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WHAT IS THE PROCESS OF BECOMING AN ADOLESCENT SEXUAL RISK TAKER, AND WHAT FACTORS CONTRIBUTE TO SEXUALLY RISKY BEHAVIOUR IN ADOLESCENCE

BY

JASON SCHMELZLE

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

IN

FAMILY ECOLOGY AND PRACTICE

DEPARTMENT OF HUMAN ECOLOGY

EDMONTON, ALBERTA
FALL 2001

UNIVERSITY OF ALBERTA

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TITLE OF THESIS: WHAT IS THE PROCESS OF BECOMING AN ADOLESCENT SEXUAL RISK TAKER, AND WHAT FACTORS CONTRIBUTE TO SEXUALLY RISKY BEHAVIOUR IN ADOLESCENCE

DEGREE: MASTER OF SCIENCE

YEAR THIS DEGREE GRANTED: 2001

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Abstract

The primary objectives of this study were to investigate the processes of becoming an adolescent sexual risk taker and assess the factors that contribute to sexually risky behaviour in adolescence. A qualitative study using grounded theory was employed to determine the processes. Twelve participants shared their personal experiences with sexually risky behaviour. Three processes of becoming sexually risky arose from the data collected. Each of these processes originated from the parent-child relationship. Parents employed a parenting style described as strict, absent or emotionally unavailable. Furthermore, five major themes that contribute to adolescent unsafe sexual behaviour were determined. They are comorbidity, parent-child relationship styles, peer affiliation, independence and exploration, and meeting emotional needs and developing identity. Two articles were composed to illustrate the results of the project. Limitations of the study and implications are discussed.

Key Words: **Adolescent Sexually Risky Behaviour, Process, Risk Behaviours, Parent-Child Relationships**

ACKNOWLEDGEMENTS

I extend my deepest gratitude to those individuals whose assistance and support enabled me to complete this project.

Dr. Brenda Munro for her direction, support and ability to answer countless tedious questions; for providing me with the opportunity and means to collect primary data; for her genuine interest in the study.

Dr. Nancy Gibson for her input and feedback over the course of the study; for her caring and supportive nature; and for her optimism.

Dr. Gretchen Hess for her thought provoking insight and participation in this project.

Sheena George for her tremendous efforts with study preparations and data collection; and her insight in other academic matters.

The 12 participants that were willing to share the personal details of their lives and provide insight into this important area of study.

Linda Mirans for her infinite knowledge in the administrative matters of this project and degree; and for providing the answers to innumerable trifling questions.

Errol Billing for his computer genius; and the use of transcribers and tape-recorders.

The many individuals in the Department of Human Ecology at the University of Alberta whose efforts, large or small, contributed to the completion of this project.

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CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

INTRODUCTION

Presently many adolescents are participating in sexually risky behaviour (Lear, 1996). Adolescents are considered especially vulnerable to contracting the human immunodeficiency virus (HIV) because of their risky sexual behaviour (Munro, Doherty-Poirier, Mayan, & Salmon, 1994). These very behaviours are exposing them to HIV and various other sexually transmitted infections (STIs) (Miller, Forehand, & Kotchick, 1999). As the spread of HIV has progressed, the median age of those infected has dropped from 32 to 23 years of age (Hawa, Munro, & Doherty-Poirier, 1998). This suggests that many HIV carriers may have become infected in their adolescence (Munro et al., 1994). Researchers have found that the average age of first vaginal intercourse is 16 and 17 for males and females respectively (Leigh, Morrison, Trocki, & Temple, 1994; Seidman & Rieder, 1994). This suggests that many high school students engage in sexual activities, which potentially expose them to HIV and other STIs. Furthermore, adolescents engage in shorter sexual relationships thereby increasing their number of sexual partners and exposure to HIV (Baldwin & Baldwin, 1988; Kann et al., 1998; Miller et al., 1999).

Researchers have found that adolescents use condoms at low rates and inconsistently (Keller, 1993; Galambos & Tilton-Weaver, 1998). One researcher found that 85.3% of the sample reported not using condoms at least once (Keller,

1993). In addition, adolescents decrease their use of condoms over the age of 17 and as relationships progress over time. This occurs because of an increase in the use of birth control pills after the age of 17. Likewise, this same effect is evident in longer lasting relationships. Furthermore, researchers have discovered that having shorter relationships and multiple partners promotes inconsistent condom use (Civic, 1999). However, it must be noted that not using condoms does not necessarily create a higher risk of contracting HIV and other STIs. For example, a disease free monogamous couple may not use condoms and feel that this is not risky sexual behaviour. Consequently, one must not assume that the non-use of condoms is necessarily a high-risk behaviour. However, it must also be noted that often the low and inconsistent use of condoms does promote contracting HIV and other STIs. In other words, reporting of condom use must be reviewed with caution.

Information contained in one article suggests that half of all new HIV infections in the United States occurs in people under the age of 25 ("Facts about youth HIV in the U.S.," 1998). In addition, acquired immunodeficiency syndrome (AIDS) has increased by 400% in the 13 to 30 age range of Americans (Neel, 1998). In Canada and the United States, youth between the ages 15 to 19 have the highest rates of gonorrhea and chlamydia (Bowler, Sheon, D'Angelo, & Vermund, 1992; Lindsay, Devereaux, & Bergob, 1994). Adolescents that have STIs are more likely to become infected with HIV if exposed to it.

Other factors increase the likelihood that adolescents will participate in sexually risky behaviour. Research has shown a positive association between the

use of drugs and alcohol and an increased likelihood of having unprotected sex (de Gaston, Jensen, & Weed, 1995; Hewitt, Vinje, & MacNeil, 1995). Secondly, adolescents that have experienced physical or sexual abuse are more likely to participate in high-risk sexual behaviour (Ferguson, Horwood, & Lynskey, 1997). Lastly, researchers have found that many adolescents have misconceptions about the risk of contracting HIV and other STIs. Often young adults claim to known instinctively that a partner is not infected, and many still consider AIDS a homosexual disease (Keller, 1993; "Library watch," 1996).

Clearly adolescents are a sexually risky population. At a young age, they participate in sexual activities that expose them to HIV and other STIs. Furthermore, youth use condoms inconsistently and at low rates. This is compounded by such factors as drug and alcohol use, and physical and sexual abuse. Because adolescents are a sexually risky group and find themselves in a time where unsafe sex can kill, a critical area of study is the sexual risk behaviours of this population group. While much is known about the practices, sexual knowledge and attitudes of young adults, little is known about the process of becoming a sexual risk taker. This process needs to be clearly identified. A clearer understanding of this process can contribute to positive change in adolescents' lives. It is vital that the process is addressed as a means to help change the sexual behaviour of adolescents.

Objectives

The goal of the researcher was to identify the process of becoming a sexual risk taker in the period of adolescence. An additional goal was to learn more about the factors that contribute to adolescents' participation in sexually risky behaviours. Secondary to these goals, is the encouragement of further scholarly study in this area by other researchers and progression towards the application of research findings. The research question addressed in this study was: What is the process of becoming a sexual risk taker in adolescent populations, and what factors contribute to sexually risk behaviour in adolescence?

Youth that have participated in high-risk sexual behaviour and those that continue to practice this behaviour comprised the sample in this project. Furthermore, both males and females participated in the study. Participants were interviewed individually and interviews were tape-recorded.

Terms Defined

Participants in this study were between the ages of 18 to 27. Each participant experienced sexually risky behaviour during the period of adolescence. Participants' sexual risk taking occurred between the age span of 14 to 20 years of age. Baumrind (1991) refers to adolescence as the age span between the ages of 10 to 21. The researcher has used Baumrind's definition of the age span of adolescence for the purposes of this project. The terms adolescent, teen and youth are used interchangeably. High-risk youth are those who engage in

unprotected sex, have multiple partners and have sex with individuals considered high-risk (Bowler, Sheon, D'Angelo, & Vermund, 1992).

REVIEW OF LITERATURE

Sexual Behaviour

Today many sexually active youth engage in sexual behaviours, which may expose them to HIV and other STIs (Miller, Forehand, & Kotchick, 1999). According to Small and Luster (1994), the vast majority of young people experience first vaginal intercourse between the ages of 14 to 21. Canadian researchers have found that the majority of Canadian high school students have participated in sexual activities that have exposed them to the HIV virus prior to their completion of secondary schooling (Maticka-Tyndale, 1991). According to the 1994/95 Canadian National Population Health Survey, 44% of males and 43% of females aged 15 to 19 had sexual intercourse in the year prior to the survey, while the corresponding figures for those aged 20 to 24 years were 78% for males and 81% for females (Galambos & Tilton-Weaver, 1998). In addition, adolescents tend to engage in short sexual relationships that are serially monogamous. Therefore, they increase their exposure to multiple partners, in turn increasing the risk of contracting STIs and experiencing other negative consequences of sexually risky behaviour (Baldwin & Baldwin, 1988; Kann et al., 1998; Miller et al., 1999). Furthermore, adolescents are a sexually experimental population, and this creates a higher probability of contracting STIs (Koch, Palmer, Vicary, & Wood, 1999).

In summary, many adolescents are engaging in sexual activity at a young age. The fashion in which members of this group engage in sexual activity puts them at risk of contracting HIV and other STIs. Unfortunately, adolescents do not consistently use condoms, therefore increasing the probability of contracting STIs.

Condom Use

Researchers have suggested (Anderson & Mathieu, 1998; Smith & Brown, 1998) that youth are more likely to use condoms if they believe it will prevent HIV, but not if they feel condoms will reduce physical pleasure, are embarrassed about condom use or do not perceive a risk of contracting HIV. Researchers have found that 60% of adolescents use a condom on their first experience of vaginal intercourse (Maticka-Tyndale, 1991; Nguyet Nguyen, Saucier, & Pica, 1996). However, this rate drops with youth over the age of 17 because of increased use of the birth control pill. Likewise, as a relationship progresses over time the rate of condom use drops. Results of one study indicated that half of the respondents reported consistent condom use in the first month of the relationship, as compared to 34% in the last month of the partnership (Civic, 1999). While youth may still be taking measures against unwanted pregnancy in this fashion, they remain vulnerable to contracting STIs. According to the 1994/95 Canada National Population Health Survey (Galambos & Tilton-Weaver, 1998) 51% to 53% of females and 29% to 44% of males that were sexually active reported not using a condom in the last year. One research group (Leigh, Morrison, Trocki, &

Temple, 1994) reported that males are more likely than girls to report condom use. Another researcher found that having shorter relationships and multiple partners resulted in more inconsistent condom use (Civic, 1999).

The non-use and inconsistent use of condoms by adolescents creates a high-risk of contracting STIs. Many youth are jeopardizing their health by not using condoms effectively and consistently. This is supported by the prevalence of STIs in this population.

Sexually Transmitted Infections Prevalence

Adolescents, unsurprisingly, have a high-risk of contracting STIs. Half of all new HIV infections in the United States occur in people younger than 25, and 110,000 people between 13 to 29 years of age have been diagnosed ("Facts about youth HIV in the U.S.," 1998). Neel (1998) has stated that the heterosexual transmission of AIDS has increased by 400% in the 13 to 30 age group of Americans. According to this research, this is the fastest growing age by risk factor category in the United States. In a study, researchers found that from 1991 through 1995 the number of young females diagnosed with AIDS increased by 63% versus 12.8% in men (Key & DeNoon, 1998). This points to the fact that AIDS is increasing in the female population at a rate faster than males, however, the number of AIDS cases in females is still lower than males. HIV antibodies are not present in the body for at least six months after infection; therefore, many youth are not aware of this highly infectious period in themselves and others. Given this, high-risk sexual behaviour becomes even more risky and increases

the likelihood that continued spreading of this disease is inevitable. In the United States, approximately three million new cases of STIs are diagnosed each year among youth under the age of 19 ("Teen sex rates level off, but pregnancy and STD rates remain high," 1999). Adolescents in Canada and the United States between the ages 15 to 19 have the highest rates of chlamydia and gonorrhea in their respective countries (Bowler, Sheon, D'Angelo, & Vermund, 1992; (Lindsay, Devereaux, & Bergob, 1994).

Research findings illustrate the high prevalence of HIV and AIDS in adolescent populations. In spite of this, adolescents' condom use is inconsistent and unreliable which helps explain the high rates at which young adults are increasingly becoming infected with HIV and other STIs.

Comorbidity

Drug and alcohol use has been found to increase the occurrence of high-risk sexual behaviour in adolescents, as well as decrease the likelihood of condom use (Brown, DiClemente, & Park, 1992; "Library watch," 1996). Hewitt, Vinje, and MacNeil (1995) reported that "Studies have consistently shown a positive association between level of alcohol use and sexual activity and between alcohol use level and the likelihood of having unprotected sex" (p. 42). Hewitt et al. (1995) also reported that alcohol is the most frequently used drug by youth in Canada. Likewise, a review of a 1990 American national risk behaviour survey (Bowler, Sheon, D'Angelo, & Vermund, 1992) revealed that alcohol use is widespread among American youths. Of illegal drugs, marijuana is the most

commonly used illicit drug by adolescents (Cole & Weissberg, 1994). In fact, adolescents that use intravenous drugs potentially have the worst survival pattern among youth (Wishon, 1988). This is due to an increase in sexual risk taking and susceptibility to contracting HIV as a result of sharing needles with those infected with the HIV virus. DeGaston, Jensen, and Weed (1995) found that 20% of their sample reported they had used drugs or alcohol at the time of first vaginal intercourse; females were more likely to use drugs and alcohol than males (22.7% vs. 15.6%).

Sexual risk taking does not occur in isolation, therefore research efforts must continue to assess the comorbidity of high-risk sexual behaviour with such things as alcohol and drug use. The context of high-risk sexual behaviour is dynamic; therefore the comorbidity between these behaviours remains an essential component of research.

Gender Differences

Females on average experience first vaginal intercourse at an older age than males, and feel more pressured than males to participate in sex (de Gaston, Jensen, & Weed, 1995). Sexually active females are at a higher risk of contracting STIs due to a greater physiological vulnerability to infections (Bowler, Sheon, D'Angelo, & Vermund, 1992). Females are more likely to possess negative emotions such as feeling bad, dirty and used after sex. In spite of this, researchers have found that most female young adults feel good after sex (Donald, Lucke, Dunne, & Raphael, 1995). Researchers have found that females

may engage in casual sex as a means to increase the probability of a long-term commitment from the sex partner (Regan & Dreyer, 1999), and care more about safe sex than males (Levinson, Jaccard, & Beamer, 1995).

On the other hand, males possess specific sexual characteristics, many of which are opposite of those inherent in females. Due to the physiological makeup of the penis less mucous membranes are exposed, therefore it is more difficult for males to contract STIs. Males on average experience first vaginal intercourse at an earlier age than females, and males on average have sex more frequently and with more partners than females. Furthermore, males are more likely to pressure females into sexual participation than vice versa (deGaston, Jensen, & Weed, 1995). Male youth perceive more strongly than female youth that they will have sex in the next year. In an opposite fashion to females, young males have less negative emotions and guilt after sex (Donald, Lucke, Dunne, & Raphael, 1995). Lastly, males have been found to engage in casual sex to achieve status enhancement or comply with normative peer group behaviour (Regan & Dreyer, 1999).

Knowledge and Attitudes

Adolescents often do not consider themselves at risk for HIV and other STIs, and this is referred to as the optimistic bias (Ellen, Boyer, Tschann, & Shafer, 1996). In one study, 50% of the sample claimed to intuitively know a partner was safe and not infected (Keller, 1993). An alarming finding by Westerman and Davidson (1993) suggested that many adolescents do not feel vulnerable to

AIDS, because they still regard it as a homosexual disease. Researchers have suggested that youth are becoming increasingly knowledgeable about HIV/AIDS, yet Buysse (1996), and DiClemente, Forrest, and Mickler (1990) found that substantial confusion is present about the transmission of the virus. For example, some adolescents believe that AIDS can be contracted from casual contact. In addition, similar misconceptions were found regarding practical condom use. The investigators suggest that there is a difference between perceived and actual knowledge. Other researchers have found that many youth view health as an absence of symptoms and believe they can tell who is likely to be infected with HIV and other STIs (Bowler, Sheon, D'Angelo, & Vermund, 1992). A common theme found in the literature is that knowledge does not necessarily predict behaviour (Neel, 1998).

Many adolescents remain poorly educated about the transmission of STIs and the use of condoms. Clearly, misconceptions are vast in this population and this is problematic. If youth are going to become more informed and lead less risky sexual lives, behaviour, knowledge and attitudes need to be reformed.

Process

One area of scholarly inquiry that may help to alter the sexual behaviour of adolescents is research focusing on the process of becoming a sexual risk taker. If the process becomes clearer then efforts can be made to help youth address the process of becoming sexual risk takers.

Studies have been conducted with the purpose of examining the process of various risk behaviours. Staton et al. (1999) found that substance abuse at a younger age (6^{th} to 10^{th} grades) is related to riskier sexual behaviour as a young adult (19 to 21). While this study alludes to the predictive elements of risk behaviours, it also speaks of process, in that these earlier behaviours are components of the stages to becoming a risk taker. In a different study, Singer (1995) interviewed 228 drug users to discover the role of past and current life experiences and the association with the participants' inability to change their risk of contracting HIV. The author reported that many of the subjects had abusive childhoods, relationship and sexual difficulties, loss of others and social isolation. These experiences may be regarded as life events that led to and formed the process of becoming a risk taker in the domains of various behaviours. A grounded theorist investigated the process of women changing their behaviours after repeatedly contracting STIs (Redfern-Vance, & Hutchinson, 1995). The researchers found a process of movement from self-abdication to personal sovereignty as the women attempted to change their sexual behaviours. Another grounded theorist examined the process of casual sexual encounters (Hoffman & Cohen, 1999). Twelve focus groups were conducted with 42 participants from a public STI clinic. The researchers found five temporally ordered stages of casual sex encounters. Lear (1996) looked at the process of young adults negotiating sexual relationships. The author claims

that, "We must understand the construction of sexuality, risk and relationships" (p. 112).

Research designed to investigate the processes of various risk behaviours has been illustrated in this section. However, it appears that minimal research exists in the area of the process of becoming a sexual risk taker in adolescence. The purpose of this research was to develop a better understanding of the process of becoming sexually risky in adolescence.

Summary of the Literature

A review of the literature on adolescents' sexual risk behaviours provides a comprehensive illustration of this population's practices, knowledge and attitudes. It is evident that a great number of adolescents participate in sexual activity with great frequency and little protection. The consequences of these behaviours are potentially devastating.

PROBLEM STATEMENT

Unfortunately, little research has addressed the process of becoming a sexual risk taker. The research reviewed in this chapter clearly demonstrates that adolescents are a high-risk group for unsafe sex and exposure to STIs. Scholars have studied the sexual behaviour, STI prevalence, comorbidity, gender differences and knowledge and attitudes of youth's sexuality, but this may be of little value in the absence of the "whole picture." Research on the process of becoming a sexual risk taker may help to put these components into context.

PURPOSE

The purpose of this research was to examine the process of becoming an adolescent sexual risk taker and the factors that contribute to adolescent sexually risky behaviour. The significance of this study lies in its potential to encourage further inquiry in this area. In addition, the application of findings from future research becomes a significant component of the success derived from this project. Ideally, increased research in this area will eventually enable educators, practitioners, parents and adolescents themselves to alter the paths to becoming sexually risky. If research findings are applied, the process can be addressed and many young adults may not become sexual risk takers. If this is achieved, presumably adolescents will live healthier and longer lives.

The following report includes two articles and a general discussion. The second chapter contains an article in which the study of the process of becoming an adolescent sexual risk taker is discussed. The second article, in chapter three, presents the component of the study in which the factors that contribute to adolescent sexual risk taking were examined. The final chapter addresses the limitations and implications of this research.

METHOD

The method used in this research is grounded theory. This theory, developed in sociology by Barney Glaser and Anselm Strauss (1967), is influenced by symbolic interactionism. This influence is manifested in the assumptions of grounded theory. Grounded theorists presume that individuals devise order and

make sense of their environment. In addition, the theory holds the assumption that one's perception of reality changes according to the definitions and meanings he or she ascribes to the environment and interactions with others. Grounded theory allows the researcher to determine the process or movement through stages of an experience over time (Morse, 1992). Therefore, it is well suited to studying the process of becoming sexually risky in adolescence. Furthermore, the goal of a grounded theorist is to generate a theory that relates to a specific situation or phenomenon; theory should be "grounded" in the data of actions, interactions and social processes of people (Creswell, 1998). The process of generating a grounded theory is both inductive and deductive, whereby concepts and constructs are grounded in the data and hypotheses arising from the data are tested (Field & Morse, 1985a).

Setting

Data were collected on the University of Alberta campus in an interview room assigned by the researcher's thesis supervisor. Access to this room was flexible in consideration of participants' time availability. If room access, due to unforeseeable circumstances, was not available, alternate space was available in the supervisor's research office. Privacy was of utmost importance and ensured in both spaces.

