comfortable atmosphere, and a steady relationship. When viewed together, the conflicting results reported from studies of sexual decision making in adolescence suggest that there is still wide variation in the decision making skills evidenced in the younger and older adolescent population. This observation has been supported by neuroscience researchers who have indicated that cognitive processes and frontal lobe brain development do not fully mature until young adulthood (Sowell et al., 1999).

Coital Debut

Researchers' interest in the area of coital debut (first intercourse) has increased secondary to public health concerns about the potential consequences of early sexual activity and has been focused primarily on younger adolescents. A body of existing literature revealed that initiation of intercourse during early adolescence was associated with a significant increase in the number of lifetime sexual partners and subsequently higher rates of STIs and unintended pregnancies (Coker, Richer, Valois, McKeown, Garrison, & Vincent, 1994; Henshaw, 1997; Kaestle, Halpern, Miller, & Ford, 2005; Williams, Frank, Ilegbodu, Sangi-Haghpeykar, Corboy, & Poindexter, 1997). Negative consequences of contracting a STI during adolescence may continue into adulthood and manifest as pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and/or preterm birth (Moodley & Sturm, 2000). Developmentally, adolescent thinking is oriented in the present and therefore most adolescents are unable to consider that there may be future consequences from current behaviors.

Seasonal Effect

Seasonal patterns have been explored as contributing to sexual onset among adolescents. Coital seasonality has been previously linked to peaks in both warm summer months (Rogers, Harris, & Vickers, 1992) and during the winter season (Seiver, 1985). More recently, the relational context of coital debut has been linked to seasonal patterns of adolescent sexual activity (Levin, Xu, & Bartkowski, 2002). The specific quality of the partner relationships appeared to have an influence on coital debut timing. Summertime sexual activity (summer vacation effect) tended to be casual, nonromantic and associated with seasonal activities and free and potentially unsupervised time during summer

vacation. Christmas time coital debuts (holiday season effect) were disproportionately associated with adolescents who reported being involved in a romantic relationship (Levin et al., 2002). These results supported earlier research that suggested romantic interpersonal contexts of sexual behavior are important influences on the sexual timetables of adolescents (Feldman, Turner, & Araujo, 1999).

Parental Influences

The influence of family psychosocial and behavioral factors on adolescent coital debut has been explored. In a secondary analysis of over 2000 ninth and tenth grade high school students, Watts and Nagy (2000) found that the most significant protective factor for delaying the onset of sexual activity included an intact two-parent family. Regardless of race or gender, younger adolescents (<15 years) who perceived greater parental and peer disapproval of sex were more likely to delay first intercourse. Overall, findings indicated that living with both parents appeared to be the strongest protective factor for positive attitudes toward delaying coitus. Also, adolescent females who indicated they had a close relationship with their fathers were less likely to report early intercourse compared to girls who reported less positive paternal relationships (Regnerus & Luchies, 2006).

Peer Influences

In addition to parental factors, peer influence has been consistently linked to adolescent sexual activity. Adolescents who are highly involved in peer relationships may be influenced by a social context that encourages romantic dating relationships (Connolly, Furman, & Konarski, 2000). Researchers had indicated that adolescents who began dating relationships at a younger age and those whose dating partners were older

reported beginning sexual activity earlier than their peers who were less romantically involved (Marin, Kirby, Hudes, Coyle, & Gomez, 2006). The timing of adolescent coital debut has been influenced by the norms for early sexual behavior among groups of friends, and linked to first intercourse during middle adolescence (Sieving, Eisenberg, Pettingell, & Skay, 2006). Although peers can be influential in beginning intercourse, normative peer behavior can also support delaying sexual behavior. When peer norms included refraining from sexual activity, these relationships became a protective factor for early coital debut (Santelli, Kaiser, Hirsch, Radosh, Simkin, & Middlestadt, 2004). Among peers who participated in virginity pledges as the norm, Brucker and Bearman (2005) indicated that pledgers experienced first sex later in adolescence than peers who did not pledge.

Personal Values and Cognitive Factors

Factors specific to individual adolescents have also been investigated in relation to timing of coital debut. Researchers have demonstrated that adolescents who were cognitively susceptible to initiating intercourse could be distinguished from those who delayed intercourse by a combination of factors that included more fully developed physical maturity, increased sexual feelings, greater confidence in sexual relationships, and perceptions that their peers were engaging in sexual activity (L'Engle, Jackson, & Brown, 2006). These susceptible adolescents also reported fewer positive connections to their parents, school, and church. Research by Cotton et al. (2004) supports these findings. When adolescents were surveyed regarding their perceptions of the timing of their first intercourse, 78% reported they had been too young. Those who did not have

positive feelings about their coital debut were also more likely to report less parental support of education and less parental supervision.

In contrast, when abstinence was considered a personal value, adolescents were more likely to delay intercourse (DiIorio, Dudley, Kelly, Soet, Mbware, & Potter, 2001; Paradise et al., 2001). This finding was consistent with that of earlier researchers who demonstrated that female adolescents who reported delaying coital debut cited religious or moral beliefs as their reason for abstinence (Moore, Driscoll, & Lindberg, 1998). (Rostosky, Regnerus, and Wright (2003) found that religiosity reduced the likelihood of coital debut among both male and female adolescents who stated that religious beliefs and anticipated negative consequences of engaging in sexual intercourse were their reasons for abstinence.

Sources of Sexual Information

How adolescents make decisions regarding sexual activity is related to not only growth, development, and the processing of information, but also to the quantity, quality, and sources of the sexual information. It is clear that adolescents receive information about sexual activity from a variety of sources. A significant problem is that much of this information is contradictory. This conflicting information, coupled with incomplete cognitive development, may leave adolescents ill-prepared to make responsible decisions. I will use an ecological perspective to examine the multiple layers involved in the acquisition of adolescent sexual information.

Parents

Aquilina and Bragadottir (2000) demonstrated that adolescents frequently want parental guidance for sexual decision making. Due to the fact that most parents do not

want their children to be sexually active prior to adulthood, these parents tend to assume their children are not involved in sexual behavior and delay communicating important information to them (Weiss, 2007). Although communication between adolescents and parents may be delayed, there is a body of research that suggests this communication is an essential component in the development of more responsible and safer adolescent sexual behavior.

Compared with peers who lack sexual communication with parents, adolescents who maintain open communication with parents are less likely to be sexually active (DiIorio, Kelley, & Hockenberry-Eaton, 1999; DiIorio, et al., 2000), have fewer sexual partners, and use condoms more frequently (Holtzman & Rubinson, 1995). Adolescents who frequently discuss sex with their parents are more receptive to adopting their parents' beliefs and values regarding sexual behavior (Dittus, Jaccard, & Gordon, 1999) and those adolescents who feel comfortable discussing sexual activity with their parents are more likely to delay intercourse (Guzman, Schlehofer-Sutton, Villanueva, Stritto, Casad, & Feria, 2003).

In addition to the importance of communication, parents have an important role as the providers of sexual information. Although Rosenthal and Feldman (1999) found that college-aged adolescents did not identify their parents to be important sources of sexual information, work with mid-range adolescents (aged 15-18) revealed different findings. In a sample of 672 high school adolescents, Somers and Surmann (2004) found that parents were overwhelmingly preferred as the primary providers of sex education over information from peers and school-based education programs. The conflicting results between studies most likely represent older adolescents' increasing developmental

independence and establishment of an adult identity beyond that of their parents. Also, the perception of the adolescent is important. Younger adolescents who have less life experiences may view parents as an important source of information compared to older adolescents who have access to larger sources of information and broader social context.

School Based Sexual Information

School based sexual education in the United States is heavily focused on abstinence only information, but much of this information is considered inadequate, incomplete, and/or misleading (Waxman, 2004). There is also question as to the effectiveness of these programs. Researchers studying sex education programs have produced conflicting results about program success. Pledges to remain abstinent until marriage are a typical component of abstinence based education. While adolescents who pledge to abstain from sexual activity appear to delay intercourse, numerous researchers have shown this effect to be only temporary. Most adolescents still engage in sexual activity prior to marriage (Bearman & Brucker, 2001; Bersamin, Walker, Waiters, Gisher, & Grube, 2005; Brucker & Bearman, 2005). Additionally, when pledgers do become sexually active, they are less likely to use condoms (Bersamin et al., 2005).

Abstinence based programs have not been shown to significantly decrease risk-taking behavior (Kirby, Lepore, & Ryan, 2005; Sather & Zinn, 2002). Of particular concern is that in the southeastern United States where abstinence education is emphasized, the rates of adolescent sexual activity, pregnancy, and STIs are among the highest in the country (Weiss, 2007). Although school based sexual information has been shown to increase adolescent knowledge regarding pregnancy and STIs, this has not

translated into improved sexual negotiation skills, communication, and decreased risk behavior (Maynard, et al., 2005).

Peers

An adolescent's peer group can be a significant source of information and modeling behavior. Over the last two decades, friends have consistently been identified as a main source of information regarding sex, especially among adolescents older than fifteen (Sutton, Brown, Wilson, & Klein, 2002). Unfortunately, the relationship between the source of sexual information and subsequent adolescent sexual behavior is not well understood (Berenson, Wu, Breitkopf, & Newman, 2006).

Investigators have focused on the relationship of peer perception of sexual activity or risk for sexual activity. Associating with older peers, peers who engage in risky behavior and peers who are sexually active has been influential in early adolescents participating in sexual activity (DiIorio et al., 2004). Age is also a factor in dating relationships. Dating a partner who is two or more years older increases the chance of sexual activity (Marin et al., 2006).

Friends were listed among the top sources of information about dating and relationships. Of all potential sources of information, adolescents reported that their friends had the most influence on their dating choices even though the mid-adolescents surveyed reported they believed that parents and sex educators had the most reliable information (Wood, Senn, Desmarais, Park, & Verberg, 2002). Consistent with these results, Berenson et al. (2006) found that in a survey of 892 female adolescents between the ages of 15-18, 75% reported discussing sexual activity and/or contraception with their friends. Similarly, results from the National Survey of Adolescents and Young Adults

indicated that 78% of females aged 15-24 indicated friends were their primary source of sexual information (Hoff, Greene, & Davis, 2003).

Mass Media

The mass media are ever-present entities in the lives of adolescents. In the 21st century society, there seems to be an almost limitless amount of media exposure, whether it is television, radio, iPod, computer and Internet, or video games. Adolescents in the United States watch an average of three hours of television each day (Roberts, Foehr, & Rideout, 2005); the majority of viewing occurs outside of parental awareness and supervision (Roberts, 2000). According to Kunkel et al. (2005), in television shows most popular with teens, the average number of scenes with sexual content is 6.7 per hour, which is substantially higher than an industry wide level of 5.0 per hour. In short, risky, sexually enticing, and dramatic behavior makes for exciting television that draws in large numbers of viewers. The potential effect on adolescent sexual activity by establishing behavioral norms is so considerable that the media have been referred to as [a] “sexual super peer”, especially for girls who experience early pubertal development (Brown, Halpern, & L’Engle, 2005). This type of normalization of sexual activity is in direct contrast to the school-based messages of abstinence.

During the late 1980s and continuing into the 1990s, a growing number of researchers began to investigate whether a link exists between watching sexual content on television and the sexual activities and beliefs of viewers. In an early study of 475 undergraduates by Strouse and Buerkel-Rothfuss (1987), the relationship between popular media consumption and the sexual attitudes and behaviors of college students was examined. The findings were reported in terms of gender differences, showing that

females consumed more sexually suggestive media than men, and that Music Television (MTV) viewing was the only media form significantly associated with permissiveness for females. In additional research, Buekel-Rothfuss and Strouse in 1993 revealed that individuals who viewed the greatest amount of sexual content on television perceived a higher frequency of sexual behaviors in the real world. Brown and Newcomer (1991) reported that there was a correlation between watching sexually laden television content and adolescents' early initiation of sexual intercourse. Also in 1991, Peterson, Moore, and Furstenberg examined younger adolescents' sexual television diet and relationship to onset of sexual activity. Although their results were neither strong nor consistent, these researchers found the highest prevalence of sexual activity among males who were heavy television viewers. Bryant and Rockwell (1994) examined potential influences of entertainment media on the moral development of young adolescents between the ages of 13 and 14, and found that adolescents who watched sexual content on television had less negative views toward casual sexual encounters and more permissive attitudes toward sexual behavior.

Since 2000, a significant number of researchers have focused on exposure to sexual media content as a predictor of sexual activity. In a longitudinal survey of 1017 adolescents between the ages of 12-14, Brown, L'Engle, Pardun, Guo, Kenneavy and Jackson (2006), found that exposure to sexual content in music, movies, television, and magazines accelerated the sexual activity of Caucasian adolescents and increased the risk of engaging in early intercourse. Similar results were noted by Collins et al. (2004) in a national longitudinal survey of 1762 adolescents between the ages of 12-17. These investigators found that adolescent virgins who viewed more sexual media at baseline

were more likely to initiate intercourse within the next year as compared to those who viewed the lowest amounts of sexual content. Somers and Tynan (2006) surveyed a random sample of 473 adolescents between the ages of 12-19. Results varied by age and gender. For Caucasians, older age and exposure to sexual content predicted more sexual activity and a greater number of sexual partners. Sexual content significantly predicted frequency of oral sex and intercourse for males, and more liberal attitudes toward premarital sex for females.

L'Engle, Brown, and Kenneavy (2006) showed a consistent and significant association between media influence and early adolescents' sexual intentions and behaviors. Results from their survey questionnaires distributed to 1011 adolescents aged 12-15 revealed that media influences accounted for 13% of the variance in intentions to have intercourse in the near future. Media predicted more variance in sexual intentions than both singular factors of religion and school. Intention to engage in sex was also a finding from a study in which Pardun, L'Engle, and Brown (2005) examined outcomes of exposure to sexual media. These researchers randomly sampled 1074 adolescents between the ages of 12-15. They found that consumption of sexual content in a variety of media showed a positive association between sexual activity and intent to become sexually active.

Additional investigators have focused on how sexual media content influences adolescents' attitudes toward sexual activity and behavior. Brown et al. (2005) investigated the effects of mass media on girls experiencing early pubertal development. Their results indicated a consistent relationship between earlier pubertal timing and greater interest in sexual media content, which suggested that media were a factor in

adolescent girls' sexual socialization. Ward and Friedman (2006) used a correlational and experimental methodology to investigate the associations between television viewing and adolescents' attitudes and behaviors. In their purposeful sample of 244 high school students, television viewing emerged as a significant correlate of sexual activity. Respondents also had more permissive sexual attitudes and identified sex as a recreational activity.

Similar results were also found in a larger and slightly earlier study by Martino, Collins, Kanouse, Elliott, and Berry (2005). These researchers used multi-group structural equation modeling to investigate how social cognitive process mediates the relationship between exposure to sexual content on television and adolescents' sexual behavior. In an ethnically diverse sample of 1290 adolescents ages 12-17, viewing sex on television was associated with less negative expectations about the potential consequences of intercourse. Liberal attitudes toward sex after watching sexual television content also emerged as a common theme among an older adolescent population in a study of 188 college undergraduates between the ages of 18-26 in an investigation by Taylor (2005). Study participants who perceived sexual content on television to be realistic were more likely to have permissive attitudes toward sex and be more accepting of sex in relationships characterized by less mutual commitment.

In contrast to the above studies, Werner-Wilson, Fitzharris, and Morrissey (2004) found significant differences between adolescent and parental perceptions of media influence on sexuality. Using focus group interviews with 8 girls and 6 boys, ages 15 and 16, these investigators reported that media were rarely discussed as influences on sexual

activity in the adolescent focus groups, although parents expressed concern and believed teens to be passive recipients of media messages.

