

ADOLESCENT SEXUAL DEVELOPMENT AND SEXUALITY

Assessment and Interventions

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Chapter 6

The Complexities of Sexual Decision Making in Adolescence

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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-

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 development, 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-

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.

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 &

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

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.

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

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):

- 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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