Participants

Twelve individuals between the ages of 18 to 27 participated in this research project, and each was given a $20 honorarium for their participation. Of these,

seven were males and five were females. The number of participants needed was flexible, in that more or less may have been necessary to saturate data. A purposive sample was compiled for this project, because it allowed the researcher to examine individuals that could contribute to the evolving theory. A purposive sample was necessary, because it provided a group of participants that had experienced high-risk sexual behaviour. This type of sample, whereby all participants similarly engage(d) in the phenomenon being studied, is most ideal. Consequently, participants had specific knowledge and characteristics, which added to or contradicted (negative cases) the theory (Field & Morse, 1985a). The research question required answers from an emic perspective, in that only those engaging in high-risk sexual behaviour could provide the answers; this provides further rationale for using a purposive sample. Appropriate research participants were recruited through electronic mail to student associations, ads posted on campus bulletin boards and an advertisement in the University of Alberta newspaper, The Gateway (see Appendix B). Furthermore, snowball or chain sampling was employed. This type of sampling "identifies cases of interest from people who know people who know what cases are information rich" (Marshall & Rossman, 1999, p. 78). Once potential participants were identified, they received a study information letter describing the project (see Appendix D). Furthermore, prior to participation, an initial consultation was conducted by telephone or electronic mail whereby it was determined if the individual was a suitable participant for this project.

Data Collection

Data were collected by conducting face-to-face in-depth interviews, and participants were interviewed by a same sex interviewer if possible. However, if participants were not comfortable with a same sex interviewer they were interviewed by an opposite sex interviewer. Some participants were not comfortable with an interviewer of similar ethnic origin; consequently, they opted to be interviewed by the other interviewer, regardless of sex. Participants were required to complete a demographic data form (see Appendix F) which was useful in data analysis, because it illustrated the variation in participant characteristics. Examples include ethnicity, and sexual and religious orientation. In addition, the researcher used reflection and memoing to help develop the theory. This was essential to unravel and organize the information being collected and analyzed. Interviews were recorded on a portable cassette recorder and later transcribed. Participants were notified (Appendix D & E) that they may be contacted for a follow-up. The interviews were open-ended, in that participants could fully explain their experience of the risky sexually behaviour. The opening interview question was: "High-risk behaviour can mean different things to different people. It is important that you tell me what high-risk behaviour means to you." The intention of the interviewers was to acquire a clear understanding of each participant's definition of high-risk behaviour.

Data Analysis

Data analysis occurred concurrently with data collection. Contextual notes were made during each interview. Transcribed interviews were checked for

accuracy, and additional contextual notes, such as the tone of the interview, were compiled as soon as possible after each interview. Furthermore, transcriptions and contextual notes were reviewed to identify and code themes and central ideas. This is called open coding (Strauss & Corbin, 1990). This resulted in the development of categories that were derived from the data. Constant comparison was then used to compare each piece of data with every other piece and this occurred throughout data collection (Field & Morse, 1985a). This process is ideal when comparing new data from more recent interviews with older data from previous interviews. Data collection continued until all categories were saturated. Saturation occurs when all new data fit within existing categories; therefore, no new categories are needed. Axial coding was then used to examine any relationships between categories. This process is accomplished by putting data back together in new ways by making connections between categories. Selective coding was the final step of data analysis. This involves the integration of concepts around a core category and the filling in of categories in need of further refinement and development (Strauss & Corbin, 1990).

Transcription Coding Sample

Transcription	**Open Coding**
Participant "E" 10/15/00 (fictional narrative)	
I used to be what everybody called a nerd. I remember in grade 11 and 12 I wasn't the most popular girl at school. In fact, I used to get bugged by the other kids quite often. I don't even know if I was thinking about sex at that point. I can't remember. All I know is I was more concerned about just being accepted by all of those	**Unpopular** **Not accepted** **Not Sexually Active**

jerks. I don't know why I cared; most people were just assholes. **Bitter**
I had one really good friend but she moved before grade 12 started. **Lonely**
I got through grade 12 more or less on my own. I became **Wanted friends**
trapped in my bedroom and started to skip school. My parents didn't **Isolated**
even seem to notice. Kids started to bug me even more at school **Lacks support**
in grade 12 and bugged me about being a "little virgin." There was **Frustration**
one guy I hated especially, but I don't even want to get started with **Hatred**
that. I can't believe I survived that hellish year. My parents really **Relief**
wanted me to go to university, but I hated the idea. I started at the **Pressure**
U of A right after grade 12. I lived in Lister Hall, which really
sucked at first. Within a month, I was one of the more popular **Disbelief**
girls on the floor, and I couldn't believe it. There were two guys **Surprise**
on my floor that were really interested in me. This was a first. I
lost my virginity to one of them one night after we got really drunk. **Loses**
I didn't know what to think, but I finally felt normal. There was a lot **virginity**
of drinking that first year. It seemed like I was drinking two or three **Confused**
times a week. This was the first time in my life that I was drinking, **Normalcy**
and I have to admit I really liked it. I ended up getting together with **Drinking**
the guy I lost my virginity to. He was really great until.... One day **often,**
I found out he was sleeping with two other girls in rez and he had **likes it**
a girlfriend back home. I was devastated. It got worse. A week later **Devastated**
I went to Health Services and found out I had herpes. I couldn't **STI**
believe how stupid I was. I don't know why I never used protection. **Unsafe sex**
It seemed like after that I just didn't care. I was ready to screw, **Disbelief**
someone else around. People started to call me a slut, well mostly **Feels**
the other girls. I'm in my second year now and it seems like since **stupid**
all that crap happened I just don't care. I haven't got any other STIs **Uncaring**
but I still don't practice safe sex. I don't know what I am trying to **Losing**
prove. The last year and a half have been such a switch, and I don't **acceptance**
know who I am anymore it seems. Even my mom said she didn't **Still unsafe**
know me anymore, and that really hurts.... **sex**
Confusion
Hurt
Loss of self

Trustworthiness

In this research, all efforts were made to keep data in its original form. This was achieved with tape-recorded interviews, accurate transcriptions and the use of interview notes and memos. In addition, participants were asked to verify that

the results represented their perception of reality, unfortunately only one participant responded to this request. She stated that the results accurately portrayed her experience, however she was surprised that the other participants had similar experiences. The use of purposive sampling in this research increased trustworthiness, in that negative cases were more likely to be discovered; this increased the likelihood that all information about the process was revealed. Furthermore, purposive sampling is appropriate in that participants had experienced the process being studied. This increased the sample's credibility to offer data in this research area. In addition, theoretical sensitivity, which strengthens trustworthiness, was reinforced by the researcher's knowledge of the literature in this area, similar age to participants and experiences as an adolescent (Strauss & Corbin, 1990). Participants were interviewed individually, and ideally, this created a level of comfort in which participants could express their thoughts on this sensitive topic. Because the researcher was close in age to the participants they may have felt more relaxed and offered information more accurately, comfortably and securely. The researcher aspired to create the highest level of comfort for research participants during the interview. Consequently, a female interviewer was hired to interview female participants. It was essential that participants had the option to be interviewed by a same sex interviewer. Furthermore, participants had the opportunity to be interviewed by an interviewer of different ethnic origin. This proved to be beneficial in that some participants opted for this choice. The female interviewer was also

knowledgeable in the area of human sexuality and similar in age to the participants.

Ethical Considerations

Ethical clearance was obtained from the University of Alberta. Informed consent of the participants was required in this research project. Potential participants were informed of the research objectives and provided with an information letter (see Appendix D). Consent forms were completed at the time of the interview. Each participant was provided with a consent form to keep. Furthermore, subjects were informed that no known risks or benefits of participation existed. However, due to the sensitive nature of this research, participants were provided with a list of appropriate community services and organizations (see Appendix G) where they could discuss any issues arising from the interviews. After each interview, participants were offered this list. Although participants were notified that there were no known benefits from participating in this study, it is noted that participants may have benefited from the interview in that they had an opportunity to share their experiences. In addition, participants were made aware that participation was not mandatory and that they could discontinue taking part in the study at anytime. Anonymity of all subjects was maintained, and only the researcher and/or interviewer knew the identity of participants. Furthermore, anonymity will be upheld in any publications or presentations of research data and findings. All data and confidential information derived from the project are secured.

Timeline

This project took approximately 12 months to complete (see Appendix A). A one to two month allowance was made to acquire a sample. It took approximately four months to complete the interviews. Data analysis was ongoing throughout the process of data collection. Lastly, four months were designated to the preparation of the thesis.

References

Anderson, P. B., & Mathieu, D. (1998). Drinking and safer sex: Are college students at risk? *Journal of Sex Education & Therapy, 23,* 297-301.

Baldwin, J. D., & Baldwin, J. I. (1988). Factors affecting AIDS-related sexual risk-taking behaviour among college students. *Journal of Sex Research, 25,* 181-196.

Baumrind, D. (1991). Effective parenting during the early adolescent transition. In P. A. Cowan, & M. Hetherington (Eds.), *Family Transitions* (pp. 111-163). Hillsdale, NJ: Lawrence Erlbaum Associates.

Bowler, S., Sheon, A., D'Angelo, L., & Vermund, S. (1992). HIV and AIDS among adolescents in the United States: Increasing risk in the 1990s. *Journal of Adolescence, 15,* 345-371.

Brown, L. K., DiClemente, R. J., & Park, T. (1992). Predictors of condom use in sexually active adolescents. *Journal of Adolescent Health, 13,* 651-657.

Buysse, A. (1996). Adolescents, young adults and AIDS: A study of actual vs. perceived need for additional information. *Journal of Youth and Adolescence, 25,* 259-270.

Civic, D. (1999). The association between characteristics of dating relationships and condom use among heterosexual young adults. *AIDS Education & Prevention, 11,* 343-352.

Cole, P. S., & Weissberg, R. P. (1994). Substance use and abuse among urban adolescents. In T. P. Gullotta, G. R. Adams, & R. Montemayor (Eds.), *Substance misuse in adolescence* (pp. 92-122). Thousand Oaks, CA: Sage.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

deGaston, J. F., Jensen, L., & Weed, S. (1995). A closer look at adolescent sexual activity. *Journal of Youth and Adolescence, 24,* 465-478.

DiClemente, R. J., Forrest, K. A., & Mickler, S. (1990). College students' knowledge and attitudes about AIDS and changes in HIV-preventive behaviours. *AIDS Education & Prevention, 2,* 201-212.

Donald, M., Lucke, J., Dunne, M., & Raphael, B. (1995). Gender differences associated with young people's emotional reactions to sexual intercourse. *Journal of Youth and Adolescence, 24,* 453.

Ellen, J. M., Boyer, C. B., Tschann, J. M., & Shafer, M. (1996). Adolescents' perceived risk for STD and HIV infection. *Journal of Adolescent Health, 18,* 177-181.

Facts about youth HIV in the U.S. Health Initiatives for Youth. (1998, May). *World, 7,* 1.

Ferguson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual

abuse, adolescent sexual behaviours and sexual revictimization. *Child Abuse and Neglect, 21,* 789-803.

Field, P. A., & Morse, J. M. (1985a). *Nursing research: The application of qualitative approaches.* Rockville, MD: Aspen Publishers.

Galambos, N. L., & Tilton-Weaver, L. C. (1998). Multiple-risk behaviour in adolescents and young adults. *Health Reports, 10,* 9-20.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Hawa, R., Munro, B. E., & Doherty-Poirier, M. (1998). Information, motivation and behaviour as predictors of aids risk reduction among Canadian first year university students. *The Canadian Journal of Human Sexuality, 7,* 9-18.

Hewitt, D., Vinje, G., & MacNeil, P. (Eds.). (1995). *Horizons three young Canadians' alcohol and other drug use: Increasing our understanding.* Ottawa, ON: Health Canada.

Hoffman, V., & Cohen, D. (1999). A night with Venus: Partner assessments and high-risk sexual encounters. *AIDS Care, 11,* 555-566.

Kann, L., Kinchen, S. A., Williams, B. I., Ross, J. G., Lowry, R., Hill, C. V., et al. (1998). Youth risk behaviour surveillance- United States, 1997. *Journal of School Health, 68,* 355-369.

Keller, M. L. (1993). Why don't young adults protect themselves against sexual transmission of HIV? Possible answers to a complex question. *AIDS Education & Prevention, 5,* 220-233.

Key, S. W., & DeNoon, D. J. (1998, January 5). Study reveals views of young people toward sex, health, AIDS. *AIDS Weekly Plus,* 18-19.

Koch, P. B., Palmer, R. F., Vicary, J. R., & Wood, J. M. (1999). Mixing sex and alcohol in college: Female-male HIV risk model. *Journal of Sex Education & Therapy, 24,* 99-108.

Lear, D. (1996). "You're gonna be naked anyway": College students negotiating safer sex. *Qualitative Health Research, 6,* 112-134.

Leigh, B. C., Morrison, D. M., Trocki, K., & Temple, M. T. (1994). Sexual behaviour of American adolescents: Results from a U.S. national survey. *Journal of Adolescent Health, 15,* 117-125.

Levinson, R. A., Jaccard, J., & Beamer, L. (1995). Older adolescents' engagement in casual sex: Impact of risk perception and psychosocial motivations. *Journal of Youth and Adolescence, 24,* 349-362.

Library Watch. (1996, October). *The Brown Digest of Addiction & Application, 15,* 9-10.

Lindsay, C., Devereaux, M. S., & Bergob, M. (1994). *Youth in Canada* (2nd ed.). Ottawa, ON: Statistics Canada, Housing, Family and Social Statistics Division.

Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research.* Thousand Oaks, CA: Sage.

Maticka-Tyndale, E. (1991). Sexual scripts and AIDS prevention: Variations in adherence to safer-sex guidelines by heterosexual adolescents. *Journal of Sex Research, 28,* 45-66.

Miller, K. S., Forehand, R., & Kotchick, B. A. (1999). Adolescent sexual behaviour in two ethnic minority samples: The role of family variables. *Journal of Marriage and the Family, 61,* 85-98.

Morse, J. M. (1992). *Qualitative Health Research.* Newbury Park, CA: Sage.

Munro, B., Doherty-Poirier, M., Mayan, M. L., & Salmon, T. (1994). Instructional strategies used in HIV/AIDS education: Correlations with students' knowledge, attitudes and intended behaviour. *The Canadian Journal of Human Sexuality, 3,* 237-243.

Neel, K. L. (1998). Youth and HIV: Predicting sexual risk-taking behaviour. *Dissertation Abstracts International: Section B: The Sciences & Engineering, 59 (3-B),* 1374.

Nguyet Nguyen, M., Saucier, J., & Pica, L. A. (1996). Factors influencing the intention to use condoms in Quebec sexually-inactive male adolescents. *Journal of Adolescent Health, 18,* 48-53.

Redfern-Vance, N., & Hutchinson, S. A. (1995). The process of developing personal sovereignty in women who repeatedly acquire sexually transmitted diseases. *Qualitative Health Research, 5,* 222-236.

Regan, P. C., & Dreyer, C. S. (1999). Lust? Love? Status? Young adults' motives for engaging in casual sex. *Journal of Psychology & Human Sexuality, 11,* 1-24.

Seidman, S. N., & Rieder, R. O. (1994). A review of sexual behaviour in the United States. *American Journal of Psychiatry, 151,* 330-341.

Singer, N. (1995). Understanding sexual risk behaviour from drug users' accounts of their life experiences. *Qualitative Health Research, 5,* 237-249.

Small, S. A., & Luster, T. (1994). Adolescent sexual activity: An ecological risk-factor approach. *Journal of Marriage and the Family, 56,* 181-192.

Smith, C. D., & Brown, J. M. (1998). Sexual behaviours, extroversions, and alcohol use among college students. *Journal of Alcohol & Drug Education, 44,* 70-79.

Staton, M., Leukefeld, C., Logan, T. K., Zimmerman, R., Lynam, D., Milich, R., et al. (1999). Risky sex behaviour and substance use among young adults. *Health & Social Work, 24,* 147-154.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Teen sex rates level off, but pregnancy and STD rates remain high. (1999, August). *Brown University Child & Adolescent Behaviour Letter, 15,* 1.

Westerman, P. L., & Davidson, P. M. (1993). Homophobic attitudes and AIDS risk behaviour of adolescents. *Journal of Adolescent Health, 14,* 208-213.

Wishon, P. M. (1988). Children and youth with aids. *International Journal of Adolescence and Youth, 1,* 213-227.

CHAPTER II

AN EXPLORATION OF ADOLESCENTS' PROCESSES OF BECOMING SEXUAL RISK TAKERS: THE IMPACT OF PARENTING STYLES

INTRODUCTION

According to Miller, Forehand, and Kotchick (1999), data from a number of national surveys indicates that sexual activity among American adolescents has increased over the last two decades. Of those adolescents that are sexually active many participate in sexually risky behaviour, which may expose them to the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) (Lear, 1996; Miller et al., 1999). Youth are considered especially vulnerable to contracting HIV because of their risky sexual behaviour (Munro, Doherty-Poirier, Mayan, & Salmon, 1994). High-risk adolescents are those who engage in unprotected sex, have multiple partners and have sex with individuals considered high-risk (Bowler, Sheon, D'Angelo, & Vermund, 1992). Researchers have found that the majority of Canadian high school students engage in unsafe sexual behaviour prior to completing secondary school (Maticka-Tyndale, 1991). Consequently, these students are potentially exposing themselves to HIV and various other STIs (Miller et al.). In the United States, approximately three million new cases of STIs are diagnosed each year among youth under the age of 19 ("Teen sex rates level off, but pregnancy and STD rates remain high," 1999).

Clearly, many adolescents are making unhealthy choices regarding their sexual behaviour. Research focusing on the process of becoming a sexual risk taker in adolescence is an important field of study, because it will help recognize the steps or stages that lead to sexually risky behaviour . With a clearer understanding of these stages, efforts can be made to help adolescents recognize and address the processes of becoming sexual risk takers.

Purpose

The purpose of this study was to investigate the processes of becoming sexually risky in adolescent populations and the factors that contribute to sexually risky behaviour in adolescence. While the predominant aim of this research is to learn more about the processes and contributing factors that are involved in adolescent sexual risk behaviour, a secondary goal is to encourage other scholars to further explore this area of study. Furthermore, if this study can contribute to a pool of research that ultimately implements practical applications of research findings in adolescents' lives then the importance of this project increases significantly.

Research Question

The research question explored in this project was: What are the processes of becoming an adolescent sexual risk taker, and what factors contribute to sexually risky behaviour in adolescent populations. This article focuses on the processes of becoming sexually risky and is complimented by another article that describes

the factors which contribute to sexually risky behaviour in adolescents' lives. The processes that were discovered in this study all originated from the point of the parent-child relationship.

Terms Defined

Participants, in this study, were individuals between the ages of 18 to 27. However, participants' experiences of sexually risky behaviour occurred between the ages of 14 to 20. Baumrind (1991) referred to adolescence as the age span between the ages of 10 and 21, and the researcher utilized this age span for this study. The terms, adolescents, youth and teens are used interchangeably. High-risk adolescents are those who engage in unprotected sex, have multiple partners and have sex with individuals considered high-risk (Bowler, Sheon, D'Angelo, & Vermund, 1992).

REVIEW OF LITERATURE

Studies on Process

Several studies have been employed to investigate the process of various risk behaviours. Staton et al. (1999) discovered that substance abuse at a younger age (6^{th} to 10^{th} grades) is positively correlated with riskier sexual behaviour as a young adult (19 to 21). This research informs one of the predictive elements of risk behaviours, however it also speaks of process, in that these earlier behaviours in one's life are potentially segues to the stages to becoming a risk taker. Singer (1995) interviewed 228 drug users to assess the role of past and current life experiences and the association with the participants' inability to

change their risk of contracting HIV. The author reported that many subjects had abusive childhoods, relationship and sexual difficulties, loss of others and social isolation. These experiences may be described as life events that contributed to the process of becoming a risk taker in various behaviours. Using a grounded theory approach research was conducted that looked at the process of women altering their behaviour after repeatedly contracting STIs (Redfern-Vance, & Hutchinson, 1995). Researchers discovered a process of movement from self-abdication to personal sovereignty as the women attempted to change their sexual behaviours. Also using a grounded theory approach, Hoffman and Cohen (1999), examined the process of casual sexual encounters. Researchers conducted 12 focus groups with 42 participants from a public STI clinic. The author found five temporally ordered stages of casual sex encounters. Lear (1996) conducted a study in which she examined young adults' negotiation of sexual relationships. She claims that, "We must understand the construction of sexuality, risk and relationships" (p. 112).

All of these studies investigated the process(es) involved in various risk behaviours, and they contribute to a growing pool of scholarly work on processes of risk behaviours. However, none examined, specifically, the processes of becoming a sexual risk taker in adolescence. Therefore, an examination of the processes of teens' sexually risky participation is warranted, because it can contribute to and encourage further research in the area of adolescent sexual risk behaviour processes.

Parent-Child Relationships

Parent-child relationships undoubtedly have a profound affect on the sexual behavioural outcomes of youth (Shucksmith & Hendry, 1998; Slicker & Kim, 1996; Somers & Paulson, 2000; Werner-Wilson, 1998). Much research has been conducted that has investigated the relationship between parent-child relationships and adolescent sexual behaviour (Meschke, Bartholomae, & Zentall, 2000; Slicker & Kim, 1996; Taris & Semin, 1998;). Some researchers argue that parental behaviour before the onset of adolescence augments a basic foundation that older adolescents utilize to make behavioural choices, including sexual behaviour, outside of parental reach (Longmore, Manning, & Giordano, 2001).

Two types of parental influence on adolescents that researchers have examined are monitoring and control, and support. Parental monitoring and control refers to parental supervision or regulation of a child's behaviour. (Pettit, Laird, Dodge, Bates, & Criss, 2001). Parental support refers to parental behaviours toward one's child that include praise, physical affection and encouragement, and which indicate to the child that the parent cares (Rollins & Thomas, 1979 as cited in Longmore, Manning, & Giordano, 2001). Support appears to mediate the level of communication that adolescents have with their parents (Meschke, Bartholomae & Zentall, 2000).

