AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS *for* FAMILIES

No. 33 (11/95) (Updated 1/00)

CONDUCT DISORDER

"Conduct disorder" is a complicated group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill.

Children or adolescents with conduct disorder may exhibit some of the following behaviors:

Aggression to people and animals

- bullies, threatens or intimidates others
- often initiates physical fights
- has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
- is physically cruel to people or animals
- steals from a victim while confronting them (e.g. assault)
- forces someone into sexual activity

Destruction of Property

- deliberately engaged in fire setting with the intention to cause damage
- deliberately destroys other's property

Deceitfulness, lying, or stealing

- has broken into someone else's building, house, or car
- lies to obtain goods, or favors or to avoid obligations
- steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)

Serious violations of rules

- often stays out at night despite parental objections
- runs away from home
- often truant from school

Children who exhibit these behaviors should receive a comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated.

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Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In developing a comprehensive treatment plan, a child and adolescent psychiatrist may use information from the child, family, teachers, and other medical specialities to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention, impulse problems, or those with depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, early treatment offers a child a better chance for considerable improvement and hope for a more successful future.

For additional information see *Facts for Families*: #3 Teens: Alcohol and Other Drugs, #55 Understanding Violent Behavior in Children and Adolescents, #72 Children with Oppositional Defiant Disorder, #6 Children Who Can't Pay Attention, #12 Children Who Steal, and #38 Manic-Depressive Illness in Teens. **See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).**

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American Academy of Child & Adolescent Psychiatry

Facts for Families

No. 58 (06/01)

NORMAL ADOLESCENT DEVELOPMENT

Late High School Years and Beyond

Parents are often worried or confused by changes in their teenagers. The following information should help parents understand this phase of development. Each teenager is an individual with a unique personality and special interests, likes and dislikes. However, there are also numerous developmental issues that everyone faces during the adolescent years. The normal feelings and behaviors of the late high school adolescent are described below.

Movement towards Independence

- Increased independent functioning
- Firmer and more cohesive sense of identity
- Examination of inner experiences
- Ability to think ideas through
- Conflict with parents begins to decrease
- Increased ability for delayed gratification and compromise
- Increased emotional stability
- Increased concern for others
- Increased self-reliance
- Peer relationships remain important and take an appropriate place among other interests

Future Interests and Cognitive Changes

- Work habits become more defined
- Increased concern for the future
- More importance is placed on one's role in life

Sexuality

- Feelings of love and passion

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- Development of more serious relationships
- Firmer sense of sexual identity
- Increased capacity for tender and sensual love

Morals, Values, and Self-Direction

- Greater capacity for setting goals
- Interest in moral reasoning
- Capacity to use insight
- Increased emphasis on personal dignity and self-esteem
- Social and cultural traditions regain some of their previous importance

Older teenagers do vary slightly from the above descriptions, but the feelings and behaviors are, in general, considered normal for each stage of adolescence.

For additional information see *Facts for Families*: #24 Know When to Seek Help For Your Child, #03 Teens Alcohol and Other Drugs, #63 Gay and Lesbian Adolescents, #65 Children's Threats: When Are They Serious? **See also: *Your Adolescent* (1999 Harper Collins).**

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AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 9 (Updated 11/98)

CHILD SEXUAL ABUSE

Child sexual abuse has been reported up to 80,000 times a year, but the number of unreported instances is far greater, because the children are afraid to tell anyone what has happened, and the legal procedure for validating an episode is difficult. The problem should be identified, the abuse stopped, and the child should receive professional help. The long-term emotional and psychological damage of sexual abuse can be devastating to the child.

Child sexual abuse can take place within the family, by a parent, step-parent, sibling or other relative; or outside the home, for example, by a friend, neighbor, child care person, teacher, or stranger. When sexual abuse has occurred, a child can develop a variety of distressing feelings, thoughts and behaviors.

No child is psychologically prepared to cope with repeated sexual stimulation. Even a two or three year old, who cannot know the sexual activity is "wrong," will develop problems resulting from the inability to cope with the overstimulation.

The child of five or older who knows and cares for the abuser becomes trapped between affection or loyalty for the person, and the sense that the sexual activities are terribly wrong. If the child tries to break away from the sexual relationship, the abuser may threaten the child with violence or loss of love. When sexual abuse occurs within the family, the child may fear the anger, jealousy or shame of other family members, or be afraid the family will break up if the secret is told.

A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling of worthlessness and an abnormal or distorted view of sex. The child may become withdrawn and mistrustful of adults, and can become suicidal.

Some children who have been sexually abused have difficulty relating to others except on sexual terms. Some sexually abused children become child abusers or prostitutes, or have other serious problems when they reach adulthood.

Often there are no obvious physical signs of child sexual abuse. Some signs can only be detected on physical exam by a physician.

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Sexually abused children may develop the following:

- unusual interest in or avoidance of all things of a sexual nature
- sleep problems or nightmares
- depression or withdrawal from friends or family
- seductiveness
- statements that their bodies are dirty or damaged, or fear that there is something wrong with them in the genital area
- refusal to go to school
- delinquency/conduct problems
- secretiveness
- aspects of sexual molestation in drawings, games, fantasies
- unusual aggressiveness, or
- suicidal behavior

Child sexual abusers can make the child extremely fearful of telling, and only when a special effort has helped the child to feel safe, can the child talk freely. If a child says that he or she has been molested, parents should try to remain calm and reassure the child that what happened was not their fault. Parents should seek a medical examination and psychiatric consultation.

Parents can prevent or lessen the chance of sexual abuse by:

- Telling children that “if someone tries to touch your body and do things that make you feel funny, say NO to that person and tell me right away”
- Teaching children that respect does not mean blind obedience to adults and to authority, for example, don't tell children to, “Always do everything the teacher or baby-sitter tells you to do”
- Encouraging professional prevention programs in the local school system

Sexually abused children and their families need immediate professional evaluation and treatment. Child and adolescent psychiatrists can help abused children regain a sense of self-esteem, cope with feelings of guilt about the abuse, and begin the process of overcoming the trauma. Such treatment can help reduce the risk that the child will develop serious problems as an adult.

For additional information see *Facts for Families*: #4 The Depressed Child, #5 Child Abuse, #10 Teen Suicide, and #62 Talking to Your Kids about Sex. **See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).**

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AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 62 (01/02)

TALKING TO YOUR KIDS ABOUT SEX

Talking to your children about love, intimacy, and sex is an important part of parenting. Parents can be very helpful by creating a comfortable atmosphere in which to talk to their children about these issues. However, many parents avoid or postpone the discussion. Each year about one million teenage girls become pregnant in the United States and three million teens get a sexually transmitted disease. Children and adolescents need input and guidance from parents to help them make healthy and appropriate decisions regarding their sexual behavior since they can be confused and overstimulated by what they see and hear. Information about sex obtained by children from the Internet can often be inaccurate and/or inappropriate.

Talking about sex may be uncomfortable for both parents and children. Parents should respond to the needs and curiosity level of their individual child, offering no more or less information than their child is asking for and is able to understand. Getting advice from a clergyman, pediatrician, family physician, or other health professional may be helpful. Books that use illustrations or diagrams may aid communication and understanding.

