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Understanding Motivations for Abstinence among Adolescent Young Women: Insights into Effective Sexual Risk Reduction Strategies

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Abstract

Introduction—Pregnancy and sexually transmitted infections pose a significant threat to the health and wellbeing of adolescent young women. Abstinence when practiced provides the most effective means in preventing these problems, yet the perspective of abstinent young women is not well understood. The purpose of the investigation was to characterize female adolescents' motivations for abstinence.

Method—As part of a larger, cross-sectional quantitative study investigating predictors of HIV risk reduction behaviors, qualitative responses from study participants who never had intercourse were analyzed in a consensus-based process using content analysis and frequency counts. An urban primary care site in a tertiary care center served as the setting, with adolescent young women ages 15–19 years included in the sample.

Results—Five broad topic categories emerged from the data that characterized motivations for abstinence in this sample: 1) Personal Readiness, 2) Fear, 3) Beliefs and Values, 4) Partner Worthiness and 5) Lack of Opportunity.

Discussion—A better understanding of the motivations for abstinence may serve to guide the development of interventions to delay intercourse.

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Keywords

abstinence; adolescent young women; pregnancy/STI/HIV prevention and cultural diversity

Introduction

Sexual activity among adolescent young women increases the risk of pregnancy and sexually transmitted infections (STIs) including human immunodeficiency virus (HIV). The profound and negative impact of these problems elucidates the need for clinicians that care for adolescent young adults to include sexual health assessments in the plan of care. Furthermore, interventions to educate about the responsibilities and risks of sexual activity are needed in working with adolescents to promote sexual health. When practiced, abstinence is the most effective method in preventing pregnancy and sexually transmitted infections. Therefore, there is much that clinicians can learn from sexually abstinent young women. Their reasons for abstinence may inform clinicians' discussions with their patients. Moreover, understanding the motivations of adolescent young women who abstain from or delay first intercourse may provide clinicians with valuable insights that can contribute to the development of interventions to reduce pregnancy and STIs.

Yet despite increased interest in understanding abstinence or delayed intercourse among female adolescents, abstinence has not been widely investigated from a qualitative approach to gain their first person perspective. Further, qualitative data are vital in developing effective sexual risk-reduction interventions (Gamel, Grypdonck, Hengeveld, & Davis, 2001; Jemmott, Jemmott, & Fong, 2010; Jemmott, Jemmott, & O'Leary, 2007; Villarruel, Jemmott, & Jemmott, 2006). Given that the target population may vary by ethnic and racial backgrounds, qualitative data derived from diverse populations may guide the development of culturally sensitive and specific interventions. Therefore, the purpose of this study was to characterize the motivations for abstinence among adolescent young women of diverse cultural backgrounds, and address the research question, "What are the expressed reasons for sexual abstinence in young women of diverse cultures?"

It is imperative to address this question given the high stakes of early intercourse. Teenage pregnancy has deleterious effects on the lives of adolescent young women and society as a whole. The educational and economic deprivation resulting from teenage pregnancy, as well as the negative health and social consequences, can have life-long ramifications (National Campaign to Prevent Teen and Unplanned Pregnancy, 2010b). Parenthood is a leading cause of school dropout among teen girls. Only half of teen mothers have a high school diploma, and only two percent of mothers who have children before age 18 complete college by the age of 30 (National Campaign to Prevent Teen and Unplanned Pregnancy, 2010c). Consequently, teen mothers are less likely to complete the education necessary to qualify for a well-paying job, and are at great risk of living in poverty. Two-thirds of families begun by a young unmarried mother are poor (National Campaign to Prevent Teen and Unplanned Pregnancy, 2010e). Although a significant decline in teenage pregnancy during the last two decades is cause for encouragement, a modest, yet recent increase in teen pregnancy rate reminds us that adolescent pregnancy remains a significant problem (National Campaign to Prevent Teen and Unplanned Pregnancy, 2010a).

Further, teen pregnancy is associated with negative health implications for both the mother and child. Teen mothers are more likely to smoke than mothers over 25, far less likely to receive timely and consistent prenatal care, and often have inadequate weight gain during pregnancy (National Campaign to Prevent Teen and Unplanned Pregnancy, 2010d). Infants of teen mothers are more likely to be born prematurely and at low birth weight compared to

children of older mothers. Hence, these children are at greater risk for a host of negative health outcomes (National Campaign to Prevent Teen and Unplanned Pregnancy, 2010d). Beyond the profound impact pregnancy can have on the individual adolescent, the total public sector costs are substantial. It is estimated that the national costs of teen childbearing were 10.9 billion dollars in 2008 alone, with most of these costs associated with the negative consequences for the children of teen mothers (National Campaign to Prevent Teen and Unplanned Pregnancy, 2011).