The findings on the relationship between parental influences, including monitoring and control, and adolescent sexuality are mixed (Meschke, Bartholomae & Zentall, 2000). The majority of researchers have found that higher levels of parental monitoring are associated with adolescent delay of first intercourse (Capaldi, Crosby,

& Stoolmiller, 1996; Danziger, 1995; Ku et al., 1999; Sonenstein & Pleck, 1993). One researcher found that sexually active adolescents who have parents that monitor their sexual behaviour, are more likely to minimize the sexually risky activity that they engage in as compared to young adults whose parents monitor them less (Boyce Rodgers, 1999). Researchers have found that adolescents who perceived less parental monitoring were more likely to test positive for a sexually transmitted disease, report not using condoms at last sexual intercourse, have multiple sex partners in the past six months, have risky sex partners and have a new sex partner in the past 30 days (DiClemente et al., 2001). According to Taris & Semin (1998), there is a widespread belief that less parental control is, in part, responsible for adolescents' participation in sexual activity at a young age. Other researchers have found no relationship between parental monitoring and control, and adolescent sexual behaviour (Meschke et al., 2000).

Researchers have suggested that parental support plays a profound role in adolescent sexual risk behaviours (Boyce Rodgers, 1999; Longmore, Manning, & Giordano, 2001). Generally, parental support has been related to reduced adolescent sexual activity and increased contraceptive use (Meschke, Bartholomae, & Zentall, 2000). Boyce Rodgers (1999) suggests that a non-supportive parent-child relationship may inhibit mutual exchange and understanding of ideas about sexuality between the parent and child. Researchers found that female and male sexually risky adolescents perceived their parents as less supportive than peers who participated in lower-risk sexual activity and used birth control consistently within a monogamous relationship

(Luster & Small, 1994). In a recent study, researchers found that greater parental communication about sex was related to greater knowledge, however, unexpectedly researchers also found that greater communication was also related to greater sexual behaviour (Somers & Paulson, 2000).

Sexual Conduct

According to the 1994/95 Canadian National Population Health Survey, 44% of males and 43% of females aged 15 to 19 had sexual intercourse in the year prior to the survey, while the corresponding figures for those aged 20 to 24 years were 78% for males and 81% for females (Galambos & Tilton-Weaver, 1998). Adolescents have a tendency to engage in short sexual relationships, which are serially monogamous. Hence, their exposure increases with each multiple partner, thus magnifying the risk of contracting STIs (Baldwin & Baldwin, 1988; Kann et al., 1998; Miller, Forehand, & Kotchick, 1999). With the progression of HIV, the median age of those infected has dropped from 32 to 23 years of age (Hawa, Munro, & Doherty-Poirier, 1998). This suggests that many of those infected with HIV are contracting the disease earlier in life (Health Canada, 1999; Munro, Doherty-Poirier, Mayan, & Salmon, 1994), and one can conclude that people are participating in unsafe sexual conduct earlier in life.

Pervasiveness of Sexually Transmitted Infections

Youth are at high-risk of contracting STIs. In 1997, HIV was the seventh leading cause of death among those aged 15 to 24 in the Unites States (CDC, 1999). Half of all new HIV infections in the United States occurs in people under the age of 25 ("Facts about youth HIV in the U.S.," 1998). Furthermore, acquired

immunodeficiency syndrome (AIDS) has increased by 400% in the 13 to 30 age range of Americans (Neel, 1998). In Canada and the United States, individuals between the ages 15 to 19 have the highest rates of gonorrhea and chlamydia (Bowler, Sheon, D'Angelo, & Vermund, 1992; Lindsay, Devereaux, & Bergob, 1994). In addition, adolescents that have STIs have a higher risk of becoming infected with HIV if exposed to it. Youth that have STIs such as herpes, chancroid and syphilis may be more susceptible to acquiring HIV because of open sores on the genitals. Bowler et al. (1992) found that 15 to 19 year old Americans have the highest rates of syphilis, chlamydial cervicitis and hospitalizations for pelvic inflammatory disease. HIV antibodies are not present in the body for at least six months after infection; therefore, many adolescents are not aware of this highly infectious period in themselves and others.

Condom Use

Researchers have found that youth use condoms at low rates and inconsistently (Galambos & Tilton-Weaver, 1998; Keller, 1993). One researcher discovered that 85.3% of the research sample reported not using condoms at least once (Keller, 1993). According to the 1994/95 Canada National Population Health Survey (Galambos & Tilton-Weaver, 1998) 51% to 53% of females and 29% to 44% of males that were sexually active reported not using a condom in the last year. Researchers suggest that adolescents are more likely to use condoms if they believe it will prevent HIV, but not if they feel condoms will reduce physical pleasure, are embarrassed about condom use or do not perceive a risk of contracting HIV

(Anderson & Mathieu, 1998; Smith & Brown, 1998). Adolescents use condoms less beyond the age of 17 and as sexual relationships progress over time. This occurs because of an increase in the use of birth control pills after the age of 17. Furthermore, researchers have discovered that having shorter relationships and multiple partners promotes inconsistent condom use (Civic, 1999). However, it must be noted that not using condoms does not necessarily create a higher risk of contracting HIV and other STIs. For example, a disease free monogamous couple may not use condoms and feel that this is not risky sexual behaviour.

Comorbidity

Other factors that place youth at risk are the use of drugs and alcohol. Drug and alcohol use is positively correlated with a higher occurrence of high-risk sexual behaviour in adolescence, including decreased condom use (Brown, DiClemente, & Park, 1992; de Gaston, Jensen, & Weed, 1995; Hewitt, Vinje, & MacNeil, 1995; "Library watch," 1996). Hewitt et al. (1995) reported that, "Studies have consistently shown a positive association between level of alcohol use and sexual activity and between alcohol use level and the likelihood of having unprotected sex" (p. 42). Likewise, a review of a 1990 American national risk behaviour survey revealed that alcohol use is widespread among American youth (Bowler, Sheon, D'Angelo, & Vermund, 1992). Hewitt et al. also reported that alcohol is the most frequently used drug by youth in Canada. Of illegal drugs, marijuana is the most commonly used illicit drug by young adults (Cole & Weissberg, 1994). Youth that use intravenous drugs conceivably have the worst survival pattern among youth (Wishon, 1988).

DeGaston et al. (1995) found that 20% of their sample reported they had used drugs or alcohol at the time of first vaginal intercourse; females were more likely to use drugs and alcohol than males (22.7% vs. 15.6%). Researchers have also found that adolescents that have experienced physical or sexual abuse are more likely to participate in high-risk sexual behaviour (Ferguson, Horwood, & Lynskey, 1997).

Knowledge and Attitudes

Many adolescents do not consider themselves at risk for HIV and other STIs, and this is referred to as the optimistic bias (Ellen, Boyer, Tschann, & Shafer, 1996). In one study (Keller, 1993), 50% of the sample claimed to intuitively know a partner was safe and not infected. Westerman and Davidson (1993) suggested that many adolescents do not feel vulnerable to AIDS, because they still regard it as a homosexual disease. This coincides with researchers who have suggested that youth are becoming increasingly knowledgeable about HIV/AIDS, yet they remain unclear about the transmission of the virus (Buysse, 1996; DiClemente, Forrest, & Mickler, 1990).

Gender Differences

Females on average experience first vaginal intercourse at an older age than males, and yet feel more pressured than males to participate in sex (de Gaston, Jensen, & Weed, 1995). Sexually active females are at a higher risk of acquiring STIs than males due to a greater physiological vulnerability to infection (Bowler, Sheon, D'Angelo, & Vermund, 1992). Compared to males, females tend to have sex with less frequency and less partners than males (Levinson, Jaccard, &

Beamer, 1995). In addition, females are more likely to possess negative emotions such as feeling bad, dirty and used after sex. In spite of this, researchers have found that most female teens feel good after sex (Donald, Lucke, Dunne, & Raphael, 1995). Researchers have found that females may engage in casual sex as a means to increase the probability of a long-term commitment with their sex partner (Regan & Dreyer, 1999). Conversely, males have been found to engage in casual sex to achieve status enhancement or comply with normative peer group behaviour (Regan & Dreyer, 1999).

Summary

It is clear that many adolescents participate in sexual activity with great frequency and minimal protection, which exposes them to HIV and other STIs. Their behaviour is compounded by such factors as alcohol and drug use. The implications of these behaviours are potentially devastating. Researchers have a comprehensive understanding of young adults' sexual behaviour and attitudes, however research in this area is incomplete. At present, research does not provide a complete depiction of the process of becoming sexually risky during the period of adolescence. Therefore, research must move beyond description and focus on process. It is essential to build upon the foundation of our understanding of adolescent sexually risky behaviour. A clearer understanding of this process is the first step to changing it.

METHOD

The method employed in this qualitative research project was grounded theory. Glaser and Strauss (1967), the founders of grounded theory, describe the basic theme of the theory as "the discovery of theory from data systematically obtained from social research" (p. 2). They posit that devising grounded theory is a means of arriving at a theory appropriate to its supposed uses. Charmaz (2000), described grounded theory as a method that consists of "systematic inductive guidelines for collecting and analyzing data to build middle-range theoretical frameworks that explain the collected data" (p. 509). Creswell (1998) purported that the objective of a grounded theory is to produce a theory that relates to a specific situation or phenomenon; theory should be "grounded" in the data of actions, interactions and social processes of people. Grounded theory is influenced by symbolic interactionism. The assumptions of symbolic interactionism are the foundation of grounded theory. Grounded theorists presume that individuals devise order and make sense of their environment. The theory aspires to the assumption that an individual's perception of reality changes according to the meanings and definitions he or she assigns to the environment and interactions with others (Morse, 1992). The process of generating a grounded theory is both inductive and deductive, whereby concepts and constructs are grounded in the data and hypotheses arising from the data are tested (Field & Morse, 1985a). Grounded theory is a suitable research method with which to investigate the process or movement across the stages of an

experience over time (Morse, 1992). Consequently, grounded theory is an ideal method with which to determine the processes of becoming sexually risky in adolescent populations.

In-depth face-to-face interviews were employed for this grounded theory qualitative research project. The interview schedule was comprised of open-ended questions. Ethics approval was attained through the University of Alberta. Interviews were conducted with individuals that had engaged in sexual risky behaviour in the past or continued to be sexually risky at the time of the interviews. Participants were assured that their responses would be confidential and nobody would be informed of their participation in the study.

Participants

Twelve individuals participated in the study, each of which received a $20 honorarium for their participation. Seven of the 12 participants were male, and the remaining five participants were female. The ages of the participants ranged from 20 to 27 years of age. Participants experienced sexually risky behaviour between the ages of 14 to 20. Consequently, the majority of participants described a period in their lives that was in the past, however some were still sexual risk takers at the time of the interviews. Nine of the participants were currently completing university undergraduate degrees, one had completed an undergraduate degree and two had earned a college diploma. In addition, 10 participants described their marital status as single at the time of the interview, one was divorced and the remaining participant had a common-law partner. Participants lived with parents, roommates, partners or

alone. Furthermore, 10 of the participants described their sexual orientation as heterosexual and two interviewees stated that they were bisexual. Nine interviewees stated they had no religious orientation, two stated that they were Catholic and the remaining participant was Protestant. Participants belonged to various ethnic groups, which included Caucasian, Asian, Southeast Asian, European and East Indian. Participants originated from both urban and rural locations. Each participant had in the past engaged in sexual behaviour deemed risky by themselves.

Data Collection

Interviews were conducted by an individual interviewer, however two interviewers collected data. Interviews ranged in length from 45 minutes to two hours. Participants were recruited through the campus newspaper, e-mails to student associations, advertisements on campus bulletin boards or word of mouth. Much of the sample was attained with snowball sampling. Prior to the interview, participants were provided with an information letter that described the objectives of the study. Any questions regarding the research project and the information letter were addressed prior to the interview. Informed consent was necessary for participation in this project. Interviews were conducted on the University of Alberta campus in a designated research room in which participants were assured of their privacy. Upon completion of the interview, participants were offered a resource list of services and organizations in the community that they could contact if troubled by the content of the interview. Interviews were audiotaped and later transcribed verbatim to help ensure accuracy.

Data Analysis

Data analysis began during the process of data collection. This strategy, known as concurrent analysis, was an effective means in which each interview was compared with one another early in the data collection process. Concurrent analysis enabled the researcher to perform constant comparison whereby more recent interviews were compared to older interviews (Field & Morse, 1985a). Interviewer notes and audiotaped copies of the interviews were utilized to perform constant comparison until interview transcriptions were prepared. Constant comparison was an essential tool that was used to discover whether or not new categories or information were found as interviews progressed. Once new information was no longer being acquired categories were saturated and data collection was concluded. General themes began to emerge from the data during this point of the data analysis. Transcriptions were read twice as they became available and notes were created. At this point, open coding was performed. Open coding is the "process of breaking down, examining, comparing, conceptualizing and categorizing data" (Strauss & Corbin, 1990, p. 61). Themes that were recognized earlier in the data collection process were further refined to develop codes. Once categories, or codes, were discovered in the data they were then related to one another. This process is known as axial coding. Upon the completion of axial coding selective coding was performed. This entailed combining the categories and developing a complete view of the process of becoming a sexual risk taker (Strauss & Corbin, 1990). From this, three typologies were developed (see Figure 2-1) that illustrate the processes of becoming an adolescent sexual risk taker.

Trustworthiness

Credibility, dependability and confirmability were pursued throughout the data collection and analysis processes as a means to appraise trustworthiness (Lincoln & Guba, 1985). This was accomplished in a number of ways. Interviews were audiotaped and transcribed verbatim. In addition, interviewer triangulation was employed, whereby interviewers discussed the effectiveness of the interview questions and made necessary changes when deemed appropriate. During data collection and analysis, the interviewers discussed emerging themes and categories, which further provided researcher triangulation. Furthermore, interviewers assessed their interviewing skills throughout the data collection process to develop their interviewing technique. In addition, participants were provided with the results of the data analysis and given the opportunity to provide feedback. This manner of triangulation was intended to assess whether or not participants felt that the analysis was credible and accurate. Unfortunately, only one participant replied to the follow-up. This participant felt that the results properly described the influences and process of becoming sexually risky that she experienced in her life. She was surprised that the other participants experienced similar feelings and processes, because she thought that her experience was more unique than other individuals in the study who experienced the process of becoming risky. Lastly, the principal investigator maintained regular contact with his thesis supervisor during the data collection and analysis process as a means to help guide it.

RESULTS

Each participant experienced a similar process to becoming sexually risky, however three different processes arose from the data. Each process began with a different parent-child relationship. One process began with a parent-child relationship in which the participants deemed parents strict and controlling. Another process originated from a parent-child relationship in which at least one parent was physically absent. The final process evolved from a parent-child relationship in which the participant had no emotional involvement with at least one parent. Each process originated from a different point, however all participants became sexual risk takers. The three processes are not mutually exclusive, and it must be stressed that there is overlap between processes. For example, some participants' parents were both strict and absent. Furthermore, some participants had parents that were both strict and unemotionally involved with their child. In spite of this overlap between parent-child relationship styles, each participants' process of becoming sexually risky originated predominantly from one of the three styles.

One negative case was encountered in the study. A negative case is a piece of data that does not fit the model and either disconfirms a model or implies that new connections between cases need to be made (Ryan & Bernard, 2000). Strauss and Corbin (1990) describe a negative case as follows:

> [Negative cases] don't necessarily negate our questions or statements, or disprove them, rather they add variation and depth of understanding. The negative or alternative cases tell us that something about this instance is different, and so we

must move in and take a close look at what this might be. (p. 109)

The negative case in this study described his parents as "really accepting." Furthermore, he expressed that there was no conflict between his parents and himself. He illustrated the level of communication he had with his parents by stating,

> I've always been open with my family as far as social things [are concerned]. They know that I smoke weed. They know that I drink which is no problem there . . . . Sexually . . . it's always been open . . . my parents knew within the same week that I had slept with a girl for the first time . . . . They've met all of my girlfriends, so they're fairly close.

This participant varies from other participants in that he appears to have had the most supportive and open relationship with parents. However, he followed a similar process of becoming sexually risky as participants who had absent parents. It appears that this participant had parents with a permissive parenting style. His parents appear to have been more supportive than the other participants of the absent parent process, however their parents also appear to have been supportive. It seems that this participant was a negative case because his parents were physically available, however it seems that the negative case indeed fits within the process which originates with a permissive parenting style.

The most profound difference between the negative case and the majority of other participants was that he had a self-defined positive relationship with his parents. It is important to account for this variation. It appears this participant was afforded a high-level of freedom by his parents, much like participants with absent parents, in which

he had the independence to develop relationships with peers of his choice and participate in risk behaviours, including sexually risky behaviour.

THEMES

STRICT PARENTING STYLES CONTRIBUTE TO A NEED FOR INDEPENDENCE

Participants that had parents that they considered controlling and strict experienced a unique path to becoming sexually risky. Participants stated that they had a strong desire to be independent and free of their parents' strict manner of parenting. This contributed to participants rebelling against their parents' rules and becoming involved with peer groups involved in risk behaviours such as alcohol and drug use. Once participants became experienced with other risk behaviours they then participated in sexually risky behaviour.

Strict Parenting Style

Some participants' parents were described as "very controlling" and parent-child relationships were tense. One participant expressed that she did not talk to her parents unless it was necessary. Furthermore, participants felt that their parents put too much pressure on them and did not allow them to be individuals. One participant stated, "[Her parents] weren't really sure how far they should let me go to be an individual." Furthermore, participants expressed that they often fought with their parents. Disagreements between the parents and participants were often the result of conflicting ideals about the level of freedom to which the participant should be entitled. A participant stated, "There was a lot of fighting, we had a lot of disagreements. They were pretty straight-edged." Another participant stated, "I felt

like they were constantly antagonizing me." Two participant's parents were physically and emotionally abusive. One participant stated, "I remember my dad just not [pause], beating the crap out of me, but he was getting his punches in there, because basically every time I got busted he'd beat the crap out of me."

Struggling for Independence

Participants that had strict and controlling parents developed a desire to be more independent. They were interested in going out with friends and doing things on their own, but parents were more concerned that their child maintained good grades and followed curfew. One participant stated, "[I] wanted to get away from them . . . wanted more freedom." With increased independence from parents participants felt that they could partake in activities with their peer group. One participant stated,

> When I came to university . . . I had a lot more freedom from my parents and that was the main thing that prevented me from doing a lot of stuff before. Ya, because when I got to university I could lie and say I was studying 'til 2:00 or 3:00 a.m. in the mourning.

Participants felt that their parents' "strict" control of their lives contributed to rebellion. The next stage of participants' process of becoming sexual risk takers involved rebelling against parents, and rebellion manifested itself within the participants' peer groups.

Rebellion within the Peer Group

One means that participants used to gain freedom from their parents was rebellion. One participant stated, "[Parents] can't tell me I'm not going to do this." Participants'

association with a peer group was most often their source of rebellion. They became involved with peer groups that participated in risky sexual activity, alcohol, drug and tobacco use and crime. One participant described the use of alcohol as common within the peer group. She stated, "Within my circle of friends and myself there tends to be a lot of drinking especially." One participant described rebellion through peer group affiliation by stating, "I started hanging around with some different people. I was going through this punk phase. Dyed my hair green, piercing everything I could. I really certainly could chalk at least some of that up to rebellion." One participant described having to lie to her parents and stated "That definitely destroyed some trust." Participants described "bonding" with the peer group by participating in risk behaviours such as unsafe sexual activity and alcohol and drug use. This rebellion with the peer group was described as "cool." One participant stated,

> There's always the tendency to go with the wrong crowd, in a way, the fast partying type crowd . . . . [My dad] would do anything to keep me in the house. He even called and checked up on me one day. I said, "I'm going to the bar, that's right man." He said, "No you're staying home because I'm sick of this crap you keep doing." I said, "No, I'm going because you can't control me." That rebellious stuff.

Affiliation with peer groups that participated in risk behaviours because of a desire to rebel against one's parents ultimately led participants to begin engaging in risk behaviours themselves.

Becoming a Participant in Risky Behaviours

Exposure to new ideas and activities within the peer group contributed to participants' involvement in behaviours that they deemed risky. One participant stated,

> My neighbour was three years older than me. We spent quite a bit of time together with his friends. So he was kind of the first guy to get me drunk off his parents' booze. Maybe at the beginning I was trying to keep up to what they were doing.

Participants became actively involved in alcohol and drug use. One participant expressed that she had become an alcoholic during this period in her life. Participants used marijuana, hashish, mushrooms, ecstasy, LSD, cocaine and heroin. Some participants became involved in criminal activities such as theft and violence.

Sexually Risky Behaviour

Participation in other high-risk behaviours preceded that of risky sexual behaviour. Participants first engaged in such activities as alcohol and drug use before becoming sexual risk takers. While many of the other risk behaviours preceded sexual risk taking, many participants used drugs and alcohol during times of sexual activity. Some participants engaged in group sex, casual sex and anonymous sex. One participant described not learning how to use a condom until the age of 23. He described risky sexual activity by stating,

> It was like a game . . . bragging rights . . . . I don't know what we thought of condoms. It was just something I didn't personally use, because I never went and bought some. I rarely heard anyone talking about using condoms . . . . We would

be cutting up guys who got crabs or that got some kind of STD and it would be the big joke of the day . . . . It never registered in your head, use condoms.