The issue of sexual content in popular music is also emerging as an area of concern, although very few researchers have specifically addressed this topic. Over two decades ago, Wells and Hakanen (1991) discovered that music served as a powerful communication medium for high school teenagers, who used music as a tool to manage emotions. This finding was later supported by Larson (1995) who found that adolescents spent a significant amount of time alone in their rooms, listening to music as a way to cope and work through relationship issues that are characteristic of adolescence. Further exploration into the sexual content of songs revealed that there had been a continual increase in the sexual explicitness of the lyrics in popular music during the previous five decades (Strasburger, 1995; Christenson & Roberts, 1998).

Recently, researchers have looked directly at the relationship between music content and sexual activity. Pardun, L'Engle and Brown (2005) investigated the association between exposure to sexual content in music and adolescent's sexual intentions. Using a large sample (n=1074) of young adolescents between 12 and 15, the researchers questioned them about their popular music choices and their current level of sexual activity and future intentions regarding sex. Although Pardun, L'Engle and Brown found that adolescents who reported listening to music that contained references to sexual behavior and romantic relationships had the highest levels of sexual activity and future anticipation of sex, these researchers also hypothesized that sexually active adolescents chose to listen to more sexually charged lyrics.

Martino, Collins, Elliott, Strachman, Kanouse, and Berry (2006) also investigated the relationship between sexual song lyrics and adolescent sexual activity. These researchers conducted a national longitudinal telephone survey of 1461 adolescents between the ages of 12 to 17 years to determine the association between the content of music lyrics and subsequent changes in sexual experience. They found that adolescents who listened to music containing degrading sexual lyrics progressed more quickly in their sexual behaviors than their peers who did not listen to degrading and objectifying lyrics.

Conclusion

Beginning with the onset of puberty, adolescence extends beyond the second decade of life and ends with the transition to adult roles. It is the developmental stage that encompasses much physical, emotional, and cognitive growth, the rates of which will vary greatly from individual to individual. It is during this time period that many adolescents begin sexual activity; almost half of all U. S. teenagers reported being sexually active by the time they left high school (CDC, 2006), the results of which are represented in national statistics. One in two sexually active adolescents will contract an STI by age 25 (American Social Health Association, 2005) and the United States has the highest teenage pregnancy rate of any developed country (Alan Guttmacher Institute, 2006).

A critical issue for today's 21st century youth is developing a healthy understanding of their sexuality, and the United States Surgeon General has labeled this challenge as one of the nation's leading public health concerns (Office of the Surgeon General, 2001). Knowledge that is acquired and processed in the formative years of adolescence may provide the foundation for values and beliefs about sexual activity and

sexual norms that extends far into adulthood and shapes life long health behavior.

Adolescents often have a difficult time determining who they are and how they want to behave sexually, and this puts them at significant risk for negative outcomes such as pregnancy and STIs. This risk is heightened by immersion in a complex social environment that at best provides mixed messages, and at worst promotes unhealthy sexual attitudes and behaviors (Brown, Steele, & Walsh-Childers, 2002).

A thorough, comprehensive understanding of adolescent growth and development is fundamental to understanding adolescent behavior. Prevailing theories in this area posit that younger adolescence is dominated by concrete, present-oriented thinking lacking consideration of potential consequences of behavior. Abstract and futuristic thinking develops during later adolescence and early adulthood, although some individuals may never reach this level of formal cognition (Inhelder & Piaget, 1958). Egocentric behavior, feelings of invulnerability (Elkind, 1967), formation of an individual identity beyond that of parents (Erikson, 1980), expansion of cognition to incorporate complex information (Perry, 1999), and the ability to make meaning from experiences (Marcia, 1989) are all hallmarks of adolescent development.

In addition to developmental theories, neurologic researchers have demonstrated that adolescent brain development is an ongoing process with myelination in the frontal cortex and regulation of emotion continuing into young adulthood (Sowell et al., 1999). There is evidence of a disconnect between increased arousal and emotion brought on by puberty and the development of regulatory competence to manage these emotions. Therefore, acknowledging the existence of gaps between emotion, cognition, and behavior is fundamental to understanding the effect of developmental time on difference

in judgment, risk-taking, decision making, and sensation seeking behaviors (Steinberg, 2004).

Existing decision making theories, although helpful in providing an overall framework for the complicated process of judgment and choice, are of limited usefulness with the adolescent population. As a whole, theories of decision making have been formulated using an adult population, and do not relate well to the incomplete, transitional thinking of adolescence. They include underlying assumptions of mature cognition and communication skills (Patel et al., 2002) and the ability to make logical and correct judgments (Gutnik et al., 2006). Theorists addressing emotion (Gutnik et al., 2006) and stress (Janis & Mann, 1977) have posited that decisions are negatively affected when either of these two emotions are elevated, a common occurrence in adolescence. Additionally, when compared with adults, adolescents consider options differently, identify different consequences, and place different values on consequences (Furby & Beyth-Marom, 1992), all important factors in successful decision making.

This review of the literature has revealed major categories that are integral to an understanding of adolescent sexual decision making. These categories include: 1) cognitive ability, problem solving, and self-concept; 2) misperceived risk; 3) risk and protective factors; 4) perceived relationship safety; and 5) a category of related findings that includes social norms, personal characteristics of partners, and opportunity. Narrowing the concept of decision making to adolescent sexual decision making about coital debut encompasses the personal, parental, and peer influences in addition to the effect of seasonal timing. Sexual decision making is also influenced by the sources of sexual information, including parents, peers, school, and the media. Many times these

sources provide conflicting information that complicates the decision making process and adolescents need to sort out what is correct and applicable to their own needs.

Adolescence often is the genesis for the developmental roots of lifetime behaviors. The trajectories set in adolescence can have a positive or negative impact in later life. Therefore, providing information, role models, and supports that focus on responsible decisions and behaviors should theoretically have positive results. However, not all adolescents will be able to benefit from these inputs. While many adolescents navigate this stage well and manage without difficulty, others will exhibit emotionally laden, reckless behavior and impulsive decision making (Dahl, 2004). Development into a responsible adult requires attaining self control over actions and emotions that regulate behavior to avoid negative consequences.

Although various sources have been identified as contributing to adolescent coital debut and subsequent sexual activity, there are no investigators whose work in the literature have asked the adolescent to tell his/her story, to share memories and perceptions of events contributing to sexual decision making. The apparent gap in the literature is the first-hand account from the sexually active adolescent enumerating his/her primary sources of influence for engaging in sexual activity.

CHAPTER 3

Methodology for the Study

Introduction and Rationale

Through a review of the literature related to adolescent sexual decision making, I have recognized that this is a complex phenomenon with multiple contributing factors. The gap in the extant literature is the absence of the adolescents' perspective related to the process of sexual decision making. In this study, I addressed that gap. Through the use of narrative inquiry, I explored the factors that influence the sexual decision making of adolescents from coital debut (first intercourse) through their current thinking. The aim of the study was to explore adolescents' stories about their sexual decision making to facilitate or support understanding of this complex phenomenon. The following research questions guided the study:

1. What are late adolescents' perceptions of personal, interpersonal, social and environmental factors that influenced their decision to become and remain sexually active?
2. What is the effect of sexual decision making regarding coital debut on subsequent sexual activity?

My interest in these questions came from my clinical work as a women's health nurse practitioner. My patient population is almost entirely comprised of mid to late adolescents, aged 15-22 years, who are seeking either family planning services or screening and treatment for sexually transmitted infections (STIs). Many have been sexually active for more than a year prior to requesting contraception and reproductive health care. Understanding how adolescents arrive at their decision to become and remain

sexually active will provide the foundation from which to formulate specific educational strategies aimed at effectively informing adolescents about their choices, concerns, and potential risk factors associated with sexual activity. A developmentally appropriate understanding about adolescents' decision making and their perception of the factors that influenced their sexual debut constituted the gap in the literature and the rationale for the study. The findings from this study will advance knowledge for practice by assisting clinicians working in this area of health care to develop, refine, and implement sexual risk-reduction interventions. Additionally, the results from this small study will serve as the groundwork for my future program of research in which I plan to focus on effective educational strategies for reducing adolescent sex-related risky behaviors. In the remaining portion of this chapter, I will review the method of narrative inquiry, discuss the rationale for selecting this method for my study, and describe the process of data collection and analysis.

Narrative Inquiry

Narrative inquiry rests on the epistemological assumption that individuals make sense of their experiences by organizing the story structures (Bell, 2002). The overall purpose of narrative research is to discover the details of life events and why the events occurred as they did (Parse, 2001). To engage in narrative inquiry, the researcher uses the collection of stories as the source of data (Duffy, 2007) and examines the personal accounts of individuals' motives, experiences, and interpretations of their actions (Holloway & Freshwater, 2007). According to Sandelowski (1991), narrative inquiry can provide insight into the way human beings understand their lives and reveal how participants explain their situations and construct life events. Considered a social process,

the storytelling of narrative inquiry gives participants the power to define their own identities and experiences rather than having their reality shaped by the researcher. Through first person narratives, the researcher is able to gain insight into the ways in which individuals construct their worlds. The environment becomes the filter through which individuals perceive and attach meaning to their experiences and become active agents in building their perceptions of social reality (Holloway & Freshwater, 2007).

Contemporary narrative inquiry can be characterized as an amalgam of multiple disciplinary lenses, diverse approaches, and traditional and innovative methods that all revolve around an interest in biographical particulars that are narrated by the ones who live them (Chase, 2005). According to Chase, narrative is retrospective meaning making that shapes and orders past experiences. Narration is part of human nature, and individuals have a natural desire to share stories of experiences and communicate how those experiences have affected them. Knowledge acquired through narratives encapsulates human emotion and helps to explain why individuals behave as they do. Through storytelling, individuals are able to organize and connect disparate parts of their experiences into an integrated whole (Holloway & Freshwater, 2007). Additionally, narrative is a way of understanding the actions of others; connecting and seeing the consequences of actions and events over time (Chase, 2005).

I chose narrative inquiry as the research method for this study because it addresses the gap in the literature, that is, the absence of first hand accounts of the adolescents' decision making process related to sexual activity. Only a limited number of studies exist that focus on the sexual decision making process of adolescents, and these do not provide a clear and detailed description of the phenomenon. Therefore, this study

was necessary to capture the context and participants' frames of reference that contributed to their coital debut decision making. Using narrative inquiry encouraged individual participants to reflect on their decisions about sexual activity, tell their stories, and make meaning of their experiences. This method provided me the opportunity to elicit in depth descriptions and develop an understanding of a complex phenomenon from the viewpoint of the adolescents who have experienced it. From this perspective, the narratives recorded during this research were significant because they embodied and gave insight into adolescent decision making about sexual activity within specific social contexts. This perspective is not currently represented in the literature and is necessary prior to designing relevant interventions for the adolescent population.

Sampling and Recruitment

Once thought of as a single developmental stage, adolescence is now viewed as having three stages: early (11-14 years), middle (15-17 years), and late (18-22 years) (Gutgesell & Payne, 2004). The target population for this study was male and female late adolescents between eighteen and twenty-two years of age. All other age groups were excluded. Late adolescents were the target population because developmentally this age group has the ability to think reflectively and abstractly and to evaluate information in relation to the context in which it occurred (Inhelder & Piaget, 1958; King & Kitchener, 2004). These behavioral and cognitive skills were essential to their ability to narrate their stories and evaluate their decision making process. Because I am interested in adolescents' perceptions of factors that influenced their sexual decision making process, only adolescents who were sexually active were considered for inclusion. Inclusion was limited to study participants who were able to read, speak, and understand English as this

is the only language I am sufficiently fluent in to ensure accurate interviews and transcriptions.

The sample was drawn from clients who use a family planning and sexually transmitted infection (STI) clinic that has locations in four different cities in the Northeast United States. The geographical boundary was set at a fifty mile radius from each clinic. All four clinic locations were used to avoid a completely homogeneous population and allow for the inclusion of different socioeconomic, ethnic, educational, and employment characteristics of the population. The four clinics have a combined volume of approximately 800 clients per month, and represent the following different characteristics and socioeconomic groups: Caucasian, Hispanic/Latino, African American, high school and college students, laborers, service workers, and those who are unemployed.

Recruitment strategies included both purposive and snowball sampling techniques. I used a combination of both techniques to increase recruitment of participants and expand potential participants' awareness of the study. Purposive sampling in qualitative research limits the sample to the experts; those who have experienced the phenomenon and therefore are better able to inform the researcher's understanding of the research question. Snowball sampling identifies cases of interest from others who know potential information-rich sources (Creswell, 2007).

This research study included a discussion of personal sexual activity, which could be considered uncomfortable by some, thus causing reluctance to participate. Participants were informed that participation was voluntary and they could decline to answer any

question(s) that they chose. To make participants feel more at ease, they picked the time and location of the interview.

I first obtained Boston College Institutional Review Board (IRB) approval as well as a written letter of approval from the participating agency (Appendix A). Next I posted flyers that briefly described the study purpose, target population, and contact information for the researcher. These flyers were placed in the four participating clinics in the following areas: waiting room, reception area, lab area, exam rooms, and bathrooms. The flyers had my contact information identifying me as the researcher on tear-off strips that participants could take and save until they wanted or were ready to contact me (Appendix B). Prior to the start of the study, I conducted an in-service session at each clinic to inform the clinic staff of the study purpose and inclusion criteria. Although they did not participate in direct recruitment, clinic staff had knowledge of the study and were able to inform clients that the study was occurring. They were able to direct interested participants to my contact information that was posted on the flyers. Remuneration in the form of a \$25 iTunes® gift card was given to each study participant for her/his time at the completion of the interview.

Sampling in qualitative research is an evolving process because data collection and analysis occur simultaneously. Decisions regarding sample size are not straightforward and need to remain flexible. For this study, sampling continued until saturation was evident and new data did not provide any unique insights related to the research questions and study aims. To be certain that there were no new categories and the relationships between and among data in existing categories were clear I enrolled additional participants after I had reached data saturation. I also had a participant whose

story provided a negative case. I examined this case thoroughly, thus ensuring that there were no additional data that needed to be explored to inform the study.

Based upon sampling and data analysis criteria set forth by Sandelowski (1991), the final sample size for this study was 11. By the seventh interview, it was becoming evident that the adolescents were describing similar and recurring events. Interviews eight through 10 confirmed the existing categories, and did not contain information that contributed to new relationships in the data. The last interview was the negative case. This participant told a different account of her decision to become sexually active. Although she did not experience the specific situations that other participants reported as influential, the details of her narrative supported the storyline set forth in previous interviews.

Protection of Human Subjects

Prior to conducting the study, I obtained permission from the IRB at Boston College and the participating agency. I fully explained the study to each participant and encouraged each participant to ask questions prior to the interview. I explained to the participants that participation was voluntary and that they could withdraw from the study or stop the interview at any time without retribution. I also explained that the interview was separate from their health care and neither participation in nor withdrawal from the study would affect the health care they received from the participating agency. I obtained written informed consent prior to the start of the interview, and gave participants a copy of the consent form for their records (Appendix C). After consenting, participants were asked to complete a short demographic questionnaire (Appendix D).

My role as a women's health nurse practitioner working with an adolescent population regarding issues related to sexual health was fully disclosed to the participants prior to the interview process. Participants were informed that the information they shared as part of the research study would not become part of their medical records and clinic staff would not have access to information from the interviews. I did not interview any clients for whom I have cared as an advanced practice nurse. Participants were informed that I have completed training in the protection of human subjects in research.

Due to the sensitive nature of the study questions regarding sexual activity, confidentiality was a main concern. Participants were assured that their confidentiality was protected in a number of ways. Participants each picked a pseudonym prior to the start of the interview to provide anonymity. All data were reported as group data with no identifiers that could be linked to any specific participant. All audiotapes and corresponding transcripts referred to participants by their pseudonyms only, thus eliminating any link to their real identities. All study data, including field notes, journals, audiotapes, transcripts, and coding notes were stored in two separate locked file cabinets to which only I had access. Identifiable data were stored separately from deidentified data.