Children have different levels of curiosity and understanding depending upon their age and level of maturity. As children grow older, they will often ask for more details about sex. Many children have their own words for body parts. It is important to find out words they know and are comfortable with to make talking with them easier. A 5-year-old may be happy with the simple answer that babies come from a seed that grows in a special place inside the mother. Dad helps when his seed combines with mom's seed which causes the baby to start to grow. An 8-year-old may want to know how dad's seed gets to mom's seed. Parents may want to talk about dad's seed (or sperm) coming from his penis and combining with mom's seed (or egg) in her uterus. Then the baby grows in the safety of mom's uterus for nine months until it is strong enough to be born. An 11-year-old may want to know even more and parents can help by talking about how a man and woman fall in love and then may decide to have sex.

It is important to talk about the responsibilities and consequences that come from being sexually active. Pregnancy, sexually transmitted diseases, and feelings about sex are important issues to be discussed. Talking to your children can help them make the decisions that are best for them without feeling pressured to do something before they are ready. Helping children understand that these are decisions that require maturity and responsibility will increase the chance that they make good choices.

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Talking to Your Kids About Sex, "Facts for Families," No. 62 (01/02)

Adolescents are able to talk about lovemaking and sex in terms of dating and relationships. They may need help dealing with the intensity of their own sexual feelings, confusion regarding their sexual identity, and sexual behavior in a relationship. Concerns regarding masturbation, menstruation, contraception, pregnancy, and sexually transmitted diseases are common. Some adolescents also struggle with conflicts around family, religious or cultural values. Open communication and accurate information from parents increases the chance that teens will postpone sex and will use appropriate methods of birth control once they begin.

In talking with your child or adolescent, it is helpful to:

- Encourage your child to talk and ask questions.
- Maintain a calm and non-critical atmosphere for discussions.
- Use words that are understandable and comfortable.
- Try to determine your child's level of knowledge and understanding.
- Keep your sense of humor and don't be afraid to talk about your own discomfort.
- Relate sex to love, intimacy, caring, and respect for oneself and one's partner.
- Be open in sharing your values and concerns.
- Discuss the importance of responsibility for choices and decisions.
- Help your child to consider the pros and cons of choices.

By developing open, honest and ongoing communication about responsibility, sex, and choice, parents can help their youngsters learn about sex in a healthy and positive manner.

For additional information see *Facts For Families:* #31 When Children Have Children, #30 Children & AIDS, # 9 Child Sexual Abuse, and #63 Gay and Lesbian Teens. **See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).**

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American Academy of Child & Adolescent Psychiatry

FACTS for FAMILIES

No. 30 (11/95) (Updated 11/99)

CHILDREN, ADOLESCENTS AND HIV/AIDS

Today adolescents of both sexes face a serious risk of HIV infection, which is the cause of AIDS. AIDS is a chronic and most often fatal disease. Despite growing understanding and awareness, HIV infection is a serious threat to both heterosexual and homosexual teens. When adolescents take certain risks, they are more likely to become infected with HIV and develop AIDS:

These are the most important facts about AIDS:

- AIDS is most often fatal
- Anyone can get AIDS - many teens (both boys and girls) have been infected
- Condoms can reduce the risk of getting AIDS
- You can get AIDS from use of even one contaminated needle or one sexual act with a partner who has HIV/AIDS

Risk of AIDS is increased by:

- an increased number of sexual partners
- IV drug use
- anal intercourse
- any sex (oral, anal or vaginal) without condoms
- alcohol and other drug use (sex is more impulsive and use of condoms less likely if under the influence of alcohol or other drugs)
- tattoos and body piercing with contaminated (unsterile) needles or instruments

AIDS (Acquired Immune Deficiency Syndrome) is a chronic illness caused by infection with HIV (human immunodeficiency virus). Millions of Americans are believed to be infected with HIV. Some of them have AIDS, but most have no symptoms at all, and many do not know they are infected. Despite significant advances in available medical treatment for HIV, there are no definitive cures or vaccines that can prevent the disease. New treatments have enabled many people with AIDS to live longer. AIDS can be prevented by avoiding risk behaviors.

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HIV is transmitted through exchange of certain bodily fluids such as blood, semen, vaginal secretions, and breast milk. To produce an infection, the virus must pass through the skin or mucous membranes into the body.

HIV infection is preventable. Knowledge about HIV is an important aspect of prevention. Parents should educate their children and also work closely with schools, churches, youth organizations, and health care professionals to ensure that children and teens receive sex education and preventive drug abuse courses which include material on HIV.

The HIV virus dies quickly when it is outside the human body. It cannot be transmitted by day-to-day or even close social contacts not mentioned above. Family members of an individual infected with HIV will not catch the virus if they share drinking glasses with the person. There is no known instance in which a child infected with HIV has passed the virus to another child in the course of school activities.

HIV infection occurs in all age groups. Twenty-five percent of the babies born to untreated mothers infected with HIV develop HIV infection themselves. Many of these children die within one or two years, but some live for years, although their development is slowed and they can get many infections. Mothers-to-be with HIV must get special treatment to try to prevent transmission of the virus to their fetuses. New treatments for pregnant women may reduce the transmission of the virus to fewer than one in ten babies of HIV-positive mothers.

Drug and/or alcohol abuse, premature and/or promiscuous sexual activity are serious risk behaviors. Evaluation by a child and adolescent psychiatrist can be an important first step in helping a family respond effectively to high risk behaviors in their children and adolescents.

For additional information see *Facts for Families:* #52 Comprehensive Psychiatric Evaluation, #3 Teens: Alcohol and other Drugs, #9 Child Sexual Abuse, #63 Gay and Lesbian Adolescents, and #62 Talking to Your Kids about Sex. **See also*: Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).**

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American Academy of Child & Adolescent Psychiatry

Facts for Families

No. 63 (01/02)

GAY AND LESBIAN ADOLESCENTS

Growing up is a demanding and challenging task for every adolescent. One important aspect is forming one's sexual identity. All children explore and experiment sexually as part of normal development. This sexual behavior may be with members of the same or opposite sex. For many adolescents, thinking about and/or experimenting with the same sex may cause concerns and anxiety regarding their sexual orientation. For others, even thoughts or fantasies may cause anxiety.

Homosexuality is the persistent sexual and emotional attraction to someone of the same sex. It is part of the range of sexual expression. Many gay and lesbian individuals first become aware of and experience their homosexual thoughts and feelings during childhood and adolescence. Homosexuality has existed throughout history and across cultures. Recent changes in society's attitude toward homosexuality have helped some gay and lesbian teens feel more comfortable with their sexual orientation. In other aspects of their development, they are similar to heterosexual youngsters. They experience the same kinds of stress, struggles, and tasks during adolescence.

Parents need to clearly understand that homosexual orientation is not a mental disorder. The cause(s) of homosexuality are not fully understood. However, a person's sexual orientation is not a matter of choice. In other words, individuals have no more choice about being homosexual than heterosexual. All teenagers do have a choice about their expression of sexual behaviors and lifestyle, regardless of their sexual orientation.

Despite increased knowledge and information about being gay or lesbian, teens still have many concerns. These include:

- feeling different from peers;
- feeling guilty about their sexual orientation;
- worrying about the response from their families and loved ones;
- being teased and ridiculed by their peers;
- worrying about AIDS, HIV infection, and other sexually transmitted diseases;
- fearing discrimination when joining clubs, sports, seeking admission to college, and finding employment;
- being rejected and harassed by others.

Gay and lesbian teens can become socially isolated, withdraw from activities and friends, have trouble concentrating, and develop low self-esteem. They may also develop depression. Parents and others need to be alert to these signs of distress because recent studies show that gay/lesbian youth account for a significant number of deaths by suicide in adolescence.