PHYSICALLY ABSENT PARENTS CONTRIBUTE TO FREEDOM IN ADOLESCENCE

Participants that had parents that were physically absent stated that they had a great deal of freedom. In these cases, parents were absent due to high work demands. The freedom that participants had enabled them to become involved in peer groups that were involved in high-risk behaviours such as crime and violence. These peer groups were also involved in other risk behaviours such as alcohol and drug use. This involvement with a peer group involved in these activities led to participation in a number of risk behaviours. Risky sexual activity then followed involvement in other risk behaviours.

The Absent Parent

Absent parents were those that had very demanding work schedules, therefore they had minimal interaction with their child. Consequently, these participants were freer than those struggling for independence, and they conducted themselves with minimal parental control. Participants described their parents as "never being home." One participant stated, "It was my home. It was like I was living there alone." Participants described themselves as being very independent. For example, they became accustomed to being alone and did not feel reliant on their parents for emotional and financial support.

Ease of Independence

Parents of these participants did not intervene in their child's behaviour. Consequently, participants had a great deal of independence. Unlike participants with strict parents, these participants appeared to have been granted freedom without rebelling. They felt that freedom from parental control enabled them to increase their experiences of risk behaviours. One participant stated,

> I never had much of a family life. My parents were always working when I was growing up. My brother had his own stuff to do. My sister was always studying. I just kind of went on my own.

These participants seemingly took their high level of freedom for granted. Parents did not appear to monitor their child's freedom or modify the accessibility that their child had to it. It appears these participants were not accountable to their parents for their behaviour. Consequently, participants' high level of freedom or independence contributed to involvement with peers that were involved in a multitude of risk behaviours.

Peer Group Involvement

These participants became involved with peer groups that they considered less desirable. These participants appeared to differ from the other participants in that they were affiliated with peer groups that participated in more extreme risk behaviours. One participant expressed this notion by stating,

> [It's like] grasping onto something that could be necessarily bad for you. I hung out with this kid that was put in the school not for academic reasons, but to keep

him out of trouble. We hung out with just a bunch of ruffians, I guess. They were involved in a lot of activities like selling drugs and acid. They were just a bunch of miscreants, I guess, and they were involved in a lot of that gang violence . . . . There was also . . . a friend of mine prostituting these girls that he had met, and me witnessing. There was instances of a lot of drug use . . . . There was cocaine being sold, cocaine being used.

Risky Activity

Participants that experienced this process generally participated in high-risk activities that were different than the other two processes. For example, they participated in risky activities such as drug selling, gun running, theft and violence. However, in a similar fashion to participants with strict parents participants also used alcohol and drugs. One participant stated that he was previously affiliated with an organized crime gang. He described the violence associated with selling drugs that occurred in his life,

> [Customers] tried to screw with me a couple times, but they got . . . beat pretty bad and hurt . . . . A couple guys . . . tried not to pay me . . . and those guys got a curbing, you know what curbing is? [You] get beat up really bad, and then [somebody] put[s] your mouth on the curb and then someone hits it. I've done that to people.

Sexually Risky Behaviour

In a fashion similar to other participants in this study, participants in this process had high participation levels in unsafe sexual practices. Likewise, risky sexual

activity followed participation in other risk behaviours. Furthermore, participants were often under the influence of alcohol and/or drugs while practicing unsafe sex. One participant stated that he used condoms three times in his life and described his experience contracting gonorrhea by stating,

> I get tested after every second chick . . . . every second girl I've slept with. I know how a STD . . . spreads because when I was 17 or 16 I had a girlfriend, and I was sleeping with this other girl on the side, and she was sleeping with a whole bunch of other people and she got a STD . . . . She gave it to me and I gave it to my girlfriend.

When asked if he used condoms after contracting gonorrhea the participant replied, "Sadly enough, no."

UNEMOTIONAL PARENTS LEAVE EMOTIONAL NEEDS UNMET

Participants that had at least one parent which was not emotionally available because they had a strained relationship with them experienced a sense of not having their emotional needs met. One participant stated, "I thought nobody cared." This contributed to a desire to discover an outlet in which they could fulfill their emotional needs. Unlike the two preceding processes, participants followed a path in which they met their emotional needs through a combination of peer group involvement, risky activity and/or sexual risky behaviour. In other words, this process was more circular rather than linear like the other two processes. For example, some participants had less peer group involvement and became involved in risky sexual activity without participating in other risk behaviours.

Unemotional Parenting Style

These parents were unavailable emotionally because they had a strenuous relationship with their child. Participants expressed that their relationship with at least one parent was very stressful. Two participants' parents divorced when they were very young. Each of these participants had very unstable relationships with their fathers. During the period of sexual risky behaviours, these participants felt a great deal of anger and resentment towards their fathers. One participant described her relationship with her father by stating,

> I didn't expect anything from men, because I'd never got anything from them . . . . My dad was an idiot . . . . I couldn't handle my dad . . . . He's one of those dads that thinks . . . his daughters should be seen and not heard. They should just be nice young ladies who look pretty and . . . don't say anything, don't cause trouble . . . . He just couldn't be the dad that I wanted him to be.

The other participants had emotionally distant relationships with their parents. One participant described his relationship with his parents as "neutral" and suggested that is was not supportive.

Emotional Needs Unmet

Participants that experienced this process felt that their emotional needs were not met through the relationship they had with their parent(s) and in some instances siblings. One participant stated,

> I was not really close to my parents...and I was not close to my sisters and brothers either. We really didn't talk. I didn't really communicate with my

parents. If I had a problem I couldn't run to them for sure. I probably could have, but I didn't really have that kind of relationship where I could just tell them the problem.

Participants made it very clear that they felt they could not talk to their parents. One participant expressed that she received financial support from her parents, however she did not feel that they were emotionally supportive. A participant stated, "They wouldn't really communicate with me . . . . they'd just tell me to go to school." Furthermore, participants described feelings of not getting enough attention. One participant described her suicide attempts as efforts to get more attention, because she did not feel that anyone in her life was listening to her. It appears that participants' desire for attention relates to a sense of powerlessness that some described. One participant felt enormous pressure during her early adolescence. Her father was suicidal and she felt that she had nobody to talk to, and she felt very powerless to change the circumstances in her life.

Support within the Peer Group

Participants ultimately found support within their peer group, however not all participants became actively involved with peers prior to engaging in risk behaviours, including unsafe sexual practices. A participant that felt nobody had listened to her and described her relationship with peers by exclaiming, "Finally somebody was listening . . . and saying I know what you mean." One participant illustrated the emotional support that she received from her peer group by stating, "I could run to my friends . . . . They'd understand . . . my emotions and thoughts I could share it

with them." However, this support varied in degrees depending on the period in the participants' lives. Participants that were not as close to a peer group initially ultimately became "tighter" with their peer group. One participant described the peer group as "my only social network...and so pretty exclusive."

Risky Behaviour

Participants that experienced this process participated in risk behaviours similar to many of the other participants. For example, they had high rates of drug and alcohol use. Interestingly, one participant did not use drugs nor did she ever consume alcohol during times of sexual activity. Therefore, she differed from other participants in this manner. She described her rationale behind not drinking during sex by stating, "I was never drunk . . . when I had sex. Being drunk . . . I thought was going to take away from sex. I didn't have very good judgement anyway. It's probably a good thing that I wasn't drinking." One participant also participated in criminal activity, including break and enter.

Sexually Risky Behaviour

Two participants in this process followed a similar path to sexual risk taking as the other participants. They became involved in risky sex following participation in other risk behaviours such as alcohol and drug use. However, the remaining participants' sexual experiences differed from other participants in the study. For example, one participant became involved in sexually risky behaviour earlier in the process. She did not proceed through a high level of peer group involvement and participation in other risk behaviours prior to engaging in risky sexual activity. She described her

confusion about why she was participating in sexually risky activity by stating, "I don't know if I was hurting, or if I was trying to take back what I'd lost." Her involvement with peer groups was minimal when she began experiencing sexual activity. Furthermore, this participant experienced group sex, swinging and homosexual sex. The remaining participant was more involved with his peer group and engaged in other risk behaviours such as drug and alcohol use before sexual activity. However, he followed a pattern similar to the participant just discussed. He had a stronger association with peers, however he made the transition to sexual activity at a rate similar to the second participant in this process. Furthermore, he engaged in sexual activity with a prostitute as well as prostituted for same sex clients. One participant described not using condoms, "Sometimes I think I just thought oh well."

Summary of the Findings

Participants each experienced a process of becoming sexually risky. Three processes arose from the data and each originated with the parent-child relationship (see Figure 2-1). The first process began with a strict parenting style. Consequently, participants had a desire to acquire independence from their parents. They appear to have achieved this through affiliations with peers that were involved in risk behaviours, such as alcohol and drug use. Participants then began to engage in risk behaviours and then progressed to participation in unsafe sexual behaviour.

The second process originated with a parent-child relationship in which at least one parent was physically absent from their child's life. Thus, these participants had

access to a great deal of freedom from their parents. Consequently, they became involved with peers that participated in risk behaviours, such as alcohol and drug use and crime. As a result, they actively participated in risk behaviours and then progressed to a level in which they became sexual risk takers.

The last process began with a parent-child relationship in which parents were unemotionally available to their children. This process of becoming a sexual risk taker varied, to a degree, from the other two processes that arose from the data. Two participants followed a path in which they became highly involved with peers as a means to receive emotional support. Consequently, they participated in risk behaviours similar to those that their peers were participating in, like alcohol and drug use. Unsafe sexual activity then followed the period of involvement in other risk behaviours. The remaining two participants of this process found emotional support through a combination of peer affiliation and unsafe sexual activity. In other words, they did not proceed through a linear progression to sexually risky behaviour like the other participants. One of these two participants participated in risky behaviour such as alcohol and drug use, while the other did not. Therefore, the process that these two participants experienced was circular rather than linear.

DISCUSSION

This study was developed to examine the process of becoming an adolescent sexual risk taker. Participants experienced a range of processes, each of which ended with unsafe sexual behaviour. Three processes of becoming sexually risky were evident in the data, all of which originated with the parent-child relationship. These

parent-child relationships significantly contributed to the process of becoming a sexual risk taker. The findings from this study suggest that the parent-child relationship is profoundly related to adolescent behavioural outcomes. This sentiment is supported by many researchers (see Baumrind, 1966, 1968, 1993, 1996; DiClemente et al., 2001; Furstenburg, 2000; Longmore, Manning, & Giordano, 2001; Luster & Small, 1994; Maccoby & Martin, 1983; Meschke, Bartholomae, & Zentall, 2000; Miller, Forehand, & Kotchick, 1999; Shucksmith, Hendry, & Glendinning, 1995). These researchers concur that the type of relationship that parents have with their children affects how children will proceed through adolescence.

The present study supports the models of parental control, based on the dimensions of control and acceptance, developed by Baumrind (1966) and Maccoby and Martin (1983). Baumrind developed three types of parental control. They are, authoritarian, permissive and authoritative. Maccoby and Martin later made a distinction between permissive parenting and the indifferent-uninvolved pattern, thereby developing a fourth model (Shucksmith and Hendry, 1998). Shucksmith, Hendry, and Glendinning (1995) refer to this style as neglectful. Baumrind's authoritarian and permissive parental control styles, and Maccoby and Martin's indifferent-uninvolved parental style pattern were supported in this study. Furthermore, Baumrind's authoritative model was indirectly supported in that participants' responses to their parents control styles did not conform to the positive outcome that children with authoritative parents generally have. Researchers have expressed that an authoritative parenting style generates the most positive outcome

for child functioning (Baumrind, 1966, 1968; Maccoby & Martin, 1983; Shucksmith & Hendry, 1998; Slicker & Kim, 1996). None of the participants' parents practiced an authoritative style. Authoritarian, permissive and neglectful parental control styles are associated with negative outcomes in children and adolescents compared to the authoritative style. The results of this study strengthen Baumrind and Maccoby and Martin's conceptions of parental control models and their corresponding outcomes in adolescents' lives.

The authoritarian parental control style is characterized by several qualities. Firstly, parents use a set standard of conduct, which is absolute and often theologically based, to shape and control the child's behaviour. In addition, authoritarian parents value obedience, use punitive and forceful measures. Lastly, these parents restrict the child's autonomy and self-will.

The permissive parenting style is non-punitive, accepting and affirmative. Children are afforded self-regulation of their behaviour while the parent avoids exercising control. Furthermore, obedience is not defined by a set of external values. Permissive parents also consult the child on family decisions. In addition, the parent exercises few demands on the child's contribution to household duties. Lastly, permissive parents use manipulation and reason rather than power.

Low levels of control over the child characterize the indifferent-uninvolved, or neglectful parenting style. Furthermore, neglectful parents also have a low level of acceptance. It differs from Baumrind's permissive style on the dimension of

acceptance where the permissive style has a higher level of acceptance (Shucksmith & Hendry, 1998).

Authoritative parents are rational, issue-oriented and value autonomy and conformity. These parents also use reason, power and reinforcement as a means to shape the child's behaviour. Authoritative parents are firm yet allow some independence. Lastly, these parents encourage a reciprocal verbal dialogue.

Baumrind's authoritarian model most resembles the parenting control style employed by the "strict" parents in this study. These parents had an absolute standard of conduct that their children had to adhere to. One set of parents had a theologically based standard of child conduct. Parents were punitive, and in one case parents employed physical and emotional abuse to control their child. This was an extreme case of instilling obedience in the adolescent. Authoritarian parents also made great efforts to restrict their children's autonomy and social activities.

Parents classified as "absent" closely resembled Baumrind's permissive typology. These parents were non-punitive and appeared to be accepting of their children. Participants with absent parents had a high-level of behavioural self-regulation and were not controlled by their parents. Furthermore, parents did not exert demands on their children for household responsibilities and orderly behaviour. It also appears that parents who adhered to a permissive control style did not use power as a source of control over their children. It is unclear whether or not absent parents based their standards of conduct on external values or if participants were consulted on family

decisions. In spite of this, absent parents appear to have utilized a permissive parental control style.

Parents described as "unemotional" approximated Maccoby and Martin's indifferent-uninvolved, or neglectful, parenting style. These parents had low-levels of control over their children. This appears to be the result of parents' distant relationship with their child. Given that these parent were uninvolved in their child's life it stands to reason that they exerted little control over their child's conduct. Unemotional parents also appear to have had minimal acceptance for their children. It is clear that two participants with unemotional parents were not accepted by their fathers. Thus, the control style of these parents appears to typify Maccoby and Martin's neglectful style.

It is very important that the process of becoming sexually risky is well understood. It is only then that this process can be addressed. An important question that must be asked is where in the process can effective intervention occur. Presumably, the most ideal point at which effective change can occur is earlier in the process. Given that many researchers suggest that the parent-child relationship has an impact on child behavioural outcomes, focus on the parent-child relationship is appropriate. It is conceivable that had participants' parents employed an authoritative parental style that participants may not have progressed to a level of unsafe sexual behaviour.

Baumrind (1966) found that children with authoritative parents were more likely to be autonomous than children with authoritarian or permissive parents which

includes neglectful parents. In addition, offspring of authoritative parents tend to have higher self-esteems than children whose parents employ the other parenting styles.

Conceivably, factors other than parent-child relationships influence the process of becoming a sexual risky adolescent, however the findings attained in this study suggest that parenting styles are a powerful influence on the sexual behaviour of adolescents, and therefore warrant attention. Meschke, Bartholomae, and Zentall (2000) acknowledge that the relationship between parent-child relationships and adolescent sexual behaviour has been researched extensively, however findings are mixed. Hence, scholars and practitioners need to further investigate how parent-child relationships correspond to adolescent sexual behaviour. Furthermore, given that the parent-child relationship weighed heavily on the process of unsafe sexual behaviour that participants experienced in this study, researchers must focus on how the parent-child relationship relates to adolescent sexual behaviour in the context of process.

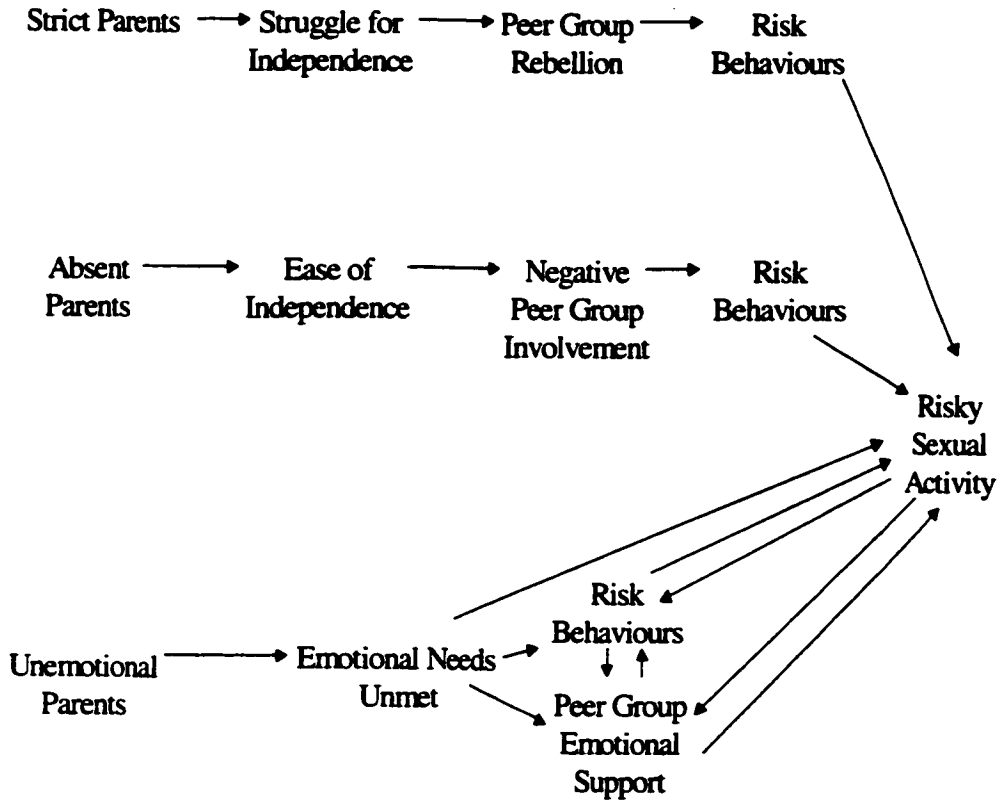
It is speculative to assume that addressing the process of becoming an adolescent sexual risk taker at the stage of parent-child relationships will automatically cause the outcome of the process to change, however one can infer that the probability of adolescents making healthier choices regarding sexual behaviour increases. Given this, one must ask in which ways parent-child relationships can be improved, and who has the power to affect change.

The challenge for families, researchers and practitioners is to determine how to improve parent-child relationships. However, the family must first recognize that a healthier parent-child relationship is necessary and attainable. If families have an

awareness of the ramifications of the parent-child relationship and resources with which to create a healthier parent-child relationship perhaps many young adults may not embark on a path of unsafe sexual behaviour.

In summary, the results of this study indicate that the parent-child relationship has a significant impact on adolescent sexual behaviour outcomes. Each participant experienced a process of becoming sexually risky that originated with the parent-child relationship and moved through peer relationships, risky behaviours and then sexually risky behaviour, or a combination thereof. The results of this project supports authoritarian and permissive parental control styles developed by Baumrind (1966) and the indifferent-uninvolved parental style developed by Maccoby and Martin (1983). Findings warrant continued research on parent-child relationships and consequent adolescent sexual behavioural outcomes.

Figure 2-1: Three Processes of Adolescent Sexually Risky Behaviour



References

Anderson, P. B., & Mathieu, D. (1998). Drinking and safer sex: Are college students at risk? *Journal of Sex Education & Therapy, 23,* 297-301.

Baldwin, J. D., & Baldwin, J. I. (1988). Factors affecting AIDS-related sexual risk-taking behaviour among college students. *Journal of Sex Research, 25,* 181-196.

Baumrind, D. (1966). Effects of authoritative control on child behaviour. *Child Development, 37,* 887-907.

Baumrind, D. (1968). Authoritarian vs. authoritative parental control. *Adolescence, 3,* 255-272.

Baumrind, D. (1991). Effective parenting during the early adolescent transition. In P. A. Cowan, & M. Hetherington (Eds.), *Family Transitions* (pp. 111-163). Hillsdale, NJ: Lawrence Erlbaum Associates.

Baumrind, D. (1993). The average expectable environment is not good enough: A response to Scarr. *Child Development, 64,* 1299-1317.

Baumrind, D. (1996). Parenting: The discipline controversy revisited. *Family Relations, 45,* 405-414.

Bowler, S., Sheon, A., D'Angelo, L., & Vermund, S. (1992). HIV and AIDS among adolescents in the United States: Increasing risk in the 1990s. *Journal of Adolescence, 15,* 345-371.

Boyce Rodgers, K. (1999). Parenting processes related to sexual risk-taking behaviours of adolescent males and females. *Journal of Marriage and the Family, 61,* 99-109.

Brown, L. K., DiClemente, R. J., & Park, T. (1992). Predictors of condom use in sexually active adolescents. *Journal of Adolescent Health, 13,* 651-657.

Buysse, A. (1996). Adolescents, young adults and AIDS: A study of actual vs. perceived need for additional information. *Journal of Youth and Adolescence, 25,* 259-270.

Capaldi, D. M., Crosby, L., & Stoolmiller, M. (1996). Predicting the timing of first sexual intercourse for at-risk adolescent males. *Child Development, 67,* 344-359.

Centers for Disease Control and Prevention. (1999, June). *Trends in HIV-related sexual risk behaviours among high school students - - selected U.S. cities, 1991-1997.* Retrieved August 10, 2001, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4821a2.htm

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.