All written study findings and reports were stored on a single password protected computer that only I could access. All data stored on the computer identified participants by their pseudonyms only. A copy of the master list with participants' names, contact information, and their corresponding pseudonyms was stored separately from all other data in a locked file. Although confidentiality was rigorously protected, the participants were informed that as a mandated reporter, I was obligated to disclose reports of on-

going or current child abuse, elder abuse, and/or threats of self-harm or harm to others to the proper legal authorities. All study materials, including original audio recordings, will be kept until the completion of the project and publications from the work and then destroyed.

It was possible that during the story-telling process, participants might have revealed information about past or current risky sexual behaviors and expressed concerns about potential consequences (ie: unplanned pregnancy or STIs). The interview process also could have resulted in emotional distress from discussing potentially sensitive memories or past events. As a researcher, I was not able to address their specific health concerns. However, I had in place a plan for referral to an affordable, confidential clinic that specializes in reproductive and sexual health care that could address their physical and emotional concerns. I arranged for an advanced practice nurse with certification in child and adolescent mental health to be available to respond to participants if they became emotionally distressed or expressed the desire to speak with a health care provider about any emotional issues raised during the interview (Appendices E & F). Participants were assured that I did not have access to records that might contain information about their diagnoses, treatments, or plans of care, and I did not correspond with any health care providers after the initial referral.

Procedure

Potential participants contracted me by phone or email if they were interested in participating in the study. At that initial contact they were informed of the purpose of the study, approximate time commitment, and remuneration. A convenient time and location to conduct the interview was set by the participants, and I traveled to meet them at the

designated locations. During nice weather, some participants opted to conduct the interview outside at a café or local park. Other interviews were conducted on college campuses or in local coffee shops. After introductory conversation and answering of any questions, the participants gave informed consent and the data collection process began. Narrative inquiry consists of an open ended question asking participants to tell their story about the phenomenon of interest. The researcher may ask some follow-up questions or probe for more detail but does not ask additional new questions. The participants were asked to respond to the question “Please tell me, in your own words, the story of your decision to first have sex.” Probing questions were used for clarity and depth. Some of these questions included asking participants to clarify or elaborate on previous statements. I constructed an interview guide prior to each interview consisting of the broad opening question and a sample of probing questions that could be used to elicit further information if needed (Appendix G). Interviews ranged from 30-60 minutes in length.

Interviews were audiotape recorded verbatim on a digital tape recorder. I did minimal note taking during the interviews to avoid distraction. I wrote the majority of my field notes immediately after each interview to document characteristics that might not be well represented with an audio recording, such as overall appearance, eye contact, mood, posture, and facial expressions. My reactions to the interview and overall impressions of the dialogue were also documented in a reflective journal. This journal contained my thoughts about the interview process, insights about a participant’s behavior or story, and ideas for questions that might be useful probes in subsequent interviews. The field notes and journal entries were included in the data analysis detailed below.

Preparation of Data and Analysis

Prior to engaging in data analysis, I made a conscious effort to bracket my clinical work as a women's health nurse practitioner and my experiences with sexually active adolescents. This meant that I acknowledged and set aside my assumptions and personal values and beliefs in order to have a fresh perspective and allow the data to speak to me. Laying aside my personal orientations and clinical experiences with the adolescent population decreased bias that might have resulted from my years of experience in the area of adolescent sexual health.

At the conclusion of each interview, I prepared the data for analysis using the following steps. I transcribed the audio-tapes verbatim onto a personal computer that was access protected. I created a back-up copy of the transcript onto a password protected flash drive that was designated for only this study. The resulting transcript was then printed and stored separately from any identified data. I double checked each interview transcript by listening to the original audio recording while reading the transcript. This ensured accurate representation of the data.

Data for analysis consisted of the printed transcripts, my reflective journal, and field notes from each interview. I reviewed prior interviews before each session with a new participant and adjusted potential probing questions as necessary. I conducted only one interview per week to ensure that I had enough time to transcribe and review the previous interview before beginning a new one.

Beginning with the first interview, I read each transcript carefully and thoughtfully. I analyzed the field notes and entries from my reflective journal that corresponded to each interview simultaneously with the transcripts as part of the raw

data. For example, when I was reading Lydia's transcript and the field notes that went with her interview, I noticed that I had documented that she wore a button on her backpack that said "Got Consent?" Lydia, who appeared confident and at ease with the interview process, spoke passionately about empowered sexual decision making and sexual assault. I wondered if the button was something that was always present or if she wore it specifically for the interview, and I reflected on what she was attempting to convey.

In addition to analyzing the field notes and journal entries, I read each transcript multiple times to gain an overall view of adolescent thinking. This allowed me to begin to understand the sexual decision making process of adolescents. During this process, I was totally immersed in the data. As I allowed the data to "talk to me," I was able to picture each interview and reflect on questions such as "What is this adolescent telling me?" "What is the story she is trying to communicate?" and "Why is this story important?"

Through in-depth reading of the transcripts, I realized that the stories of the adolescents were not linear. Although each participant began her or his story with the decision to become sexually active for the first time, remaining parts of the story telling were not in chronological order. The discussion of certain events and activities triggered memories of previous decision making, and the adolescents moved back and forth through past and present events as they told their stories. Recognizing this non-linear interweaving characterized each interview, I made the decision to arrange each story in chronological order to represent a beginning, middle, and end for each adolescent's decision making process.

This decision was consistent with the process of narrative analysis described by Riessman (2006). According to Riessman (2006), narrative analysis is the method that is used

to analyze text that occurs in storied form, with plot sequences that are ordered, connected and meaningful. Through the use of narrative analysis, nuances are constructed within the context of the participant's story, and the chronological order of events determines the "plot" of the narrative. This analysis allowed me to explain how subtexts were constructed within the context of the participant's story, and focused on the way in which the story was put together. This process allowed me to identify elements that were found in the text, including an introduction, orientation, complicating actions, an evaluation and a potential resolution. This sequential, temporal order of events determined the "plot" of the narrative, and representation of the story resulted from this plot (Holloway & Freshwater, 2007).

In addition to the narrative analysis that ordered the story into a sequential plot, I wanted to learn more about what constituted the plot. To do this I used content analysis as a method of further data analysis. After immersion in the data through multiple readings and reflection, I began the process of coding the data. I went through the first transcript and highlighted sentences, phrases, and words that were consistently repeated by the adolescent. I followed this process for each successive transcript. During this first level of *in vivo* coding, I used words directly from the adolescents to give sections of the transcripts an initial label that helped me to organize the data. I made notes and comments in the margins of the transcripts to help me focus on what seemed to be important aspects of the adolescents' stories. These notes also helped guide my early thoughts about the data and often generated more questions that I might investigate in the future. I repeated this initial process of coding the data for each transcript.

After completing initial general coding on each transcript, I used across document analysis to compare similarities and differences between each section of data. Next I analyzed

units of *in vivo* coding together from all transcripts to form initial broad categories that began to describe aspects of adolescent sexual decision-making. Within each of these categories, I identified similar patterns of adolescent thinking and behavior that helped to explain the relationships among the data. Although categories were still broad, at this point in the analysis these patterns helped tell the story of adolescent sexual decision making at a preliminary albeit vague level.

As I reflected on the story that was emerging and what the data were saying, I clustered similar codes within the broad category into smaller subcategories and gave them a descriptive general label to represent the overall idea of the subcategory. These labeled, smaller subcategories helped me focus my thinking as I reflected on the question “What is the story here?” Through multiple readings of the transcripts, labeling, coding, recoding, and reorganizing the data, I was able to winnow the data into final concepts that contributed to the conceptual understanding of adolescent sexual decision making. These final concepts comprised the four distinct components that helped to tell the story of sexual decision making from the perspective of the adolescents. The narratives generated from the analysis of this study were grounded in actual data and reflected the participants’ unique perspectives, without contamination of preconceived theory or a priori conclusions.

The coding of the narratives is represented in Table 3.1. The interviews were informative and conducted with relative ease. Participants seemed interested and eager to be part of the study, and many remarked that it was an “important topic”. When I asked participants the broad opening question “Please tell me, in your own words, the story of your decision to first have sex” they took me back to a precise place in time that held significance for them. Each story started with a description of how old the participant was at coital debut

and the events that surrounded the decision to engage in sexual activity. These adolescents were able to recall specific details about whom they were with and how the relationship formed. Mary discussed starting to have oral sex at age 16 to “impress . . . a male friend who wasn’t interested”. Marren reminisced about growing up in a small, religiously conservative town. Although she had been instructed to abstain from sexual activity until marriage, she began her story by stating “in the back of my mind I always believed that was just really not probably true for me personally.”

Table 3.1 Sample of Coding Process

In vivo units of major content	Categories	Descriptive patterns of responses
<p>“It was time for me to try it”</p> <p>“Is like anyone around this night?”</p> <p>“I don’t know how people go to college and not end up having sex”</p> <p>“He was older and experienced”</p> <p>“Definitely alcohol”</p> <p>“The freedom of what happens when you do go to college”</p>	<p>Curiosity</p> <p>Supervision/time</p> <p>Partners</p>	<p>Environmental Context</p>
<p>“A story I want to be able to tell”</p> <p>“Crazy random hook-ups”</p> <p>“Just what the societal standard is”</p> <p>“Very . . . sex-oriented type of relationship”</p> <p>“No one is worth getting pregnant for”</p> <p>“I didn’t use condoms as much as I should have”</p>	<p>Reflecting Society</p> <p>Relationships</p> <p>Caution</p>	<p>Expected Social Norms</p>
<p>“People don’t ask before they have sex with someone”</p> <p>“Just went along with it”</p> <p>“I couldn’t think of another way out of the situation”</p> <p>“Really not even a decision anymore”</p>	<p>Complicated</p> <p>Unavoidable</p> <p>Inevitable</p>	<p>Implied Sexual Consent</p>
<p>“In it for the right reasons”</p> <p>“I just didn’t want to regret it”</p> <p>“I wish someone had told me what to say and when to say it”</p> <p>“I wish someone had told me what to say and when to say it”</p> <p>“There wasn’t anything in there about safe situations and talking with your partner”</p>	<p>Change</p> <p>Regret</p> <p>How to help</p>	<p>Self-reflection and Evaluation</p>

Rigor

Rigor was maximized in a variety of ways. The credibility of a study is directly related to its purpose and how well that purpose is accomplished (Milne & Oberle, 2005). Authenticity was maintained by accurately representing the participants' perceptions, and by allowing each participant to direct the flow of the interview to capture the story that was important to the individual participant. Integrity was maintained by staying true to this format. This format ensured a participant-driven interview process, which allowed for participants voices to be heard and their stories to be told.

I also established an audit trail. Original recorded interviews, field notes and interview probes, follow-up questions, accurate transcripts, and a record of data analysis and coding procedures were maintained. These were available for inspection and review by interested researchers and my advisor. Each participant was offered the transcript of her/his interview and asked to comment on whether or not it authentically represented her/his story. Changes suggested by the participants were made on their interview transcripts. Recording and documenting the phenomenon of interest as closely as possible to the actual event depended upon accurate data collection and transcription. Accurate transcription was essential to increase rigor. The transcribed interviews were checked against the original audio-tapes to ensure accuracy through self-check and advisor review.

Study participants were asked to review and validate their stories that were generated from the interview transcripts. This was done after all data collection had been completed, and participants were informed of the estimated time frame from interview to completed summary. Rigor was maintained through member checks by allowing

participants to validate the content descriptions and/or correct any areas they felt were inaccurate, misleading, or missing. Soliciting the participants' views increased credibility by allowing them to be the experts, and this was congruent with the overall importance of staying true to the study purpose.

I sought, found, and explored a negative case. The negative case was a story that contrasted with the general theme of the findings and was important to investigate. In negative case analysis, the researcher attempts to understand all that encompasses the phenomenon under investigation and offer explanation for those stories that don't seem to "fit" with the majority.

Validity, Trustworthiness, and Authenticity

Validity in narrative research is the believability of a statement or knowledge claim, and its validity is a function of intersubjective judgment and consensus within a community of scholars (Polkinghorne, 2007). The purpose of the validation process is to convince readers that there is enough support for the research claim that it represents understanding of human action. Narrative research results in a composite story that provides insight and understanding about life events for individuals and how these individuals understand themselves, others, their context and situations (Polkinghorne, 2007).

Reflexivity is a necessary element of quality and assists in establishing the trustworthiness of the study (Holloway & Freshwater, 2007). I considered not only the narratives of the participants, but also my own emotions and feelings toward the interviews. My clinical work as a women's health nurse practitioner with sexually active adolescents was fully disclosed to participants and included in the written results of the

study. This type of transparency allowed readers to be aware of how my background influenced the research design, procedures, and analysis. Readers were able to evaluate that the findings, which achieved the aim of the study and were not a result of my assumptions or preconceptions.

Additionally, the following steps set forth by Creswell (2007) were also followed to ensure validity as it specifically related to narrative inquiry. The study question and story was focused on a significant issue related to the participant's life. For this study, that significant issue was the decision to engage in sexual activity. A chronology was developed that connected the different aspects of the narrative and reordered it to tell a persuasive and interesting story that held true for the participants. According to Riessman (2002), a social constructionist perspective places less emphasis on the verification of "facts" and more on the perception of those events from the view of the participant. Thus, understanding the changing details of events for the individuals involved and how these events are located in a social context is a main component of validity. The purpose of narratives is to interpret the past in stories rather than reproduce the past exactly as it was (Riessman, 2002). This is also supported by Polkinghorne (2007) who stated "storied texts serve as evidence for personal meaning, not for the factual occurrence of the events reported in the stories" (p. 479).

Although many facts in each narrative could be verified, the focus was not on the "truth" of the story, but on the way in which participants described their world and their reality from their perspectives. This included how their stories were constructed over time with the influence of context and culture. Narratives reveal connections and intentions, and researchers need to suspend belief in the "truth" to analyze the underlying

implications in the narratives. The end product was not merely a retelling of the participants' stories, but an interpretation through critical reflection on the part of myself, the researcher. Therefore, these narratives should not be viewed as testable and verifiable facts but rather plausible versions of experiences that held significant meaning for the participants. The final account had a sense of verisimilitude, and when the narratives were read, they appeared to be truthful (Holloway & Freshwater, 2007).

Conclusion

Narrative inquiry allows researchers to understand the experiences of others and present these in story form while preserving the richness and complexity of the experiences as they occurred. With this approach, the effect of the participants' experiences is not disregarded for the sake of outcomes (Bell, 2002). Narrative inquiry was used to answer the following questions: 1) What are late adolescents' perceptions of personal, interpersonal, social and environmental factors that influenced their decision to become and remain sexually active? and 2) What is the effect of sexual decision making regarding coital debut on subsequent sexual activity?

Analysis of my participants' stories allowed for unexplored contexts and decision-making factors to be heard and become central to answering the research question. In addition, narrative inquiry gave voice to the adolescents who might never have been recognized as having something significant to say. Their stories provided a window into their beliefs and experiences, and became powerful and valuable tools for the construction of future programs of education for others with similar situations. In this chapter, I have provided detail on the research method, sample, procedures, and data analysis. In the following chapter, I will present the study findings and interpretations.

CHAPTER 4

Findings and Discussion

Introduction

Through immersion in the data and multiple levels of analysis, the story of adolescent sexual decision making emerged and revealed the experience of these adolescents as they processed multiple levels of influence. Although the stories shared similarities and differences, all participants began their stories with a description of the environmental context at the time of coital debut. Context included both external physical elements as well as internal elements such as the individual's perspective of socialization experiences and personal thought processes. Together, these elements set the stage for decision making. All other influences were then interwoven with the context to produce a complicated web of situations through which the adolescents navigated as they formed their decisions.

Description of the Sample

This narrative inquiry was accomplished with 11 late adolescents between the ages of 18 to 22 years of age. All were currently sexually active, and the mean age of reported coital debut was 17. The mean age of the study sample at the time of interview was 20. The majority of participants were college students (81%), and all but one participant was female. Although the students in this study were all attending public and private colleges in the Northeast area, they reported growing up and attending high school in the Southern and Midwestern parts of the United States. The two participants who were working and not enrolled in school held jobs in the immediate study area. Selected demographic characteristics are presented in Appendix H.