It is important for parents to understand their teen's homosexual orientation and to provide emotional support. Parents often have difficulty accepting their teen's homosexuality for some of the same reasons that the youngster wants to keep it secret. Gay or lesbian adolescents should be allowed to decide when and to whom to disclose their homosexuality. Parents and other family members may gain understanding and support from organizations such as Parents, Families and Friends of Lesbians and Gays (PFLAG).

Counseling may be helpful for teens who are uncomfortable with their sexual orientation or uncertain about how to express it. They may benefit from support and the opportunity to clarify their feelings. Therapy may also help the teen adjust to personal, family, and school-related issues or conflicts that emerge. Therapy directed specifically at changing homosexual orientation is not recommended and may be harmful for an unwilling teen. It may create more confusion and anxiety by reinforcing the negative thoughts and emotions with which the youngster is already struggling.

For additional information about Parents, Families and Friends of Lesbians and Gays (PFLAG) visit PFLAG's website www.pflag.org or contact: PFLAG,**1726 M Street, NW Suite 400 Washington, DC 20036: (202) 467.8180; (202).467.8194 FAX**
Also see other Facts for Families: #62 Talking to Your Kids About Sex, # 10 Teen Suicide, # 4 The Depressed Child, and # 30 Children & AIDS. **See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).**

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Facts for Families

No. 31 (4/96) (Updated 1/00)

WHEN CHILDREN HAVE CHILDREN

Babies born in the U.S. to teenage mothers are at risk for long-term problems in many major areas of life, including school failure, poverty, and physical or mental illness. The teenage mothers themselves are also at risk for these problems.

Teenage pregnancy is usually a crisis for the pregnant girl and her family. Common reactions include anger, guilt, and denial. If the father is young and involved, similar reactions can occur in his family.

Adolescents who become pregnant may not seek proper medical care during their pregnancy, leading to an increased risk for medical complications. Pregnant teenagers require special understanding, medical care, and education--particularly about nutrition, infections, substance abuse, and complications of pregnancy. They also need to learn that using tobacco, alcohol, and other drugs, can damage the developing fetus. All pregnant teenagers should have medical care beginning early in their pregnancy.

Pregnant teens can have many different emotional reactions:

- some may not want their babies
- some may want them for idealized and unrealistic ways
- others may view the creation of a child as an achievement and not recognize the serious responsibilities
- some may keep a child to please another family member
- some may want a baby to have someone to love, but not recognize the amount of care the baby needs
- many, do not anticipate that their adorable baby can also be demanding and sometimes irritating
- some become overwhelmed by guilt, anxiety, and fears about the future
- depression is also common among pregnant teens

There may be times when the pregnant teenager's emotional reactions and mental state will require referral to a qualified mental health professional.

Babies born to teenagers are at risk for neglect and abuse because their young mothers are uncertain about their roles and may be frustrated by the constant demands of caretaking. Adult parents can help prevent teenage pregnancy through open communication and by providing guidance to their children about sexuality,

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contraception, and the risks and responsibilities of intimate relationships and pregnancy. Some teenage girls drop out of school to have their babies and don't return. In this way, pregnant teens lose the opportunity to learn skills necessary for employment and self survival as adults. School classes in family life and sexual education, as well as clinics providing reproductive information and birth control to young people, can also help to prevent an unwanted pregnancy.

If pregnancy occurs, teenagers and their families deserve honest and sensitive counseling about options available to them, from abortion to adoption. Special support systems, including consultation with a child and adolescent psychiatrist when needed, should be available to help the teenager throughout the pregnancy, the birth, and the decision about whether to keep the infant or give it up for adoption.

For additional information see *Facts for Families*: #62 Talking to Your Kids About Sex, #4 The Depressed Child, #5 Child Abuse: The Hidden Bruises, #15 The Adopted Child, #66 Helping Teenagers with Stress, and #30 Children and AIDS. **See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).**

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Adolescent Sexual Development and Sexuality

Assessment and Interventions

Editors:
Donna A. Gaffney, R.N., D.N.Sc., F.A.A.N.
Carol Roye, R.N., Ed.D., C.P.N.P.

Civic Research Institute
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Donna A. Gaffney and Carol Roye

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Chapter 2

The Adolescent Brain and Cognitive Development

Donna A. Gaffney, R.N., D.N.Sc., F.A.A.N.

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INTRODUCTION

Appreciating the adolescent's ability to think, reason, and make decisions requires an understanding of brain development and cognitive functioning. For a clinician to effectively communicate with teens, assess their ability to make decisions, and evaluate their risk-taking behaviors, the clinician has to be aware of the nuances of adolescent thinking and how it differs from the cognitive abilities typical in childhood and adulthood.

ADOLESCENT BRAIN DEVELOPMENT

The advent of new imaging techniques has resulted in recent studies that have identified major changes in brain development during adolescence. The etiology of these alterations is not yet determined, but it appears that there are periods of accelerated neuron growth alternating with periods during which there is a loss of neurons (pruning). Although discussion regarding the effects of genetics and environment on brain maturation has always existed, the actual influence of experience is not well understood and the question remains, does experience help create new neurons and synapses, and does adolescence provide increased opportunities for such experiences?

Magnetic resonance imaging (MRI) studies have paved the way for

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researchers attempting to answer questions previous studies could not, and advancements in MRI image analysis are providing new insights into how the brain develops. Early studies revealed that the brain overproduces neurons for a brief period in early development, beginning in utero and continuing for the first eighteen months of life. After the period of heightened neuron growth, a period of "pruning" occurs. Essentially, unnecessary neurons are eliminated, making the brain more efficient. Giedd et al. (1999) found a second surge in the neuron development in the cortex of the brain, followed again by pruning, immediately preceding puberty. It seems that the adolescent's neuron development increases and decreases in different parts of the brain at different times. Just prior to puberty, the overproduction of neurons seems to be far more dominant in the frontal lobe, which is the center of the cognitive skills of planning, impulse control and reasoning.

Researchers using MRI technology have targeted nerve bundles in the brain as key indicators in the differences between the adolescent and adult brain. This research may offer a new way of viewing teen cognitive functioning. Although an adolescent seems to have mature language and spatial functions, the areas of the brain that control the executive functions, such as decision making and risk assessment, may not fully mature until young adulthood. This research is so new it is difficult to predict or even correlate teens' cognitive processing and decision making with the structural changes in the brain. However, it is important to recognize that in the years ahead there may be significant findings related to brain function and highly charged emotional choices and difficult decisions (i.e. sexual intimacy).

Myelinization is the process whereby a protective, fatty material called myelin wraps around nerve cells located in the peripheral and central nervous systems. Myelin protects the nerve fibers and makes them more efficient, much like insulation wrapped around electrical wiring, improving its conductivity. Although the process can take up to ten years to reach completion, the bulk of myelinization occurs during the fetal and infancy stages. Thompson et al. (2000) analyzed data collected from brain scans and created time-lapse animations of children's brain development. The researchers found that a surge of myelinization begins at the front of the brain in early childhood, and extends to the back of the brain, receding after puberty. There are other growth spurts noted from the ages of 6 to 13 years in brain regions specialized for language and understanding spatial relations within the temporal and parietal lobes.