The harmful consequences of early sexual intercourse for adolescent females extend beyond teenage pregnancy. Persons who initiate sex early in adolescence are at higher risk for STIs. Although the course of many STIs is benign, some infections may have significant sequelae including pelvic inflammatory disease, chronic pelvic pain, infertility, ectopic pregnancy and cervical cancer (Centers for Disease Control and Prevention, 2011b; Forhan et al., 2009). Furthermore, the prevalence of STIs among female adolescents is substantial, and begins to be acquired soon after sexual initiation and with few sex partners (Forhan, et al., 2009). Specifically, the reported rates of chlamydia and gonorrhea are highest among females aged 15–19 years, and many persons acquire Human Papillomavirus, a cause of cervical cancer, during their adolescent years (Centers for Disease Control and Prevention, 2011b).

In addition to the morbidity associated with the aforementioned STIs, HIV infection is a threat to the lives of adolescents and young adults worldwide (Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization, 2009). Though improvements in antiretroviral therapy and early diagnosis have delayed the progression of HIV infection to Acquired Immunodeficiency Syndrome (AIDS), and reduced the mortality rate of AIDS, the disease continues to be a leading cause of death among young adults (Centers for Disease Control and Prevention, 2011c) and women of reproductive age specifically (World Health Organization, 2009). Given the slower progression of HIV infection to AIDS in the adolescent population, many of the young adults diagnosed with HIV were infected as adolescents (Centers for Disease Control and Prevention, 2008). The majority of HIV cases diagnosed among adolescent and young adult females are attributed to high-risk heterosexual contact (Centers for Disease Control and Prevention, 2011e). Thus, effective HIV prevention programs must target youth, particularly adolescent women, to encourage delayed sexual debut, sexual abstinence and to educate in safer sex practices.

Adolescent and adult women are disproportionately at risk for heterosexual transmission of HIV infection in comparison to men (Centers for Disease Control and Prevention, 2011d). Heterosexual contact accounts for 90% of HIV infection in adolescent young women compared to 5% in adolescent young men (Centers for Disease Control and Prevention, 2011e). Women may be vulnerable to heterosexual transmission of HIV, as well as other STIs, due to their often unequal status in relationships. Gendered power relationships between men and women may affect a woman's ability to take steps to reduce risk for infection (Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002). This appears particularly relevant to adolescent females, and underscores the need to listen to their perspectives about how power may construct and constrain their choices in sexual decision-making.

Further, significant racial and ethnic disparities exist among adolescent and adult women with HIV infection. The overall rate of diagnosis of HIV infection among Black women is nearly 20 times higher than White women. The rate for Hispanic women is nearly 5 times the rate of non-Hispanic White women (Centers for Disease Control and Prevention, 2011f). Given the racial and ethnic disparities, implementation of inclusive and culturally sensitive HIV prevention interventions is imperative. Hence, it is of great importance to understand the perspective of adolescent females of multiple cultural backgrounds who practice

abstinence, particularly in those cultures in which HIV/AIDS and other STIs are most prevalent.

Investigators have proffered specific operational definitions for abstinence (Bersamin, Fisher, Walker, Hill, & Grube, 2007; Santelli, Kowal, & Wheeler, 2011b; Uecker, Angotti, & Regnerus, 2008). Primary abstinence is defined as never having had sexual intercourse and secondary abstinence describes the practice of those who have had intercourse, but choose to periodically refrain from intercourse (Santelli, Kowal, & Wheeler, 2011a). When used, both forms of abstinence are highly effective means of preventing HIV infection, other sexually transmitted infections, and pregnancy. However, the definition of abstinence reported by adolescents varies widely. Many young people substitute non-vaginal sexual activities for vaginal intercourse in order to maintain what could be called "technical virginity" (Uecker, et al., 2008), while other adolescents attribute a loss of virginity to behaviors such as genital touching and oral sex (Bersamin, et al., 2007). For the purposes of this study, abstinence was operationalized as never having had oral, anal or vaginal intercourse with a male. Stress and coping theory served as the conceptual basis for this study (Pearlin, Menaghan, Lieberman, & Mullan, 1981; Pearlin & Schooler, 1978).