Civic, D. (1999). The association between characteristics of dating relationships and condom use among heterosexual young adults. *AIDS Education & Prevention, 11,*

343-352.

Cole, P. S., & Weissberg, R. P. (1994). Substance use and abuse among urban adolescents. In T. P. Gullotta, G. R. Adams, & R. Montemayor (Eds.), *Substance misuse in adolescence* (pp. 92-122). Thousand Oaks, CA: Sage.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Danziger, S. K. (1995). Family life and teenage pregnancy in the inner city: Experiences of African-American youth. *Children and Youth Services Review, 17,* 183-202.

deGaston, J. F., Jensen, L., & Weed, S. (1995). A closer look at adolescent sexual activity. *Journal of Youth and Adolescence, 24,* 465-478.

DiClemente, R. J., Forrest, K. A., & Mickler, S. (1990). College students' knowledge and attitudes about AIDS and changes in HIV-preventive behaviours. *AIDS Education & Prevention, 2,* 201-212.

DiClemente, R. J., Wingwood, G. M., Crosby, R., Sione, C., Cobb, B. K., & Harrington, K. (2001). Parental monitoring: Association with adolescents' risk behaviours. *Pediatrics, 107,* 1363-1373.

Donald, M., Lucke, J., Dunne, M., & Raphael, B. (1995). Gender differences associated with young people's emotional reactions to sexual intercourse. *Journal*

of Youth and Adolescence, 24, 453.

Ellen, J. M., Boyer, C. B., Tschann, J. M., & Shafer, M. (1996). Adolescents' perceived risk for STD and HIV infection. *Journal of Adolescent Health, 18,* 177-181.

Facts about youth HIV in the U.S. Health Initiatives for Youth. (1998, May). *World, 7,* 1.

Ferguson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. *Child Abuse and Neglect, 21,* 789-803.

Field, P. A., & Morse, J. M. (1985a). *Nursing research: The application of qualitative approaches.* Rockville, MD: Aspen.

Furstenberg, F. F. (2000). The sociology of adolescence and youth in the 1990's: A critical commentary. *Journal of Marriage and the Family, 62,* 896-910.

Galambos, N. L., & Tilton-Weaver, L. C. (1998). Multiple-risk behaviour in adolescents and young adults. *Health Reports, 10,* 9-20.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Hawa, R., Munro, B. E., & Doherty-Poirier, M. (1998). Information, motivation and

behaviour as predictors of aids risk reduction among Canadian first year university students. *The Canadian Journal of Human Sexuality, 7,* 9-18.

Health Canada. (1999). *Toward a healthy future* (chap. 5). Retrieved from http://www.hc-sc.gc.ca/hppd/report/toward/pdf/english/chapter_5.PDF

Hewitt, D., Vinje, G., & MacNeil, P. (Eds.). (1995). *Horizons three young Canadians' alcohol and other drug use: Increasing our understanding.* Ottawa, ON: Health Canada.

Hoffman, V., & Cohen, D. (1999). A night with Venus: Partner assessments and high-risk sexual encounters. *AIDS Care, 11,* 555-566.

Kann, L., Kinchen, S. A., Williams, B. I., Ross, J. G., Lowry, R., Hill, C. V., et al. (1998). Youth risk behaviour surveillance – United States, 1997. *Journal of School Health, 68,* 355-369.

Keller, M. L. (1993). Why don't young adults protect themselves against sexual transmission of HIV? Possible answers to a complex question. *AIDS Education & Prevention, 5,* 220-233.

Ku, L., Sonenstein, F. L., & Pleck, J. H. (1993). Factors influencing first intercourse for teenage men. *Public Health Reports, 108,* 680-694.

Lear, D. (1996). "You're gonna be naked anyway": College students negotiating safer

sex. *Qualitative Health Research, 6,* 112-134.

Levinson, R. A., Jaccard, J., & Beamer, L. (1995). Older adolescents' engagement in casual sex: Impact of risk perception and psychosocial motivations. *Journal of Youth and Adolescence, 24,* 349-362.

Library Watch. (1996, October). *The Brown Digest of Addiction & Application, 15,* 9-10.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Lindsay, C., Devereaux, M. S., & Bergob, M. (1994). *Youth in Canada* (2nd ed.). Ottawa, ON: Statistics Canada, Housing, Family and Social Statistics Division.

Longmore, M. A., Manning, W. D., & Giordano, P. C. (2001). Preadolescent parenting strategies and teens' dating and sexual initiation: A longitudinal analysis. *Journal of Marriage and Family, 63,* 322-335.

Luster, T., & Small, S. A. (1994). Factors associated with sexual risk-taking behaviours among adolescents. *Journal of Marriage and the Family, 56,* 622-632.

Maccoby, E. E., & Martin, J. (1983). Socialization in the context of the family: Parent-child interaction. In P. H. Mussen (Series Ed.) & E. M. Hetherington (Vol. Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (4th ed., pp. 1-101). New York: Wiley.

Maticka-Tyndale, E. (1991). Sexual scripts and AIDS prevention: Variations in adherence to safer-sex guidelines by heterosexual adolescents. *Journal of Sex Research, 28,* 45-66.

Meschke, L. L., Bartholomae, S., & Zentall, S. R. (2000). Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Family Relations, 49,* 143-154.

Miller, K. S., Forehand, R., & Kotchick, B. A. (1999). Adolescent sexual behaviour in two ethnic minority samples: The role of family variables. *Journal of Marriage and the Family, 61,* 85-98.

Morse, J. M. (1992). *Qualitative health research.* Newbury Park, CA: Sage.

Munro, B., Doherty-Poirier, M., Mayan, M. L., & Salmon, T. (1994). Instructional strategies used in HIV/AIDS education: Correlations with students' knowledge, attitudes and intended behaviour. *The Canadian Journal of Human Sexuality, 3,* 237-243.

Neel, K. L. (1998). Youth and HIV: Predicting sexual risk-taking behaviour. *Dissertation Abstracts International: Section B: The Sciences & Engineering, 59 (3-B),* 1374.

Pettit, G. S., Laird, R. D., Dodge, K. A., Bates, J. E., & Criss, M. M. (2001). Antecedents and behaviour-problem outcomes of parental monitoring and

psychological control in early adolescence. *Child Development, 72,* 583-598.

Redfern-Vance, N., & Hutchinson, S. A. (1995). The process of developing personal sovereignty in women who repeatedly acquire sexually transmitted diseases. *Qualitative Health Research, 5,* 222-236.

Regan, P. C., & Dreyer, C. S. (1999). Lust? Love? Status? Young adults' motives for engaging in casual sex. *Journal of Psychology & Human Sexuality, 11,* 1-24.

Romer, D., Stanton, B., Galbraith, J., Fiegelman, S., Black, M. M., & Li, X. (1999). Parental influence on adolescent sexual behaviour in high-poverty settings. *Archives of Pediatrics & Adolescent Medicine, 153,* 1055-1067.

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 769-802). Thousand Oaks, CA: Sage.

Shucksmith, J., & Hendry, L. B. (1998). *Health issues and adolescents: Growing up, speaking out.* London: Routledge.

Shucksmith, J., Hendry, L. B., & Glendinning, A. (1995). Models of parenting: Implications for adolescent well-being within different types of family contexts. *Journal of Adolescence, 18,* 253-270.

Singer, N. (1995). Understanding sexual risk behaviour from drug users' accounts of their life experiences. *Qualitative Health Research, 5,* 237-249.

Slicker, E. K., & Kim, J. K. (1996, August). *Parenting style and family type revisited: Longitudinal relationship to older adolescent behavioural outcome.* Paper presented at the 104th Annual Meeting of the American Psychological Association, Toronto, Ontario, Canada.

Smith, C. D., & Brown, J. M. (1998). Sexual behaviours, extroversions, and alcohol use among college students. *Journal of Alcohol & Drug Education, 44,* 70-79.

Somers, C. L., & Paulson, S. E. (2000). Students' perceptions of parent-adolescent closeness and communication about sexuality: Relations with sexual knowledge, attitudes, and behaviours. *Journal of Adolescence, 23,* 629-644.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Taris, T. W., & Semin, G. R. (1998). How mothers' parenting styles affect their children's sexual efficacy and experience. *Journal of Genetic Psychology, 159,* 68-79.

Teen sex rates level off, but pregnancy and STD rates remain high. (1999, August). *Brown University Child & Adolescent Behaviour Letter, 15,* 1.

Werner-Wilson, R. J. (1998). Gender differences in adolescent sexual attitudes: The influence of individual and family factors. *Adolescence, 33,* 519-528.

Westerman, P. L., & Davidson, P. M. (1993). Homophobic attitudes and AIDS risk behaviour of adolescents. *Journal of Adolescent Health, 14,* 208-213.

Wishon, P. M. (1988). Children and youth with aids. *International Journal of Adolescence and Youth, 1,* 213-227.

CHAPTER III

FACTORS THAT CONTRIBUTE TO UNSAFE ADOLESCENT SEXUAL BEHAVIOUR

INTRODUCTION

Adolescents are a segment of the population with a significant risk of contracting the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) because of their risky sexual behaviour (Munro, Doherty-Poirier, Mayan, & Salmon, 1994). High-risk adolescents are those who engage in unprotected sex, have multiple partners and have sex with individuals considered high-risk (Bowler, Sheon, D'Angelo, & Vermund, 1992). Half of all new HIV infections in the United States occur in people younger than 25, and 110,000 people between 13 to 29 years of age have been diagnosed ("Facts about youth HIV in the U.S.," 1998). The 1994/95 Canadian National Population Health Survey noted that, 44% of males and 43% of females aged 15 to 19 had sexual intercourse in the year prior to the survey, while the corresponding figures for those aged 20 to 24 years were 78% for males and 81% for females (Galambos & Tilton-Weaver, 1998). Research suggests that adolescents use condoms at low rates and inconsistently (Keller, 1993; Galambos & Tilton-Weaver, 1998). According to Hewitt, Vinje, and MacNeil (1995) alcohol is the most frequently used illicit substance by youth. Hewitt et al. (1995) stated, "Studies have consistently shown a positive association between level of alcohol use and sexual

activity and between alcohol use level and the likelihood of having unprotected sex" (p. 42).

It is evident that many adolescents participate in risky sexual activity. Research with an aim of establishing the factors that contribute to adolescent sexually risky behaviour is warranted, because it can provide further evidence that past research is accurate. Furthermore, an awareness of the factors that contribute to teen sexually risky activity can enable the researcher to incorporate these factors to other areas of inquiry. For example, the process of becoming a sexually risky adolescent is very much intertwined with the factors that contribute to youth sexual risk taking. The contributing factors are part of the process.

Purpose

A great deal of research has focussed on the factors that contribute to adolescents' participation in sexual behaviour. This research was designed to investigate the factors that contribute to unsafe sexual participation, rather than just sexual participation. The results from this study are not mutually exclusive from the broader field of sexual behaviour research and the goal of the researcher is to compliment the existing research pool. The following article supplements a research project that was undertaken to learn about adolescents' processes of becoming sexually risky. The findings illustrated in the following article support what other researchers have found. The factors that contribute to sexual behaviour are many, and this research provides further evidence of their permanence. However, if some insight has been illustrated as

to why these factors contribute to unsafe sexual activity rather than just sexual activity then the purpose of this study has been fulfilled.

Research Question

The research question investigated in this study is: What are the processes of becoming an adolescent sexual risk taker, and what factors contribute to unsafe sexual behaviour in adolescent populations. This article describes the factors that contribute to unsafe adolescent sexual behaviour and compliments another article that illustrates the processes that participants experienced while becoming sexually risky.

Terms Defined

Participants, in this study, were individuals between the ages of 18 to 27 and participated in sexually risky behaviour between the ages 14 to 20. Baumrind (1991) referred to adolescence as the age span between the ages of 10 to 21, and the author employed Baumrind's definition of the age span of adolescence. The terms adolescents, teens and youth are used interchangeably. High-risk youth are those who engage in unprotected sex, have multiple partners and have sex with individuals considered high-risk (Bowler, Sheon, D'Angelo, & Vermund, 1992).

REVIEW OF LITERATURE

Sexual Behaviour

A great deal of youth participates in sexually risky behaviour that may expose them to the human immunodeficiency virus (HIV) and other STIs (Lear, 1996; Miller, Forehand, & Kotchick 1999). Adolescents are very susceptible to contracting HIV because of their risky sexual behaviour (Munro, Doherty-Poirier, Mayan, & Salmon,

1994). Researchers have found that the majority of Canadian high school students participate in sexual activities, which potentially expose them to HIV prior to their completion of secondary schooling (Maticka-Tyndale, 1991). Researchers have found that the average age of first vaginal intercourse is 16 and 17 for males and females respectively (Leigh, Morrison, Trocki, & Temple, 1994; Seidman & Rieder, 1994). According to the 1994/95 Canadian National Population Health Survey, 44% of males and 43% of females aged 15 to 19 had sexual intercourse in the year prior to the survey, while the corresponding figures for those aged 20 to 24 years were 78% for males and 81% for females (Galambos & Tilton-Weaver, 1998). Adolescents have a tendency to engage in short sexual relationships that are serially monogamous. Thus, their risk of contracting STIs increases because they engage in sexual activity with a greater number of partners (Baldwin & Baldwin, 1988; Kann et al., 1998; Miller et al., 1999). The median age of those infected HIV has dropped from 32 to 23 years of age as time has progressed (Hawa, Munro, & Doherty-Poirier, 1998).

Condom Use

Adolescents generally use condoms at low and inconsistent rates (Galambos & Tilton-Weaver, 1998; Keller, 1993). One researcher found that 85.3% of the research sample reported not using condoms at least once (Keller, 1993). According to the 1994/95 Canada National Population Health Survey (Galambos & Tilton-Weaver, 1998) 51% to 53% of females and 29% to 44% of males that were sexually active reported not using a condom in the last year. Researchers have suggested that adolescents are more likely to use condoms if they believe it will prevent HIV, but

not if they feel condoms will reduce physical pleasure, are embarrassed about condom use or do not perceive a risk of contracting HIV (Anderson & Mathieu, 1998; Smith & Brown, 1998). In addition, youth decrease their use of condoms over the age of 17 and as relationships progress over time. This occurs because of an increase in the use of birth control pills after the age of 17. Likewise, this same effect is evident in longer lasting relationships. Furthermore, researchers have discovered that having shorter relationships and multiple partners promotes inconsistent condom use (Civic, 1999). It must be noted, however, that a lack of condom use does not necessarily create a higher risk of contracting HIV and other STIs. For example, a couple in a monogamous relationship may not use condoms and feel that they do not practice unsafe sexual behavior.

Comorbidity

Drug and alcohol use has been found to increase the occurrence of high-risk sexual behaviour in adolescents and decrease the likelihood of condom use (Brown, DiClemente & Park, 1992; "Library watch," 1996). Hewitt, Vinje, and MacNeil (1995) reported that, "Studies have consistently shown a positive association between level of alcohol use and sexual activity and between alcohol use level and the likelihood of having unprotected sex" (p. 42). A review of a 1990 American national risk behaviour survey (Bowler, Sheon, D'Angelo, & Vermund, 1992) revealed that alcohol use is widespread among American youth. Hewitt et al. (1995) reported that alcohol is the most frequently used drug by adolescents in Canada. Of illegal drugs, marijuana is the most commonly used illicit drug by adolescents (Cole & Weissberg,

1994). DeGaston, Jensen, and Weed (1995) found that 20% of their sample reported they had used drugs or alcohol at the time of first vaginal intercourse; females were more likely to use drugs and alcohol than males (22.7% vs. 15.6%). Another factor that increases the likelihood of engaging in sexually risky behaviour is experiencing physical and sexual abuse. Youth that have experienced physical or sexual abuse are more likely to participate in high-risk sexual behaviour (Ferguson, Horwood, & Lynskey, 1997).

Sexually Transmitted Infections Prevalence

Acquired immunodeficiency syndrome (AIDS) has increased by 400% in the United States amongst those between the ages of 13 to 30 (Neel, 1998). In Canada and the United States, individuals between the ages 15 to 19 have the highest rates of gonorrhea and chlamydia (Bowler, Sheon, D'Angelo, & Vermund, 1992; Lindsay, Devereaux, & Bergob, 1994). In the United States, approximately three million new cases of STIs are diagnosed each year among people under the age of 19 ("Teen sex rates level off, but pregnancy and STD rates remain high," 1999). Adolescents that have STIs such as herpes, chancroid and syphilis are more susceptible to acquiring HIV because of open sores on the genitals. Bowler et al. (1992) stated that 15 to 19 year old Americans have the highest rates of syphilis, chlamydial cervicitis and hospitalizations for pelvic inflammatory.

Gender Differences

Females on average experience first vaginal intercourse at an older age than males, and feel more pressured than males to participate in sex (de Gaston, Jensen, & Weed,

1995). Furthermore, sexually active females are at a higher risk of contracting STIs due to a greater physiological vulnerability to infection (Bowler, Sheon, D'Angelo, & Vermund, 1992). Despite the erosion of the societal belief in a hyperactive male sexuality, the fact remains that females still tend to have sex with less frequency and with fewer partners than males (Levinson, Jaccard, & Beamer, 1995). In addition, females are more likely to possess negative emotions such as feeling bad, dirty and used regarding their sexual activity. In spite of this, researchers have found that the majority of female adolescents feel good after sex (Donald, Lucke, Dunne, & Raphael, 1995). Studies found that females may engage in casual sex as a means to increase the probability of a long-term commitment with the sex partner (Regan & Dreyer, 1999). Lastly, males have been found to engage in casual sex to achieve status enhancement or to comply with normative peer group behaviour (Regan & Dreyer, 1999).

Knowledge and Attitudes

Adolescents often do not consider themselves at risk for HIV and other STIs because they feel unsusceptible to infection, and this is referred to as the "optimistic bias" (Ellen, Boyer, Tschann, & Shafer, 1996). In one study, 50% of the sample claimed to intuitively know a partner was safe and not infected (Keller, 1993). An alarming finding by Westerman and Davidson (1993) suggested that many adolescents do not feel vulnerable to AIDS, because they still regard it as a homosexual disease. Researchers have suggested that youth are becoming increasingly knowledgeable about HIV/AIDS, yet found that substantial confusion is

present about the transmission of the virus (Buysse, 1996; DiClemente, Forrest, & Mickler, 1990).

Summary

Evidence of adolescents' sexually risky behaviour is convincing. Many teens are participating in sexual activity that puts them at risk of contracting HIV and other STIs. Several factors contribute to adolescent sexually risky activity. These include early age of first vaginal intercourse, inconsistent and low levels of condom use, alcohol and drug use, and short- term serial monogamous relationships that tend to be sexually risky. An analysis of factors that contribute to adolescent sexually risky behaviour fostered this study in a significant manner. The primary objective of this study was to investigate the process of becoming a sexual risk taker in adolescence. An analysis of the factors that contribute to sexual risk behaviour in youth populations compliments this objective, because the factors are highly interrelated to the process. In other words, the factors contribute to the process occurring. The process describes the procession of becoming a sexually risky adolescent while the contributing factors help explain why each component of the process transpires.

METHOD

Grounded theory was the research method utilized for this study. It was appropriate in that the intention of the study was to learn more about the process of becoming a sexual risk taker in young adult populations and the factors that contribute to sexually risky conduct. Grounded theory allows the researcher to determine the process or movement through stages of an experience over time

(Morse, 1992). This theory, developed by Barney Glaser and Anselm Strauss (1967), is influenced by symbolic interactionism and is evident in the assumptions of grounded theory. Grounded theorists infer that individuals devise order and make sense of their environment. Furthermore, the theory holds the assumption that one's perception of reality changes according to the definitions and meanings he or she attributes to the environment and interactions with others (Morse, 1992). The goal of a grounded theorist is to generate a theory that relates to a specific situation or phenomenon, and the theory should be "grounded" in the data of actions, interactions and social processes of people (Creswell, 1998). The process of generating a grounded theory is both inductive and deductive, whereby concepts and constructs are grounded in the data and hypotheses arising from the data are tested (Field & Morse, 1985a).

In-depth face-to-face interviews were employed for this grounded theory qualitative research project. The interview schedule was comprised of open-ended questions. Ethics approval was attained through the University of Alberta. Interviews were conducted with individuals that had engaged in sexual risky behaviour in the past or continued to be sexually risky at the time of the interviews. Participants were assured that their responses would be confidential and nobody would be informed of their participation in the study.

Participants

Twelve individuals participated in the study, and each participant was given a $20 honorarium for their participation. Seven of the 12 participants were male, and the

remaining five participants were female. The ages of the participants ranged from 20 to 27 years of age. Participants experienced sexually risky behaviour between the ages of 14 to 20. Consequently, the majority of participants described a period in their lives that was in the past, however some were still sexual risk takers at the time of the interviews. Nine of the participants were currently completing university undergraduate degrees, one had completed an undergraduate degree and two had earned a college diploma. In addition, 10 participants described their marital status as single at the time of the interview, one was divorced and the remaining participant had a common-law partner. Participants lived with parents, roommates, partners or alone. Furthermore, 10 of the participants described their sexual orientation as heterosexual and two interviewees stated that they were bisexual. Nine interviewees stated they had no religious orientation, two stated that they were Catholic and the remaining participant was Protestant. Participants belonged to various ethnic groups, which included Caucasian, Asian, Southeast Asian, European and East Indian. Participants originated from both urban and rural locations. Each participant had in the past engaged in self-defined risky sexual behaviour.

