Adolescent Females and Decisions About Sexual Health:

A Qualitative Approach

THESIS

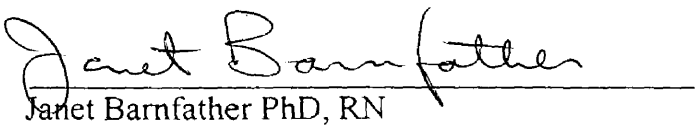
Submitted to the Department of Nursing of
University of Michigan/Flint

In Partial Fulfillment of the Requirements for
The Degree of Master of Science in Nursing

2001

by

Christina Kalisz
Hurley Medical Center School of Nursing RN Diploma
Michigan State University BSN

Committee Chairperson 
Janet Barnfather PhD, RN

Committee Member 
Carol Rossman MSN, CFNP, CS

Acknowledgments

There are several people that I would like to give credit to for being supportive of me in a variety of ways while I completed this thesis. First and foremost to my daughter Amanda Aplin, who unselfishly gave me the time I needed to complete this project and showed great patience for a child. Next, my parents and my sister helped me every week with childcare that enabled me to attend class and all of the associated functions. Third, my husband Tom, who frequently went to functions solo and understood when I was "too busy". Without the assistance of Sue Jaskiewicz, Devora Lattimore, and Stacie Wilson, I would not have been able to complete my data collection; and I am grateful for their help. I would also like to acknowledge Dr. Kay Taylor, the Director of Research at Hurley Medical Center for her encouragement and assistance with data analysis. I would like to thank my committee member and friend Carol Rossman for her support in various ways throughout this endeavor. Lastly, but in no way least, I would like to acknowledge Dr. Janet Barnfather for her unwavering support and patience with a new researcher. She painstakingly reviewed hundreds of pieces of paper and made important suggestions. She also gave support when this sometimes overwhelmed graduate student needed it.

Table of Contents

List of Tables

Table

List of Appendices

Appendix

Abstract

Very little qualitative research has been done in the area of adolescent sexual health and decision-making. An array of national, state and local literature exists to show how dismal the statistics are in terms of teen pregnancy, infant mortality and sexually transmitted diseases, including HIV. But what is not understood is how adolescents make decisions related to their sexual health. Five low-income adolescent females who resided in inner-city Flint, Michigan, ages 15-17, obtained as a convenience sample from an area home care maternal support services population, were interviewed using a loosely structured set of predetermined questions to elicit information about sexual health and decision-making. Responses were audio-taped, transcribed and compiled into data analysis tables using a phenomenological approach. The following nine patterns and themes were identified: communication about sexual behavior, decision-making related to sexual behaviors, plans for future education, knowledge deficit related to sexual health in general, peer pressure related to sexual activity, religion and its role in decisions, self-esteem as identified by non-verbal communication, trusting sex partners, and values in relation to decision-making. Participants did not appear to know how to make informed decisions. They did not decide purposefully about their sexual health. It just happened. The results are an important basis for further research because healthcare providers need clearer information on components of adolescent decision-making about sexual health before meaningful education and intervention can occur.

CHAPTER I

Introduction

Adolescence, which Edelman and Mandle (1998) define as 10 to 21 years of age, is a unique time of great physical and psychological change which incurs an equally unique set of challenges for the teens and for health care providers. These unique physical changes include those with puberty ranging from obesity and nutritional deficits to risk-taking behaviors. The risk-taking behaviors have been defined to include teen pregnancy, school truancy, chemical abuse, early, unprotected sexual intercourse, abuse of alcohol, use of firearms, and use of cigarettes (Bock, 1997). This same study noted that when adolescents have a feeling of personal connection to home, family and school, that they are much less likely to engage in these high-risk behaviors (Bock).

Edelman and Mandle (1998) note that adolescents are in the process of developing patterns of problem solving and health habits that are presumably ones that the adolescent will have for life. The following have been identified as factors that influence adolescents' health care service use: severity of the illness, duration of signs and symptoms, restrictions on daily routine, cost, availability of a competent, sympathetic provider, awareness of the need for care and proximity to health care.

Adolescence is also a time when teenagers discover ways to become more independent. This is as well a time for learning health-related behaviors, some of which are health-enhancing as self-care, but some are health-compromising, such as the high-risk behaviors noted earlier. Most of the health problems of adolescents are related to social and behavioral factors. Every year hundreds of thousands of adolescents have serious consequences from health-risk behaviors (Levenberg, 1998). The term risk

taking is commonly being used to describe the patterns of behavior initiated during adolescence which are responsible for the majority of negative health outcomes occurring in the second decade of life (C. Irwin, 1990). According to Quinn Youngkin and Szmania Davis (1998, p. 46):

- Every 22 seconds, an American teenager becomes pregnant
- Every 67 seconds, an American teenager has a baby
- Every day, six teenagers commit suicide
- Every day, 623 teenagers get a sexually transmitted disease

Dickinson (1999) referred to the recent information from the National Center for Health Statistics that the birth rate for teenage girls ages 15 to 17 is the lowest it has been in 40 years. This is still a formidable number of teenage pregnancies if they are occurring every 22 seconds as mentioned earlier. Levenberg continues to note that more than 70% of adolescent morbidity and mortality is due to behavioral factors and is preventable.

Given the national statistics, it is imperative that high-risk behavior in adolescents be addressed. Nurse practitioners, (NPs), are uniquely qualified to meet the needs of this diverse population. Nurse practitioners are identified to provide care to adolescents because the NP is more than capable of meeting the diverse health needs of adolescents with the highest quality, most cost-effective approach (Auer, 1999). While much research exists to support the need for nurse practitioner intervention with teens and their health, little to no research exists on how teens make decisions related to their health and high-risk behaviors. Much quantitative data exists to support the need for this area to be addressed. However, little qualitative research has been done in terms

of what affects the decisions that these teens make. It would serve the nursing profession well to further investigate what impacts the decisions adolescents make regarding health behaviors. "The shift to social causes of ill health is evident: risky behaviors increasingly threaten the health and well-being of the adolescent population" (Nerdahl, et al., 1999, p. 185). Irwin proposed that risk behaviors are associated with one another in predictable ways. For instance, Irwin found that substance use is positively correlated with early initiation of sexual behavior. Other researchers have found the association of early sexual activity and ineffective contraceptive use with use of cigarettes and/or alcohol.

With this information in mind, it is crucial for the nursing profession to further investigate what affects the health behavior choices of adolescents. New adjustments and new strategies can be developed to further meet the unique needs of the adolescent population. A qualitative study focusing on the decisions that adolescents make related to sexual health can help answer the question of this study: How do adolescent females make decisions related to their sexual health?

CHAPTER II

Literature Review

A variety and great quantity of literature exists on adolescents and high-risk behavior, and specifically sexual behavior. From the literature reviewed, five categories were discovered: risk-taking among adolescents, decision-making related to sexual behaviors, developmental tasks of adolescents, social context of sexual behaviors, and adolescent knowledge.

Risk-taking

A mass array of literature exists on adolescents and high-risk behaviors. Most of the studies reviewed were quantitative and clearly spoke to the increasing numbers of teens engaging in high risk-behaviors and some of the consequences.