Telling the Story

Four components emerged that helped to tell the story of adolescent sexual decision making from coital debut to the present. The story began with the setting of environmental context at the time of coital debut and included the adolescents (the story teller and her/his partner) as the main characters. Each adolescent described how this combination of internal and external elements served as the backdrop to her/his perspective of entering the next stage in life. To make the story flow, I sequentially rearranged and based on the content analysis exploded the categories identified in Chapter 3 to make evident sub-categories existing within the category. I then renamed all the categories to represent the richness of the data provided by these adolescent participants. These actions allowed me to present more detailed groupings of data while still being comprehensive, thus facilitating the telling of the story. This final coding process is represented in Table 4.1

Table 4.1 Sample of Final Coding Process

In vivo units of major content	Categories	Renamed categories	Sub-categories
<p>“It was time for me to try it”</p> <p>“Is like anyone around this night?”</p> <p>“I don’t know how people go to college and not end up having sex”</p> <p>“He was older and experienced”</p> <p>“Definitely alcohol”</p> <p>“The freedom of what happens when you do go to college”</p>	<p>Curiosity</p> <p>Supervision</p> <p>Partners</p>	<p>Internal environment</p> <p>External environment</p>	<p>Thinking about it</p> <p>Responding to expectations</p> <p>Being alone together</p> <p>And then there’s alcohol</p> <p>Fewer barriers</p>
<p>“A story I want to be able to tell”</p> <p>“Crazy random hook-ups”</p> <p>“Just what the societal standard is”</p> <p>“Very . . . sex-oriented type of relationship”</p> <p>“No one is worth getting pregnant for”</p> <p>“I didn’t use condoms as much as I should have”</p>	<p>Reflecting</p> <p>Society</p> <p>Relationships</p> <p>Caution</p>	<p>The social scene</p> <p>Progression to intercourse</p> <p>Pregnancy & STI prevention</p>	<p>Hook-ups</p> <p>Dating relationships</p> <p>It’s all about sex</p> <p>Fear of pregnancy</p> <p>STIs less threatening</p>
<p>“People don’t ask before they have sex with someone”</p> <p>“Just went along with it”</p> <p>“I couldn’t think of another way out of the situation”</p> <p>“Really not even a decision anymore”</p>	<p>Complicated</p> <p>Unavoidable</p> <p>Inevitable</p>	<p>A gray area</p> <p>Lack of partner communication</p>	
<p>“In it for the right reasons”</p> <p>“I just didn’t want to regret it”</p> <p>“I think I would have made different decisions”</p> <p>“I wish someone had told me what to say and when to say it”</p> <p>“There wasn’t anything in there about safe situations and talking with your partner”</p>	<p>Change</p> <p>Regret</p> <p>How to help</p>	<p>Behavior change</p> <p>The missing piece</p>	<p>Reconsidering past actions</p> <p>What isn’t taught</p>

Context served as the introduction to the story, setting the stage for the plot and conclusion. Intriguing and complex thoughts and behaviors provided the material for the plot or middle of the story. The plot consisted of two components. The first one contained comments about expected social norms regarding dating relationships. The second one focused on issues surrounding consent and the complex interweaving of perspectives, assumptions, and implications entailed in any discussion of consensual sex. The narrative concluded with the adolescents describing a process of retrospective self-evaluation and reflection on their decisions. An outline of the story components is presented below:

Setting the stage: Context and characters

Internal environment

Thinking about it

Responding to expectations

External environment

Being alone together

And then there's alcohol

Fewer barriers

Plot: Expected Social Norms

The social scene

Hook-ups

Dating relationships

Progression to intercourse

It's all about sex

Pregnancy and STI prevention

Fear of pregnancy

STIs less threatening

Plot: Complication: Implied Sexual Consent

A gray area

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Setting the Stage: Environmental Context and Character Introduction

The influence of the environmental context at the moment these adolescents' were faced with having to make a decision about whether or not to engage in sexual activity set the stage for adolescent sexual decision making. Reported age of onset of sexual activity varied among participants, with coital debut ranging from age 15 years to 19 years. The individual's external and internal environmental context was highly influential to decision making. Even though specific sexual situations varied from high school to college or work force environments, context contained the constant elements that influenced the decision to initiate sexual activity.

Internal Environment

Thinking about it. The decision to begin sexual activity was discussed as a very straight forward process. This thinking occurred simultaneously in the context of time alone with a sexual partner. Female participants described that although they might not

have considered sexual activity in the absence of opportunity, when sexual activity became possible due to their current situation, they often made the decision quickly without much deliberation. This was represented by Marren's statement that "if the opportunity presents itself I'm good with it." With the exception of Stacy who thought she was "in love and . . . thought it was gonna last", and Heather, who "had an idea of what [she] wanted like in terms of a . . . relationship with a guy", the decision to engage in first intercourse was rarely connected with emotion. Instead, many participants reported being "kind of curious" about sexual activity. Erica simply stated "I want to see what it's like and want to try it." For Lydia, having sex at age 15 was described as "just sort of an age where it seems . . . like it's logical". Jen, who became sexually active at 17 during her senior year of high school, stated "I know it wasn't like really love or anything like that prompted it . . . it was time for me to try it." Overall, participants expressed the idea that sexual activity was just "something" to do with a partner that was described as a "fun connection" without the feeling "like our souls are entwined."

Being able to "separate emotional sex from physical sex" and viewing sexual activity as "not some deep connection" at the time of decision making was consistently present throughout the decision making process as reported by these adolescents. April's attitude toward first intercourse was summed up as "Oh yeah sure I'll try it." Several of the adolescents viewed progressing to being sexually active as an important "category change". Mary, who became sexually active freshman year in college, discussed growing up and how ". . . my friends weren't having sex so I felt no pressure in high school to have sex. She went on to state that her high school was ". . . incredibly academically driven . . . " and the rigorous work load contributed to her decision to delay intercourse.

But once in college she explained that “I didn’t want to be a virgin. I wanted to be able to say I had already had sex I wanted to get past it.”

The internal environmental context remained highly influential to sexual decision making into late adolescence. Marren, who “grew up in a really religious family in a really conservative area”, described how her thinking about premarital sexual activity was challenged by a writing assignment for a human sexuality class in college:

. . . one of the assignments in it was like going through and kind of identifying like your ideas about sex and where they came from, and why you held them, and if they changed over time. And I guess writing that paper really made me think about me personally, and what I believed about sex. And how I didn’t think it actually needed to be saved for marriage and how I was nineteen and a half, and half way through my, more than half way through my first year of college and I was like you know, I’m like holding on to this for no particular reason other than like it’s just what’s like been ingrained in me.

Responding to expectations. In addition to curiosity, mid adolescents who became sexually active during the high school years reported that in environmental context of “dating someone that was a little older” their decision to engage in sexual activity was influenced by the immediate availability of an older partner who had “experience.” April, who became sexually active at age 15, stated “I think just for me at least the really big thing was having an older boyfriend. Someone who knew what he was doing And I figured that’s what he wanted”. Participants talked about how older partners had previous sexual experience and they “expected” sex to be part of the relationship. Stacy, who at age 16 was dating a 19 year old, reported:

I knew that he had had sex before and he was experienced so I was like ‘oh this is what I’m supposed to do’ I feel like I was influenced because of, he was older and he was experienced so I felt like I should, I guess.

For some participants the influence of an older partner on sexual decision making extended into late adolescence. Amy, who became sexually active at age 19, discussed her first sexual partner:

. . . he was older and experienced. He just moved us, like moved our relationship in that direction I mean he had been hinting that he wanted to have sex. I knew he had other girlfriends like before me so I just assumed he had had sex before. Like I'm sure he did. So it's not like I had no idea that's where he was going with it.

External Environment

Being alone together. Consistent with concrete thinking that can extend into mid adolescence, participants who reported beginning sexual activity in high school described their decisions to become sexually active in very simple and mechanical terms. Lydia, who started having sex at age 16, talked about this decision in relation to having time alone with her partner: "I think also in high school is more about is like anyone around this night or is anyone going to catch us or do we have some sort of privacy?" Anna reported a similar experience at age 17:

When I was younger, you know, like in high school it was not gettin' caught by no one, you know, like bein' private and stuff. Me and my boyfriend needed to be alone, you know, which was hard sometimes. But if we got alone we had sex. So back then it was just tryin' to not get caught.

And then there's alcohol. Alcohol and parties were reported as being part of the "college drinking culture" and influenced the sexual decisions of many participants. Deciding to consent to sexual activity "under the influence" of alcohol was frequently referred to as "common". Amy elaborated on how alcohol affected the decision making process:

You just can't think when you drink like that. So um, like the lines between what you think was said and what you really did say become completely blurred. And

that's just a bad place to be . . . a lot of . . . girls don't even remember if they said it was OK to have sex.

Mary reported that on her campus "the social scene . . . revolves around like random people's room parties and a lot of alcohol." Heather reported feeling "pressured to drink because everyone else is", and Erica discussed the influence of alcohol on decision making by stating: "To be honest, if people are drinking it's easier to get, you're less shy I think, and you're less inhibited and like people are more likely to you know, to do that [sex]." Stacy talked about the influence of drinking on her sexual decisions:

. . . in the majority of the [sexual] hook-up situations I have it definitely would have because if I, I feel like if I was in the right state of mind it, it wouldn't have gotten that far. And you know, I don't think it would have gotten to the point where, you know, someone would come back to my room or I would go back to someone's room in college, I'm saying. I don't think being sober that that would have happened. I think I would have realized what was going on.

Fewer barriers. The majority of participants were either current college students or recent graduates, and they spoke at length about the culture of college and how it influenced their decisions regarding sexual activity. Being sexually active was described as ". . . totally part of college life" because of a more ". . . open atmosphere . . . just a more open culture" and ". . . more freedom." Amy discussed the difficulty of transition from more structure of high school and life with "strict" parents to a more open college atmosphere: "I went from like almost no freedom to almost complete freedom. Like now I'm a junior so I'm used to it but freshman year was, it was um, kind of hard to manage everything." Lydia just simply stated "I think it's hard to not be sexually active in college" because of an existing "culture of sex" on college campuses. She elaborated by stating:

Like a lot of people always talk about freshman and sophomore year, they're very promiscuous . . . I don't know if I'd say that it's considered a good thing or a bad

thing. But it's certainly not considered an unexpected thing, to sort of have casual sex . . . I think, there, that definitely is a culture thing like you should go out and you know it's cool if you can hook-up with someone on the weekend.

Jen, who became sexually active during senior year of high school, talked about the influence of the college environment on sexual decisions: "If you haven't [had sex] you still feel a little like you're behind or something if you haven't." She went on to state that "I do think some people . . . feel they come to college like, who are virgins who sort of feel a little bit like unsure about stuff or various pressure maybe in your freshman year maybe to lose it or something like that." The freedom and adjustment to college life and how that influenced the decisions participants made about sexual activity were frequently discussed:

I do know a lot of people who weren't sexually active in high school who became sexually active in college. And I think a lot of it comes from the freedom of what happens when you do go to college . . . And I think that plays a big, a big part in it. You know, you get this new found freedom and you're like 'oh I can do this and I can do whatever I want'. But I think that a lot of times you don't realize, especially your first year or so of college you don't realize the implications it will have on you. (Stacy)

Like I felt more protected somehow in high school. Like maybe it was a smaller group of people or just some of that structure of my parents, but I found the freedom of college to be kind of overwhelming sometimes. And I think that just creates this place where hook-ups happen and people just get pulled along with it. I don't know how people go to college and not end up having sex, or not having bad sex with someone. Just new people, new situations. It's just hard to manage it, um or maybe I should like say hard to manage it well. Or maybe some people do a better job than I did. (Amy)

During the mid adolescent years, the influence of both internal and external environmental context was seen individually with unsupervised time alone, heightened curiosity, and the availability of an older partner. When all three situations occurred simultaneously and the characters were positioned within the environment, a triad of influential contextual factors formed that made sex a "possibility," and resulted in

opportunistic thinking such as “if I wanna have sex I should probably have it now.” The opposite was found when the participants transitioned to college. In contrast, they spoke of “freedom” and an “open culture” that supported “random sex” and “a lot of alcohol” and “parties.” It was these environmental factors that fostered the adolescents’ perceptions of what was normative sexual behavior.

Plot: Expected Social Norms

As the story of sexual decision making evolved, these adolescents’ perceptions of what was “expected” and “the norm” for sexual activity and relationships shaped their decision making process, and were often interwoven with the context of the situation.

The Social Scene

Hook-ups. What has become the most common and accepted method of meeting and beginning an intimate relation is known as the hook-up. The adolescents described hook-ups, or one-time sexual encounters without the expectation of a relationship (Paul, McManus, & Hayes, 2000) as “prevalent”, and “the ideal path” to relationships. Anna, a 19 year old receptionist, commented that hook-ups were an expected part of weekend socialization and described the hook-up culture that existed at a local dance club she frequented: “Like they hook-up and stuff after dancin’ and drinkin’. Sometimes it works out, like datin’, but a lot of times it’s just a one time thing. And then you know you do it again the next weekend.”

Each participant who was a college student identified hook-ups as “totally . . . part of college life”, and Mary felt that having a random hook-up was “part of the obligation of being in college”. These adolescents described one time sexual encounters in college in terms of being part of “just what the societal standard is” and that not participating in a

random hook-up would make you “. . . feel a little like you’re behind or something if you haven’t.” Mary shared her thoughts on why she participated in hook-ups:

But people talk about their random hook-ups like it’s a story that I wish I could also have, because it sounds like it’s really exciting, even though I’m sure it’s not that exciting. But it’s a story I want to be able to tell, I don’t know I guess other friends who aren’t here. My friends from high school. When they ask what’s going on in my life. Especially male friends. I definitely feel like more that I need to impress male friends with all of my sexual escapades. . . . when people refer back to their college lives, like ‘Oh yeah, these crazy random hook-ups.’ And me, no not really. I’d never lived liked that so I thought I was like, I’ll cross that-get that out of the way-check it off my list.

One adolescent participant discussed that she “never did the hook-up thing.” Heather, who was the only participant to have one lifetime sexual partner and be in a long-term relationship, offered insight into the occurrence of hook-ups from the perspective of “an outsider looking in”:

I think college just, like it kind of like maybe reflects society? It’s just so much more accepted, or um, maybe like not accepted but tolerated? Or both There just isn’t this feeling, like with society, that sex is terrible, like sex before marriage is wrong I think that . . . you see it [sex, random hook-ups] at college. Students are away from parents, parent’s rules, and without society telling them it’s wrong, I think society becomes stronger than what their parents told them to do.