In another study, Sowell, Thompson, Holmes, Jernigan, and Toga (1999) compared MRI scans of young adults ages 23 to 30 with those of adolescents, ages 12 to 16 years. The researchers looked for areas of myelinization in both groups of subjects. Areas of the frontal lobe showed the greatest differences between young adults and adolescents. The adult group showed increased myelinization in the frontal cortex suggesting a maturation of cognitive processing and other "executive" functions. In the adolescent brain, the parietal

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and temporal areas (the areas that mediate spatial, sensory, auditory, and language functions) appeared mature with full myelinization.

Baird et al. (1999) addressed the relationship between brain development and emotions. The researchers scanned subjects' brain activities as they identified emotions displayed in facial images on a computer monitor. Although young teens did not accurately identify emotions on the faces, the MRI scans revealed that the amygdala, a structure in the brain that mediates fear and other emotional responses, was far more activated than the frontal lobe during the process. With older teens the brain activity tended to increase in the frontal lobe, ostensibly leading to more reasoned perceptions and improved performance. The researchers also found that as teens got older, the frontal lobe became more activated (as opposed to the temporal lobe) during a language skills task.

COGNITIVE DEVELOPMENT

Stages of Development

Jean Piaget (1952) was among the first to conceptualize how children and adolescents process information and conceptualize their world. He identified specific stages of children's cognitive development. Toddlers and preschoolers learn language and recognize objects in the world around them during the sensorimotor stage. Between the ages of 6 and 12 years (the stage of concrete operations) children think in a concrete manner. They learn how to combine and separate numbers and objects (addition, subtraction, and division), form categories (as when children alphabetize and group objects, words, and letters), and understand the process of reversibility, the skill a child uses to retrace the steps from point B back to point A. As children move through the latter part of the concrete operational stage and into formal operations their ability to cognitively process information in the world around them also matures.

A number of authors theorized that experience could influence both the content of and acquisition of stages (Laurendeau & Pinard, 1962; Piaget, 1972). In other words, the acquisition of stage-related skills can be accelerated by the nature and frequency of the phenomena observed. For example, a child interested in baseball may have more advanced cognitive skills in that particular area than a child uninterested in the sport. Piaget's work has always been hotly debated, particularly regarding the issue of his somewhat prescriptive nature of stage acquisition. Flavell (1970) suggested that the transition between stages is more often a gradual process rather than an abrupt departure from one stage to the next. During the transition periods a child is likely to exhibit cognitive skills representative of the previous stage as well as the present stage.

Adolescence parallels the beginning of the period of formal operations, marked by increasingly complex thinking including abstract reasoning, inductive

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and deductive reasoning, the ability to consider multiple viewpoints while weighing various criteria in debate, and expression of opinions. It is also a time during which the adolescent is capable of developing philosophical views and thinks about his or her own thinking.

Ability to Use Reasoning Skills

Although adolescents have the ability to conduct higher-order reasoning, the question remains, Are they able to use these sophisticated skills of reasoning when they are confronted with complex, emotionally laden problems in day-to-day life? DiSessa (1988) stated that adolescents demonstrate an inadequate level of critical thinking when asked to perform certain tasks. Keating (1990) suggested that adolescent thinking in everyday situations is not always as orderly and reasonable as that elicited by problems presented to subjects in the laboratory setting. In other words, it is possible that adolescents' real-world reasoning relies less on abstract thinking and formal logic than on down-to-earth thinking which is based on the teen's own prior experiences (Koslowski, Okagaki, Lorenz, & Umbach, 1990).

Although children move from concrete operations to formal operations at about the same age, there are individual differences among young adolescents (Overton & Byrnes, 1991). Not every teen achieves the same skills at the same age. Strahan (1983) found that only one-third of the eighth-grader subjects and almost half of the college student subjects consistently used hypothetical-deductive analysis when reasoning was measured using Piagetian tasks. In addition, there is even variation within individual adolescents. A teen will be able to demonstrate skills consistent with abstract thinking in one area (e.g., math) but not necessarily in other areas (e.g., understanding causes of health and illness) (Gaffney, 1986). As mentioned earlier, the nature of the content may possibly influence how effective the adolescent is in making decisions and reasoning. During adolescence, especially, reasoning skills are inconsistent. Reasoning concerning one topic might be at a mature level, but that maturity may not be transferred to other issues or subjects (Byrnes, 1988). Case (1997) and Glaser (1984) offer that adolescents are more likely to use a higher-level reasoning in areas in which they have meaningful experience.

Piaget predicted that the most sophisticated reasoning would occur during early adolescence with minimal growth afterwards; however, there is strong evidence that differences in thinking ability in early and later adolescence are fairly significant. During the idealistic years of young adolescence, anything seems possible. With age, adolescents develop a more complex level of reasoning. They are able to recognize that although there may be a number of possible solutions to a problem, not all the solutions are appropriate. They begin to see that some solutions may have positive outcomes whereas others may have negative outcomes and thus can be eliminated. Changes related to critical reasoning and

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exploration of choices and consequences may continue well into late adolescence and adulthood (Labouvie-Vief, 1994; Perry, 1981).

Cognitive Developmental Changes During Adolescence

Some common indicators of a progression from simple to complex cognitive development are described in the following sections.

Early Adolescence

During early adolescence, the use of more complex thinking is focused on decision making that is personal. Choices and decisions about home, school, peers, and intimate relationships will begin to surface.

- The young adolescent begins to demonstrate use of formal logical operations in schoolwork.
- The young adolescent begins to question authority and society standards.
- The young adolescent begins to form and verbalize his or her own thoughts and views on a variety of topics, usually more related to his or her own life. In terms of sexuality and intimate relationships these issues can focus on initiating romantic attachments and activities:
  - — Identification of groups or peers that are more appealing;
  - — Determination of personal dress and appearance as desirable or attractive;
  - — Assessment of parental rules/restrictions related to dating, clothing; and
  - — Activities as acceptable or not.

Middle Adolescence

During middle adolescence there is a surge in complex thinking processes. The focus of middle adolescence begins to expand beyond individual concerns and moves toward more philosophical and futuristic concerns, including:

- Increased challenging and analysis of issues and concerns;
- Initiation of an individual code of ethical behavior;
- Awareness of different possibilities for the development of individual identity (including gender orientation); and
- Recognition of future goals and plans that may lead toward these goals (but although the middle adolescent begins to think in the long

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term, there are still choices and decisions that reflect urgency and impulsivity).

In this period, systematic thinking begins to influence an adolescent's relationships with others. This is often characterized by in-depth discussion of all relationships in the teen's life.

Late Adolescence

During late adolescence, complex thinking processes are used to focus on less self-centered concepts as well as personal decision making, this includes:

- Increased thoughts about more global concepts such as justice, history, politics, and patriotism;
- Development of idealistic views on specific topics or concerns, which can include issues related to the characteristics of the ideal partner, and what constitutes the ideal relationship;
- Engaging in debate with peers as well as parents and developing intolerance of opposing views;
- Focusing thinking on making career decisions; and
- Recognition of one's emerging role in adult society, often including sexual relationships.

ENSURING COMPREHENSION OF REPRODUCTIVE HEALTH CARE NEEDS

As adolescents develop more mature cognitive skills and an enhanced capacity to process complex, abstract situations, it is important to remember that issues related to sexuality are among the most personal and the most emotionally charged. Thus it is crucial to address sexual anatomy and physiology, sexuality, and sexual decision making from the earliest interaction with the young adolescent to later sessions with older adolescents. Do not assume a one-time approach will prepare the adolescent to adequately deal with future decisions and their consequences.