With the start of the new Millennium , it is appropriate to review the *Healthy People 2000 Objectives* that impact adolescents and high-risk behavior, specifically in relation to sexual health. These objectives include fewer teen pregnancies, slower increase in HIV infection, less gonorrhea and syphilis infections (Edelman & Mandle, 1998). Current statistics show: pregnancy rates among 15 to 19 year-old girls increased by 9%, and birth rates increased by 18% from 1985 to 1990. Nerdahl et al., (1999) discusses monthly reports about adolescent morbidity and mortality and note that risk-taking behaviors and the social and economic situations in which they occur contribute to most adolescent morbidities.

Many adolescents engage in behaviors that put their health at risk. Approximately 25% of adolescents will have a sexually transmitted disease before they graduate from high school (Center for Disease Control, 1994). Levenberg (1998) notes that increasing

numbers of adolescents are experimenting with health risk behaviors, and are doing it at an earlier age, and often participating in more than one health risk behavior. A long-term concern is that adolescents may survive the here and now, but the habits of high-risk behaviors established during adolescence may encourage major health problems that affect these adolescents as adults. Further, the Add Health (Bock, 1997) survey confirmed that a significant proportion of teens engage in risky behaviors. Add Health was the first study designed to measure key aspects of the adolescents' social world that influence health and behavior. Morbidity and mortality for today's adolescent are most often connected to complex behavioral and psychosocial risk factors than in the past, (Allensworth & Bradley, 1996).

To further look at how healthy America's teenagers are, the AMA published *Profiles of Adolescent Health* (Gans, Blyth, Elster & Gaveras, 1990, p. 8), which disclosed the following:

- By age 18, 65% of boys and 51% of girls are sexually active. About half of these teenagers do not use contraceptives for the first sexual encounter.
- Over 10% of 15 to 19 year-olds become pregnant each year, for a rate of 55 births per 1,000 teenage girls.
- Approximately 2.5 million teenagers contract a sexually transmitted disease each year.
- 1% of all AIDS cases occur in adolescents between the ages of 13 and 19.

It is clear from the above findings that adolescents are engaging in high-risk behaviors. Levenberg (1998) recommends that these statistics suggest the need for a fundamental change in the paradigm for delivering health care services to adolescents. Levenberg also recommends routinely evaluating adolescents for early detection of psychosocial concerns and health risk behaviors and medical problems. What remains to be studied is the impact that health care providers can have on the health behaviors,

specifically the sexual health decisions, of adolescents. A growing number of studies suggest that providers can influence positive change. Hungson, Strunin, and Berlin (1990) found that teenagers who discussed AIDS with a health care provider were more likely to use condoms. Cohen and Juzcak, (1997), noted that NPs are well suited to address the complex health problems of underserved adolescents because they have been educated to provide culturally appropriate care around preventable health problems, specifically health problems resulting from risky behaviors.

The U.S. Preventive Services Task Force (1989), as requested by the Office of Disease Prevention and Health Promotion of the United States Public Health Service, developed "The Guide to Clinical Preventive Services" for all age groups including adolescents. In 1990, the American Medical Association, in cooperation with the CDC-Division of Adolescent and School Health, initiated guidelines for adolescent health promotion and prevention for primary care providers. By 1992, the American Medical Association had developed a set of 24 recommendations from national experts in public health, medicine, and the social and behavioral sciences, primary care representatives, and the insurance industry, (Levenberg, 1998). The result was a comprehensive set of guidelines for preventive services for families and adolescents between 11 and 21 years of age to promote a healthy adjustment to adolescence and to prevent biologic and behavioral disorders. These guidelines are known as Guidelines for Adolescent Preventive Services (GAPS).

GAPS has four goals: to deter adolescents from participating in behaviors that jeopardize health; to detect physical, emotional, and behavioral problems early and to intervene immediately; to reinforce and encourage behaviors that promote healthy living;

and to provide immunizations against infectious disease (Levenberg). Allensworth and Bradley (1996) found evidence is accumulating that nurse practitioners are successfully integrating GAPS into their practices. Health risk behaviors are assessed by using a GAPs trigger questionnaire with medical history and clinical interview. Adolescent outcomes with the GAPS trigger questionnaire have yet to be accurately measured, and will only be as good as the time invested by the provider in the interview after completion of the questionnaire by the adolescent, and the referrals made on the findings.

Dr. Joycelyn Elders (1996), former Surgeon General of the U.S., believes that a recent 0.8% drop in teen pregnancies from 1995 compared to 1994 was due to the increased attention that teen pregnancy had been receiving in the media, schools and in homes as well. While this number may seen very small, it represents up to 20,000 girls who did not become pregnant in 1995 that did in 1994. High rates of teen pregnancy have been with us for years, but that we as a nation are only now willing to recognize it. Among all other developed nations, the U.S. has the highest rates of pregnancy, childbirth, and abortion, even though adolescent sexual activity in other countries appears to be very similar to that in the United States. What accounts for the difference? According to Dr. Elders, the difference can be seen in the outlooks and education available in other countries. Most other developed countries have comprehensive health and sexuality education from kindergarten through twelfth grade. In all other developed nations, discussion of contraception is widespread in the media, especially the use of condoms. Also, in all other developed nations, universal health care makes contraceptive services readily available and free to very low cost.

Feroli et. al (1992) noted that risk-taking behaviorspracticed by teens have roots in

many complicated reasons, and that no quick fix exists for unhealthy adolescent behavior. However, there are many factors that contribute to change, such as providing adequate knowledge of health care issues, and available health care facilities. Throughout the literature it is noted that a lack of measurable or definite outcomes of health promotion and health behavior interventions exists in relation to adolescents. It is also noted that the effectiveness of health care providers in helping adolescents lead healthier lives and preventing or reducing health-threatening behaviors has been underestimated, specifically in relation to sensitive reproductive situations (Levenberg, 1998). For many adolescents, their health care provider is the only adult in whom they can trust and share concerns and health risk behaviors.

Of the five categories of literature reviewed, the greatest quantity and most devastating was the information on risk-taking. All of these studies were quantitative and clearly delineated the importance of addressing the impact of these high-risk behaviors.

Decision-making

Decision making plays a vital role in health risk behaviors, and adolescents often lack "process" information about decision making necessary to change risky behavior or improve health outcomes (Hollen, 1998). Decision-making is poorly practiced by many teens, especially those less than 15 years of age. Much of this decision-making process is determined on the cognitive development level of the teen. Hammes and Duryea (1986) found that more health-promoting decisions were made by eighth through eleventh grade teens with strong abstract thinking skills than were made by those with concrete thinking skills.