Dating relationships. The perception that hook-ups were just part of the sexual social norm shaped the way in which participants viewed their decisions surrounding dating and relationships, especially during college. Jen admitted that “dating can exist if you make it exist”, but also acknowledged that “. . . it’s so hard to meet people . . . that you know well enough and people that are willing to wait and kind of get to know you.” Overall, participants felt that “. . . girls feel like guys want um, a certain amount of freedom, especially . . . they want to try out different people” and they didn’t “want to

feel obligated” to “try and make [a relationship] work.” The complexity of relationships was reflected in the following statements:

I think like a lot of guys don't want long-term relationships or stuff and this is sort of better [hook-up] . . . I think a lot of girls would rather this; this option is sort of better than like nothing, on one level. And a lot of the cases I feel like, um, people do hope it will turn into something more . . . and that it won't just be a one-night thing. But, a lot of the times, sometimes it is just sort of a thing, a one-night thing. (Jen)

Like I do think though from a girl's perspective . . . if someone has like sex with someone . . . I think most times you do want something more to come out of it. And like maybe you think having sex will like lead to something. . .(Erica)

That was like all I wanted was that random hook-up and not like the start of a new relationship . . . but for some reason, like I still feel-I feel bad if I'm not having sex with him. Because I feel like that's what he actually wants and um, and because I'm not doing it like I'm not holding up my end of the bargain...but for some reason I can't kick the feeling that like now that I'm like regularly seeing this guy I will be forced to regularly have sex even if I don't have time for it. (Mary)

Progression to Intercourse

It's all about sex. When discussing their decisions to first become sexually active, participants reflected on the relationship that surrounded their first sexual experience. Sex was consistently described as something that “happened very quickly” or “just happened” after dating for “two weeks”, “a couple of weeks”, or after “dating for one month”. Joe, who became sexually active at age 15, recalled that “we didn't date long before we had sex, like um, probably the 3rd or 4th date.” April, who was also 15 at the time of coital debut, recalled that sexual activity became part of the relationship quickly: “. . . really the second or third week after we started dating it was just like it happened.” Sex was routinely described as progressing quickly because “one thing led to another.” Oral sex was considered “almost always a precursor” to vaginal intercourse. Mary considered oral sex to be “the gateway drive”, and described starting to have oral sex “was like I was

agreeing to the full pass.” Jen described her decision to be sexually active in terms of other non-coital activities: “. . . because we had been doing other stuff before and like, eventually we were just like, well, obviously we know what the next step might be.”

Dating relationships were often described as a “very . . . sex-oriented type of relationship”, and the decision to engage in intercourse was made because “we had kind of done everything else.” April described her first sexual relationship: “Well, we don’t really have anything else better to do so why don’t we just have sex.” Anna stated that “guys expect sex to be part of bein’ with them” and that sex was “what datin’ was”. Joe stated:

I mean, if you were dating it was just, um, kind of, um, like assumed that sex was part of it. You know, you dated for a while but then you had sex. That was the end point, you know. The end goal. I mean that’s why you dated to begin with, right?

A quick progression to intercourse remained common beyond coital debut and persisted into later relationships. Participants acknowledged that there was an assumption in all relationships “sex is expected” and that it can be “quite a bit awkward that people have a difference in expectation” about what they want from a relationship. Jen discussed the difficulty associated with deciding to be sexually active while trying to “connect” with a new partner:

But to the point of where it’s just like one or two dates or three dates and they’re starting to expect something besides just hanging out or even just like a kiss goodnight. And they’re like, you know, I want to come home at this point. So, it’s hard to even get into that without knowing that at some point you’re gonna have to try and establish some solid lines and hope that they concur about them.

With the exception of Heather who was in a long-term, monogamous relationship, all participants described trying to establish relationships as “difficult”. Their ideas of what they wanted and their perceptions of what they could have were influenced by the

current social norm of hook-ups, which supported the concept of sex without obligation of emotional connection. Participants identified that this struggle began in the mid adolescent years when they stated that early “dating” after coital debut consisted of “hanging out” and “stuff”, but “sex was always there.” This helped establish sex-focused normative behavior that carried over into subsequent relationships that became “so less focused on the emotional partnership, camaraderie, part of the relationship.”

Pregnancy and STI Prevention

Fear of pregnancy. All participants described a high level of concern over pregnancy. Many declared themselves “incredibly cautious” and stated that they “always used condoms”. Lydia simply stated “I would not have sex with someone who wouldn’t want to use a condom,” and 18 year old Joe was very clear about his concerns over pregnancy: “I have always used a condom, even if the girl said she was on the pill . . . I don’t feel like paying child support for the next 18 years.”

Some participants decided to delay the onset of sexual activity until they had access to birth control. Mary waited until she was at college and could obtain a prescription for birth control before she decided to have sex: “I did not want to start having sex until I knew that I was on the birth control pill and we could also get condoms.” Marren also waited to initiate sexual activity until she had “been on birth control for a few months.” Heather had similar concerns about avoiding pregnancy and waited a month after starting birth control pills before she became sexually active: “. . . I didn’t want to get pregnant and I wanted to go on the pill before we did anything.”

STIs less threatening. Although every participant took precautions against an unplanned pregnancy, protection against STIs was inconsistent. For Stacy, pregnancy

was “scarier than having an STD” and she admittedly “didn’t use condoms as much as I should have.” Amy shared this view and stated “I knew I didn’t want to be pregnant but I didn’t really think about any STDs when I first had sex.” Lydia, who at one point in the interview declared that she wouldn’t have sex with anyone without a condom also revealed that “. . . I guess I’m certainly less cautious if I really know the person . . . I have had unprotected sex when I’ve been on birth control. You know, if I’m honest, even otherwise, you know, once or twice.”

Consistent with Lydia’s statement that she “really” knew her partner, being familiar with a sexual partner or knowing a partner’s sexual history were the main reasons given for not always having a high concern over STIs. Jen discussed her first sexual experience in high school and admitted that “. . . we didn’t talk about STDs because I knew that we were both like the only ones.” But she also acknowledged that prospective partners might not be completely truthful about their sexual history. She went on to state that although she “thought” she was her boyfriend’s only partner she admitted that “people always think they know but that never crossed my mind really.” Jen described that even when “someone . . . did not pose a risk of any kind of sexually transmitted infections based on his history” there could still be risks involved that were not completely clear:

But then it just always bothers me ‘cus they always say well ‘oh yeah I got tested like 6 months ago’. They won’t tell you the people in between that they’ve probably had sex with but they’ll be like I got tested then or I just know they’ve only had one girlfriend but who knows what that girlfriend was doing.

Marren had a more philosophical view of the potential for STIs when she talked about condom use and her decisions to engage in sexual activity:

The idea of sex and the idea of safe sex are sometimes two different things . . . there's no such thing as safe sex. Just safer. Um, but if I'm gonna decide to make the decision then there's going to be some sort of risk. You know whenever you cross the street there's a risk you might get hit by a bus. Um, and so I felt like I'm doing as much as I can.

Participants discussed how they didn't "consider oral sex [to be] sex" and that their perception was that "no one uses any sort of protection for oral sex". Although participants discussed that oral transmission of STIs was possible, condom use for this activity was low. Erica elaborated by stating:

. . . obviously STIs are definitely really important and I would always use condoms but then I think about cases, like oral sex where I haven't necessarily used protection all the time and you can still transmit, you know STIs through that so in that case I guess I haven't been as sort of as careful about that.

The adolescent participants in this study had a high awareness and concern for contraception and actively sought out birth control prior to intercourse. None of the participants revealed that intercourse occurred in the absence of contraception, and the feeling toward unplanned pregnancy was summed up by Mary who stated that pregnancy was the "worst thing that could ever happen to me." For the female participants, birth control pills were the most common contraceptive method, and condom use declined once pregnancy was no longer a concern. Although able to articulate that STIs were prevalent and condoms provided some protection, participants admitted to "not being as careful" as they should have.

Plot: Complication: Implied Sexual Consent

My participants' discussion of sexual decision making repeatedly included dialogue that referred to issues regarding consent for sexual activity. According to participants, consent was rarely verbal and clear. Instead, sexual consent was most often "assumed", "expected", or "alluded to".

A Gray Area

When discussing sexual activity, participants also described how they “just went along with it” because “if you start making out it’s going to like lead to sex” and that being “physical . . . in the moment . . . leads to like going over the top to what you didn’t want to do.” Lydia, who described nonconsensual sex as “quite common” stated: “I feel like people don’t ask before they have sex with someone. They do have expectations that they’re gonna have sex.” Anna discussed the relationship with her boyfriend and talked about how she “knew by what he was doin’ he wanted sex.” Jen discussed how consent for sexual activity was not a routine occurrence in her relationships:

. . . it just kind of happened. I was going to hang out and I barely knew him. And that’s just what like being young does...a guy thinks I’m like attractive, he wants to hang out, and you’re just kind of like fit to please sometimes You know, just one thing leads to another. It wasn’t like anyone ever asked me because I’m sure if someone probably stopped and asked me and looked at me pretty sincerely I would probably say no So probably for most guys that I had sex with it was probably a good idea not to ask me.

Stacy discussed how sexual consent was not always easy to distinguish:

. . . the first time it actually happened we didn’t actually say ‘OK, yes’. I think it just, happened. And we had talked about it before a little bit but when it was actually happening it wasn’t implicit that this is what we’re gonna do. It . . . just happened . . . it’s just implied [sex]. I think that . . . you’re with someone and things start happening and then it’s just like ‘oh, ok, whatever’. But then looking back on it you’re like ‘oh, why didn’t I, why didn’t I stop it?’ But it’s, hard; . . . it’s easy to say that you can stop in the middle of it. But it’s like, I think you just feel like that’s what you should do. And it’s just like implied that’s it’s going to happen so it just does.

Participants discussed that, although consent was often not clearly asked for or given, it was implied by the situation and that they “knew what he was getting at”. Even though Amy stated that “. . . you should be able to be with a guy and not just have it like assumed that sex will happen” she acknowledged that this rarely occurred and described

that “. . . like with the hook-ups I had in college you got the standard ‘want to go back to my dorm?’ line. So you um, you pretty much knew what that meant.” Jen reported similar experiences and stated “I think that, or sometimes guys ask like ‘should I get a condom?’ which is sort of a ‘do you want to do this?’ thing.” Joe, who was the only male adolescent interviewed, echoed the statements made by the female participants. He discussed how there was no verbal consent from his partner when he first had sex at age 15:

We were kissing, a lot, and um, we just kept going. It just happened. I never asked her if it was OK, but she never said she didn’t want to. I mean I didn’t force her. I don’t want you to think that I forced her. It was just sort of, I don’t know, assumed that was what was going to happen [sex].

Lack of Partner Communication

Participants talked at length about decisions involving sexual communication with partners and how progression to intercourse happened without implicit consent because it was difficult “to just stop cold turkey and have a boy completely understand” or because they “just didn’t stop him.” Anna elaborated on the problems with partner communication:

I guess I just got, you know, like it had gone that far so I didn’t stop it. . . I mean when it gets to that point what are you gonna do? Like you can’t really say no then if you let it get that far . . . when things got goin’ I just didn’t stop him. Like maybe it would have been better if I did, but I didn’t know what to say. Like do you say ‘stop’, do you say ‘wait’, do you say ‘slow down’? Like what do you say? No one told me what to say. Like I just didn’t know what to do once it got that far.

Being unable to communicate with a partner about how to handle a sexual situation resulted in sex that Lydia described as “put into action and it goes to completion.” Not being able to stop non-coital activities such as kissing from progressing to intercourse was frequently reported. April talked about how sexual situations were “really easy up to the very last moment” but once intimate activities progressed to a certain point then it

was “really not even a decision anymore” and sex just occurred. Multiple other participants reported similar experiences:

And so it was kind of like inevitable [sex]. At the time I was thinking like I guess I want to continue making out with him, but I’m not sure I want to continue that right now or if I want to postpone it. But I couldn’t see a way to postpone it. I couldn’t see a way to be like, ‘Um this is fun-here’s my number’. Because it just seemed like it would be an awkward end. So it seemed like it was inevitable that it would happen. I couldn’t think of another way out of the situation. (Mary)

. . . oh I really wanted to make-out but like that’s all I wanted to do but then it’s so awkward to have someone in your room or you’re in their room and you’re making-out and at what point, it’s so awkward to try and stop things in the middle. (Lydia)

I think a lot of the times people . . . go back to the person’s room and it’s sort of that line like ‘oh, I’ve gone to the person’s room’, you know obviously you still have a choice but I think a lot of people once they’ve made that decision that like, you know, if you start making out it’s going to like lead to sex. (Erica)

Heather, who was in a long-term relationship, reflected on the issue of consent and problems that she thought might occur, especially outside of a committed relationship:

I didn’t really do the whole hook-up thing. . . . Like it can just put you in place where, where like it’s not so clear what everyone wants or you don’t like really know what you want. Like you’re put in the position of, of having to decide right then and there, like um, you know, on the spot, under pressure with this guy who is like all over you. And that can’t be good. I don’t think well like that.

Inability to effectively communicate with sexual partners was a main contributing factor to sexual consent that was implied by the situation instead of clearly stated by the adolescent. Additionally, as participants’ stories evolved, the layering effect of environmental context and prevailing social norms intersected with implied consent to form a complex influential dynamic that was seen from coital debut through the present. As the adolescents’ progressed in their social, cognitive, and emotional development from time of first intercourse, they were able to evaluate their behavior and offer insights into how others might be able to manage multiple layers of influence on decision making.

Conclusion: Self-Reflection and Evaluation

As participants ended their stories they reflected back on their decision making process and evaluated past activities and their influence on current behavior. Present sexual decision making was consistently described as “not as big a deal” and “a much easier decision” than deciding to first become sexually active. Lydia reflected on her present decision making process: “So once you’ve made the decision to have sex, and you know you’re sexually active, it’s really not a big a deal to make the decision again.” Erica shared this view and stated “I think it’s something that once you’ve done it you’re like ‘OK’, you’ve just sort of done it already.” According to 19 year old Anna, after coital debut subsequent decisions about sexual activity became “easier” because sex was “just part of bein’ with someone”, and was an “expected” part of the relationship. Amy discussed the influence of her first sexual relationship with her boyfriend from high school:

So I didn’t have some bad experience to look back on and make me think all, like all guys were going to be like that or um, think ‘oh, I never want to do that again’ . . . So I guess in that way it was easier to decide to have sex with someone new. Like once I got over that big first decision it wasn’t such a huge thing anymore.

Behavior Change

Reconsidering past actions. Participants discussed their sexual decisions in terms of how their decision making process evolved in the years since coital debut. Current thinking among most participants included the concept that “a relationship should not be based on sex” and that it should also be about “more than just sex” and not be “all sex-centered.”

Many participants admitted that “it was kind of stupid to have sex that fast with someone I barely knew” or that their decisions had been “really stupid”. They seemed to

have a general awareness that “something” negative could have happened as a result of their decisions. Participants who did not experience any negative outcomes from their sexual activity expressed a sense of relief. Anna, who failed to ask about her boyfriend’s sexual history, stated that she “got lucky” when she did not get a STI. Marren, who described having multiple sexual partners as a “liberating experience” cautioned that “. . . it’s not something I would recommend for most people losing their virginity in a one-night stand.” She discussed how she had a “really high sex drive” and found it “very easy to separate emotional sex from physical sex” but acknowledged that many people would “have a very difficult time dissociating the emotional aspects of sex from the physical.”

April, who was 15 when she first became sexually active, described her sexual history as “continually a poor decision”, and stated “I look back on it and I’m like ‘Oh my God, I was so dumb’. And I think about how much I know now.” April elaborated on the catalyst for the change in her sexual decisions and behaviors:

I um, ended up having abnormal pap smears . . . and so I realized I had HPV . . . I had to have that really hard conversation with my boyfriend...And I told him as soon as I did know but that he couldn’t do anything about it and perhaps he had it by that point as well. And so that really just kind of like, it was like ‘April, you really like, you really got to calm down.’ And really evaluate like this decision, like your self-worth, um, whether you’re ready for it or not, self-control, um, self-respect, and taking care of yourself and the others around you. So you can’t continue doing this like this way.

Stacy also admitted that she “made a lot of mistakes” and stated that “I do regret how young I was and the decisions that I made.” She went on to explain:

. . . now it’s different. But my boyfriend I have now we didn’t have sex for like the first 3 months. We talked about it because I had made a lot of mistakes and I wanted to make sure it was, this was something I wanted to do. So it’s kind of funny now that I’m older it’s, I guess I see the meaning to it more than I did when I was younger . . . it’s not until, literally until after I graduated college that I started thinking about it differently. And it is a huge part of a relationship. It’s a bigger decision than I thought it was when I was 16.