The following approaches will help clinicians and therapists facilitate a positive, working relationship with the adolescent patient and allow ease in exploring issues related to sexuality:

- Include adolescents in decision making and planning for every health care session. At the outset identify what will be included in the session identify reasons for each procedure/action/question and ask if they have any specific requests/questions.

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- Offer open discussion on a variety of topics relating to sexuality. Discussion may extend beyond the traditional concerns about symptoms and prevention issues and focus on types of sexual behaviors, satisfaction, questions about performance, and sexual response.
- Informally encourage adolescents to share ideas and thoughts with you. Allow time for the adolescent to think about what you have said, and then ask about his or her thoughts, questions, or concerns.
- Allow and encourage adolescents to think independently. Let them identify their own ideas for solutions to problems and concerns, and help them think of a variety of options available to them at any time.
- Assist adolescents in setting their own sexual health care goals.
- Recognize and praise adolescents for well-thought-out, responsible decisions in the past as well as for the future.
- Assist adolescents in reevaluating decisions that have negative consequences ("Would this work for you again?" "How would you do this differently?").

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Adolescent Sexual Development and Sexuality

Assessment and Interventions

Editors:
Donna A. Gaffney, R.N., D.N.Sc., F.A.A.N.
Carol Roye, R.N., Ed.D., C.P.N.P.

Civic Research Institute
4478 U.S. Route 27 • P.O. Box 585 • Kingston, NJ 08528

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Chapter 3

Adolescent Emotional Development and Romantic Attachments

Donna A. Gaffney, R.N., D.N.Sc., F.A.A.N.

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Young love is a flame; very pretty, often very hot and fierce, but still only light and flickering. The love of the older and disciplined heart is as coals, deep-burning, unquenchable.

— Henry Ward Beecher (1813–1887)

The emotional development of the adolescent has been the subject of much discussion. Once called a time of *sturm und drang*, or storm and stress, the years between 13 and 18 are often viewed with dread by parents, teachers, and other adults working with teens. Yet, the adolescent years are perhaps the most important in an individual's life, providing the testing ground for the essential transition from child to adult. Emotional development is perhaps the most challenging. Moodiness, conflict, and distancing regularly occur within the teen's family, particularly during the middle adolescent years. This chapter presents an overview of the critical characteristics of the emotional development of the teen as well as the nature of romantic attachments in adolescence.

NORMAL ADOLESCENT DEVELOPMENT

Erikson (1998) was among the first to identify the developmental tasks for the healthy personality. The critical task for adolescence is the development of identity. It is a time of questioning previously held ideas about the self. Teens begin to explore how they appear in the eyes of others as well as perceptions of self. The danger during this time is that of role diffusion. Adolescents will have doubts about who they are, their sexual identity, and their goals in life and they

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will overidentify with those around them. Love at this stage is an attempt to further define the self. The task of identity formation is the foundation for the next step, the development of intimacy.

Adolescent development can be divided into three stages: early, middle, and late adolescence. This chapter outlines the typical emotional responses and behaviors of adolescents for each stage, categorized into issues addressing independence, emotions and affect, relationships, physical appearance, school and work interests, and sexuality and romantic attachments. This outline is adapted from the American Academy of Child and Adolescent Psychology (2002).

Early Adolescence

This category comprises adolescents from 12 to 14 years of age.

- *Independence*: Initial movement toward independence with a new developing sense of identity
- *Emotions and affect*:
  - — Experience of labile moods, mood swings
  - — Tendency to return to childish behavior, fought off by excessive activity
  - — Enhanced ability to describe one's emotional state with words (yet, emotions are still more likely to be expressed in actions than words)
- *Relationships*:
  - — Close friendships become important; less attention shown to parents.
  - — Occasions of disrespect, irritability, and impatience.
  - — Recognition that parents have faults.
  - — Search for new people to love in addition to parents
  - — Same-sex friends and group activities
- *Physical appearance and body*:
  - — Peer group influences interests and clothing, makeup and hair.
- *School, work, or career interests*:
  - — Career interests are not important with more interest in present/near future.
  - — Greater ability to work
  - — Ethics and self-direction established through rule and limit testing
- Sexuality and romantic attachments
  - — Girls enter puberty earlier than boys 12–24 months.

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— Shyness, blushing, and modesty and an interest in privacy.

— Experimentation with body (masturbation)

— Concerns about normal development

Middle Adolescence

This category comprises adolescents from 14 to 17 years of age.

- *Independence*: Continued movement toward independence revealed through self-involvement, alternating between unrealistically high expectations and poor self-concept
- *Emotions and affect*:
  - — Periods of sadness as the psychological loss of the parents and home takes place
  - — Examination of inner experiences, which may include writing a diary
- *Relationships*:
  - — Protests about parental involvement with social life, perception of interference
  - — Lowered opinion of parents, withdrawal of emotions from them
  - — Effort to make new friends
  - — Strong emphasis on the new peer group with the group identity of selectivity, superiority, and competitiveness
- *Physical appearance and body*:
  - — Extremely focused and concerned with appearance and with one's own body
  - — Sense of being a stranger in one's own body.
- *School, work, or career interests*:
  - — Intellectual interests gain importance with an interest in moral reasoning
  - — More consistent evidence of conscience
  - — Greater capacity for setting goals
  - — Recognition and growth of ideals and identification of role models
- *Sexuality and romantic attachments*:
  - — Concerns about sexuality and sexual attractiveness
  - — Some sexual energies directed into "safe" interests in the creative arts or career

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— Frequently changing short-term relationships
— Movement toward heterosexuality with fears of homosexuality
— Tenderness and fears shown towards opposite sex
— Emotional connection to significant other expressed as love and passion

Late Adolescence

This category comprises adolescents from 17 to 19 years of age.

- *Independence*:
  — More fully developed sense of identity
  — Self-reliance
  — Ability to make independent decisions
- *Emotions and affect*:
  — Ability to delay gratification
  — More developed sense of humor
  — Increased emotional stability
  — Self-regulation of self-esteem and focus on personal dignity
  — Ability to gain insight into emotions and behaviors
  — Stress on personal dignity and self-esteem
- *Relationships*:
  — Greater concern for others
  — Recognition of parents as a resource
  — Acceptance of family and cultural traditions as well as social institutions
- *School, work, and career interests*:
  — More defined work habits
  — Stability interests
  — Ability to process ideas and express them in words
  — Ability to compromise
  — Pride in one's work
  — Increased level of concern for the future
  — Thoughts about one's role in life
  — Ability to set goals and follow through

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- *Sexuality and romantic attachments*:
  - — Concern with serious relationships
  - — Clear sexual identity
  - — Capacities for sensitivity and caring, sensual love

ROMANTIC ATTACHMENTS IN ADOLESCENCE

The adolescent romantic relationship provides opportunities for adolescents to move toward establishing the potential for intimate relationships while developing their own sense of identity. Most of the research and literature in the area of romantic relationships address heterosexual relationships, but a number of authors suggest that similar developmental patterns occur in same-sex romantic relationships (Furman & Shaffer, in press).