In a study reported by the Centers for Disease Control and Prevention (Kann, 1993), health promotion interventions that include cognitive development as a primary strategy are "almost non-existent", and consideration of the timing of cognitive development in relation to attitude toward health and subsequent behavior is "another unexplored frontier." Along the same thought process, is the statement from the holistic model of health, which posits that health is equated with choice (Hollen, 1981). This theoretical framework is the first explicit framework to be discovered in the literature reviewed. In addition, the conflict model of decision-making by Janis and Mann (1977) has been used to predict decision-making behavior for consequential decisions. The main premise for this theoretical model, is that stress affects decision-making negatively, and yet high level cognitive processes, which many adolescents do not possess, are needed for quality decision-making (Hollen, 1998). References are also made to Piaget's (1972) cognitive development framework that discusses formal and concrete operations, which also seems to be vital in assessing and intervening with adolescents related to high-risk behaviors (Hollen, 1998).

Rosenthal, Lewis, and Cohen (1996) studied the sexual decision-making of inner-city adolescent girls and found that in order for successful intervention one must understand the way that adolescent girls make sexual decisions. The amount of power the adolescent feels she has in a relationship has been correlated to her ability to make sexual decisions. To reduce the risk of engaging in intercourse, girls used the presence of others, either friends or family. Pressure to become sexually active appeared to be related to curiosity and peer pressure. Results showed that initial intercourse by female adolescents appeared to be related to a desire to fit in with their peer group and be

accepted. Adolescent girls often expected less than equal relationships with boys and expected to be inferior in the relationship. In this situation, the adolescent may feel that she must have sexual activity in order to maintain the relationship. It was recommended that these girls must be educated to expect mutual relationships and to demand more for themselves in terms of being able to decide what they want to do and not to give into expectation.

Decision-making theories were represented in the literature, however, it was difficult to find evidence about why adolescents make decisions about their sexual health. Most studies looked at one particular perspective and somehow associated the perspective of decision-making about another topic to that of sexual decision-making. Further studies need to be done in this area, specifically qualitative studies, as only one (Rosenthal et al., 1996) study was found.

Developmental Tasks

Hickey-Ervin (1998) declares that health care providers must also evaluate adolescents' abilities to care for themselves which includes assessing their health-enhancing and health-compromising behaviors. Modeling also plays a role in adolescents and health behaviors. Damrosch (1991) reported that modeling is observing and adopting the behavior of others. Thus, the impact of peer pressure and resistance education is a vital piece in high-risk behavior modification.

J. Irwin (1996) specifically looked at adolescent developmental tasks related to movement from the concrete stage of thinking to the formal stage, with some of the most obvious tasks consisting of handling a more mature body, and forming a sexual identity, among other tasks. How adults respond to these tasks can determine a adolescent's

development of at-risk behaviors. Adults can positively influence the development of the adolescents' personal identity, also known a self-concept, social skills and responsibility, personal autonomy, and character and values. Irvin also found that early alienation from parents puts adolescents at an increased risk of susceptibility to negative peer influences and participation in unhealthy, and even risky behaviors. It is recommended that understanding and appreciating the normal behaviors needed to accomplish developmental tasks by adults and educators will help reduce the risk behavior of many adolescents.

Developmental tasks of adolescents was well represented in the literature and lent much credence to the process in which adolescents make decisions and how they differ from the decisions of children and adults. It was here that renowned theorists explored the developmental tasks of adolescence. However, only the Rosenthal et al. (1996), study was qualitative. This study did add important information related to how adolescents make decisions related to sexual behaviors and what they are thinking and feeling when they make these decisions. Further qualitative studies are needed to gain insight into the developmental tasks of sexual decision-making of adolescents.

Social Context

Friedman (1994) states that the sexual behavior of young people depends significantly on the nature of their relationships both with each other, but as importantly with their parents and other significant adults in their families, with schools and with health care providers. Friedman suggests that the way health care providers and educators are trained must be improved specifically in regards to interpersonal communication, especially listening skills. It is very clear if adolescents are given sound information and

trust, that they are more likely to make responsible decisions about their health and that of others.

Taris and Semin (1998) examined how mothers' parenting styles related to their children's sexual efficacy and experience. Results supported that if parents are involved with their children but do not try to control them, the children are more likely to develop an internal locus of control. It was also noted that in families where parent-child communication consists of warmth, openness, and mutual understanding, the adolescent remains a virgin longer. It seems likely that parenting styles do affect adolescent sexual behavior. Taris and Semin recommend that parents can influence their teenager's sexual behavior by creating circumstances that promote or prevent the development of an internal locus of control. Development of an internal locus of control involves creating self-esteem and gradually assisting the teen in making good decisions and learning from the not-so-good decisions.

Social context was also well represented in the literature but again only study (Rosenthal et al., 1996) took a qualitative approach in this area. This is another opportunity for further qualitative research to be conducted to discover more about the social context of adolescent sexual health and decisions.

Adolescent Knowledge

Adolescent's knowledge of sexual health has been studied by various researchers and a variety of theoretical models and causal relationships have been identified. A recent study found that the family was important in the exchange of sexual knowledge and that communication and emotional climate in the family are vital factors in the development of adolescent sexuality (Huerta-Franco & Malacara, 1999). In this same

study, the term "locus of control" is mentioned again. This article concludes by noting that there are multiple causal factors to completely understanding adolescent sexuality. Psychosocial and relationship variables with parents and peers are of particular importance in adolescent sexuality.

Whitehead (1994) looked at the various methods of sex education across the U.S. and in other countries. She found varying results and recommendations from various programs and a lot of diversity in program approach. This study found that girls' sexual conduct, unlike that of boys, is governed less by hormones than by social controls.

Hogben and Byrne (1998) explored the social learning theory in relation to differences in human sexuality. They noted that sexuality theorists and researchers have referred to the social learning theory for many years. Hogben and Byrne note that lack of knowledge does not appear to be the antecedent related to adolescents engaging or not engaging in sexual behavior. However, they did purpose that adolescents' sexual behavior depends on the interaction between the environment and their cognitive skills, and further that risky sexual behavior results from ineffective social cognitive skills, such as the inability to resist peer pressure. This same article states that individual self-efficacy is enhanced through observational learning, which is also a predictor in reducing risk behavior. Teens need to be provided with cognitive and behavioral skills necessary for desired behavior. Bandura (1977) examined self-efficacy as a predictor of sexually risky behaviors with social support as a stimulator of self-efficacy. He further noted that self-efficacy predicts perceptions of barriers to risk-reducing behaviors, and therefore, intentions and behaviors themselves.

C. Irwin (1990) proposed a causal model of adolescent risk-taking behavior, that

supports timing of biological maturation directly influences four psychosocial factors: cognitive scope, self-perceptions, perceptions of the social environment, and personal values. This model clearly shows how vital the relationship with peers and family is in relation to the adolescent making decisions related to behaviors. Adolescent risk-taking behavior can be predicted through the mediating effects of risk perception and peer group characteristics. The way adolescents view risk is critical in understanding the final pathway for the onset of risk taking. Irwin studied a sample of adolescents who rated behaviors as being high, moderate or low risk. The same behavior was viewed differently by many teens, which supports a qualitative approach to learning more about adolescents make decisions about sexual health.

Irwin found that in general, decreased cognitive competence was associated with onset of high-risk behavior. It is clear from this model that there are many factors that impact an adolescent's entry into high risk behaviors. It is critical for the clinician to recognize that a single behavior may serve as a clue for the clinician to ask the adolescent about other risk behaviors. Since the intention to engage in a behavior is one of the most accurate predictors of initiation, that basic questions about intention need to become a routine part of the clinician's assessment for all adolescents.