Stacy discussed how her feelings about herself affected her decisions to engage in sex, especially hook-up situations in college:

I think that I had low self esteem at one point and I thought that like OK, if someone sleeps with me than they think I'm attractive, they think I'm pretty, you know? But then it comes out the next day like, OK, that's the extent of it. That's all that it was. And then, and then you're back to lower than you were before. It's a vicious cycle and I think that the way, especially before I was drinking like I talked about the way I felt about myself, plus alcohol, made it like a bad situation and you know, I've learned a lot from it. And I think the way I felt about myself definitely, probably was the biggest influence in most of my sexual experiences . . . I was in that cycle of like feeling bad about myself so I'll sleep with someone and feel better about myself and then I couldn't get out of that, couldn't get out of that for a while, until very recently.

Amy also reflected on past sexual decision making. She reported a history of “hook-ups” and “casual” sex which were often the result of meeting someone at a party. She detailed how her decision making process changed after “a completely blind hook-up” turned “bad”:

. . . this one guy was just not nice. He was um, just rough and arrogant, really aggressive about hooking-up too. Like, he was all over me all night...when we were alone he kind of treated me like I was, like I don't know, like his property or something. It made me feel really dirty and used The whole thing was just bad. That was like my wake-up call . . . it scared me a little, you know? Like he was too rough and at one point I thought he might hurt me. And I didn't really know him at all. So like he could have been unstable, you know, dangerous like. Um, just because he goes to my school doesn't mean he couldn't hurt someone. It kind of made me think like what was I doing . . . I realized I put myself in the same situation that I tell other people to avoid. Like situations where you can get hurt.

Heather's sexual decisions were influenced by how she felt after watching friends experience negative or unsuccessful relationships, especially when alcohol was involved with hook-up situations. She reflected on why she delayed coital debut until she was 19 and in a long-term relationship:

. . . for me, like deciding to have sex, like I just didn't want the experience to be like a lot of my friends. Like treated poorly, or just a one time thing . . . a few people have said that um, like I need to have the experience of like sex with different people. But it doesn't look like um, like their experience was that good . . . Like I wanted sex to be like, like I just didn't want to regret it. Like I didn't want to look back and think 'My God, that was the biggest mistake of my life.' And um, I'm pretty sure if I was drunk with someone I didn't know that would feel like a big mistake.

The Missing Piece

What isn't taught. As participants reflected back on their sexual decisions, they talked about information that they wished they could have received. All participants had some form of school-based sexual education, and the usefulness of the information they received ranged from "a total joke" and "pretty useless" to "great" and "very comprehensive". Of those who thought that the information they received in school was adequate, they cited that it gave them solid information on birth control and that they "knew" that they needed to use a contraceptive method prior to intercourse. Mary agreed with this and said that for her, discussing condoms and birth control with a prospective partner was "inserted . . . into the dialogue" and not "completely foreign" because she was familiar with these terms from her school program.

Other participants had more critical views of their school-based sexual education. Amy, who participated in an abstinence-based program in her Catholic high school, discussed where she thought the information she received in school failed:

There wasn't anything in there about safe situations and talking with your partner because you weren't supposed to have a partner, at least not until you were married and then I guess the assumption is that there is nothing to consent to because sex is just part of marriage.

Heather agreed that the school sexual education curriculum was "just so on the surface" and did not cover all of the information she needed to make informed sexual decisions.

She worried that “if people are using that, like if they’re just using that information that’s where they’re going to go wrong. It just doesn’t tell you enough.” Joe thought back to his high school years and remembered that in his sexual education class “some of the kids were already having sex” and commented about the usefulness of the class he took:

I mean really, how was it supposed to help? It was all about the male and female reproductive system and conception and how the different body parts work . . . but really, if you were already having sex, you had already figured out how your dick worked. All they kept saying was the only 100% sure way of not being pregnant was not having sex. Well, no s**t. Like we couldn’t figure that out?

Although school-based sexual education programs were universal among my participants, they identified parents as their preferred information source. Participants described problems with this and talked about how communication with their parents was difficult, even though they longed for information. Many described how when growing up the issue of sex was “kind of a hush topic” or “an off limits discussion” that was “never talked about” or if it was, “sex was talked about in the abstract”. Other participants described information from parents as “ambiguous”, “awkward” or an “indirect, passive, type of way of communicating.” Amy recalled the relationship she had with her mother and how the issue of sex was handled in her house growing up:

And I mean I love my mother but um, she wasn’t any help really . . . she was so uncomfortable . . . so the ‘sex’ talk was something like when you get married you can have a baby or some really lame crap like that. And I mean I’m not kidding. That was it. Nothin’. It’s not like I could have EVER [with emphasis] gone to her and told her I had a boyfriend and we were thinking about like having sex and stuff.

Erica, who stated that she had an “open” relationship with her parents, commented that “I can talk to my mother about anything. But the one thing I can’t, I felt like I couldn’t really talk to her about was sex.” Joe recalled receiving little information from his father, other than a warning about pregnancy. Earlier in the interview he discussed that after his

first sexual experience he worried because it “just happened”, and that his girlfriend might accuse him of rape. He expressed much anxiety over this incident and stated:

I wish my father had talked to me about more of like that part of it, the part I didn't know. Like what to say and do afterward . . . Maybe that's why I didn't ask her if she wanted to have sex, you know? 'Cus I really didn't know how. I don't know, does that make sense? I wish someone had told me what to say and when to say it, you know?

In addition to Joe, multiple other participants recalled that the only sexual information their parents shared was “no sex before marriage” or to “wait until you get married”. Others stated that they were told “don't get pregnant” or that their parents made a vague comment about how they should “use a condom”, but the discussion never went further than that.

Stacy, who stated that she regretted many of the decisions she made, became tearful when reflecting back on what she wished her mother said to her:

I really wish I had, before I did for the first time, I could have gone to my mom and said, 'you know, we've been talking about it and we've been thinking about it' and that she wouldn't be like freaked out about it and would have just said 'this, it's a big decision and it's an emotional thing, it's not just something that's physical'. And I think that, the open lines of communication with your kids, as awkward and weird as it is, is very important. Because I do feel like I would have been different . . . it would have made me think about my choices more... I feel like if my mom had...talked to me more about how it would affect a relationship and myself I think my decisions would have been different. . . . I think I would have made different decisions.

April talked about the emotional aspects of a sexual relationship. She stated that her mother would share “horror stories” with her about teenage pregnancy, but never provided any guidance about the emotional impact of sexual activity or how to work through the decision making process:

I think what would have helped is if someone had just sat me down and questioned me about whether I had thought about this or not. And then that would allow me to kind of set up a system to question myself: to ask the right questions.

Instead of saying do you know you need to be ready, you need to know how emotional it is. It would have been like: Do you think you're ready? Do you know what ready means? Do you know what emotional means?

Amy also struggled with her feelings after becoming sexually active at age 19 and discussed how she wished she had a more open relationship with her mother regarding sexual topics:

I was OK with having sex with that boyfriend but um I also felt really alone. Like I didn't know what to say to him afterwards. . . . Even though everything was OK I still had some questions. Or like not even questions but like, just wanting to talk with someone. Like um, I felt weird. Not like physically weird but emotionally. Like lonely, and I don't know, kind of like um, left wondering about what my boyfriend thought, you know, did I compare to past girlfriends, would he think of me different, would he talk about me to his friends, should I call him or should he call me? Stuff like that. It would have been good to have been able to talk to my mother, even if it was just about like, general boy and girl stuff.

Discussion

Four salient components emerged from this study. These components, drawn directly from the narratives of the adolescent participants, served as “chapters” that helped tell the story of adolescent sexual decision making from coital debut to the present. The story began with the internal and external environmental context as the setting, and included the adolescents and their partners as the main characters. The adolescents described the influence of how this combination set the stage for decision making. As the stories unfolded, the plot of expected social norms regarding relationships and issues surrounding implied sexual consent formed the nucleus of the story. Participants concluded their stories with a retrospective self-evaluation and reflection on how their behavior had changed, and also discussed their thoughts on information that they would have wanted to have when formulating their decisions.

These adolescents discussed the environmental context as highly influential to how they made sexual decisions. Anna summed up this concept when she said “I think for me it had to do with what was happenin’ at the time.” Participants who experienced coital debut in mid adolescence during high school reported curiosity, unsupervised time alone, and an older partner as common reasons for why sex “just happened”. This finding is consistent with that of previous researchers who linked older partners to early sexual activity, non-autonomous sexual decisions, and sex with a relatively new partner (Mercer, Wellings, Macdowall, Copas, McManus, Erens, et al., 2007; Young & D’Arcy, 2005). According to Kaestle, Morisky, and Wiley (2002), when compared with females with same-age partners, those with older partners had a higher risk of having had sexual intercourse. Additionally, older partners with previous sexual experience may influence the quick progression of romantic relationships due to greater expectations of sexual activity. Participants claimed that older partners didn’t “pressure” or “force” them to have sex, but admitted that sex was “the goal of where he was going in the relationship,” and that sex was “expected”.

For participants in this study, time alone with a romantic partner outside of parental supervision led to sex that “just happened because there was no one to stop us”, especially among participants who initiated sexual activity in mid adolescence. Participants discussed parental supervision in the context of dating relationships. Although they did not specify how much monitoring they received from parents, they talked in terms of whether parents “knew where they were”. For some, parents were aware of the relationship but not the sexual activity. Other participants, such as Amy who was dating an 18 year old when she was 15, completely hid the relationship from her

parents who “would have freaked” if they had known she was “hanging around with an older guy and his older friends.”

Previous researchers have suggested an overall decreased likelihood of adolescent intercourse and a decreased number of sexual partners in the presence of parental supervision (Fortenberry, Katz, Blythe, Juliar, Tu, & Orr, 2006; Huebner & Howell, 2003). Additionally, researchers have demonstrated the existence of a strong inverse association between total hours of parental supervision and sexual activity. Cohen et al. (2002) reported that high school students who were highly supervised by parents (i.e. fewer than 5 hours a week without supervision) had fewer lifetime sexual partners and were less likely to have initiated early sexual intercourse.

The environmental context continued to be influential beyond mid adolescence and into late adolescence. While participants reported older age of partner, curiosity, and having time alone with a sexual partner as influential in the mid adolescent years of high school, the college environment that was prevalent in late adolescence presented a new set of influences on sexual decision making. These adolescents reported that the increased freedom of college, along with parties, alcohol, and an “atmosphere of sex” were situations they needed to navigate while making decisions regarding sexual activity. Heavy alcohol use among college students has been well documented (O’Malley & Johnston, 2002), and my participants concurred this as an influential factor.

The broad category of expected social norms emerged with multiple subcategories of progression to intercourse, dating relationships, and pregnancy/STI prevention. The results of my study mirror a common normative shift in dating trends, from longer-term exclusive dating relationships to a more casual dating pattern of “friends with benefits”

(Puentes, Knox, & Zusman, 2008). The prevalence of hook-ups on college campuses has been well established (Gute & Eshbaugh, 2008; Paul & Hayes, 2002; Paul, McManus, & Hayes, 2000), and there is evidence to suggest that hook-ups also exist as the normative dating pattern during mid (Manning, Giordano, & Longmore, 2006)

Consistent with recent qualitative studies by researchers examining coital debut among females during mid to late adolescence (Skinner, Smith, Fenwick, Fyfe, & Hendriks, 2008), participants in this study reported that intercourse, both at coital debut and at subsequent sexual encounters, “just happened” and that they “couldn’t see a way to stop it”. My participants viewed sexual activity as a more passive event that once started “goes to completion”. Although one participant stated that “nonconsensual sex is quite common” and many more participants described sexual situations in which consent was never asked for or given, none accused their partners of rape or assault. Many were quick to defend the actions of their partners, and stated that “I don’t want you to think he did anything wrong”. Others, such as Amy, admitted that she put more responsibility on the actions of the female: “I always looked at it like if you weren’t planning on having sex than you shouldn’t go back to the dorm and put yourself in that situation.” Lydia talked about how her male friends viewed the issue of consent and stated that “I know there’s a lot of anxiety on this male side of that like they’re going to be wrongfully accused.”

There is much existing literature on overt sexual coercion, assault, and date rape within the late adolescent population in college settings (Adams-Curtis & Forbes, 2004; Flack, Daubman, Caron, Asadorian, D’Aurelia, Gigliotti, et al., 2007; Gross, Winslett, Roberts, & Gohm, 2006). There is also literature to support the existence of sexual

coercion and violence in mid adolescent dating relationships (Blythe, Fortenberry, Tamkit, Tu, & Orr, 2006). According to these authors, coercive unwanted sexual experiences are most often discussed in terms of sexual activity to please a partner or maintain the status of the relationship. The more subtle aspects of implied sexual consent that emerged from my data have not been evaluated. Considering the overwhelming rationalization from my participants who described nonconsensual sexual activity as “OK, whatever” or “OK if that’s what he wanted”, this is clearly an area that needs further exploration.

According to the narratives of my participants, inability to clearly communicate with sexual partners contributed to sexual situations in which consent became a “gray area.” As evidenced by a recent meta-analysis, researchers studying partner communication and safer sexual behaviors have focused on negotiating condom use to decrease HIV transmission (Noar, Carlyle, & Cole, 2006). These researchers determined that conversations about sexual history may be protective for safer sex behaviors. Additionally, researchers have suggested that a longer dating period or more dating activities prior to sexual intercourse is positively associated with sexual communication among partners, possibly due to an increased comfort level for discussing uncomfortable topics (Ryan, Franzetta, Manlove, & Holcombe, 2007). In addition to the importance of communication among partners to increase condom and/or contraception use, researchers have suggested that miscommunication of sexual intentions among partners is an important factor in date rape (Winslett & Gross, 2008). Although none of my participants considered the actions of their partners to be rape, without skills or a plan for negotiating

sexual situations, inadequate communication contributed to the progression of sexual activity for which they clearly never gave consent.

Participants reflected back on their sexual decisions and discussed what they would have wanted to know that might have prevented “stupid” decisions. Almost universally, parents were named as those whom they would have wanted to talk with.. Previous researchers had shown an association between parental communication and the reduced risk of adolescent sexual behavior (DiClemente, Wingood, Crosby, Cobb, Harrington, & Davies, 2001; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Miller & Whitaker, 2001). More recently, Asby, Vesely, Oman, Rodine, Marshall, and McLeroy (2007) suggested that the type of communication between parents and adolescents could have a positive effect on reducing early sexual intercourse. These researchers found that among early and mid adolescents, participants were less likely to initiate intercourse if their parents had taught them to say no, set clear limits and rules, and talked about delaying intercourse. Researchers have also demonstrated that, in addition to safer sexual behavior, adolescents who have higher levels of connectedness with their parents make safer sexual decisions overall (Perrino, Gonzales-Soldevilla, Pantin, & Szopacznik, 2000).

Clearly, parents have the opportunity and ability to influence their children’s sexual decisions, and the participants in my study overwhelmingly identified their parents as the preferred source of sexual information over peers, school, and media sources. In addition to being the first choice of adolescents, a significant benefit of parental involvement in communication is that parents are able to express sexual expectations that specifically reflect the values and beliefs congruent with those of their own families.

While other sources such as media outlets, schools, and peers may provide general or supplemental information, these entities are unable to tailor sexual messages to reflect the specific needs of individual adolescents and their families. The ability to tailor communication may result in sexual information that is more useful and relevant to the adolescent, or as one participant stated, “more real”. Adolescents who feel that sexual information is specific to their particular situations may be more likely to use this information to successfully formulate safer sexual decisions.

According to the participants, school based information on contraception and STIs varied from setting to setting, with noticeable differences reported among public, private, and Catholic high schools. Some participants reported “very comprehensive” programs, while others described their sexual education in high school as “useless”. Although their awareness of condom use was high, these adolescents were less able to access other birth control options, especially during their high school years. Also, even though all my participants were highly motivated to prevent pregnancy, many reported episodes of unprotected sex, being “less cautious” than they should have been, and admitted that they “didn’t really think about any STDs”. Consistent with the statements of some adolescent participants, school based sexual information has been shown to increase adolescent knowledge about pregnancy and STIs, but this has not translated into improved sexual negotiation skills, communication, and decreased risk behavior (Maynard, et al., 2005). Making adolescent sexual education truly comprehensive involves changing the current curriculum to include clear and accurate information on access to sexual health care, obtaining contraception, and STIs.