Early interactions among opposite sexed adolescents occur in the safety of the larger peer group or crowd. After spending their middle childhood years socializing with the same sex, the crowd offers a comfortable environment to test out these new romantic liaisons as they "hang out" together. As adolescents mature, their romantic relationships continue to grow although they are still somewhat superficial and short-lived (Furman & Shaffer, in press). Some authors contend that romantic relationships are crucial to the developmental tasks of adolescence such as identify formation, transformation of family relationships, close relationships with peers, sexuality, and academic success (Furman & Shaffer, in press; Sullivan, 1953).

Romantic relationships in adolescence are qualitatively different from romantic relationships during adulthood, yet they are no less important. In reality, romantic relationships are a focal point in the adolescent's daily life. All aspects of the relationship, as well as the players in these daily dramas, are open to analysis and discussion during school and after school hours (Thompson, 1994). The film and literary communities have marketed their products highlighting the ideal adolescent romantic encounter. As a result, adolescents imagine their ideal partner and the ideal romance, but realistic relationships may pale in comparison and confusing media representations can lead young people to inevitable disappointment.

Clinical Perspective

From a clinical perspective, those working with teens should not take such romantic relationships lightly. If they dismiss a relationship as minor, they will alienate the adolescent and effectively put a stop to communication. In addition, romantic attachments can have a significant effect on other areas of development, as well as on mental health. An honest discussion of the relationship with

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the provider may not only engage the teen and build trust but will also help guide the teen toward behaviors that facilitate health and well-being. An adolescent who is open to talking about his or her romantic relationship will be more likely to bring up other issues of concern (e.g., intimate partner violence, fear of sexually transmitted infections, or pregnancy). These relationships can influence other aspects of the teen's life as well such as choice of college and career.

Relationships that are faltering can have an influence on other parts of the teen's life, causing school and family problems. A teen who spends a great deal of time with his or her partner distances him- or herself from friends. The result can challenge the establishment of close peer relationships with others. Dissolved relationships can also precipitate moodiness, loss, and grieving and can even signal the onset of depression (Monroe, Rhode, Seeley, & Lewinsohn, 1999).

Positive romantic relationships, on the other hand, can serve many health-promoting functions. They can offer support and companionship and facilitate the development of identity and intimacy. For the professional they can also serve as another important component of the assessment of the adolescent's sexuality.

A Guide to Asking About Romantic Attachments

Asking about boyfriends/girlfriends is much more than a social pleasantry; it is also an important assessment tool for the clinician. Here are some suggested questions to stimulate discussion.

1. Is there a relationship at the present time?
   a. Opposite sex or same sex
   b. Significant age/cultural/geographic differences
   c. Is it a public or secretive relationship?
2. How long have they been involved?
   a. Determine if this is a regular "hook up" or casual sex partner.
3. Is it a monogamous relationship?
4. How intimate have they become?
   a. Openly discuss the nature of their intimacy.
   b. If the couple is sexually active, ask how their sexual intimacy has affected the relationship.
   c. Determine if the experience is pleasurable for the adolescent, is there desire and sexual responsiveness.
   d. Ask if there is anything he or she would like to change.

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5. How has this romantic relationship affected other parts of his/her life:
   a. Peer relationships?
   b. Academic or extracurricular activities?
   c. Home and family life?
   d. How much time do they spend with each other?
   e. Does the couple regularly spend time with other couples/friends?
   f. Have they changed any plans or goals based on this relationship and, if so, how has that affected the adolescent?
6. Is there any concern about violence; aggression; physical, verbal, or sexual abuse?
7. Offer time for questions and use the session as an opportunity to provide information on healthy romantic relationships.

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Adolescent Sexual Development and Sexuality

Assessment and Interventions

Editors:
Donna A. Gaffney, R.N., D.N.Sc., F.A.A.N.
Carol Roye, R.N., Ed.D., C.P.N.P.

Civic Research Institute
4478 U.S. Route 27 • P.O. Box 585 • Kingston, NJ 08528

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Donna A. Gaffney and Carol Roye

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Chapter 6

The Complexities of Sexual Decision Making in Adolescence

Donna A. Gaffney, R.N., D.N.Sc., F.A.A.N. and
Carol Roye, R.N., Ed.D., C.P.N.P.

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INTRODUCTION

Adolescents are not "clean slates" when it comes to making decisions. Their choices are built on previous experiences, attitudes, and ideas, and there are numerous factors and influences that determine their behaviors, attitudes, and beliefs about teenage sexuality. It is critical to understand the adolescent decision making process because it is a key component to adolescent growth and independence; yet decision making with regard to initiating sexual intercourse, use of birth control and consent can have a significant impact on the health and well-being of the adolescent.

Hammes and Duryea (1986) state that "mastery of abstract cognitive processes enables an individual to hypothesize or imagine the consequences or possible solutions to various problems" (p. 224), whereas Gordon (1996) suggested that making choices is broadly based on and influenced by cognitive ability and social, and psychological development as well as cultural and societal influences. Both definitions speak to the decision-making process and outside variables affecting the process. Adolescent decision making differs from that of adults in several ways. Most important, the physiological changes occurring dur-

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ing adolescence have a strong influence on sexual drive (Udry & Billy, 1987; Udry, Talbert, & Morris, 1986). The physical transition, identity formation, and developing autonomy have a strong effect as well. Finally, the cognitive developmental changes determine the reasoning teens use as they analyze options.

Individual environmental influences and the larger societal and cultural forces also have an impact. Adolescent decisions may be influenced by such social and psychological factors as the following:

- Personality traits of the adolescent, including issues of self-esteem;
- Identity development, including sense of independence and feelings of vulnerability and intimacy;
- Physical development, including pubertal changes;
- The presence of an internal or external locus of control;
- Interactions and relationships with family and peers; and
- Behavioral practices such as substance or alcohol use.

In addition to the foregoing factors, decision making can be influenced by broader cultural and societal institutions such as religious perspective, upbringing, affinity, spiritual and moral beliefs, education status, socioeconomic status, race, gender, ethnic background, and macroenvironmental factors (i.e., the media and political systems) (Gordon 1996). In regard to media influences, the Kaiser Family Foundation found that more than half of all television programs contained sexual content of some sort. Among those programs with sexual content, only 9 percent included any mention of the possible risks of sexual activity, references to contraception, or safer sex (Kaiser Family Foundation, 1999).

THE ELEMENTS OF DECISION MAKING

A number of elements contribute to the decision-making process. Every decision entails taking a risk, pursuit, or action that involves an uncertain outcome. There are three major categories of developmental factors that influence decision making: cognitive development, emotional developmen, and, finally, social development (Fischhoff, 1992).

Cognitive Development

Cognitive development is a cornerstone of both adolescent development and the decision-making process. As mentioned earlier, the period of formal operations allows the adolescent to begin to imagine the long-term consequences of behavior and actions, identify various problem-solving techniques involved in making choices, and develop the ability to engage in deductive reasoning (Duerst, Keller, Mockrud, & Zimmerman, 1997). Without formal oper-

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ational thinking, adolescents are unable to assess potential risks and consequences resulting from their choices (Grant & Demetriou, 1988). Their new cognitive abilities may not be refined or honed enough to allow for realistic cost-benefit analysis of a given situation, therefore increasing the chance that they will choose "risky" options (Grant & Demetriou, 1988). In addition, there is great individual variability. One teen may be fairly advanced in this regard at age 14, while another youngster at age 17 is less mature in terms of deductive reasoning.

The factors related to cognitive development are divided into three components: *capacity*, *knowledge*, and *skills*. All three increase with age and can be limited by developmental disability. *Capacity* is the ability to use cognitive resources to think through problems. It requires focus and consideration of abstract and concrete issues.