Nangle and Hansen (1998) used a conceptual framework based on a social-learning theory for understanding the relations between social skills, high risk sexual behavior, and many of the problems associated with adolescent sexual activity. Researchers long ago concluded that knowledge level of the risks associated with high-risk sexual behavior alone is not enough to change the behavior of adolescents. From a cognitive-behavioral perspective, effective intervention has at least two key ingredients. First, adolescents need to be "sensitized" to the risks associated with their

behavior. It is proposed that this is accomplished through risk education designed to enhance the accuracy of personal vulnerability appraisal. Second, once sensitized, adolescents need to learn to change the behavior patterns that place them at risk. According to Kelly and Murphy (1992), behavior change is facilitated by the direct training of skills, such as: safer sex practices; assertiveness to communicate safer sex commitments to sexual partners or to resist peer pressure to engage in high-risk behavior; and self-management and problem-solving skills to anticipate and/or avoid high-risk situations.

Despite the crucial role of heterosocial skills, that current literature has failed to address the social skills needed in sexual interactions (Nangle & Hansen, 1998). Researchers do not appear to be gaining enough insight into the "how and why" of sexual decision-making by adolescents. Biological changes have long been named the culprit in the hormonal surge that often leads to adolescent sexual activity. However, Berger (1986) suggests that adolescent sexual behavior might be influenced more heavily by social expectations and the social significance of patterns of sexual activity than by actual biological factors. Kelly (1982) refers to hetersocial skills as the social behaviors necessary for initiating, maintaining, and terminating social and sexual relationships with persons of the opposite sex. Sexual-interaction skills are a further subset of heterosocial skills that can be defined as the hetersocial skills required for competent sexual interactions (Nangle & Hansen, 1998). The process of making decisions regarding sexual practices has also been considered to be a component of a social skill known as problem-solving (Kelly, 1982). The conceptual model known as the social-skills deficit model emphasizes that social skills deficits increases the likelihood that adolescents will engage

in high-risk sexual behavior (Nangle & Hansen). Kelly (1982) notes that social skills are mostly acquired through direct learning opportunities.

When adolescents get information regarding sexual activity directly from their parents, they tend to engage in intercourse less frequently, have fewer sexual partners, begin sex at a later age, and be more likely to use contraception (Nangle & Hansen, 1998). Adolescents may not be able to comprehend the probabilities of distant negative consequences of sexual activity or may believe that they are immune to the consequences of their sexual behavior believing that only other people get pregnant or contract HIV. Although social competence can be defined, it remains a challenge to best assess for its presence in adolescents. It is highly recommended that cognitive behavioral skills interventions that directly teach adolescents new skills be utilized widely as components of prevention efforts.

Adolescent knowledge is also well represented in the literature. Several quantitative studies have been done to measure the knowledge level of adolescents about sexual behaviors. However, no qualitative studies were found. This is an unexplored area of adolescent sexuality and could lend much information to the base of knowledge of adolescent sexual health and decision-making.

Synthesis of Literature

Literature related to five categories of risk-taking among adolescents, decision-making related to sexual behaviors, developmental tasks of adolescents, social context of sexual behaviors, and adolescent knowledge related to sexual health has been examined and it is clear that a "how and why" component is limited, if not absent, in this research. Only one other qualitative study was found that explored "how and why" adolescent females

one other qualitative study was found that explored "how and why" adolescent females make decisions related to their sexual health (Rosenthal et al., 1996) What is clear from the literature review is that America's adolescents are engaging in health-risk behaviors. These behaviors can have an impact on America's well-being as well as on the adolescent now and often as an adult. While the literature does allude to and even give examples of outcomes, it is clearly an area of untested waters.

Several articles referred to the fact that further research needs to be done to quantify, and particularly qualify, the impact of the interventions for adolescents. Carmack (1997) reports that empowering families with knowledge can be one of the best tools an NP provides to them. The Add Health study (Bock, 1997) reiterates that social context, such as relationships with families, friends, and peers, influences the health-related behaviors of young people, and that understanding this basic principle is vital to developing efforts to modify health behaviors of adolescents. Further research needs to be done in this area of "how and why" adolescents are making these decisions related to their sexual health.

To summarize the literature reviewed, five components related to adolescent sexual health are predominant in the literature, risk-taking, decision-making, developmental tasks social context, and adolescent knowledge. National statistics blatantly show how adolescents are involved in high-risk behaviors. Several studies describe how the level of cognitive development and the relationship with decision-making is crucial. Several studies approach what is currently known about how adolescents make decisions. The social context of adolescent sexual behavior is well documented. Lastly, adolescent knowledge about sexual health is also well documented and has been explored in depth. Adolescents know about the consequences of high-risk sexual behaviors but continue to

engage in them. What is not known is the "how and why" of adolescent decision-making related to sexual behaviors.

Thus the intent of this research study is to further understand the "how and the why" of these decisions. The purpose of this research project is further understand what impacts the decisions adolescent females make regarding their sexual health. It is essential to better understand the "social context" that Bock (1997) referred to in the Add Health study on adolescents, to develop interventions, and more significantly, prevent these risky health behaviors. Nursing as a profession, as well as psychology, and sociology, among others, can benefit from a study that asks, "How are adolescent females making choices related to their sexual health?" It is also necessary to know what impacts these decisions. Once this is known, interventions and preventative care can be applied to some of the daunting statistics such as the 800,000 adolescent pregnancies per year (Levenberg, 1998).

CHAPTER III

Methods

Hermeneutical phenomenology was used in this qualitative study which explored how adolescent females make decisions related to their sexual health. Polit and Hungler (1999) describe hermeneutical phenomenology as a method that is rooted in philosophy and psychology, and which uses the lived experiences of people as a tool for better understanding the social, cultural, political, or historical manner in which those experiences happen. Biering (1998) further states that hermeneutical phenomenology includes the researcher's understanding of the phenomenon to be studied, and that his preconceptions cannot be separated out of the interactions of the study.

It is not worth trying to separate the preconceptions of the researcher, because without a pre-understanding, the experiences from which our understanding grows would not be possible. The research plan was approved by both the University of Michigan-Flint Institutional Review Board and the Institutional Review Board at a local hospital, a home care population was used for sampling.

The questionnaire, (Appendix A), was piloted with two African American females ages 15 and 17 for content and ease of understanding by the teens. Some modifications were made to the questionnaire after this pilot study based on the feedback from the two adolescents. The findings of from the pilot testing were used to clarify and simplify the questions. The data were not analyzed in the final results.

Participants

Five adolescent females were chosen from a home care maternal support services program as a convenience sample. After a briefing and explanation from the principal

and a social worker, both masters prepared, took consents and information out to prospective participants (Appendix B). Five consents were obtained, including parental consent for all due to their ages. All five adolescents agreed to be interviewed when the principal investigator later contacted them by phone. Two were 15 years of age and the other three were 17. All had newborns less than 2 months old except for one 17 year-old who was due to deliver within 3 months. One was Caucasian and four were African American. Two had completed the eighth grade and planned to continue their educations within a few months. The other three had completed through the tenth grade and all planned to continue their educations soon. None were married, although four were still in some kind of a relationship with child's father. All lived within inner city Flint and were low income. This was the first pregnancy for all participants. One lived alone with her child, while the four others lived with family. Upon completing the interview, all participants were promised a twenty dollar gift certificate to a local department store.