Data Collection

Interviews were conducted by an individual interviewer, however two interviewers collected data. Interviews ranged in length from 45 minutes to two hours. Participants were recruited through the campus newspaper, e-mails to student associations, advertisements on campus bulletin boards or word of mouth. Much of the sample was attained with snowball sampling. Prior to the interview, participants were provided

with an information letter that described the objectives of the study. Any questions regarding the research project and the information letter were addressed prior to the interview. Informed consent was necessary for participation in this project. Interviews were conducted on the University of Alberta campus in a designated research room in which participants were assured of their privacy. Upon completion of the interview, participants were offered a resource list of services and organizations in the community that they could contact if troubled by the content of the interview. Interviews were audiotaped and later transcribed verbatim to help ensure accuracy.

Data Analysis

Data analysis began during the process of data collection. This strategy, known as concurrent analysis, was an effective means in which each interview was compared with one another early in the data collection process. Concurrent analysis enabled the researcher to perform constant comparison whereby more recent interviews were compared to older interviews (Field & Morse, 1985a). Interviewer notes and audiotaped copies of the interviews were utilized to perform constant comparison until interview transcriptions were prepared. Constant comparison was an essential tool that was used to discover whether or not new categories or information were found as interviews progressed. Once interviews no longer provided new information categories were saturated and data collection was concluded. General themes began to emerge from the data during this point of the data analysis. Transcriptions were read twice as they became available and notes were created. At this point, open coding was performed. Open coding is the process of identifying potential themes by extracting

real examples from the data (Strauss & Corbin, 1990). Themes that were recognized earlier in the data collection process were further refined to develop codes. Once categories, or codes, were discovered in the data they were then related to one another. This process is known as axial coding. Upon the completion of axial coding selective coding was performed. This entailed combining the categories and developing a set of factors that contributed to participants becoming sexually risky (Strauss & Corbin, 1990).

Trustworthiness

Credibility, dependability and confirmability were pursued throughout the data collection and analysis processes as a means to evaluate trustworthiness (Lincoln & Guba, 1985). This was accomplished in a number of ways. Interviews were audiotaped and transcribed verbatim. In addition, interviewer triangulation was employed, whereby interviewers discussed the effectiveness of the interview questions and made necessary changes when deemed appropriate. During data collection and analysis, the interviewers discussed emerging themes and categories, which further provided researcher triangulation. Furthermore, interviewers assessed their interviewing skills throughout the data collection process to develop their interviewing technique. In addition, participants were provided with the results of the data analysis and given the opportunity to provide feedback. This manner of triangulation was intended to assess whether or not participants felt that the analysis was credible and accurate. Unfortunately, only one participant replied to the follow-up. The participant felt that the findings aptly described how she experienced her life

and sexual behaviour at the time of risky sexual activity. However, she was surprised that the other participants were influenced by the same factors and experienced similar processes of becoming sexually risky. Her surprise was the result of thinking that her experience was unique, and she realized that is was very similar to that of the other participants. Lastly, the principal investigator maintained regular contact with his thesis supervisor during the data collection and analysis process as a means to help guide it.

RESULTS

Several factors, or major themes, contributed to participants' engagement in sexually risky activity. These themes are comorbidity, or use of alcohol and drugs during the periods of sexually risky involvement, parent-child relationships, peer affiliation, independence and exploration, and fulfilling emotional needs and developing identity. Each participant described these elements as areas in their lives that promoted participation in sexually risky behaviour.

The themes identified in this study are not mutually exclusive. Rather, they are highly interrelated. A strained parent-child relationship may not, in itself, directly promote the practice of unsafe sex, however it may encourage a young adult to become involved with peer groups that promote risky sexual activity. For example, if a young adult is rebelling against strict parents they may be more inclined to become involved with peers that participate in many risk behaviours, including unsafe sex. Conversely, intoxication promotes unsafe sexual practices more directly. When participants were under the influence of alcohol or drugs they were more likely to

participate in risky sexual behaviour. The themes identified may vary in their ability to directly or indirectly promote sexually risky behaviour, however the data revealed that each theme discussed in this article strongly contributed to participation in sexually risky behaviour.

THEMES

Comorbidity

Participants described a strong relationship between alcohol and drug use, and risky sexual activity. They were often under the influence of alcohol and/or drugs when they participated in sexually risky behaviour. One participant described the comorbidity between risk behaviours by stating,

> I started smoking when I was 12. Then I moved onto alcohol when I was 13 . . . . Drugs followed at 14 . . . . Crime followed that, same age. Sex also the same age. So I was 14, just boom, cannonball exploded. My first partner, she was my drinking buddy. Then after that my second partner actually turned out to be my drug dealer.

Participants stated that alcohol and drug use made them more sociable and less sexually inhibited, therefore it was easier to engage in conversation with potential sexual partners and participate in sexual activity. It appears that alcohol and drug use made participants more comfortable socially and sexually rather than create a situation in which them found themselves participating in sexual activity unintentionally. One participant stated,

> I'm a very shy person, and . . . I had a hard time communicating with people.

When I drank it gave me more confidence . . . . I would get stupidly drunk, and I would be able to communicate with [guys] . . . . I knew that they only wanted sex . . . . When a guy talks to a girl in a bar who's falling over drunk, he just wants to get laid, and I knew that.

The influence of alcohol and drugs made participants less inclined to practice safer sex. For example, participants described engaging in self-destructive behaviour when drinking and consequently going home with strangers and having unsafe sex. One participant illustrated this by saying,

I was 18 years old and we were all at this party. I met this guy and just took off with him . . . . I was so intoxicated that I kind of couldn't control it. I knew we should be protecting ourselves . . . . He probably had a few thrusts and then I said "Stop," and then I went to his car and gave him oral sex. I didn't even know this guy.

Another participant stated,

I got drunk and hammered and they were there hitting on me . . . . You know when you're pretty hammered, it doesn't even occur to you [to use a condom] . . . . I think I've used a condom three times in my life . . . . I started having sex when I was 13 . . . . By the time I was 18 I slept with like 14 people.

One participant stated, "There's not a single one-night stand I've had didn't involve alcohol. So there's a huge correlation there."

Parent-Child Relationships

Some participants described a relationship with their parents in which parents were physically absent from their day to day lives due to a highly demanding work schedule. One participant stated, "I never had . . . a great family life. Even to this day I don't have a great family life . . . . We had conflicting schedules. If they [parents] were home I was gone." This created abundant opportunities in which participants were freer to engage in activities such as sexually risky behaviour without their parents' knowledge. Consequently, these participants experienced minimal, if any, parental reaction to their sexual conduct. Therefore, participants did not endure any consequences from their parents regarding their sexual behaviour.

Many participants described their parents as overly controlling and strict. These participants expressed a strong desire to rebel against their parents which often entailed participation in risk behaviours such as unsafe sexual practices. The motive for participating in risk behaviours was that participants perceived behaviours that their parents would not approve of as a form of rebellion. One participant stated that she wanted to "rebel" against her "strict parents." The relationships that these participants had with their parents were so strenuous that they impeded an open dialog about healthy sexual behaviour.

The remaining participants had relationships with at least one parent in which they did not feel emotionally supported. One participant stated, "I had nobody to talk to." Participants felt isolated from their parents and did not feel that they could approach their parents with problems. One participant stated,

I was not really close to my parents. We didn't really talk . . . . I couldn't communicate with my parents. They would just get mad at me . . . . If I had a problem I couldn't talk to them, for sure . . . . I didn't really have that relationship where I could just tell them the problem.

These participants also described a lack of attention shown by at least one parent. Some of these participants also cited sexual activity as a source of power. For example, they felt powerless in their familial environment and sexual activity was an outlet in which power could be achieved. One participant described how she achieved a sense power over males as a result of a power imbalance with her father and spouse by stating,

I was trying to take back my power and confidence, and after that I knew I could walk [into] a room and take home anybody I wanted, and that was power . . . . It doesn't matter if they love me, this is about me, not about them . . . . Apparently I got something that I needed that was missing before.

Furthermore, many participants who did not feel emotionally supported by their parents felt very angry towards at least one parent. Sexual activity was an outlet in which they felt these emotional needs, including attention, power and emotional support could be fulfilled. For example, participants often felt that sex provided them with attention. Furthermore, sexual activity contributed to many participants feeling a sense of power and control of others and themselves.

It appears that participants' relationship with their parents did not promote healthy sexual behaviour. The vast majority of parents did not have relationships with their

children that favored an atmosphere in which the risks of unsafe sex could be expressed. One participant stated, "[Nothing was] instilled in me to use condoms." In a related fashion, participants generally did not feel that they could approach their parents with questions about sexuality and safe sexual practices. One participant stated,

> I certainly didn't talk to my mom about sex although I'm sure she assumed . . . that I was doing stuff. I have no idea why I couldn't talk to my mom about sex. Maybe it's just because she's your mom . . . . I thought she had too much on her mind to deal with me.

Lastly, parents were often not physically available to teach their children about healthy sexual practices. For example, one participant felt like he was living alone, because he rarely saw his parents. Consequently, they were not available to educate their child about healthy sexual practices.

Peer Affiliation

A significant factor that influenced participants' choice to become sexually active was their affiliation with their peer groups. One participant stated,

> I got involved in a circle of friends that was sexually active and . . . we figured out that we were teenage girls and we had breasts, a figure and we could have sex and guys would pay attention to us . . . . Everybody's doing it or they're talking about it.

Some participants cited peers as "bad influences" and often felt that peer influence created a lot of temptation to engage in risk behaviours including sex. One participant illustrated this type of peer influence by stating,

> We just picked him up one night, and it was a dare, and I slept with him. That started a downhill slide from there . . . . That was the first time I had sex, at 15 . . . it was a dare and I did it you know to prove something, I don't know what . . . . Then a couple of weeks later I started sleeping with his friend . . . well I didn't start sleeping with him, I started fooling around with him. Then I did sleep with him . . . and we weren't safe about it.

Another participant described how her friends' sexual relationships affected her desire to become sexually active by stating,

> When I was 16 a few of my friends were starting to have sex, and I never had a boyfriend, but I was really curious. Then I met this guy when I was 17 . . . . We started going out . . . and one day we had [unprotected] sex. After that I asked him how many partners he's had, because I was just a virgin, and he'd had 27.

Participants also had peers that consumed alcohol and drugs. This affected participants' use of drugs and alcohol, which as previously discussed increased the comorbidity between alcohol, drugs and unsafe sex. One participant expressed this idea by stating,

> Somehow I attracted really messed up people. The boyfriend, he was crazy and he did a lot of drugs and alcohol, he drank a lot. Then I had another friend that I met in my first year [of university] who was previously like a hard core drug

addict. She'd do intravenous drugs and for six years of her life she was a cocaine addict . . . . We used to drink, go drinking a lot, and we were both really a negative influence on each other because we both couldn't control ourselves.

Participants often found themselves in peer groups whose members engaged in risky activities including risky sexual activity. Consequently, it appears that because peers did not always practice safe sex participants were less likely to do so themselves. One participant illustrated this idea by stating,

> It just got ridiculous because everyone was just a dirty dog. Like everyone was dirty, and at that point I never even used condoms. Like I didn't know how to use a condom . . . . It was like a joke to use one . . . . It was just comedy to us. We'd just laugh about it . . . . It was just condoms. It wasn't an issue.

Independence and Exploration

Participants cited newly found independence as a significant contributing factor to becoming sexual active. Independence often resulted from participants being granted more freedom by their parents. Participants discovered more independence when they either moved out of their parents' home or began post-secondary education such as university. A participant described when he began participating in unsafe sex by stating, "Actually, it was my first experience by living alone. You know I was separated with my family . . . . To first live alone from your parents, it was you know like you know a little bit of freedom . . . . It was very free." Furthermore, participants had a higher level of independence if their parents had demanding work schedules. One participant described this by stating, "A lot of things I did on my own. Initiated

things on my own." These participants were more able to conduct themselves without parental control than the other participants. Consequently, the freedom promoted engagement in risk behaviours, including unsafe sex. Some participants also experienced an increased sense of freedom when they traveled. One participant stated,

> I went to Australia on an exchange, there was a lot of binge drinking going on there. There was a lot of instances where I had unprotected sex there . . . just because of the opportunities. I guess being away, as well, you're more openly free to doing these things . . . and participating in more risky behaviours . . . . I engaged in unprotected sex there with probably at least three different partners, and so that was my biggest risk, I think, when I traveled there.

Participants described exploration as a factor that created a desire to engage in sexual activity. Increased freedom often resulted in sexual exploration. Participants cited curiousity as one factor that encouraged them to become sexually active. They engaged in various forms of sexual behaviour including homosexual, bisexual and group sex. Some participants were involved in swinging and frequented sex clubs. One participant engaged in same sex prostitution and had sex with a prostitute. Participants may have seen unsafe sex as another facet of sexual exploration.

Meeting Emotional Needs and Uncertainty of One's Identity

Participants described sexual activity as a source of attention. One participant stated that his "attention needs were met" through sexual practices. It appears that the attention needs met through sexual activity were so strong that some participants were

less inclined to protect themselves. One participant stated that she, "needed" and "craved" attention. A participant described this notion by stating,

> I needed a lot of attention . . . . I was kind of a heavier girl, and actually, getting any kind of sexual attention for me was really amazing almost. So for me it was kind of new and exciting. It made me feel really good in a way . . . . All these people want to have sex with me, it makes me feel really attractive. It must mean I'm something special.

This participant engaged in unsafe sex on a regular basis for a period of approximately two years. Some participants cited insecurity and low self-esteem as a motive to engage in sexual practices. Furthermore, many participants did not feel like others in their lives cared for them. Sexual activity was an outlet in which many could feel cared for. Participants described feelings of loneliness and "not fitting in" with others. One participant stated, "I felt really lonely most of the time." Sexual activity was often a means to decrease feelings of solitude and achieve a sense of affiliation. Realizing these emotional needs through sexual activity were, for many participants, so powerful that it often became more important than practicing safer sex. One participant stated, "Sometimes I think I just thought oh well. If they don't have them and if it's going without . . . condoms or going without sex I'd choose going without condoms for sure, every time. It didn't matter." This participant perceived sexual activity as a source of power over males.

Participants described a sense of not knowing who they were. One participant described this as "floating" and stated "I didn't know who I really was . . . . just

looking for myself." Another participant stated "I was just wandering around aimlessly for a couple of years, it was just aimless. I was pretty lost." Another participant stated, "I was just . . . struggling to find out who I was. One participant described the relationship between risk behaviours, including unsafe sex, and feeling a sense of identity by stating,

> What am I? Why am I here? . . . . Inside you're actually looking for some belonging. That's pretty much how it started with me. The longer you float, the more chances of you getting into more risky behaviours is really good, it's really high. I see people my age still floating and still engaging in that risky behaviour just because they haven't found . . . what their purpose is.

It appears that most participants were struggling to develop or achieve a sense of identity during the period of risky sexual activity. Given that participants were not making healthy sexual choices it is possible that practicing safer sex was not a way of being that participants had incorporated into their sense of identity.

Summary of the Findings

Participants expressed that a range of factors contributed to the unhealthy sexual behaviour in which they participated. The predominant themes that arose from the data are comorbidity, parent-child relationships, peer affiliation, independence and exploration, and meeting unmet emotional needs and developing one's identity. It is essential that one is cognizant of the significant relationship between the contributing factors found in this research.

Study participants stated that alcohol and drug use contributed to unsafe sexual behaviour. For example, many felt that alcohol and drug consumption enabled them to be less inhibited socially and sexually.

It appears that participants' relationships with their parents were not conducive to communication about healthy sexual behaviour. For example, most participants did not have a supportive relationship with their parents, and they did not discuss sexuality. Other participants' parents were not available to educate their children about healthy sexual choices.

Participants described peer associations as contributing factors to unsafe sexual practices. For example, peers often did not practice safer sex. It appears that communication about safer sexual behaviour was not available within the peer group environment.

Another factor that contributed to risky sexual behaviour was increased independence and exploration. With a higher level of freedom participants had the ability to engage in sexual behaviour without parents' knowledge. It appears that sexual exploration was often dependent on a higher level of independence. It is conceivable that unsafe sexual activity was one facet of sexual exploration. This is not to suggest that participants intentionally jeopardized their health by engaging in unsafe sexual behaviour. For example, participants may have wanted to experience the sensation of sexual intercourse without condoms.

The last theme that contributed to unsafe sexual practices was that sexual activity provided unmet emotional needs and was a source of identity development. Many

participants described sexual activity as a way to meet emotional needs such as attention, power and affiliation. Sexual activity also appears to be part of the process of identity development. It appears that a desire to meet emotional needs through sexual activity may have been stronger than making healthy sexual choices. Many participants described a low-level of identity during the period of sexually risky behaviour. Sexually risky activity appears to be a means to developing one's sexual identity. It seems that participants did not institute safer sexual behaviour into their sense of identity during the period of unsafe sexual participation.

DISCUSSION

Several factors that contribute to adolescent risky sexual behaviour emerged in this study. The factors are alcohol and drug use, relationships with parents, peer group affiliation, independence and exploration, and meeting emotional needs and developing identity. This study supports what other researchers have determined as factors that contribute to adolescent unsafe sexual behaviour. Furstenberg (2000) stated, "Although it is not surprising that the adolescent literature has grown over the last several decades, it is more interesting to report that many of the themes identified in the early literature endure" (p. 897).

The vast majority of participants in this study had a high-level of alcohol and drug use. Furthermore, some participants also engaged in criminal activity and violence. These activities contributed to sexually risky behaviour, and this finding is typical of what other researchers have found. Whitbeck, Yoder, Hoyt, and Conger (1999) stated, "The most robust and researched predictor of early adolescent intercourse has been

adolescent participation in other adult-like or deviant behaviours" (p. 935). There is evidence that alcohol and drug use is associated with risky sexual behaviour. Results from the 1998 Atlantic Student Drug Use Survey (as cited in Health Canada, 1999) indicate that 50% of sexually active grade 9, 10 and 12 students had unplanned intercourse on at least one occasion when under the influence of alcohol or other drugs and inconsistently used condoms. Unfortunately, engagement in multiple risk behaviours, such as alcohol and drug use and unsafe sex remains high among young people (Health Canada, 1999).

Parent-child relationships have been found to affect adolescents' sexual behaviour, and the results of this study support that sentiment. Many participants initiated intercourse at a young age, in part, as a result of emotionally distant relationships with parents. Upchurch, Aneshensel, Sucoff, & Levy Storms (1999) suggest that positive relationships, as characterized by emotional closeness and support, between the child and parent may delay onset of sexual activity. Other researchers state that there is a prevalent belief that a lack of parental control is, in part, responsible for adolescents participation in sex at a young age (Boyce Rodgers, 1999; Luster & Small, 1994; Meschke, Bartholomae, & Zentall, 2000; Taris & Semin, 1998), and this appears to have been a factor for those participants with a lack of parental control.

Participants' relationships with risk taking and sexually active peers, and consequent engagement in risky activities, including unsafe sex, lend themselves to the existing research on peer influences. Research suggests that peers may participate in similar sexual behaviour (Werner-Wilson, 1998). Results from a recent study

indicate that relationships with deviant peers, those who smoke, drink or use drugs, increases the likelihood of early sexual intercourse more than one and one-half times (Whitbeck, Yoder, Hoyt, & Conger, 1999).

Participants expressed that increased independence and freedom contributed to participation in sexual activity. Research has indicated that the age of first intercourse is positively associated with the expectation for independence (Werner-Wilson, 1998).

Participants described exploration as a factor that contributed to sexual activity. Lear (1996) suggested that the period between adolescence and adulthood may be viewed as a developmental stage marked by experimentation. Researchers have found that adolescents who are in a high state of exploration, exhibit low goal directedness and self-control, and are more likely to participate in sexual intercourse without condoms (Hernandez & DiClemente, 1992).

Many participants described sexual activity as a way to fulfill needs for attention, power, affiliation and to counter low self-esteem and feelings of solitude. Some adolescents believe that participating in sex yields an emotional intimacy otherwise unattainable (Levinson, Jaccard, & Beamer, 1995). Researchers have investigated emotional motivations for participation in sexual intercourse and have found that risky adolescent sexual behaviour may also have positive implications (Levinson et al., 1995). These researchers developed four classes of motivations for engaging in sex. Included as motivations for sexual activity are becoming more popular with same-sex friends, having a more secure relationship with one's partner, feeling better

about oneself, feeling closer to another person and reducing feelings of loneliness. Furthermore, they discovered that participants who indicated sex as a form of self-validation were more likely to have a positive orientation toward casual sex. These teens also tend to define their own self-esteem in terms of their sexuality.

Adolescence is a period in which the core developmental task is identity formation. It is marked by the transition between the safe reality of childhood and the indeterminate reality of adulthood (Baumrind, 1991; Shucksmith & Hendry, 1998). Marcia (1966) maintains that a balance between identity and role confusion is dependent on a sense of commitment to an identity, as well as the occurrence of an identity crisis in one's life. He defines an identity crisis as active exploration of the different way one may view themselves and giving serious thought to the implications of those views. During the period of unsafe sexual behaviour, participants described feelings of not knowing who they were and a desire to develop a sense of identity. It appears that participants were experiencing what Marcia (1966) refers to as an identity crisis during the period of unsafe sexual behaviour, and participants' sexual activity seemingly was a component of identity formation. Cowan (1991) suggests that question of – who am I and who will I be? – is confronted for the first time in adolescence. Marcia (1966) distinguishes four identity statuses, which include identity achievement, moratorium, foreclosure and identity diffusion. It appears that most participants were experiencing either identity achievement or moratorium during the period of risky sexual behaviour. Identity achievement applies to an individual who has experienced a period of exploration and has made a commitment

to a sense of identity. Moratorium refers to individuals that are currently in identity crisis and have not made a commitment. These identity statuses most closely apply to the participants in this study. Foreclosure refers to an individual who has made commitments with no apparent crisis. Identity diffusion involves neither commitment nor crisis.