Knowledge is the acquisition of information, and it is used to identify alternatives or options for any given situation. Upon identifying such options it is necessary to estimate and evaluate the ensuing consequences. Finally, there is the need to come to a decision, where all the options, estimates, and evaluations come together in a summary recommendation (Fischhoff, 1992). In its most simplistic form that recommendation is reduced to a "pro and con" list. However, it is more likely that the summary recommendation on which the decision rests is a knowledge of what to do in specific situations (i.e. what has worked in the past).

Skills such as hypothesis formation and assessment of odds, likelihood, and action are necessary to process information related to decision making. An individual must have confidence in his decision-making capabilities. As cognitive abilities develop with age, such confidence builds. With adolescents, however, a lack of confidence may lead to "poor" or "risky" decision making.

Emotional Development

Simply stated, emotions have the potential to change decisions. When related to decision making, emotions lie along a continuum, ranging from "cold" to "hot" (Clark & Fiske, 1982):

- *A cold emotion* or affect refers to situations when individuals rely on their basic values and cognitive skills to make a decision. They explore the facts of the situation and make a balanced and dispassionate choice, as in deciding when to study for an algebra test.
- *A hot emotion* or affect implies that there is a strong emotional undercurrent dominating a situation. This deep state of emotional arousal can actually propel individuals into an action they might not ordinarily take under less emotional conditions. Emotions that fall within the hot affect category are passion and fear.

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Situations concerning sexual decisions—using contraception or consenting to intercourse—are often flooded with passionate emotions, preventing the teen from making a balanced assessment in the "heat" of the moment. Under these circumstances "thought processes are short-circuited so that choices reflect the most salient feelings, rather than a balanced appraisal" (Fischhoff, 1992, p. 151). This may help to explain why adolescents, when asked about sexual activity (in discussions or surveys), state that it is important to "wait" for the right person or until they reach a certain age. Yet in reality, during the passion of the moment, they may choose to engage in sexual activity, the strong emotions of that event dominating their decision making.

Social Development

As adolescents develop, social beliefs and events affect their decision-making processes. This socialization may increase or decrease adolescent risk-related choices. They may or may not learn what mistakes to avoid by watching what happens to their peers. Socialization may also fail to have an effect on an adolescent, meaning that certain social values and beliefs are completely unabsorbed. It is clear that socialization not only includes learning the norms, attitudes, and values of one's group but observing others and learning from their experiences.

Social reactions and consequences of decisions are thought to be a much more important factor during adolescence than during adulthood (Beyth-Marom & Fischhoff, 1997). Vulnerability to peer influence seems to increase during the transition years from childhood to adolescence and then decline as the adolescent moves into late adolescence and adulthood (Steinberg & Cauffman, 1996). Therefore, it seems that teens not only take action based on what their peers *do* but what they *think* their peers do or what *they believe* their peers *think* they *should do* (Ajzen & Fishbein, 1980). In other words, everyone in the peer group is not necessarily having sex, although everyone might *think* that is the case. A positive scenario might be a teen stating: "I'll use a condom because my friends think it's stupid to have sex without a condom." Adolescents do not know for sure whether their friends are using condoms, but they think they are or think they should be.

Individual maturation continues while the pressures of the social world intrude and perhaps conflict with the adolescent's goals. Individuation is the time for adolescents to become their own persons in the face of parental/family/peer demands. It involves several interrelated processes: acquiring the right to make one's own choices while dealing with the expectations established by others and then managing others' influence on the consequences of decisions (Fischhoff, 1992). Advice seeking is an example of how social skills can play a part in decision making. Advice seeking is a fairly complex social skill: being able to make a situation clear, being able to understand others well enough to understand how their perspectives and interests differ from one's own (Keating &

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Clark, 1980; Shantz, 1983), and, finally, asking for comments without necessarily following them.

SEXUAL DECISION MAKING

Impact of Knowledge on Behavior

It is often thought that appropriate health information delivered at the right time will prevent high-risk sexual behaviors. However, a number of researchers have found that this is not the case; knowledge does not change behavior in and of itself. Keller, Durst, and Zimmerman (1996) suggests that although the dynamics of sexual decision making are not completely understood, certain environmental factors, drugs and alcohol specifically, have been linked to sexual risk taking (Cooper, 2002; Lowry et al., 1994). Teens' perceptions of how vulnerable they are to a sexually transmitted disease may also influence their use of safer sex strategies (Sneed, 2001). Ellen (1996) noted that though an adolescent's perceptions of risk appear to be related to anxiety about sexually transmitted infections (STIs) and HIV, their behaviors are related to peer influences and attitudes toward condom use. In fact, increased condom use among males often includes attitudes such as a strong belief in male contraceptive responsibility, concern about HIV (and potential for partners being HIV+), belief that a man's partner would appreciate condom use, and feeling comfortable buying and talking about condom use (Murphy & Boggess, 1998).

Factors Altering Prevention Behaviors

Abstinence-based sex education programs seek to change a teen's knowledge and beliefs, which seem to be effective in the short term (Arnold, Smith, Harrison, & Springer, 1999; Jemmott, Jemmott, & Fong, 1998). However, the influence of other factors in the teen's life (values, attitudes, peer influences, and emotions) may alter the decision to remain abstinent in the long run. There is also the question of how adolescents make the decision to protect against an STI or pregnancy or both. The concept of dual protection may seem unnecessary to teens, as they may see themselves as vulnerable to one or the other risk but not both. Lindsay, Smith, and Rosenthal (1999) found that older students or those who sought contraceptive advice had elevated odds of using the oral contraception rather than condoms alone. When adolescents believed that their peers used condoms, they were less likely to report pill use alone. Clearly, experience and additional information alter prevention behaviors.

There is also strong evidence that adolescents who perceive safer sex behaviors as the (social) norm will be more likely to adopt those same safe sex behaviors (Keller et al., 1996). Norms, adolescents' perceptions of other people's opinions regarding a specific behavior, are identified as one of the determinants

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of behavior according to the theory of reasoned action. This theory links individual beliefs, attitudes, intentions, and behavior (Fishbein, Middlestadt, & Hitchcock, 1994). At an age at which peer influence is most powerful, the social norm may have a significant impact on sexual decision making. However, in order for adolescents to know the norms of their peer group, their friends must talk about what they do! Two studies on the effects of social norms on condom usage bear mentioning. Jemmott and Jemmott (1991) found that the adolescent's perceived norm about condom use was a significant predictor of condom use among African-American women. In another study, high school students whose friends rarely used condoms were three times more likely to engage in risky behaviors (Walter, Vaughan, Gladis, Ragin, Kasen, & Cohall, 1992).

In addition to the variety of developmental factors mentioned earlier, it is also crucial to consider the opinions held by the teens themselves. Keller and associates ascertained the beliefs of the adolescents regarding abstinence and reasons and feelings associated with condom use and unprotected intercourse. The researchers found that four interconnected factors were strong contributors to sexual behaviors: social norms, fear, gratification or pleasure, and the availability of condoms (Keller et al., 1996).