Data Collection and Interpretation

The participants were given the choice of conducting the interview in their homes with the researcher coming to them or to meet the researcher at a study room at the University of Michigan-Flint, which was less than five miles from all participants. All chose to be interviewed in their homes. The interviews lasted from 30 to 70 minutes and were audio-taped. Eleven questions were asked of all participants with the freedom to vary and stray from the questions to other topics as the conversation allowed. The questionnaire is found in Appendix A. The participants were given the option of having their audio-tapes destroyed or returned to them at the end of the study in the Spring of 2001.

audio-tapes destroyed or returned to them at the end of the study in the Spring of 2001. None requested either method. The plan, per the institutional Review Board, is to destroy the tapes, once the data are published. The researcher did seek the advice of the agency social worker in terms of how to approach the adolescents and how to present herself so as to create the most open environment for dialogue.

Immediately after each interview, the audio-tapes were transcribed including the addition of the non-verbal communication noted by the researcher. The data were then assembled into tables according to each question and the responses of the five participants. The data was then condensed into overall responses and commonalities among the responses. These data as well as the full response data were analyzed for patterns and themes several times until no further new themes and patterns could be found.

Credibility and Confirmability

The principal investigator reviewed the data several times for patterns and themes. Another nurse researcher also reviewed the data for patterns and trends. Both researchers discussed the results, and the end result was a combination of the themes and patterns of both researchers.

CHAPTER IV

Results

In talking to these female adolescents about decision-making related to their sexual health, several patterns and themes were identified from the data analysis. In total, nine patterns and themes were identified as follows: communication about sexual behavior, decision making related to sexual behaviors, plans for future education, knowledge deficit related to sexual health, peer pressure related to sexual activity, religion and its role in decisions, self-esteem as identified by non-verbal communication, trusting sex partners, and values in relation to decision making.

The following themes are supported by verbal and nonverbal content from responses provided by the five adolescents (table 1) Communication about sexual behavior and discussion about sex with their parents was identified as the first pattern. Three of the adolescents, talked to a female relative about questions regarding sex. Of the two remaining adolescents, one had a mother who lived out of state and her father was in prison, and the other adolescent said that she was "too embarrassed" to talk to her parents about sex. However, when question three was rephrased as, *If you have an important question about sex, who do you ask and why?* The same adolescent who said that she was too embarrassed, said that she talks to her sister if she has a question about sex. The adolescent whose parents are out of state and in prison had no verbal response, and the other three responded as they had to the first question about discussing sex.

Decision-making related to sexual behaviors revealed less thought on the part of the adolescents. When asked, *How do you make a decision about your sexual behaviors? Does anything guide you?,* two responded that "I don't know." One revisited her sex

education classes in school. One stated that she used her "own beliefs." The last adolescent did not answer the question, but said, "After this, I don't want no more. This is my first and only." When asked, *Tell me what you know about contraception. How important is contraception and decisions you make about sex?*, two replied, "No condoms, no sex." Three responded that protection is "very important". When asked, *How do you think you will make decisions about sex as an adult, say in five years? How does this compare to how you make decisions about sex today?*, three responded with "No change", "No differently" and "No". One replied that she would make her decisions differently, "because you change and mature and learn more about sex." One responded that, "Yes, I will have sex with his father. I used to not be that way." Some of the adolescents appeared to be at a loss for words to this question, and it was rephrased as, *Since you have a baby will you make decisions related to sex any differently in the future?* The response as noted above, included that three would not make decisions any differently in future, in spite of having a recent unplanned pregnancy.

The third pattern to be identified was plans for future education. All but one of the adolescents had reasonably detailed plans for continuing their education. One responded, "Yes, I plan to attend college. I start back in March . . I always wanted to be a lawyer since I was in kindergarten." Another responded, "Yes, I want to be a teacher or nurse." Two wanted to go to college to be lawyers. One said that she is going to back to school in a couple of months. One replied, "I duh know", to the question, *Do you plan to attend college? If not, what do you plan to do after graduation?*

The fourth pattern to be identified was knowledge deficit related to sexual health. To the question *Do you believe that the decisions that you make today related to your*

sexual behaviors will affect your future? If so, how? If not, why not?, one adolescent responded, "I duh know." Another responded, "What do you mean?" The question was restated to each as, *Since you have a baby will you think any differently before you have sex in the future?* Four of the five participants responded, "No." The fifth merely looked away shyly. To the question, *"Tell me what you know about sexually transmitted diseases including HIV. How does this influence your decisions about sex?*, one responded, "die by having sex, using toothbrushes and razors." Two replied, "Get from having sex with dirty people." One responded, "If you don't do it right." Only one adolescent utilized fact based information that she had learned in sex education classes in school. To the question *What do you think about sex and pregnancy? Do you think you will become pregnant if you have sex?*, Three said that yes, you can get pregnant if you have sex. Two looked deeper into the question and replied yes, but not everytime and mentioned the timing of the menstrual cycle and ovulation. To the question *Tell me what you know about contraception. How important is contraception and decisions you make about sex?,* one adolescent replied, "I don't know what contraception is." The question was restated using the term birth control instead.

A fifth pattern of peer pressure related to sexual activity was identified. Only one adolescent said that she talked to her best friend about sex and was influenced by her friend's opinion. When asked, *How do your friends affect the decisions you make about sex?* The other four adolescents said that they did not talk about, and were not affected by, their friends in relation to their decisions about sex.

The sixth pattern to be identified was that of religion and its role in decisions. One of the five adolescents clearly associated her pregnancy with God and her religion. When

asked *Do you discuss sex with your parents? If so, what do you talk about? If not, why not?*, part of the adolescent's response included, "God blessed me with a baby. I don't think it is wrong." To the question *What is important to you in life and how does that relate to your sexual behavior?*, the same adolescent replied, "We are going to get married and have a life together, if it is God's will." To the question, *What do you think about sex and pregnancy? Do you think you will become pregnant if you have sex?*, the same adolescent responded in part with, "It is up to God. When he is ready you will have one."

Self-esteem surfaced as the seventh pattern identified. This was measured in terms of non-verbal communication. Two of the adolescents were very shy with poor to fair eye contact, shrugged frequently and had very soft verbal responses. One adolescent was neither shy nor confident, but fell in between, and had moderate eye contact and moderate voice quality and strength. Two of the adolescents were very well spoken, with confident voices and made good eye contact. The observation was made that the level of self-esteem rose as did the level of eye contact, and quality of the voice.

Trust of sex partners emerged as the eighth theme identified with these adolescents. To the question *Tell me what you know about sexually transmitted diseases including HIV. How does this influence your decisions about sex?*, one adolescent responded, ". . . I made my boyfriend wear a condom for a longtime. Sometimes I still wonder is he clean?" To the question *Tell me what you know about contraception. How important is contraception and decisions you make about sex?*, one teen said, " . . . You don't know where this person has been or what he has been doing."