Participants in this study were cognizant of the many factors that promote sexually risky behaviour. However, it appears that in retrospect, participants became aware just how significant the contributing factors were in their lives during the period of sexually risky behaviour. Participants, at the time of the interviews, appeared to have a much clearer sense of what contributed to their sexual risky past than they did at the time they were participating in the behaviour. Most participants, at the time of the interview, had drastically reduced or ceased practicing unsafe sex. If participants were more able to realize the ramifications of the contributing factors before the initiation of risky sexual behaviour it is conceivable that they may have avoided some of the behaviour.

The challenge lies in making adolescents more aware of the factors that contribute to risky sexual activity prior to the period of sexual risk behaviour. Parents and schools can play a role in educating adolescents about sex. Rosenthal and Feldman (1999) suggest that parents should play a pivotal role in educating their children about sex. Boyce Rodgers (1999) states that adolescents who communicate with their parents about sexual issues are likely to know specific ways of reducing sexual risks, for example, use of condoms and monogamy. Study results indicate that a school-

based AIDS prevention program reduced high-risk sexual activity among adolescents (DiClemente, 1993).

It is especially interesting how significant changes in the lives of participants altered the contributing factors of sexually risky behaviour in turn affecting participants' sexual behaviour. For example, many participants had improved familial relationships, reduced consumption levels of alcohol and drugs and established a sense of self after the period of unsafe sexual behaviour had ceased or diminished. Changes in the contributing factors and the consequent reduction in sexually risky behaviour suggests that the contributing factors found in this study, which promoted unsafe sex, are accurate. Only a limited number of participants engaged in unsafe sex at the time of interviews, however the frequency with which they were sexually risky had drastically decreased. The remaining participants were no longer involved in risky sexual behaviour at the time of the interview. Participants stated that this change of behaviour was due to a change in the contributing factors that promoted sexually risky behaviour in the first place.

Research, including this study, has clearly documented the factors that contribute to adolescent sexually risky behaviour. A field of research exists based on the factors that promote adolescent safer sex practices. Perhaps the time has come to attend more so to the factors that contribute to healthy adolescent sexual behaviour. This notion is influenced by Boyce Rodger's (1999) study in which she reframed the problem of teen sexual behaviour from factors that contribute to sexual initiation to factors related with reducing unsafe sexual behaviour among sexually active adolescents.

In summary, this study examined factors that contribute to risky adolescent sexual behaviour. Results indicate that alcohol and drug use, parent-child relationships, peer associations, increased independence and exploration, and emotional motivation and identity development contribute to adolescent sexual risk taking. The findings add support to the existing knowledge on factors that promote sexual risk taking in adolescence. Given that the contributing factors to adolescent unsafe sex have been well documented, the researcher suggests that an increased focus on factors that contribute to healthy adolescent sexual behaviour is merited.

References

Anderson, P. B., & Mathieu, D. (1998). Drinking and safer sex: Are college students at risk? *Journal of Sex Education & Therapy, 23,* 297-301.

Baldwin, J. D., & Baldwin, J. I. (1988). Factors affecting AIDS-related sexual risk-taking behaviour among college students. *Journal of Sex Research, 25,* 181-196.

Baumrind, D. (1991). Effective parenting during the early adolescent transition. In P. A. Cowan, & M. Hetherington (Eds.), *Family Transitions* (pp. 111-163). Hillsdale, NJ: Lawrence Erlbaum Associates.

Bowler, S., Sheon, A., D'Angelo, L., & Vermund, S. (1992). HIV and AIDS among adolescents in the United States: Increasing risk in the 1990s. *Journal of Adolescence, 15,* 345-371.

Boyce Rodgers, K. (1999). Parenting processes related to sexual risk-taking behaviours of adolescent males and females. *Journal of Marriage and the Family, 61,* 99-109.

Brown, L. K., DiClemente, R. J., & Park, T. (1992). Predictors of condom use in sexually active adolescents. *Journal of Adolescent Health, 13,* 651-657.

Buysse, A. (1996). Adolescents, young adults and AIDS: A study of actual vs. perceived need for additional information. *Journal of Youth and Adolescence, 25,* 259-270.

Civic, D. (1999). The association between characteristics of dating relationships and condom use among heterosexual young adults. *AIDS Education & Prevention, 11,* 343-352.

Cole, P. S., & Weissberg, R. P. (1994). Substance use and abuse among urban adolescents. In T. P. Gullotta, G. R. Adams, & R. Montemayor (Eds.), *Substance misuse in adolescence* (pp. 92-122). Thousand Oaks, CA: Sage.

Cowan, P. A. (1991). Individual and family life transitions: A proposal for a new definition. In P. A. Cowan, & M. Hetherington (Eds.), *Family Transitions* (pp. 111-163). Hillsdale, NJ: Lawrence Erlbaum Associates.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

deGaston, J. F., Jensen, L., & Weed, S. (1995). A closer look at adolescent sexual activity. *Journal of Youth and Adolescence, 24,* 465-478.

DiClemente, R. J. (1993). Preventing HIV/AIDS among adolescents: Schools as agents of behaviour change. *The Journal of the American Medical Association, 270,* 760-763.

DiClemente, R. J., Forrest, K. A., & Mickler, S. (1990). College students' knowledge and attitudes about AIDS and changes in HIV-preventive behaviours. *AIDS Education & Prevention, 2,* 201-212.

Donald, M., Lucke, J., Dunne, M., & Raphael, B. (1995). Gender differences associated with young people's emotional reactions to sexual intercourse. *Journal of Youth and Adolescence, 24,* 453.

Ellen, J. M., Boyer, C. B., Tschann, J. M., & Shafer, M. (1996). Adolescents' perceived risk for STD and HIV infection. *Journal of Adolescent Health, 18,* 177-181.

Facts about youth HIV in the U.S. Health Initiatives for Youth. (1998, May). *World, 7,* 1.

Ferguson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. *Child Abuse and Neglect, 21,* 789-803.

Field, P. A., & Morse, J. M. (1985a). *Nursing research: The application of qualitative approaches.* Rockville, MD: Aspen.

Furstenberg, F. F. (2000). The sociology of adolescence and youth in the 1990's: A critical commentary. *Journal of Marriage and the Family, 62,* 896-910.

Galambos, N. L., & Tilton-Weaver, L. C. (1998). Multiple-risk behaviour in adolescents and young adults. *Health Reports, 10,* 9-20.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory:*

Strategies for qualitative research. Chicago: Aldine.

Hawa, R., Munro, B. E., & Doherty-Poirier, M. (1998). Information, motivation and behaviour as predictors of aids risk reduction among Canadian first year university students. *The Canadian Journal of Human Sexuality, 7,* 9-18.

Health Canada. (1999). *Toward a healthy future* (chap. 5). Retrieved from http://www.hc-sc.gc.ca/hppd/report/toward/pdf/english/chapter_5.PDF

Hernandez, J. T., & DiClemente, R. J. (1992). Self-control and ego identity development as predictors of unprotected sex in late adolescent males. *Journal of Adolescence, 15,* 437-447.

Hewitt, D., Vinje, G., & MacNeil, P. (Eds.). (1995). *Horizons three young Canadians' alcohol and other drug use: Increasing our understanding.* Ottawa, ON: Health Canada.

Kann, L., Kinchen, S. A., Williams, B. I., Ross, J. G., Lowry, R., Hill, C. V., et al. (1998). Youth risk behaviour surveillance- United States, 1997. *Journal of School Health, 68,* 355-369.

Keller, M. L. (1993). Why don't young adults protect themselves against sexual transmission of HIV? Possible answers to a complex question. *AIDS Education & Prevention, 5,* 220-233.

Lear, D. (1996). "You're gonna be naked anyway": College students negotiating safer

sex. *Qualitative Health Research, 6,* 112-134.

Leigh, B. C., Morrison, D. M., Trocki, K., & Temple, M. T. (1994). Sexual behaviour of American adolescents: Results from a U.S. national survey. *Journal of Adolescent Health, 15,* 117-125.

Levinson, R. A., Jaccard, J., & Beamer, L. (1995). Older adolescents' engagement in casual sex: Impact of risk perception and psychosocial motivations. *Journal of Youth and Adolescence, 24,* 349-362.

Library Watch. (1996, October). *The Brown Digest of Addiction & Application, 15,* 9-10.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Lindsay, C., Devereaux, M. S., & Bergob, M. (1994). *Youth in Canada* (2nd ed.). Ottawa, ON: Statistics Canada, Housing, Family and Social Statistics Division.

Luster, T., & Small, S. A. (1994). Factors associated with sexual risk-taking behaviours among adolescents. *Journal of Marriage and the Family, 56,* 622-632.

Marcia, J. E. (1966). Development and validation of ego identity statuses. *Journal of Personality and Social Psychology, 3,* 551-558.

Maticka-Tyndale, E. (1991). Sexual scripts and AIDS prevention: Variations in adherence to safer-sex guidelines by heterosexual adolescents. *Journal of Sex Research, 28,* 45-66.

Meschke, L. L., Bartholomae, S., & Zentall, S. R. (2000). Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Family Relations, 49,* 143-154.

Miller, K. S., Forehand, R., & Kotchick, B. A. (1999). Adolescent sexual behaviour in two ethnic minority samples: The role of family variables. *Journal of Marriage and the Family, 61,* 85-98.

Morse, J. M. (1992). *Qualitative health research.* Newbury Park, CA: Sage.

Munro, B., Doherty-Poirier, M., Mayan, M. L., & Salmon, T. (1994). Instructional strategies used in HIV/AIDS education: Correlations with students' knowledge, attitudes and intended behaviour. *The Canadian Journal of Human Sexuality, 3,* 237-243.

Neel, K. L. (1998). Youth and HIV: Predicting sexual risk-taking behaviour. *Dissertation Abstracts International: Section B: The Sciences & Engineering, 59 (3-B),* 1374.

Regan, P. C., & Dreyer, C. S. (1999). Lust? Love? Status? Young adults' motives for engaging in casual sex. *Journal of Psychology & Human Sexuality, 11,* 1-24.

Rosenthal, D. A., & Feldman, S. S. (1999). The importance of importance: Adolescent's perceptions of parental communication about sexuality. *Journal of Adolescence, 22,* 835-851.

Seidman, S. N., & Rieder, R. O. (1994). A review of sexual behaviour in the United States. *American Journal of Psychiatry, 151,* 330-341.

Shucksmith, J., & Hendry, L. B. (1998). *Health issues and adolescents: Growing up, speaking out.* London: Routledge.

Smith, C. D., & Brown, J. M. (1998). Sexual behaviours, extroversions, and alcohol use among college students. *Journal of Alcohol & Drug Education, 44,* 70-79.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Taris, T. W., & Semin, G. R. (1998). How mothers' parenting styles affect their children's sexual efficacy and experience. *Journal of Genetic Psychology, 159,* 68-79.

Teen sex rates level off, but pregnancy and STD rates remain high. (1999, August). *Brown University Child & Adolescent Behaviour Letter, 15,* 1.

Upchurch, D. M., Aneshensel, C. S., Sucoff, C. A., & Levy-Storms, L. (1999). Neighborhood and family contexts of adolescent sexual activity. *Journal of*

Marriage and the Family, 61, 920-933.

Werner-Wilson, R. J. (1998). Gender differences in adolescent sexual attitudes: The influence of individual and family factors. *Adolescence, 33,* 519-528.

Westerman, P. L., & Davidson, P. M. (1993). Homophobic attitudes and AIDS risk behaviour of adolescents. *Journal of Adolescent Health, 14,* 208-213.

Whitbeck, L. B., Yoder, K. A., Hoyt, D. R., & Conger, R. D. (1999). Early adolescent sexual activity: A developmental study. *Journal of Marriage and the Family, 61,* 934-946.

CHAPTER IV

GENERAL DISCUSSION

This research project was comprised of two objectives. The primary purpose of this study was to investigate the process of becoming an adolescent sexual risk taker. The second objective was to determine factors that contributed to research participants' adolescent sexually risky behaviour. Not only was the process of participants' progression to unsafe sexual behaviour determined, but factors that, in part, contributed to this process were assessed. It must be noted that the factors, which contributed to risky sexual behaviour, were highly interrelated, therefore they had a role in other areas of the process beyond the act of unsafe sex itself. For example, alcohol and drug use was associated with unsafe sexual behaviour, however it also affected the acquisition of peer groups who also experienced comorbidity between alcohol and drug use and sexually risky behaviour. Consequently, the secondary purpose of this study appropriately compliments the primary objective.

Results of the study indicate that the process of becoming a sexually risky adolescent is highly related to the parent-child relationship. The process that each participant experienced evolved from the relationship that he or she had with their parents. Three parenting styles, "strict," "absent," and "unemotional," arose from the data. Participants with strict or absent parents moved through a process originating from the parent-child relationship to associations with peers groups, participation in risky behaviours and then participation in risky sexual activity. However, participants

that felt that their parents were unemotional, experienced a process in which they either followed a path similar to participants with strict and absent parents or they progressed from the parent-child relationship to affiliation with peer groups, participation in risky behaviour and unsafe sexual activity in a different temporal order.

Findings from this study lend support to many other researchers' work that recognizes a significant association between parent-child relationships and adolescent behavioural effects (see Baumrind, 1966, 1968; DiClemente et al., 2001; Furstenburg, 2000; Luster & Small, 1994; Maccoby & Martin, 1983; Meschke, Bartholomae, & Zentall, 2000; Miller, Forehand, & Kotchick, 1999; Shucksmith, Hendry, & Glendinning, 1995). Furthermore, results from this project support Baumrind's (1966) authoritarian and permissive parental control models and Maccoby and Martin's (1983) indifferent-uninvolved or "neglectful" parental control style. Parents' control styles most resembled one of these three models.

The factors that contributed to participants involvement in unsafe sexual behaviour include alcohol and drug use, parent-child relationships, peer association, independence and exploration, and emotional needs acquisition and identity development. Factors that were associated with participants' sexually risky behaviour add support to previous research findings (see Baumrind 1991; Cowan 1991; de Gaston, Jensen, & Weed, 1995; Lear, 1996; Levinson, Jaccard, & Beamer, 1995; Meschke, Bartholomae, & Zentall, 2000; Werner-Wilson 1998; Whitbeck, Yoder, Hoyt, & Conger, 1999).

Limitations

Implications for future research in the area of adolescent sexuality and recommendations for practitioners and other agents of change will be discussed. However, it is important to outline the limitations of this study first. The following limitations are manifested in this research project:

1) The first limitation is that family-structural variables were not examined in relation to adolescent risky sexual behaviour. Only family-process variables were accounted for. Overall, family-structural variables have received less attention than process variables in understanding adolescent sexual behaviour (Miller, Forehand, & Kotchick, 1999), and some researchers feel that structural variables must not be overlooked (Small & Luster, 1994). One family-structural variable is family type. Single-parent, blended and the presence of both biological parents are examples of family type or structure (Upchurch, Aneshensel, Sucoff, & Levy-Storms, 1999). Other family-structural variables are parental marriage status, education attainment and income (Meschke, Bartholomae, & Zentall, 2000). Had family-structural variables been recognized this study may have had the capacity to contribute to research in this area.

2) A second limitation of this study relates to the sample employed. Purposive sampling was employed, whereby individuals who could contribute to determining the process of becoming an adolescent risk taker were recruited. It must be noted, however that this type of sample is essential in research utilizing a grounded theory approach (Creswell, 1998), and the sample is not supposed to be representative of the

adolescent population in general. The limitation arises from the concern that a more heterogeneous sample was not then studied to assess variation in the phenomenon being investigated. For example, all participants had some level of post-secondary education. It is conceivable that a less homogeneous sample as related to educational achievement may have different sexual experiences.

3) Another limitation, which is also related to the sample used in this study, is that the majority of participants described a period in their lives that occurred during adolescence. The range that participants experienced involvement in sexually risky behaviour spanned the ages between 14 to 20. However, participants in this research project ranged in age between 18 to 27. This potentially brings into question the accuracy of participants' memories of this period in their lives. Denzin and Lincoln (2000) recognize that respondents may err due to faulty memory. Perhaps, recounting experiences from the past versus when they are occurring in adolescents' lives produces a different outcome.

4) A fourth limitation is that an analysis of gender effects was not performed. It is likely that had gender been accounted for that differences between males and females would emerge. For example, females may be more likely to view their sexual behaviour in terms of long-term and personal consequences such as pregnancy and emotional costs. Conversely, males' participation in sexual activity may be influenced by external factors such as peer group pressure (Boyce Rodgers, 1999). Furthermore, the double standard that condones male promiscuity may affect the sexual behaviour of adolescents (Levinson, Jaccard, & Beamer, 1995).

5) Another limitation in this study is that participants' ethnic group membership was not incorporated into the analysis, as it may relate to the process of becoming an adolescent sexual risk taker. Participants originated from a diverse range of ethnic backgrounds, including Caucasian, Asian, Southeast Asian, European and East Indian, and significant differences may have emerged in terms of sexual risk behaviour amongst members of different ethnic groups. Meschke, Bartholomae, and Zentall (2000) suggest that ethnicity may affect the degree to which adolescent sexual behaviour is associated with parental marital status. Furthermore, it is conceivable that ethnicity relates to adolescent sexual behaviour and other family variables in other ways.

6) A sixth limitation is that participants, with the exception of one, did not respond to a follow-up via electronic mail describing the results of the study. The follow-up was intended as one method of triangulation in that participants would have an opportunity to corroborate the findings of the study (Creswell, 1998). At the time of the interview, participants were informed that they would possibly be contacted for a follow-up. Interestingly, many participants requested that they receive results of the study once they were available, however only one responded to the follow-up.

Implications

In spite of the limitations of this study, many implications for future research and suggestions to affect change in sexually risky adolescents' lives are apparent.

1) Recognition of the limitations of this study, for example unaccounted for gender and ethnicity effects, as well as the overall findings, indicate that the study of

adolescent risky sexual behaviour in multiple contexts is essential. The primary objective of the researcher was to examine the process of adolescent sexually risky behaviour, as a result the phenomenon was studied in multiple contexts. However, it must be noted that this was a matter of degree. For example, parent-child relationships, peer group affiliation and comorbidity were investigated, yet gender and ethnicity effects were not taken into account. The researcher supports the view that adolescent unsafe sexual behaviour is influenced by multiple contexts, and researchers should incorporate multiple contexts into their studies. Furstenberg (2000) states,

> Researchers have been much more attentive in looking at adolescence in single rather than multiple contexts. Most of our studies focus on the influence of families or schools or peers or neighbourhoods; only recently have investigators begun to examine multiple contexts in a single study. If we are to gain a more complete understanding of when, how and why different contexts shape the trajectories of development we cannot continue to study one context at a time.

2) The evidence of factors that contribute to adolescent sexually risky behaviour is firmly established, and this study lends further support to other researchers' findings. Given this, it is the opinion of the researcher that scholars and other researchers move away from examinations of the factors that contribute to adolescent sexual risk taking and shift towards a focus on the factors that promote healthy sexual behaviour in adolescence. This may only be a contrasted variant of the same issue, however it is more of a health focussed view. In other words, researchers and practitioners must

work towards solutions rather than simply reexamining the problem. This belief is illustrated in a recent study in which the researcher reframed the problem of youth sexual behaviour from factors associated with sexual initiation to factors related with curtailing sexually risky behaviour among sexually active adolescents (Boyce Rodgers, 1999).

3) Results from this study indicate that the parent-child relationship is acutely related to adolescent sexually risky behaviour. Characteristics of parental communication, support and warmth, and control and monitoring affected the sexual behavioural outcomes of participants in this study. Exactly how these characteristics manifested themselves in the participants' sexual behaviour requires further analysis of the data. Other researchers acknowledge the relationship between parental qualities and adolescent sexual behaviour, however they also recognize the need for more conclusive findings (Boyce Rodgers, 1999; Meschke, Bartholomae, & Zentall, 2000). The researcher of this project supports and recognizes the need for continued study of the association between adolescent risky sexual behaviour and parental attributes.

4) Recognizing the correlation between parental characteristics and adolescent sexually risky behaviour the researcher suggests that parents be provided the means to learn more about how they affect their children's behaviour. Programs with an aim on effective parenting styles may, in part, remedy the prevalence of adolescent sexually risky behaviour. If parents are able to effectively teach their children about sexuality adolescents may make healthier choices regarding their sexual behaviour. Programs must address the parent-child relationship in terms of both adolescent sexuality and

how parents and adolescents interact with one another. The investigator proposes that researchers continue to assess the effectiveness of current adolescent sexuality programs with a parenting component and advise practitioners on improvements to the present programs. Meschke, Bartholomae, and Zentall (2000) examined 19 adolescent sexuality programs with a parent component and discovered that great diversity exists between programs. The researcher supports their view that adolescent sexuality programs with a parent component be further developed and that the efficacy of these programs is determined. Mellanby, Phelps, and Tripp (1992) state, "Evaluated interventions with agreed purpose and acceptable methodologies are essential if there is to be any real expectation of health benefit from sex education."