THE EXPRESSION OF DECISIONS THROUGH BEHAVIOR AND LANGUAGE

Decision Making and Consensual Behavior

Consent can be a verbal or behavior process indicating one's decision regarding sexual behavior. It indicates not only whether a couple does or does not want to engage in sexual behavior but also the type of behavior, use of contraceptives, timing/initiation of sexual intimacy, or the decision to abstain or postpone sexual intimacy. "Yes" is only one aspect of the dialogue between partners that establishes agreement on a decision. There are questions that will determine whether both parties are equally interested in if, how, and when they will become sexually intimate. Expressions of interest and agreement can range from "Would you like to hold hands?" to "What does intercourse mean to you? Here is what it means to me." Statements such as these not only provide information to each partner but additional opportunities for understanding the other's desires as well as reaching a mutually acceptable decision.

Making an assumption about a partner's intentions or receptivity is a choice made by an individual. That choice can lead to behaviors based on inaccurate information. Relying on an optimistic, even hopeful reading of a partner's body language can potentially result in a one-sided interpretation of a situation. The way someone *looks* at another, the way one is *dressed* or seems to be "*into it*" (kissing, touching, etc.), and even the belief that one partner *should know* what the other partner wants because it is *obvious* are not actions clearly indicating one's decision.

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Sexual decision making is among the most complex and challenging experiences for adolescents. It is not enough to assess teens' information about sexual intimacy or their perceptions of their partners; one has to recognize the significance of their life experience, cognitive abilities, and social environment as well as their emotional state.

Language

Language and word choice are crucial to partners' perceptions of control and satisfaction in intimate relationships. The absence of words does not mean that a partner can assume anything about another individual's wishes. Too many young people have acted without clear information or ignored nonverbal messages. If either of the individuals is unable to talk about sex and the possible consequences for their relationship, it may be much too soon to initiate an intimate sexual relationship.

Initiating discussion can be awkward for teens. In fact, failing to recognize that a discussion needed to take place is a missed opportunity. Teens may be embarrassed or fearful of the conversation. However, it is important for both partners to be aware of the other's behavior. If one person stops making eye contact, pulls away, stops participating or talking, or delays or is not responsive to any advances, the other person needs to stop and find out what the first person is feeling or needs. The easiest way is to simply point out the behavior ("I see you're not talking anymore") and ask, "What's going on?"

Talking about sexual intimacy after the fact may be too late. Dialogue is a means of understanding how a partner feels about sexual intimacy, and it must occur before the interaction. If teens feel they have been rushed into a sexual experience, did not practice a preferred method of safe sex, or engaged in unfamiliar sexual behaviors, they will feel distrustful and uncomfortable regardless of their original desires and intentions.

Incapacity to Give Consent

A person must be *able* to give consent. Adolescents who are drunk, drugged, asleep, passed out, developmentally delayed, or otherwise unable to indicate their wishes are unable to give consent. According to the laws of most states, sexual activity with someone who is significantly older (at least four years) or in a position of caregiving or authority is not consensual (see, e.g., http://ageofconsent.com).

Coercion

There are a number of reasons why adolescents may "give in" and not use a condom or agree to sex even though they do not feel "ready." Fear and worry

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are two reasons many teens agree to sex, especially an initial sexual encounter. They may have learned through experience that resistance, verbal or physical, does not work. They may also become frustrated from not being heard or worry that their partner will become angry and end the relationship.

Consent is a mental and/or verbal act (Muehlenhard, 1996). If a teen decides to consent to sexual behavior (or contraceptive choice), he or she must communicate this decision to his or her partner. Not doing so will leave the partner confused and, hearing no clear indication of disagreement, assuming that he or she can proceed. Without clearly indicating a decision to one's partner there is no opportunity to discuss this important part of their relationship. Unfortunately, most studies indicate that sexual consent, agreement on contraception or even types of sexual behaviors, for the most part, are not communicated in an obvious manner (Muehlenhard, 1996).

STRATEGIES TO DECONSTRUCT SEXUAL RISK-TAKING BEHAVIORS

When talking with teens regarding choices they have made in the past or choices they will face in the future, it is useful to help them to identify the parts of their decision-making process that played a major role in their decision. Here are some suggestions for that conversation:

- *General questions*:
  - — What were the circumstances that preceded the choice you made (your decision)?

    Was alcohol or a drug involved?

    Were you (physically/mentally) able to make a choice?

    Did you feel pressured by your partner, friends, others?

    If you were faced with the same situation what would you do?
  - — Had you thought about the situation prior to that time?
  - — What would be the worst thing that could happen as a result of your choice?
  - — Who could you talk to help make a decision about sex? Or if you had a problem?
  - — Do your friends talk about (condoms, sex, etc)?

    What do they say?

    Do they make suggestions or give you advice?

    What do they do in this situation?
- *Specific questions* (could relate to use and type of contraception, specific sexual behaviors or consent issues):

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— How available are condoms, or other contraceptives?

— What do you think about condoms (pleasure, time to use, availability)?

— Have you (or your partner) used a condom (female condom or dental dam)?

If not, for what reason?

If so, for how often?

— Have you (or your partner) asked your partner to use a condom (female condom or dental dam)?

Why or why not?

— Was there ever a time when you received emergency contraception?

What happened (contraception failure, no contraception, alcohol, nonconsent, etc.)?

How many times have you used emergency contraception?

— Was there ever a time that you did not want to have sex but did so anyway?

Did your partner convince you to have sex? How?

What did you say or do to express your feelings?

Was there ever a time that you were frightened having sex?

Was there ever a time when you were physically uncomfortable or hurt?

Were you upset after having sex under these circumstances?

Did you talk about it?

— Was there ever a time that you think your partner did not want to have sex but did so anyway?

What happened that you thought your partner was not as interested as you in having sex?

What did you say to him/her?

Was your partner upset after having sex under these circumstances?

Did you talk about it?

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Stages of Adolescent Development

Stages of Adolescence	Physical Development	Cognitive Development	Social-Emotional Development
Early Adolescence **Approximately 11 – 13 years of age**	• Puberty: grow body hair, increase perspiration and oil production in hair and skin, Girls – breast and hip development, onset of menstruation Boys – growth in testicles and penis, wet dreams, deepening of voice • Tremendous physical growth: gain height and weight • Greater sexual interest	• Growing capacity for abstract thought • Mostly interested in present with limited thought to the future • Intellectual interests expand and become more important • Deeper moral thinking	• Struggle with sense of identity • Feel awkward about one's self and one's body; worry about being normal • Realize that parents are not perfect; increased conflict with parents • Increased influence of peer group • Desire for independence • Tendency to return to "childish" behavior, particularly when stressed • Moodiness • Rule- and limit-testing • Greater interest in privacy
Middle Adolescence **Approximately 14 – 18 years of age**	• Puberty is completed • Physical growth slows for girls, continues for boys	• Continued growth of capacity for abstract thought • Greater capacity for setting goals • Interest in moral reasoning • Thinking about the meaning of life	• Intense self-involvement, changing between high expectations and poor self-concept • Continued adjustment to changing body, worries about being normal • Tendency to distance selves from parents, continued drive for independence • Driven to make friends and greater reliance on them, popularity can be an important issue • Feelings of love and passion
Late Adolescence **Approximately 19 – 21 years of age**	• Young women, typically, are fully developed • Young men continue to gain height, weight, muscle mass, and body hair	• Ability to think ideas through • Ability to delay gratification • Examination of inner experiences • Increased concern for future • Continued interest in moral reasoning	• Firmer sense of identity • Increased emotional stability • Increased concern for others • Increased independence and self-reliance • Peer relationships remain important • Development of more serious relationships • Social and cultural traditions regain some of their importance

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