Values surfaced as the ninth and last theme identified in this study. To the question

How do you make a decision about your sexual behaviors? Does anything guide you?, three adolescents shook their heads, "no". One responded, "No." To the question, *What is important to you in life, and how does that relate to your sexual behavior?*, all five girls responded that their baby was the most important in their life. One adolescent also said that her family was very important to her.

Table 1
Data Summary

Question	*Verbal Response*	*Non-verbal Response*
1. Do you believe that the decisions that you make today related to your sexual behaviors will affect your future? If so, how? If not, why not?	Four of the five participants responded "No". The question appeared confusing and was re-phrased to 2 out of the 5 as: "Now that you have a baby, will you think differently about having sex	One was shy with poor eye contact. The other four spoke confidently and made good eye contact.
2. How do you make a decision about your sexual behaviors? Does anything guide you?	Two of the girls responded "No, I don't know."	Two smiled shyly with poor eye contact while 3 had good eye contact and a confident voice.
3. Do you discuss sex with your parents? If so, what do you talk about? If not, why not?	Two did not talk to a family member about sex. One was embarrassed and another had no family close. The other three said "yes", they did talk to a female relative about sex.	Three had poor eye contact and smiled shyly. Two had good eye contact and confident voices.
4. How do your friends affect the decisions you make about sex?	Four responded "No" that their friends did not affect their decisions about sex. One did respond that "Yes" her friends did affect her decisions about sex.	One had poor eye contact and smiled shyly. Two had fair eye contact and smiled shyly. Two had good eye contact and confident voices.
5. Do you plan to attend college? If not, what do you plan to do after graduation?	Four responded that "Yes", they did plan to attend college for various professions. One said, "I duh know".	Three had good eye contact with confident voices. Two had poor eye contact and shrugged shyly.
6. If you have an important question about sex, who do you ask and why?	Four responded that they spoke to a female relative including mother, grandma, auntie, and sister. One just shrugged.	Two had poor eye contact with shy smiles. Three made good eye contact and had confident voices.
7. What is important to you in life; and how does that relate to your sexual behavior?	All five responded, "My baby" as being important in their life. Two responded that they would, "think more about having sex". Three did not relate their baby to their sexual behavior.	Two had good eye contact and a confident voice. Two had poor eye contact and shrugged shyly. One was moderate.

Question	*Verbal Response*	*Non-verbal Response*
8. Tell me what you know about sexually transmitted diseases including HIV. How does this influence your decisions about sex?	Two stated that, "You can get them from having sex with dirty people." Two mentioned needing to use "protection."	Three had good eye contact with a confident voice. Two had fair eye contact, with a medium voice response. Two smiled shyly.
9. What do you think about sex and pregnancy? Do you think you will become pregnant if you have sex?	Three responded that, "Yes you will get pregnant if you have sex. Two responded that "Not everytime" and expanded on the timing of the activity.	Two had good eye contact with a confident voice. Two had fair eye contact with a medium voice. One had poor eye contact and a mild voice.
10. Tell me what you know about contraception. How important is contraception and decisions you make about sex?	Four responded that contraception is "very important". Contraception was re-phrased as birth control to one participant who did not know what contraception was. One responded that she did "not know."	Two had good eye contact and a confident voice. Two had fair eye contact and a medium voice. Three smiled shyly, one with a meek voice and poor eye contact.
11. How do you think you will make decisions about sex as an adult, say in five years? How does this compare to how you make decisions about sex today?	Three responded that "No", they would not make decisions differently in 5 years as an adult.	Two had good eye contact with confident voices. Two had fair eye contact and medium voice response and one had a meek verbal response with poor eye contact.

CHAPTER V

Discussion and Summary

In this study, the sexual decision-making of five adolescent females ages 15 to 17 years of age was explored using a hermeneutical phenomenological qualitative approach with loosely structured interviews which were audio-taped and then reviewed several times for themes and patterns, of which nine were identified.

The nine themes were: communication about sexual behavior, decision-making related to sexual behaviors, plans for future education, knowledge deficit related to sexual health, peer pressure related to sexual activity, religion and its role in decisions, self-esteem as identified by non-verbal communication, trusting sex partners, and values in relation to decision-making.

The importance of knowledge about how and why adolescent females make decisions related to their sexual health is important for several reasons. National, state, and local statistics continue to show that teen pregnancy, infant mortality, rate of sexually transmitted diseases and single parents, mostly women, residing in poverty is a continuing problem. For example every 22 seconds, an American teenager becomes pregnant and every day 623 teenagers get a sexually transmitted disease, (Quinn Youngkin & Smanzia Davis, 1999). Society at large is also at risk for social problems as a result of teens making poor decisions sexual and otherwise.

Many quantitative studies have been done to gain the above results and much more quantitative data that give the rate of occurrence of these high-risk sexual behaviors. However, very few qualitative studies have been done to focus on the thoughts of individuals who demonstrate such behaviors. Thus a qualitative study has the potential to

identify relevant information about the impetus of decision-making in adolescent females related to sexual behavior. The goal is identify a beginning theory of why and how these adolescents are making decisions about such an imperative part of their lives. Once more is known about how adolescent females make decisions related to their sexual health, educators, health care providers and parents can begin to formulate an approach to intervene when necessary and educate in the areas of identified need. This study also identifies the need for future studies and research to continue to address the "how and why" in the decision-making of adolescent females related to their sexual health.

Theoretical Framework Relationship

A basic premise of qualitative research is to begin to formulate a theory about the area being researched. In the initial literature review, a relationship between human sexuality and socialization, specifically, The Social Learning Theory, was clearly identified (Hogben & Byrne, 1998). Hogben and Byrne suggest that teens need to be provided with cognitive and behavioral skills necessary for desired behavior, specifically desired sexual behavior. It is proposed that sexual behaviors can be taught.

While a theoretical framework plays a less vital role in a qualitative study vs. a quantitative study, the premise that adolescent sexuality has a direct relationship with social learning and cognitive training is interesting and supports the need for further research in this area.

Support for the Validity of Conclusions

Nine themes were identified in seeking information about how adolescent females make decisions related to their sexual behaviors. These themes were identified using

a hermeneutical phenomenological qualitative approach with data analysis being conducted using word tables for each question and then further reducing the number of tables through identification of themes. At a follow-up meeting with the interim Program Manager for Hurley Home Care's Pediatric and Maternal Support Services these findings were discussed. She verified that in her experience of over ten years of working directly with adolescent females, she too, has seen the nine identified themes as well as several others. One of the themes that she was able to identify closely with was communication about sexual behavior. She states she finds the presence or absence of such communication to be vital in these adolescents lives and resulting decisions about sexual behavior. She also readily identified level of self-esteem as a high predictor of sexual behaviors. Although 80% of the participants in this study did not closely associate peer pressure with decisions about their sexual behavior, the Hurley's program manager did comment that she has seen peer pressure be a significant influence on adolescents' decisions related to sexual behavior.