5) Participants in this study appeared to be knowledgeable about the potential negative consequences of sexual activity. However, it appears that this was not always an effective deterrent. This is congruent with findings that significant sexually risky behaviour continues despite widespread knowledge of the potentially deadly results (Levinson, Jaccard, & Beamer, 1995). The researcher proposes that efforts need to be taken to minimize the gap between adolescents' sexual knowledge and behaviour. It appears that knowledge of sexually risky behaviour and the consequences alone may not suffice.

6) Participants' sexual risky behaviour was influenced by a multitude of factors. Consequently, the investigator suggests that the field of adolescent sexual behaviour be examined in terms of its relation to multiple contexts. Such examples include peer, familial and community contexts. Furthermore, sexual risk behaviour must be

investigated in relation to other risk behaviors. Duberstien-Lindberg, Boggess, Porter, and Williams (2000) suggest that risk behaviours cannot be addressed in isolation. It is conceivable that part of the dilemma resides in a lack of methodologies that acknowledge risk behaviours are multiply determined (Lightfoot, 1997).

The implications of this study, in summary, support the need for research that examines sexual risk behaviour in its multiple contexts. Furthermore, it is the opinion of the researcher that scholars begin to frame research questions in terms of what factors contribute to healthy sexual behaviour, rather than what factors contribute to sexually risky behaviour. In addition, further examination of the role of the parent-child relationship and its relation to adolescent sexual behaviour is needed. Furthermore, it appears that parents and adolescents need to be educated in terms of the affects that their relationships have on behaviour, including adolescent sexual risk behaviour. For example, adolescent sexual education programs with a parental component may have positive benefits on the parent-child relationship in turn encouraging adolescents to make healthy sexual choices. Lastly, the gap between adolescents' knowledge of the consequences of risky sexual conduct and their sexual behaviour remains broad.

The researcher suggests that other researchers who investigate the area of adolescent sexual risk behaviour take into account the implications of this research. For example, the researcher advises that adolescent sexually risky behaviour be assessed in terms of its multiple contributing factors and contexts. This research lends support to this notion and it serves to increase the researcher's and other scholars'

awareness of the need for research that examines the multiple contexts of adolescent unsafe sexual behaviour. It appears that a primary benefit of this study is its ability to increase scholars' and practitioners' awareness of the interrelated contexts of adolescent sexual risk taking and its processes.

Acknowledgement of the researcher's assumptions throughout the course of this study may serve to contribute to other researchers' investigations of adolescent sexual risk taking. The most significant assumption that the researcher made was that adolescent unsafe sexual behaviour occurs in singular contexts. In other words, the researcher failed to conceive of adolescent sexual risk behaviour in its multiply determined contexts. It became evident during data collection and analysis that the process and contributing factors of adolescent unsafe sexual behaviour is the product of multiple determinants. For example, the various stages or phases of participants' process of becoming sexually risky were highly interrelated. For instance, there was a great deal of overlap between risky behaviour, such as alcohol and drug consumption, and sexual risk behaviours. Consequently, the researcher realized that the phenomenon of adolescent sexual risk taking could not be addressed in terms of singular dimensions, rather each dimension was significantly related.

Another assumption made by the researcher was the meaning he applied to the term risk. For the purposes of this study, risk was addressed in terms of health effects. For example, behaviours were determined to be risky if they had negative health consequences. For instance, sexual intercourse is risky if it increases the likelihood of contracting STIs. It must be noted however, that participants were asked to define risk

behaviours and consequently they discussed participation in activities that they considered risky according to their definitions of risk behaviours. The researcher now acknowledges that behaviours may be considered risky in terms of the various outcomes that they produce. For example, participation in sexual behaviour may have not only physical risks in terms of health consequences, but also social and emotional consequences. For instance, the sexual choices that adolescents make may result in contracting STIs as well as affect one's standing within one's peer group or their emotional sense of well-being. The researcher acknowledges that the term risk has many connotations and denotations. This suggests that researchers should investigate adolescent sexually risky behaviour in terms of various risks, including those mentioned. This behaviour should be addressed in terms of the potential multiple risks that it may produce, just as it should be studied in terms of the multiple contexts in which it occurs.

Lastly, the researcher assumed that the term risk is inherently negative. Consequently, risk was not considered in terms of the possible positive outcomes associated with it. For example, while an occurrence of unprotected vaginal intercourse may have negative health ramifications, it may also contribute to stronger affiliation with one's peer group. Hence, it becomes a case where the negative and positive outcomes of the risk behaviour must be considered. While a behaviour may seemingly feel risky at its onset, it may ultimately produce a positive outcome. The question that follows is whether the behaviour was a risk behaviour. Consequently,

researchers and practitioners must skillfully define risk and be cognizant of the various connotations and denotations of the term.

References

Baumrind, D. (1966). Effects of authoritative control on child behaviour. *Child Development, 37,* 887-907.

Baumrind, D. (1968). Authoritarian vs. authoritative parental control. *Adolescence, 3,* 255-272.

Baumrind, D. (1991). Effective parenting during the early adolescent transition. In P. A. Cowan, & M. Hetherington (Eds.), *Family Transitions* (pp. 111-163). Hillsdale, NJ: Lawrence Erlbaum Associates.

Boyce Rodgers, K. (1999). Parenting processes related to sexual risk-taking behaviours of adolescent males and females. *Journal of Marriage and the Family, 61,* 99-109.

Cowan, P. A. (1991). Individual and family life transitions: A proposal for a new definition. In P. A. Cowan, & M. Hetherington (Eds.), *Family Transitions* (pp. 111-163). Hillsdale, NJ: Lawrence Erlbaum Associates.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

deGaston, J. F., Jensen, L., & Weed, S. (1995). A closer look at adolescent sexual activity. *Journal of Youth and Adolescence, 24,* 465-478.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research*

(2nd ed.). Thousand Oaks, CA: Sage.

DiClemente, R. J., Wingwood, G. M., Crosby, R., Sione, C., Cobb, B. K., & Harrington, K. (2001). Parental monitoring: Association with adolescents' risk behaviours. *Pediatrics, 107,* 1363-1373.

Duberstein-Lindberg, L., Boggess, S., Porter, L., & Williams, S. (2000). *Teen risking-taking: A statistical report.* Washington, DC: Urban Institute.

Furstenberg, F. F. (2000). The sociology of adolescence and youth in the 1990's: A critical commentary. *Journal of Marriage and the Family, 62,* 896-910.

Lear, D. (1996). "You're gonna be naked anyway": College students negotiating safer sex. *Qualitative Health Research, 6,* 112-134.

Levinson, R. A., Jaccard, J., & Beamer, L. (1995). Older adolescents' engagement in casual sex: Impact of risk perception and psychosocial motivations. *Journal of Youth and Adolescence, 24,* 349-362.

Lighfoot, C. (1997). *The culture of adolescent risk-taking.* New York: Guilford Press.

Luster, T., & Small, S. A. (1994). Factors associated with sexual risk-taking behaviours among adolescents. *Journal of Marriage and the Family, 56,* 622-632.

Maccoby, E. E., & Martin, J. (1983). Socialization in the context of the family: Parent-child interaction. In P. H. Mussen (Series Ed.) & E. M. Hetherington (Vol.

Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (4th ed., pp. 1-101). New York: Wiley.

Mellanby, A., Phelps, F., & Tripp, J. (1992). Sex education: More is not enough. *Journal of Adolescence, 15,* 449-466.

Meschke, L. L., Bartholomae, S., & Zentall, S. R. (2000). Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Family Relations, 49,* 143-154.

Miller, K. S., Forehand, R., & Kotchick, B. A. (1999). Adolescent sexual behaviour in two ethnic minority samples: The role of family variables. *Journal of Marriage and the Family, 61,* 85-98.

Shucksmith, J., & Hendry, L. B. (1998). *Health issues and adolescents: Growing up, speaking out.* London: Routledge.

Small, S. A., & Luster, T. (1994). Adolescent sexual activity: An ecological risk-factor approach. *Journal of Marriage and the Family, 56,* 181-192.

Upchurch, D. M., Aneshensel, C. S., Sucoff, C. A., & Levy-Storms, L. (1999). Neighborhood and family contexts of adolescent sexual activity. *Journal of Marriage and the Family, 61,* 920-933.

Werner-Wilson, R. J. (1998). Gender differences in adolescent sexual attitudes: The influence of individual and family factors. *Adolescence, 33,* 519-528.

Whitbeck, L. B., Yoder, K. A., Hoyt, D. R., & Conger, R. D. (1999). Early adolescent sexual activity: A developmental study. *Journal of Marriage and the Family, 61,* 934-946.

APPENDIXES

Appendix A

Timeline

Activity	Time Commitment (months)										
(2000)	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Sample	———										
Data Collection		———	———	———	———	———					
Analysis		———	———	———	———	———	———	———			
Final Report								———	———		

Appendix B

Advertisement for Participants

If you are female or male (18-27yrs.) and participate or have participated in sexually risky behaviours, you can participate in a research study. We want to know how you became involved in these behaviours, and what factors contributed to engaging in them. Furthermore, if you no longer participate in these behaviours we would like to learn how your behaviour changed. If you take part in the study, you will be interviewed 1 to 2 times, and interviews will be audiotaped. You will receive $20 for your participation in this project. Please contact Jason for more information. E-mail: jay_schmelzle@hotmail.com

Appendix C

Interview Schedule

Thank-you for coming today and your willingness to be a part of this very important research project. We are trying to learn more about what causes young people to make the choices that they make. We would like to discover the processes or paths involved that encourages adolescents to participate in sexually risky behaviour. Furthermore, we would like to learn what factors contribute to participation in this behaviour. If you no longer participate in sexually risky behaviour, we would like to learn how this change of behaviour came about. Thus, I will be asking you questions about how you became involved in sexually risky behaviour. If you are still willing to participate in this project would you please sign this consent form after reading it.

Please, remember that the information you give me is strictly confidential and will be tape-recorded and transcribed. Your name will not be put on the tape, and nobody will be told who participated in this study. Would you please pick a name different from yours that can be used on the tape so there is no way of identifying you. In addition, interview tapes will be kept in a locked filing cabinet separate from any identifying information. If you are not comfortable with a question, you are not required to answer it. Furthermore, if you become uncomfortable at anytime during the interview please tell me and we may take a break or end the interview.

The nature of the topic we will discuss is very sensitive. We have compiled a list of services in the community that you may contact if you are troubled by the material in the interview. If you wish, you are free to have a copy of this list at the end of the interview.

If you have any questions during the interview please ask. If you have any questions at this point, please feel free to ask me? Are you ready to begin?

1) High-risk behaviour can mean different things to different people. It is important that you tell me what high-risk behaviour means to you.

2) Can you tell me a little about what risky behaviours you think adolescents participate in? What behaviours do you consider to be high-risk?

3) What sexually risky behaviours have you participated in (past and/or present)? How old were you when you started?

4) What was happening in your life just before you started participating in this risky behaviour? What was happening in your family? What were your parents like? What were your friends and peers like? What was happening with your partner (if applicable)? What was school life like? Were you a good student? Did you relate well to your teachers? Were you working? Were you part of other groups (e.g. sports teams, volunteer groups, religious groups, cultural groups, community groups)? Did you feel that others cared about you? If so, who?

5) Tell me more about your involvement with_____.

6) What things caused you to become involved in_____?

7) Just before you became involved in_____did you know what your plans were for life (e.g. education, career, family, politics, religion).

8) Do you feel that certain things in your life contributed to your participation in this risky behaviour? In other words, were there things happening in your life that you feel motivated or encouraged you to engage in sexually risky behaviour? Please tell me in order what happened to lead you into participating in these behaviours. What was the first thing, second thing...?

9) What was the reaction of others (e.g. family, friends, groups you were part of, schoolmates...)? Did they even know? Did it affect your relationship with others? Did it affect your perception of yourself? What impact did the behaviours have on your life? How did you feel?

10) What did you do with your free time?

11) Do you still participate in these behaviours?

a) If so, are you happy participating in these behaviours? Why or why not? What is happening in your life now? Would you change anything in your life? If not, why not? Do you feel happy with your life and feel that others care about you (family, friends, people in groups you are involved in, others)? What do you think would make you change? (Follow-up on question 7) Do you know now what you plan to do in the future as far as (e.g. career, family, education...)? Do you know about your perspective on politics? Do you know about your perspective on religion?

END HERE IF THEY ARE STILL PARTICIPATING IN THESE BEHAVIOURS. IF THEY HAVE CHANGED, CONTINUE TO QUESTION 12.

12) If you have changed, what encouraged you to change your behaviour? What is different in your life now? Did anyone help you to quit participating in _____(e.g. yourself, family, friends, groups, religion, others who care)?

13) What was the order of the experiences that led you out of the behaviour (first, second...)? Was it difficult? Why or why not? What was the hardest thing, and how could you have been helped?

14) How have you felt since you have not been involved in this behaviour?

15) Do you know now what you plan to do in the future as far as (e.g. career, family, education...)? Do you know about your perspective on politics? Do you know about your perspective on religion?

16) How do you find that you relate to others now (e.g. family, friends, groups, others in the community)?

17) Is there anything else you would like me to know about? Would you like to clarify anything? Would you like to add any feelings you have?

This is the end of the interview. Thank-you very much for your involvement in this interview. It is our hope that the information you have provided will help other adolescents in the future. Here is a small honorarium for the time you have spent with me. I may contact you in the future to further understand some of the information that you have given me.

Appendix D

Information Letter

Date:

Dear_____,

Thank-you for your interest in this research project on process and high-risk sexual behaviours. This information letter is intended to give you more information about the study and explain how you may be involved.

I am interested in the process of becoming a sexual risk taker. In other words, what occurs in adolescents' lives that lead to the participation in high-risk sexual behaviours. I am interested in discovering the process of this path to sexually risky behaviour. The research question that will be asked is: what are the paths that adolescents take, which lead to engaging in high-risk sexual behaviour, and what factors promote participation in this behaviour. Sexual risk taking is defined differently by different people. However, sexual behaviours that increase the likelihood or contracting sexually transmitted infections (STIs) may be considered high-risk. I am completing a Master of Science degree in Family Ecology and Practice at the University of Alberta, and I have chosen this research area for my thesis.

My purpose is to gain a clearer understanding of the process of becoming a sexual risk taker. An outcome of this higher understanding will be to find ways to address the process, in turn helping prevent many adolescents from experiencing potentially life changing STIs due to high-risk sexual behaviour.

I propose to conduct individual audio taped interviews with participants, and you may be required to complete a follow-up. Follow-ups may be conducted by telephone, electronic mail or in person. In the interview, you will be asked to discuss the sexually risky behaviours you participate in at present and/or the past. Furthermore, you will also be asked to describe how you became involved in these behaviours and what was and/or is going on in your life related to this behaviour. Interviews will be approximately one to two hours long and conducted at the University of Alberta at your convenience.

Confidentiality is of the utmost importance. If you participate, your name will not be linked to the information you offer in the interview. A same sex interviewer will interview participants. However, it is possible that you will be interviewed by an opposite sex interviewer if you are comfortable with this. Once you have completed an interview, the tape will be assigned a name other than your own and selected by

you. Your name will never appear in any transcriptions or publications. Quotes from your interview may be used in publications; however, you will not be identified.

I hope that you will be a part of this study, and if you would like more information or wish to participate in this research please contact me. In addition, you may contact my thesis supervisor, Dr. Brenda Munro, at 492-XXXX for more information.

Sincerely,

Jason Schmelzle, Masters Candidate, University of Alberta
Faculty of Agriculture, Forestry and Home Economics
3-54 Human Ecology Building
Phone: (780) 492-XXXX / E-mail: jay_schmelzle@hotmail.com

Appendix E

Consent Form

PROJECT TITLE: The Paths to Sexual Risk Taking in Adolescence

INVESTIGATOR: Jason Schmelzle, Master of Science Candidate
Faculty of Agriculture, Forestry and Home Economics
Department of Human Ecology
University of Alberta, Edmonton, Alberta
Phone: (780) 492-XXXX / E-mail: jay_schmelzle@hotmail.com

SUPERVISOR: Dr. Brenda Munro, PhD
Faculty of Agriculture, Forestry and Home Economics
Department of Human Ecology
University of Alberta, Edmonton, Alberta
Phone: (780) 492-XXXX

PURPOSE: The purpose of this study is to discover the process that occurs when adolescents become sexual risk takers. The goal is to increase the knowledge of the process and encourage application of the findings. If the findings of this research can help address the paths to becoming a sexual risk taker, thereby improving individuals' lives, then the goals of this research endeavor have been reached.

PROCEDURE: Participants will complete an audio taped individual interview with the researcher. Furthermore, you may be asked to complete a follow-up. This may be accomplished by telephone, electronic mail or in person. Interviews will take approximately one to two hours to complete, and they may be scheduled at your convenience. You will be asked about your sexual behaviour at present as well as in the past. The purpose is to discover, through your interview, the process of becoming a sexual risk taker that you experienced. A typed copied of each interview will be made.

PARTICIPATION: It is not required that you be in this study and you do not have to participate if you choose not to. You are entitled to drop out at any time. Furthermore, you do not have to answer any questions or discuss any subjects you are not comfortable with. You may not gain anything from participating in this study, nor is it expected that you will be harmed as a result of participating. In addition, you may contact my research supervisor, Dr. Brenda Munro, if you would like to discuss the study further.

You will retain full anonymity and your name will not appear in this research study. A name, selected by you, will replace your real name and any other identifying materials on tapes, typed interviews and notes. All audio tapes, notes and interview

transcriptions will be locked in a cabinet separate from the names, consent forms and contact information of the participants. This information will be destroyed seven years after this study is completed. Interview information may be used in further studies if approved by an ethics committee. Quotations from interviews may be used in reporting findings, but your identity will not be revealed. You will receive a summary of the research findings at the end of this study if requested.

CONSENT: I have read this consent form that describes the research procedures and my questions have been answered. I know that I may contact the researcher or his supervisor now or in the future if I have any questions. I agree to be interviewed and have these interviews tape-recorded.

I understand that I do not have to participate in this study and I may quit at any time. Furthermore, I realize that I will not benefit from participating in this research nor be harmed. I have been made aware of the security of information acquired in this study and that my anonymity will be maintained. I realize that findings of this research may be published and/or used in teaching. In addition, I accept that interview information may be used in further studies if approved by an ethics committee. I have been given a copy of this consent form.

_____ _____

(Signature of Participant) (Date)

_____ _____

(Signature of Researcher) (Date)

Appendix F

Demographic Data Form

Please respond to the following questions:

Age:____

Sex: Male___ Female___

Marital status: Single___ Married___ Common-law___ Separated___ Divorced___

With whom do you live (identified by their relationship to you – e.g. parent(s), partner, sibling(s), roommate...)

Level of education: Undergraduate___ Masters___ PhD___
Year of Program___
Other_____

What department and faculty are you in (if applicable)?_____

Mother's occupation:_____

Father's occupation:_____

Ethnic group:_____

Describe your religious orientation:_____

How many generations has your family been in Canada?____

What is your sexual orientation? Heterosexual___ Homosexual___ Bisexual___

Appendix G

Resources and Services List

Alberta Alcohol and Drug Abuse Commission (AADAC)
Adult Counselling and Prevention Services
10010-102 A Avenue
Edmonton, AB
Phone: 427-2736

AADAC
Youth Services – Counselling-Prevention
12325-140 Street
Edmonton, AB
Phone: 422-7383

The Family Centre
#20 9912-106 Street
Edmonton, AB
Phone: 423-2831

Edmonton Counselling Centre
#202 12406-112 Avenue
Edmonton, AB
Phone: 482-2424

Psychiatric Walk-In Clinic
Main Floor, University of Alberta Hospital
Phone: 407-6501

Edmonton Distress Line
Phone: 482-HELP (4357)

Student Help
030N Students' Union Building
University of Alberta Campus
492-HELP (4357)

Student Counselling Services
2-600 Students' Union Building
University of Alberta Campus
492-5205

Peer Health Educators

2-301 Students' Union Building
University of Alberta Campus
492-2612

University Health Centre
2-200 Students' Union Building
University of Alberta Campus
492-2612

Sexual Assault Centre
2-602 Students' Union Building
University of Alberta Campus
492-9771

Sexual Assault Centre of Edmonton
3rd Floor 10355 Jasper Avenue
Edmonton, AB
Phone: 423-4102
Crisis Line: 423-4121

Sexually Transmitted Disease Clinic
3B20 11111 Jasper Avenue
Edmonton, AB
Phone: 413-5156

Sexually Transmitted Disease/AIDS/
HIV Information
Phone: 1-800-772-2437

Sexaholics Anonymous
P.O. Box 87413, 62 Edmonton Centre
Edmonton, AB
Phone: 988-4411
24 Hour message/answering service

AADAC
(24 hour detoxification)
10302-107 Street
Edmonton, AB
Phone: 427-4291

AADAC
Henwood Treatment Centre (Residential)
18750-18 Street

Edmonton, AB
Phone: 422-9069

Alcoholics Anonymous
#206 10010-107 A Avenue
Edmonton, AB
Phone: 424-5900

Alcohol/Drug Information and Referral
Community Service – Referral Line
Edmonton, AB
Phone: 482-4636

Cocaine Anonymous
Edmonton, AB
Phone: 425-2715

Our House Addiction Recovery
8103-121 Avenue
Edmonton, AB
Phone: 474-8945

Birth Control Centre
#200 10111-100 A Street
Edmonton, AB
Phone: 413- 5735

Planned Parenthood Association
#50 9912-106 Street
Edmonton, AB
Phone: 423-3737

Chaplains Services
Students' Union Building (and other campus locations)
University of Alberta Campus
492-0039