Authors of the existing literature have identified peers as being influential on adolescent sexual activity (DiIorio et al., 2004; Hoff et al., 2003). Although the participants in this study talked about discussing sex with close friends, “pressure” from peers was not identified as an influence on the decision to engage in sexual activity. Conversely, many participants related that their peers were either unaware of their sexual activity or not supportive of their sexual behavior. In addition, adolescents in this study frequently discussed religion, how they were raised in their faith, and how their religious teachings did not support sexual activity prior to marriage. Despite being raised with “conservative” or “strict” Christian or Catholic views and labeling themselves as “a religious person”, religious teachings did not prove to be influential on abstaining from or delaying sexual intercourse. This finding is in contrast to that of previous researchers who identified religious or moral beliefs as reasons for abstinence (Moore et al., 1998; Rostosky et al., 2003).

In addition to peer influence, there is a considerable amount of research that has linked exposure to sexual media content to the onset of sexual activity, especially during early adolescence (Brown, et al., 2006; Collins et al., 2004; L’Engle et al., 2006). Despite these research findings, discussion of media influences by participants in my study was inconsistent. Although participants admitted that “a lot of stuff on TV is pure sex”, and labeled “television, music videos” as “subconscious influences”, very few thought the sexual content in music, television, or films influenced their personal decisions to be sexually active. Mary was the only participant who considered that media may have played a role in her sexual behavior. She talked about hook-ups at college and how she felt that sex was something she should be participating in because “I would watch movies

or TV shows about college; that's what college was. College was a lot of people having random sex." This is contrasted with other participants, such as Jen, who didn't feel sexualized media was influential because "I kind of know better." The majority of existing research of the influence of sexual media has focused on early adolescents and the consumption of sexual content as a predictor of coital debut. Given that none of these participants initiated sexual activity in early adolescence (average age of coital debut age 17), it is possible that in later adolescence they were better able to mediate the effects of sexual media.

Summary of Findings

The worldview of adolescence was reflected in the narratives of my participants, and their stories of adolescent sexual decision making revealed multiple levels of influence. Adolescents spoke of context, social norms, and issues with sexual consent as being highly influential to their decision making processes. These distinct components did not occur in isolation; rather they were often interwoven and layered to reflect the complex world adolescents must navigate as they make decisions about their sexual behaviors. Adolescents concluded their stories with reflections on past behavior and offered insights as to how and why events happened as they did. Additionally, they reflected on what they would have considered helpful to their decision making process. In the last chapter, I will discuss the implications of my findings for theory, research, practice, and education.

CHAPTER 5

Implications for Nursing Knowledge and Conclusions

The purpose of this study is to address the gap in the literature represented by an absence of first hand accounts of the factors that influence adolescent sexual decision making. Using a narrative approach, I asked a cohort of late adolescent participants to tell their stories about the events surrounding their decision to become sexually active, and how this initial decision affected subsequent decision making. Going directly to the adolescents who are experiencing the phenomenon of concern not only gave voice to this population by acknowledging interest in their stories, but also allowed me to gain a much deeper understanding of the complexities of sexual decision making.

In this chapter I will discuss the implications for nursing theory, research, practice, and education. I will also discuss issues related to health care policy addressing adolescent sexual health. Finally, I will discuss the limitations of the study.

Implications for Theory

Existing decision making theories, although helpful in providing an overall framework for the complicated process of judgment and choice related to sexual decision making, are of limited usefulness with the adolescent population. As a whole, theories of decision making have been formulated using an adult population, and do not translate well to the incomplete, transitional thinking of adolescence. These theories include underlying assumptions of mature cognition and communication skills (Patel et al., 2002) and the ability to make logical and correct judgments (Gutnik et al., 2006). The limits of existing decision making theories need to be viewed in relation to adolescent growth and development. Prevailing developmental theories posit that younger adolescence is

dominated by present-oriented thinking that lacks consideration of potential consequences of behavior (Inhelder & Piaget, 1958). Feelings of invulnerability (Elkind, 1967), and expansion of cognition to incorporate complex information (Perry, 1999), are all hallmarks of adolescent development. During adolescence intelligence and analytical skills increase and emotional capacity expands, but these functions may not be well regulated in the absence of fully matured brain development.

There is a growing body of research that indicates continued maturation of brain processes and activity throughout adolescence, including significant changes occurring well into the late adolescent years. The researchers have demonstrated that frontal lobes of the brain, which are responsible for executive function, are not fully matured until young adulthood (Giedd, Blumenthal, Jeffries, Castellanos, Liu, Zijdenbos et al., 1999; Paus, 2005; Sowell, Delis, Stiles, & Jernigan, 2001; Sowell, Trauner, Gamst, & Jernigan, 2002). These specific brain areas are the last to mature and therefore adolescents are less able than adults to judge risk, make long term plans, and accurately prediction the consequences of their actions.

On a theoretical level, nurses must acknowledge that older adolescents are not yet adults, and therefore be aware that their decision-making activities will differ accordingly. Nurse practitioners who interact with the adolescent population need to have a thorough understanding of growth and development, and realize that not only are most early and mid adolescents concrete thinkers who are oriented to the present, but that even late adolescents do not possess fully developed adult reasoning skills. Significant gains in impulse control, decision making, and emotional maturity may not be seen until early

adulthood. As the adolescent brain matures, long-term planning, decreased risk taking, and increased self control increase as frontal lobe brain development becomes complete.

Adolescent sexual decision making is a complex and multi-layered process with many levels of influence. Because of this dynamic nature of the decision making process, a social ecological model provides a useful lens through which to view decisions, consider varying levels of influence on behavior, and to recognize that decisions and behaviors result from interactions among many factors and their resultant actions. Characteristics of the individual adolescent, along with his or her history of environmental interactions and social norms, also influence behaviors. Behaviors related to sexual decision making cannot be well understood without viewing the context within which those personal decisions and behaviors occur (Grzywacz & Fuqua, 2000).

Understanding adolescent sexual decision making, perceived sexual risk, and potential protective factors requires consideration of the environmental context. A main factor that set the stage for the decision making process of these adolescents was the influence of the environmental context at that time. Although the context shifted as the adolescent transitioned from mid to late adolescence, the influence of environment remained constant even as the situations changed. Thus, the social model served as a useful filter for considering the worldview of adolescence because it provided a very broad perspective on the process of decision making.

The importance of context in the decision making process during adolescence is undeniable. However, I could not discern reciprocity in the data generated through the interviews. It was impossible to tell whether influences on sexual decisions and behaviors were due to the internal environment of the individual adolescent or the external

environment at the time of decision making. Given my findings, it is plausible to consider that there are transactional effects between adolescents' decisions and their environments, and the interaction between the two may explain differences in adolescent perceived risk and protective behaviors over time. Although more work is needed, my findings might be useful to guide development of an ecological middle-range theory of adolescent sexual decision making that considers decision making, context, perceived risk, and protection as interactive concepts. Designed specifically for an adolescent population, this theory would incorporate concepts of adolescent learning that could be adapted for the differing sub stages of adolescence. For a practice discipline, the construction of middle-range nursing theories provides a structured way of identifying and expressing salient ideas that are important to practice. Middle-range theories are limited in variables and scope, which provide the specificity needed to guide practice and research (Walker & Avant, 2005).

Implications for Research

Several additional qualitative studies have the potential to further unravel the complexities of adolescent thinking and behavior. As demonstrated through the results of this research, sexual behavior is strongly shaped by social forces through which the adolescent must navigate during the decision making process. Qualitative methods permit researchers to gain insight into behaviors in their social context, and therefore are appropriate for studying this topic.

A research question that has been generated from the findings of this study is what is the main concern of early, mid, and late adolescents as they formulate strategies to make sexual-related decisions, and are additional factors involved/included as the adolescent brain matures? A grounded theory approach to address these questions would

enable the researcher to increase knowledge of as well as move toward theoretical perspectives on adolescent sexual decision making. A researcher could employ this method to more specifically target the different sub stages of early, mid, or late adolescence, and mine its potential to reveal subtle differences among and between the stages.

Adolescents in this study identified their parents as the preferred source of sexual information, but discussed that communication with their parents was difficult. Although there was some diversity within my study sample, the voices of Hispanic adolescents were underrepresented. Sexual communication between adolescents and their parents within the Hispanic community may be affected by the same communication challenges, especially in Spanish speaking households. A research question that may begin to address this problem is what are the most effective culturally appropriate strategies to promote sexual communication between Hispanic adolescents and their parents? Participatory action research is useful as a guide for program development and community education, and may be well-suited to investigating sexual decision making among adolescents from specific ethnic backgrounds, adolescents for whom the United States is not their country of origin, and those who are illegal immigrants. Participatory action research would facilitate the involvement of both adolescents and their parents, and could be designed to teach the skills necessary for effective and culturally sensitive communication.

Issues related to sexual consent comprised a salient topic emerging from my data. The concept of implied consent is underexplored in the current literature. Due to the legal implications of nonconsensual sexual activity, this is an area that requires further investigation; for example, what are the social conditions that are likely to lead to adverse

outcomes? Researchers could formulate questions to tease out adolescents' understanding of consent and potential subsequent behaviors. They could explore adolescents' perception of situations when or where they might find themselves in unsafe sexual situations. Through this line of inquiry, investigators also could raise the awareness level of both adolescents and the general public, that this gray area of consent is a common phenomenon in adolescent dating relationships.

I see the issue of implied sexual consent as strongly related to the means by which adolescents are educated about sexual activity, including information obtained from both parents and schools. Researchers could design intervention studies to improve negotiation and communication skills between adolescent partners and thus lay the groundwork for safer sexual interactions. As demonstrated in my study, adolescents had difficulty communicating with their partners, which made sexual refusal or clear consent difficult. An intervention study to compare the effectiveness of strategies such as role playing of negotiation and communication skills with standard care (such as verbal instruction only) could be designed to test the effectiveness a partner communication intervention.

In addition to a research focus on partner communication, the narratives of the adolescents in this study highlighted the need for research to improve parents' ability to communicate with their adolescent children. Another idea for research would be creating and evaluating multifocused interventions that include both parents and adolescents. This multi-pronged approach will enable clinicians, sex educators and others to target communication issues from the perspectives of both adults and adolescents. A multifocal approach may have more power to improve sexual decision making thus reducing

adolescent sexual risk behavior. Studies that are creative and address findings from prior studies warrant serious consideration by researchers when they are designing studies.

Lastly, for this study I accessed a small sample of adolescents, the majority of whom are Caucasian, and college students. To expand our conceptualization of adolescent sexual decision making, it is essential that future researchers select a sample with participants from different ethnic and socioeconomic backgrounds, as well as adolescents who have completed high school or perhaps even dropped out. The voice of male adolescents is underrepresented in my study, so future researchers must examine male adolescents' perspectives on sexual decision making and sexual consent.

Implications for Practice

The results of this study provide evidence that adolescent sexual decision making is a complex process with multiple layers of influence. Despite this knowledge, adolescent sexual behavior is frequently characterized by simply assessing whether or not adolescents have engaged in sexual activity, thus ignoring the relational characteristics of sexual experiences (Manning, Longmore, & Giordano, 2005). For a full understanding of adolescent sexual decision making, nurses and all health care providers need to consider the fluctuating and often unpredictable nature of adolescent relationships. This must include theories of growth and development as the foundation from which all care is planned. In addition, providers must be aware of recent research on adolescent brain development that indicates continued myelination in the frontal lobe through early adulthood. Until this maturation is complete, it is common to see wide variations in judgment, risk-taking, and impulse control (Paus, 2005; Sowell, Delis, Stiles, & Jernigan, 2001; Sowell, Trauner, Gamst, & Jernigan, 2002).

Advanced Practice Nurses

Nurse practitioners often provide reproductive health care to the adolescent population through pediatric primary care, family planning clinics, and college health settings. As such, these advanced practice nurses are often the first health care providers adolescents see before and after the onset of sexual activity. As revealed by the participants in this study, hook-ups, or one time sexual encounters, are a common relationship pattern in both mid and late adolescence. Adolescents may not equate this dating pattern with having many lifetime partners or with increased sexual risk that can lead to long-term health problems and therefore not report an accurate number of lifetime partners. Nurse practitioners who are attempting to positively affect adolescent sexual decision making need to consider the meaning of the relationship to the individual adolescent before expecting any behavioral change. Therefore, on the practice level, nurse practitioners need to assess adolescent sexual behaviors in greater detail, especially focusing on the social, cultural, and psychological contexts within which sexual activity and sexual decisions occur. This individualized care may result in more successful interventions to decrease risky sexual behavior.

Nurse practitioners who care for this population need to repeatedly review safer sexual behaviors with adolescents. These include delaying coital debut, consistent condom use, limiting lifetime partners, inquiring about a partner's sexual history, avoiding impaired decision making by not engaging in substance use, and reviewing how to negotiate the limits of sexual activity. Decision making about sexual activity while impaired with alcohol was commonly reported by my participants. Another area of concern was their admission of decreased concern about STIs. Rather than having a one

time discussion, nurses and other caregivers need to engage their adolescent patients in an ongoing dialogue, incorporated into every visit, in which they address these issues in a way that is appropriate for the different sub stages of adolescence. Offering this information will open lines of communication about the process of sexual decision making and assist the practitioner and patient in identifying strategies for successful outcomes.

School Nurses

School nurses who work with students in grades 6-12 are in a position where they have significant access to the adolescent population. There is opportunity for these nurses to offer support, teaching, and guidance to adolescents by making their offices a “safe haven” for adolescents. Although their scope of practice may be limited by the school district, school nurses can be a primary source of education. Starting at the elementary school level and continuing through high school, school nurses are able to provide developmentally appropriate sexual education, both to adolescents and their parents. Additionally, they are a valuable source of information for adolescents who require a referral for contraceptive and/or reproductive health care.

Implications for Education

Lack of clear communication and guidance from parents, coupled with inconsistent sexual education in schools, resulted in unrealistic and inadequate information for the adolescents who participated in this study. The limited information they did receive was either too vague or too narrowly focused on the biologic aspects of sex and pregnancy, and did not represent the reality of the world in which these

adolescents live. Based upon the narratives of my participants, it is possible to suggest implications for improving education of not only adolescents, but also parents and nurses.

Adolescents

One participant, Joe, remembered that some of his classmates were already sexually active prior to receiving information in school. This represents an example of too little information given too late, or as Joe questioned, “how was that supposed to help?” Making adolescent sexual education truly comprehensive involves changing the current curriculums. From elementary school through high school, educators and school nurses need to provide age appropriate education that includes both biologic and psych-emotional information. As adolescents transition through the different sub stages of adolescence, sexual health nurses and educators must include clear and accurate information on access to sexual health care, obtaining and using contraception, and STI prevention and treatment.

Several of my participants commented that sexual activity occurred because they “just didn’t know how to stop” it from progressing. Recent researchers have demonstrated that the most successful sexual risk reduction programs incorporate communication and negotiation skills (Johnson, Carey, Marsh, Levin, & Scott-Sheldon, 2003; Pedlow & Carey, 2004; Robin, Dittus, Whitaker, Crosby, Ethier, & Mezooff et al., 2004). Educators who incorporate role play, communication exercises, and assertiveness and negotiation exercises as components of sexual education have the opportunity to impart skills that will help adolescents mediate complicated interpersonal situations. Being able to practice and experiment using these skills will lay the groundwork for successful interactions in future relationships. As part of this expanded educational

strategy, educators need to give adolescents clear information on sexual consent and sexual safety. This includes the ability to recognize situations that are potentially dangerous, such as being alone with a new, unfamiliar partner and making decisions when impaired from drugs or alcohol. As discussed previously, school nurses are in a position to assist with the development and implementation of these educational programs.