Guidance and validation for the method of data analysis was found in Rosemarie Rizzo Parse's "Human Becoming School of Thought" (1998). This book contains the method of identifying themes that this researcher used in the study on adolescent females and how they make decisions related to their sexual health and behaviors. Parse is a renowned nurse theorist. She describes "human becoming" as the process of coming to know and understand human experiences. She further notes that one way this process may be accomplished is through an hermeneutic process that defines the meaning of text responses. She additionally describes hermeneutical phenomenology as a method in that the universal experiences described by persons who lived them as the source of

information that is then interpreted. Hermeneutics is furthered described by Parse as a mode of inquiry that focuses on interpretation and understanding. It is a dialogical process between the researcher and text uncovering meaning interpreted with a particular perspective. She also notes that the interpretation itself is the meaning given to the text from the frame of reference of the researcher. Phenomenology, according to Parse (1998), is the study of phenomena as they appear.

Implications

Generalization in qualitative research is not recommended. However, the information gained in qualitative studies can be used to give better understanding and perspective to the adolescent decision-making process. It appears that adolescent females have the information necessary to make good decisions but may not know how to make informed decisions related to their exposure to decision-making in the past. Based on this, with sexual decision making being a learned behavior, according to Hogben and Byrne (1998), adolescents can be taught how to make sound decisions about their sexual health.

In terms of clinical practice, relevance of this study can be directly applied to primary health care of adolescent females. One place to start would be with a quick assessment during a primary care visit. The nurse practitioner could develop a mini-assessment of decision-making ability. She could ask the teen how she makes an important decision and based on the teen's answer formulate a plan to proceed. This process would take place over several visits, as the relationship develops and the teen's needs and knowledge base is better understood. The nine identified themes from this study can be validated in other samples drawn from the same populations or in different populations related to

clinical practice, research and theory.

In terms of alternative explanations for the findings, it must be pointed out that all of these teens were sexually active and new parents or expecting parents. If non-sexually active teens had been interviewed, the outcomes and themes may have been very different. Had a non-nurse interviewed the adolescents with different views and interpretative thoughts, the outcomes and themes may have been very different. With the data analysis method of hermeneutical phenomenology, another researcher may very well have discovered dramatically different results. The nature of hermeneutical phenomenology is subjective and open to interpretation of the researcher.

Limitations include the small sample size, inability of the researcher to validate the findings with the subjects post-data analysis, and qualitative nature of this study prohibits generalization of results. An additional limitation was mentioned above in that these adolescents were from a maternal support services population which by definition of being in this population were identified as being high-risk for income, age, and lack of social support. These adolescents also all were new mothers or were expecting to deliver within 3 months of the data collection. By virtue of their being in the maternal support services population, the likelihood that their answers and views would be distinctly different than teens without the associated risk factors is certainly a consideration.

Recommendations for further research include the fact that very little qualitative research has been done in this area. This area of teen decision-making related to sexual behaviors is vital given the national statistics of teen pregnancy, sexually transmitted diseases and infant mortality just to name a few. It would be interesting to conduct a similar study with a population of adolescent females who are very divergent from the

group in this study. A study focusing on a group of adolescent females at a Catholic high school for instance, would be interesting to compare findings with the current study. Decision-making in adolescent males should also be explored.

References

Allensworth, D., Bradley, B. (1996). Guidelines for adolescent preventive services: A role for the school nurse. Journal of School Health, 66 (8), 281-285.

Auer, J. (1999). School health: Yesterday, today and tomorrow. Nurse Practitioner, 24 (4), 20,23,144.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84, 191-215.

Biering, P. (1998). "Codependency":A disease or the Root of Nursing Excellence? Journal of Holistic Nursing, 16 (3), 320-337.

Berger. L.S. (1986). The developing person through childhood and adolescence (2nd ed.) New York: Worth.

Bock, R. (1997). The Adolescent Health Study. (NIH Backgrounder). Response statement.

Carmack, B. (1997). School NPs as advocates. Advanced Nurse Practitioner, 5 (9), 74. Center for Disease Control and Prevention (1994). Sexually transmitted disease surveillance. (Report).

Cohen, S. & Juzczak, L. (1997). Promoting the nurse practitioner role in managed care. The Journal of Pediatric Health Care, 11, 3-11.

Damrosch, S. (1991). General strategies for motivating people to change their behavior. Nursing Clinics of North America, 26, 833-843.

Dickinson, A. (1999). Teenage sex. Time, 154 (19), 160.

Edelman, C. & Mandle, C. (1998). Health promotion throughout the lifespan. St. Louis: Mosby.

Elders, J. (1996). Ignorance is not bliss. Politics and the Life Sciences,15 (99), 288-290.

Feroli, K., Hobson, S., Miola, E., Scott, P. & Waterfield, G. (1992). School-based clinics: The Baltimore experience. Journal of Pediatric Health Care, 6 (3), 127-131.

Friedman, H. (1994). Adolescents-the hope for the future. World Health, 60 (5), 8-10.

Gans, J., Blyth, D., Elster, A., & Gaveras, L. (1990). America's adolescents: How healthy are they? Profiles of Adolescent Health (1), 1-46.

Hammes, M. & Duryea, E. (1986). Cognitive development and dynamics of decision-making among adolescents. Journal of School Health, 56, 224-226.

Hickey-Ervin, M. (1998). Teaching Self-Care to Delinquent Adolescents. Journal of Pediatric Health, 12 (1), 20-26.

Hogben, M. & Byrne, D. (1998). Using Social Learning Theory to Explain Individual Differences in Human Sexuality. Journal of Sex Research, 38 (1), 58-71.

Hollen, P. (1981). A holistic model of individual and family health based on a continuum of choice. Advances in Nursing Science, 3, 27-42.

Hollen, P. (1998). Intervention booster: Adding a Decision-making Module to Risk Reduction and Other Health Care Programs for Adolescents. Journal of Pediatric Health Care, 12 (5), 247-255.

Huerta-Franco, R. & Malacara, J. (1999). Factors associated with the sexual experiences of underprivledged Mexican adolescents. Adolescence. (134), 389-407.

Hungson, R., Strunin, L. & Berlin, B. (1990). Acquired immunodeficiency syndrome transmission: Changes in knowledge and behavior among teenagers. Massachusettes

statewide survey 1986-1988. Pediatrics, 85, 24-29.

Irwin, C. (1990). The Theoretical Concept of At-Risk Adolescents. Adolescent Medicine: State of the Art Reviews,1 (1), 1-14.

Irwin, J. (1996). Developmental Tasks of Early Adolescence: How Adult Awareness Can Reduce At-risk Behavior. The Clearing House, 69 (3), 222-225.

Janis, R. & Mann, L. (1977). Decision-making: A psychological analysis of conflict, choice and commitment. New York: The Free Press.

Kann, L., Warren, C., Harris, W., Collin, J., Douglas, K., Collins, B., Williams, B. & Kolbe, L. Youth risk behavior surveillance 1993. Surveillance and Evaluation Research Branch. Division of Adolescent and School health, Centers for Disease Control and Prevention.

Kelly, J. (1982). Social-skills training. A practical guide for interventions. New York: Springer.

Kelly, J. & Murphy, D. (1992). Psychological interventions with AIDS and HIV: Prevention and treatment. Journal of Consulting and Clinical Psychology, 60, 476-485.

Levenberg, P. (1998). GAPS: An Opportunity for Nurse Practitioners to Promote the Health of Adolescents Through Clinical Preventive Services. Journal of Pediatric Health Care, 12 (1), 2-9.

Nangle, D. & Hansen, D. (1998). Adolescent Heterosocial Competence Revisited: Implications of an Expanded Conceptualization for the Prevention of High-risk Sexual Interactions. Education and Treatment of Children,21 (4), 431-6.

Nerdahl, P., Berglund, D., Bearinger, L., Saewyc, E., Ireland, M. & Evans, T. (1999). New Challenges, New Answers: Pediatric Nurse Practitioners and the Care of

Adolescents. Journal of Pediatric Health Care, 13 (4), 183-190.

Parse, R. (1998). Human becoming school of thought. London: Sage.

Piaget, J. (1952). The orgins of intelligence in children. New York: International Universities Press.

Polit, D. & Hungler, B. (1999). Nursing Research Principles and Methods. Lippincott: Philadelphia.

Quinn Youngkin, E. & Szmania Davis, M. (1998). Women's health: a primary care clinical guide. Appleton & Lange: Stamford.

Rosenthal, S., Lewis, L., & Cohen, S. (1996). Issues Related to the Sexual Decision-making of Inner-city Adolescent Girls. Adolescence,31 (3), 731-9.

Taris, T. & Semin, G. (1998). How Mothers' Parenting Styles Affect the Children's Sexual Efficacy and Experience. The Journal of Genetic Psychology, 159, 68-81.

U.S. Preventive Services Task Force. (1989). Guide to clinical preventive Services: An assessment of effectiveness of 169 interventions. Baltimore: Williams and Wilkins.

Whitehead, B. (1994). The Failure of Sex Education. The Atlantic Monthly (10), 1-29.

Appendix A
Procedure to be used in interviews with participants

Hello,

I am Chris Kalisz, a graduate nursing student at the University of Michigan-Flint. I have received your signed consent form indicating your interest and your parent's consent for you to participate. As part of my program, I am studying female adolescents make decisions related to their sexual health. I will be asking you 11 questions about your sexual health. The goal is to get through at least the first 6 questions, spending about 5 minutes per question. You may choose not to answer any question. Those unanswered questions will be reviewed at the end of the interview if time allows and you will have time to answer at that point if you choose. Your answers will help nurses to better understand what adolescent girls are thinking so better care can be given. Remember that your participation is completely voluntary, and that you may choose to stop the interview process at any point. You will be audio-taped, and your answers will be shared with two other nurses. However, the other nurses will not know your name. You may request the audio-tape at the end of the study. As a token for participating in the study, you will receive a gift certificate to Target for $20.00 at the completion of the interview. Let's look at your consent form. Do you have any questions about the consent form? Do your parents have any questions about the form? Now to get started, I need some basic information, (see Appendix D, demographic sheet).

Questionnaire

1. Do you believe that the decisions that you make today related to your sexual behaviors will affect your future? If so, how? If not, why not?
2. How do you make a decision about your sexual behaviors? Does anything guide you?
3. Do you discuss sex with your parents? If so, what do you talk about? If not, why not?
4. How do your friends affect the decisions you make about sex?
5. Do you plan to attend college? If not, what do you plan to do after graduation?
6. If you have an important question about sex, who do you ask and why?
7. What is important to you in life and how does that relate to your sexual behavior?
8. Tell me what you know about sexually transmitted disease including HIV. How does this influence your decisions about sex?
9. What do you think about sex and pregnancy? Do you think you will become pregnant if you have sex?
10. Tell me what you know about contraception. How important is contraception and decisions you make about sex?
11. How do you think you will make decisions about sex as an adult, say in five years? How does this compare to how you make decisions about sex today?

I will be reviewing your answers with the other two nurses and looking for patterns to draw conclusions. This will take place in the Winter of 2001. At the end of the study, in April 2001, you may request your audio-tapes be returned to you via mail. To request

that your tapes be returned to you, simply call the University of Michigan-Flint nursing office at 810-762-3420 and make this request. Your tapes will be returned to the address given during the interview. If your address has changed, you will need to leave your new address with the secretary when you call. I will also be contacting all participants in the Spring of 2001 to see if you would like the results of the study. If so, the results will be mailed to you in the same manner as the audio-tapes.

Thank you for participating in this study. Do you have any further questions or comments that you would like add? If after we are done today, you have a question or comment that you would like to talk to me about, I, Chris Kalisz, can be reached at the nursing office at U of M at 810-762-3420. Here is your gift certificate, as promised.

Appendix B

Consent Form

1. I agree to participate in the research project, Adolescent Females and Decisions about Sexual Health, that is being conducted by Chris Kalisz, RN, BSN, at the University of Michigan-Flint to learn more about adolescent females and how they make decisions related to their sexual health. I understand that this participation involves completing a one-half to one hour interview, which will be audio-taped.
2. I have been informed that my participation is voluntary and that I have the right to withdraw my consent at any time. If I do withdraw, my withdrawal will not have any negative effect for myself or my healthcare needs.
3. I understand that I will be interviewed in a quiet, private location at my home or at a study room at the University of Michigan-Flint Thompson's Library, my choice.
4. I understand that I was selected to participate in this study because I am an adolescent female who is also receiving services from the Maternal Support Services Program at Hurley Home Care.
5. I understand this study may help others to better understand how adolescent female make decisions related to sexual health and to guide future care.
6. I understand that I will receive a twenty- dollar certificate to Target at the completion of the interview.
7. I understand that the results of this study will be given to me if I ask for them and that Chris Kalisz is the person to contact if I have any questions about the study or about my rights as a study participant. Chris Kalisz can be reached through the Nursing Office at the University of Michigan-Flint at (810)762-3420.
8. I understand that I may request the audio-tape at the completion of the study or may designate Chris Kalisz to destroy the tape at the completion of the study.
9. I understand that two other nurses, members of the thesis committee, will have access to the tapes, but that my identity will remain unknown except to Chris Kalisz.
10. I further understand that all of my responses will be kept confidential, but will appear as group.
11. I understand that if I have any questions about my rights as a participant in this research that I can call the Internal Review Board at Hurley Medical Center at (810)257-9974.
12. I understand that if I feel that I have sustained any injury as a result of my participation in this research study that I should report this to Chris Kalisz at (810)762-3420 and to the Hurley Medical Center Internal Review Board at (810)257-9974.
13. I understand that there are no foreseeable risks in my participation and that if I feel any discomfort about answering any of the questions, I can choose which questions I want to answer.

14. I understand that there is no compensation for participating in this study. I also understand that there is no compensation provided in case of physical or psychological injury which I might incur as a result of this study. While medical care is available should an injury occur, the cost for such medical care will be my responsibility.

_____ Date

_____ Participant's Signature

_____ Parent Signature

_____ Interviewer's Signature