Consistent with the findings of previous researchers (Marston & King, 2006), adolescents in my study subjectively judged sexual risk by how well they knew their partners socially, even if they were only remotely acquainted. Lydia described how as her social group expanded and she became more familiar with her extended network of friends, “you don’t worry so much about the guy you’re going to have sex with”. As noted by Marston and King (2006), this behavior has the potential to promote physically unsafe encounters, underestimation of overall sexual risk, and overestimation of safety.

The participants in my study revealed that what was occurring in their social environments at the time had a strong influence on sexual decisions. Because environmental factors are not always amenable to change, it is essential to teach adolescents ways to manage the stimuli from external sources such as peer and the social scene. Participants frequently mentioned that the transition from the structure of high school and living at home to the more unsupervised freedom of work and college was “overwhelming”.

Sexual educational initiatives for adolescents should focus on major change points such as the transition from elementary school grades 1-5 to secondary school grades 6-12, from grade 12 to work or college. As part of these initiatives, educators and parents can

offer strategies for mediating an environment in which “sex is everywhere”. Anticipatory guidance from nurses, parents and sexual educators should include information about situational factors adolescents report as the most threatening to decision making (older partner, unsupervised time alone, access to alcohol, managing transition and freedom). At the elementary and secondary level, this could be accomplished by school nurses. As adolescents begin college, advanced practice nurses working in the university’s health services could be involved in the development and implementation of programs that assist adolescents to manage their transition to college life and living away from parents. Freshman orientation, dormitories, and on campus clubs and organizations are potential venues to reach out to adolescent students.

Parents

My participants were clear in their desire to communicate with their parents. Participants reported that their parents seemed uncomfortable discussing sexual topics or never talked about any sexual matters. Nurses and health educators need to expand programs to meet the needs of parents as well as the adolescents. Based upon the accounts of the adolescents who participated in this study, education to improve parental communication with children about sex would be beneficial. In addition to increasing communication, nurses who interact with parenting families are in a unique position to encourage and guide parents in discussing sexual education with their children at a young age. Honest, developmentally appropriate information establishes open lines of communication prior to adolescence and allows parents the ability to tailor the information to the specific needs of their children within the context of their family beliefs and values.

Nurses

In order for nurses to educate adolescents about healthy sexual behavior and decision making, they need to have a thorough understanding of adolescent growth and development. This foundational knowledge must be included in baccalaureate nursing programs, and student nurse need to have the opportunity to work with the adolescent population during their clinical practice rotations. Exposure to the unique needs of adolescents must continue at the advanced practice level. Adolescent or teen clinics, family planning clinics, and offices that specialize in the care of adolescents should be available as training sites for nurse practitioner students as they are precepted by experienced advanced practice nurses.

Implications for Policy

The findings from this study highlight areas in which policy changes should be considered. Expanding on the previously discussed educational implications, federally funded sexual education programs should be evaluated for effectiveness and if necessary, changed to reflect current, evidence-based information.

Public monies that are used to fund national sexual education programs should only support those programs that have documented effectiveness. Abstinence based programs have not been shown to significantly decrease risk-taking behavior (Kirby, Lepore, & Ryan, 2005; Sather & Zinn, 2002). Although school based sexual information has been shown to increase adolescent knowledge regarding pregnancy and STIs, this has not translated into improved sexual negotiation skills, communication, and decreased risky behavior (Maynard, et al., 2005). These findings from my study concur as my adolescent participants reported an increased level of knowledge about condom use and

some forms of contraception, yet reported engaging in unprotected sex, sexual activity under the influence of alcohol, and being unable to effectively communicate with sexual partners.

In addition to including evidence-based content, government funded sexual education programs need to be culturally sensitive to reflect the increasing diversity of the United States population. All levels of government (federal, state, local) need to coordinate services to eliminate inequities in the creation of programs and delivery of health care. The success of this effort will depend largely on the cooperation of many entities that intersect in the lives of adolescents: parents, schools, health care providers, religious organizations, and community groups.

Adolescents are a marginalized group within sexual health care. In order to protect adolescents from unintended pregnancy and potential long-term consequences of STIs, it is necessary to ensure they have access to confidential and affordable reproductive health care. Adolescents who are concerned about confidentiality may delay seeking care to avoid using family health insurance. The role of confidentiality and its potential violation has been explored by various researchers who have learned that adolescents would avoid seeking reproductive health care (Marks, Malizio, Hoch, Brody, & Fisher, 1983), delay obtaining care (Zabin, Stark, & Emerson, 1991), and withhold specific sexual information (Ford, Millstein, Halpern-Felsher, & Irwin, 1997). More recently, Reddy, Fleming, and Swain (2002) found in a sample of 950 adolescent girls using Planned Parenthood services almost 60% (n=556) of those surveyed indicated they would stop using all sexual health care services if their parents were notified of their visits.

The financial burden of paying out of pocket for health care may prohibit adolescents from initiating and/or continuing care, and contributes to their inability to afford contraception. Federal and state funding must be allocated to programs that are designed to meet the specific needs of uninsured or underinsured sexually active adolescents. In an effort to decrease unintended pregnancy and reduce maternal and infant morbidity and mortality in young childbearing-aged women, the federal government established Title X of the Public Health Service Act in 1970. This comprehensive program was devoted entirely to the provision of national family planning services, with a special focus on uninsured or underinsured young women and maintaining confidential services for adolescents (Dailard & Richardson, 2005). The continuation of federal funding for this program needs to be a high priority to insure adolescents have timely and affordable access to contraception and reproductive health care services.

Limitations

The results of this study must be considered in terms of the study limitations. The eleven participants in this small qualitative study were between the ages of 18 and 22 years, so the study is limited in its scope and transferability. All but one participant was female, and, therefore, the view of male adolescents is underrepresented. I conducted the study in one geographical location, so my findings may not represent the views of adolescents from other parts of the United States or different countries. Although I achieved some diversity in the sample, the majority of my participants lived in suburban areas, were Caucasian and college educated. Therefore, their views may not represent those of adolescents of different ethnicities, those who live in urban areas, are in high

school, or have not completed high school or enter the work force following graduation from high school.

Conclusions

The purpose of this narrative inquiry was to determine late adolescents' perceptions of factors that influenced their sexual decision making from coital debut to the present. That aim was met. I chose a qualitative method for my research due to the prevalent view in the literature and in society that adolescent sexual decision making ends in either good or bad decisions, with an inadequate focus on how adolescents actually make decisions about sexual behavior. These dichotomous views of adolescent sexual decision making fail to acknowledge that overall decision making patterns have many layers of environmental influences that contribute to individual decisions.

Using a narrative approach, I interviewed 11 late adolescents between the ages of 18 and 22 years and asked each participant to tell me the story of how he or she made the decision to first have sex. Four salient components emerged from the data. These components, drawn directly from the narratives of the adolescent participants, helped tell the story of adolescent sexual decision making from coital debut to the present. Context serves as the introduction to the story, setting the stage for the plot and conclusion. The plot consists of two components. The first component contains comments about expected social norms regarding dating relationships and included influences of the social scene, progression to intercourse, and pregnancy and STI concerns. The second component focuses on issues surrounding sexual consent and details how this is a gray area that includes lack of partner communication. Adolescents conclude their stories with a retrospective self-evaluation that includes how their decision making and behavior has

changed, and discuss their thoughts on information that they wished they had when formulating their decisions.

Through their stories, my participants provide rich, meaningful insights into a very complicated phenomenon. Immersion in the data allowed me to uncover a more comprehensive conceptualization of adolescent sexual decision making and related sexual behaviors. This conceptualization will improve understanding of adolescent sexual activity and provide clinicians, educators, and researchers with significant information directly from adolescents who are involved in the decision making process. Now that these adolescents have identified their areas of concern, these will guide the development of further studies and possible interventions to improve health care for this population. Potential for expanding nursing knowledge exists in the development of theories, practice innovations, research, sexual health education, and policies for addressing adolescents' needs across the continuum of development from childhood to adulthood.

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Appendix A

Boston College
Institutional Review Board
Waul House, 2nd Floor
Chestnut Hill, MA, 02467

June 4, 2008

To Whom It May Concern:

This letter is to inform you of our consent to serve as a recruitment site for the dissertation research of Heidi Collins Fantasia, PhD(c), RN, WHNP-BC. We are fully aware of her proposed research study and give permission for her to recruit her participants from our four clinic locations.

Please feel free to contact me if you have any questions.

Sincerely,

Renee LaForce
Director of Health Care Quality
Health Quarters, Inc.

Appendix B

I WANT YOUR VIEW**Have you ever thought about your decisions to have sex?**

I am doing a research study to learn about how young people make decisions about sexual activity. If you are a sexually active man or woman between the ages of 18-22 and would like to share your thoughts about sex, please contact Heidi Collins Fantasia at either heidi.collins.1@bc.edu or 781 389-5981.

You will receive a \$25 iTunes gift card for approximately one hour of your time!

Research Study
781 389 5981
heidi.collins.1@bc.edu

Research Study
781 389 5981
heidi.collins.1@bc.edu

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781 389 5981
heidi.collins.1@bc.edu

Research Study
781 389 5981
heidi.collins.1@bc.edu

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781 389 5981
heidi.collins.1@bc.edu

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781 389 5981
heidi.collins.1@bc.edu

Research Study
781 389 5981
heidi.collins.1@bc.edu

Research Study
781 389 5981
heidi.collins.1@bc.edu

Appendix C



Boston College
William F. Connell School of Nursing

Informed Consent for Taking Part in:
Late Adolescents' Perceptions of Factors That Influenced Their
Sexual Decision Making:
A Narrative Inquiry
Principal Investigator: Heidi Collins Fantasia, PhD(c), RN, WHNP-BC

Why have I been asked to take part in the study?

- Because you are sexually active and between the ages of 18 and 22.
- Because you might have an interest in sharing your story about when and why you became sexually active.

What do I do first?

- Before agreeing, please read this form.
- Please ask any questions that you may have.

What is the study about?

- The purpose of this study is about people's stories that tell about their decisions to have sex.
- Persons who take part in this study will include about 10-20 people from the Boston and North Shore area of Massachusetts.

If I agree to take part, what will I be asked to do?

1. Tell the story of what influenced you in deciding to have sex.
2. Tell the story of how and why you decided to stay sexually active.
3. You can tell as much of the story as you want to.
4. Allow me to audio tape-record the interview.
5. If you do not wish to have any part of your story tape recorded, please tell me and I will not tape record it.
6. The interview is expected to take about an hour.

What are the risks to being in the study?

- There are no expected risks. There is a small chance that you might become upset when discussing part of your story with me, the researcher. There is also a chance that you may have questions about your own health during the interview. If either of these things happens I will be able to give you the name and number of a health care clinic or a counselor that helps with emotional health. The cost to you per visit would be approximately \$25. You may also contact the clinic directly at: Health Quarters, 19 Broadway, Beverly MA 01915; (978) 922 4490 or at www.healthq.org.

What are the benefits to being in the study?

- There are no expected benefits.

Will I be paid for being in the study?

- You will receive the following payment: a \$25 iTunes gift card.

Will it cost me money to be in the study?

- There is no cost to you for being in the study.

How will things I say be kept private?

- The records of this study will be kept private.
- In any type of report I may write, I will not include your name or that of anyone else.
- You will pick an alternate name (pseudonym) that will appear on the tape and written report.
- Research records (including audio tape recordings) will be kept in a locked file.
- Research records will be destroyed at the end of the project.
- Access to the research records will be limited to me as the researcher.
- However, sometimes, sponsors, funders, regulators, and the Boston College IRB may have to review the research records.

What if I choose to not take part or leave the study?

- Taking part in the study is voluntary.
- If you choose not to take part, it will not affect your present or future relations with the health clinic or with Boston College.
- You are free to leave the study at any time, for whatever reason.
- You will not be penalized or lose health care for not taking part.
- You will not be penalized or lose health care if you stop taking part in the study.

Who do I contact if I have any questions?

- You can contact Heidi Collins Fantasia who is the researcher in charge of this study. Her number is 781 389-5981 and her email is heidi.collins.1@bc.edu.
- If you believe you may have suffered injury or harm from this research, contact Heidi Collins Fantasia at 781 389-5981. She will give you instructions on what to do next.

- If you have any questions about your rights as a person taking part in the study, you may contact: Director, Office for Human Research Participant Protection, Boston College at (617)552-4778 or irb@bc.edu.

Will I get a copy of this consent form?

- Yes, you keep the consent form for your records and future reference.

Statement of Consent:

- I have read (or have had read to me) the contents of this consent form.
- I have been encouraged to ask questions.
- I have received answers to my questions.
- I give my consent to take part in this study.
- I have received (or will receive) a copy of this form.

Signatures/Dates:

Signature of Participant

Signature of Researcher

Printed/Typed Name

Printed/Typed Name

Date

Date

Appendix D

Demographic Information

Name (pseudonym) you have picked_____

Age_____

Sex: Male_____ Female_____

Race/Ethnicity_____

Job_____

Education level:

Some high school_____

High school graduate_____

Some college_____

College graduate_____

Age when first had sex_____

Appendix E

Carol Anne Marchetti
116 John Street
Reading, MA 01867

May 1, 2008

Dear Carol,

I am writing to ask if you would be willing to serve as an on-call psychiatric mental health counselor on my dissertation study. I will be conducting interviews with late adolescents between the ages of eighteen and twenty-two. The interviews will focus on the participants' decisions to become and remain sexually active. In the event that a participant becomes emotionally distressed during or after the interview and expresses a desire to talk with a mental health care professional I need to be able to provide them with a referral to a qualified counselor. Your experience and expertise in child and adolescent psychiatry would be invaluable.

Please let me know if you would be able to provide counseling services in this capacity.

Sincerely,

Heidi Collins Fantasia, PhD(c), RN, WHNP-BC
Doctoral Candidate
Boston College
William F. Connell School of Nursing

Appendix F

Heidi Collins Fantasia
139 Cliff Avenue
Winthrop, MA, 02152

June 4, 2008,

Dear Heidi,

I received your letter regarding your dissertation research and I would be honored to provide counseling services to the participants in your study. Please feel free to provide my professional contact information to any participant that requests mental health counseling. I look forward to working with you and good luck with your dissertation.

Sincerely,

Carol Anne Marchetti, PhD(c), APRN-BC, SANE
Adolescent & Child Psychiatric Clinical Nurse Specialist
Doctoral Candidate
Boston College
William F. Connell School of Nursing

Appendix G

**LATE ADOLESCENTS' PERCEPTIONS OF FACTORS THAT INFLUENCED
THEIR SEXUAL DECISION MAKING**

Broad Opening question:

- ❖ Please tell me, in your own words, the story of your decision to first have sex

Possible Probe Questions:

- ❖ Please tell me more about.....
- ❖ Other participants have said that.....What is your reaction to this statement?
- ❖ Can you elaborate on.....
- ❖ Could you clarify.....

Appendix H
Demographic Characteristics of Sample

<u>Participant</u>	<u>Age</u>	<u>Sex</u>	<u>Race/Ethnicity</u>	<u>Occupation</u>	<u>Education Level</u>	<u>Age at Coital Debut</u>
Mary	20	Female	Caucasian	Student	Some College	18
April	21	Female	Chinese	Student	Some College	15
Joe	18	Male	Caucasian	Delivery Driver	High School Graduate	15
Erica	20	Female	African American	Student	Some College	17
Marren	22	Female	Caucasian	Student	Some College	19
Lydia	21	Female	Asian	Student	Some College	16
Jen	22	Female	African American	Student	College Graduate	17
Anna	19	Female	Spanish	Receptionist	High School Graduate	17
Stacy	22	Female	Caucasian	Math Tutor	College Graduate	16
Amy	20	Female	Caucasian	Student	Some College	19
Heather	20	Female	Caucasian	Student	Some College	19