A literature review revealed multiple predictors of abstinence. The most common predictors centered on strong parent-family connectedness, religiosity, morality, and fear of consequences of intercourse. Strong parent-adolescent relationships are a potent predictor of sexual abstinence. In a seminal study investigating predictors of long term adolescent health outcomes, abstinence was demonstrated to be associated with a higher level of parent-family connectiveness (Resnick et al., 1997). Later studies also supported the positive influence of parental involvement for primary abstainers (Cox, 2007; DiLorio, Dudley, Soet, & McCarty, 2004; Haglund, 2006; Halpern, Waller, Spriggs, & Hallfors, 2006; Maguen & Armistead, 2006; Morrison-Beedy, Carey, Cote-Arsenault, Seibold-Simpson, & Robinson, 2008; Velez-Pastrana, Gonzalez-Rodriguez, & Borges-Hernandez, 2005).

Of these studies, qualitative analysis was used to investigate the context and potential determinants of abstinence among predominantly African-American urban adolescent girls (Morrison-Beedy, et al., 2008). The positive impact of mothers in supporting their daughters in practicing abstinence was noted. A quote from the Morrison-Beedy study illustrating this support was "Mama says ... think before you let it go." In another qualitative study, sexually abstinent African American adolescent females were queried regarding their life histories (Haglund, 2006). The desire to emulate their strong mothers and grandmothers was a theme that emerged, highlighting the significance of mothers and grandmothers as role models for this sample.

Religiosity, commitment or devotion to religious faith, is another key predictor for adolescent abstinence (Doss et al., 2007; Halpern, et al., 2006; Rostosky, Regnerus, & Wright, 2003). Religious activities appear to be a protective factor in delaying intercourse for teens aged 13–14 years (Doss, et al., 2007) and reduce the likelihood of coital debut for adolescents aged 15–21 years independent of demographic factors and number of romantic partners (Rostosky, et al., 2003). Akin to the concept of religiosity is that of morality. Virgins more frequently cited "values and beliefs" than secondary abstainers as reasons for not having sex (Paradise, Cote, Minsky, Lourenco, & Howland, 2001). The specific motivations regarding abstaining from intercourse were "not the right thing for me now," wanting to wait until older, and wanting to wait until marriage.

Fear is a factor in predicting abstinence (Kaljee et al., 2007; Loewenson, Ireland, & Resnick, 2004). These fears included fear of pregnancy, sexually transmitted infections, parental disapproval and getting caught (Loewenson, et al., 2004). Girls more than boys, and primary

more than secondary abstainers, expressed these reasons for abstinence. Fear of stigmatization of sexual relations outside of marriage, particularly for young women, reinforced abstinence (Kaljee, et al., 2007). Building on these previous investigations that found strong parent-family connectedness, religiosity, morality, and fear of consequences of intercourse as predictors of abstinence, this qualitative study contributes to a fuller exploration of particular reasons for abstinence without limiting or guiding the responses of the participants.

Methods

Site and Sample

An urban adolescent clinic within a tertiary care facility in a northeastern United States city served as the setting for this study. The sample consisted of females aged 15–19 years, who had the ability to provide written informed consent in either English or Spanish, and the ability to speak and read either English or Spanish. Participants were asked to self-identify their ethnicity (Hispanic/Non-Hispanic) and race.

The participants were drawn from a larger purposive sample of 254 black, Latina and white females of whom seventy-six (29.9%) were sexually abstinent. Seventy out of the 76 adolescent females who reported never having had intercourse responded to the qualitative questions related to reasons for abstinence. Of these 70 participants, 48.4% self-identified as black, 25% as white, 21.9% as multi-racial, 3.1% as American Indian, and 1.6% as Asian. Twenty-six percent identified their ethnic affiliation as Hispanic.

Instruments

As part of a 16 question survey used to analyze the predictors of HIV risk reduction behaviors through quantitative means, qualitative responses were elicited from young women who reported never having had intercourse. In order to address the research question, “What are the expressed reasons for sexual abstinence in adolescent females?” the participants were asked the following: “What is the main reason you’ve never had sex?” and “Are there other reasons you’ve never had sex?” The definition of “sex” — oral, anal or vaginal intercourse with a male — was provided in the study questionnaire. Open-ended versus closed-ended questions were used to gain a greater understanding of the motivations for primary abstinence.

The paper and pencil questionnaire was provided to the respondents in either English or Spanish. A Spanish version of the survey was developed using a translation/back-translation procedure (Brislin, 1986). One participant of the seventy young women who provided responses to the qualitative questions completed the survey in Spanish. Participants completed the survey in either a private area away from the waiting room or in an exam room.

Analytic Procedures

Qualitative responses from study participants who never had intercourse were analyzed in a consensus-based process using content analysis and frequency counts per the following procedures (Downe-Wamboldt, 1992). Initially, the hand written responses of the participants were transcribed into a standard word processing program. The data were reviewed independently by each member of the data analysis team which consisted of three nurses who provide primary care for adolescent young women. The first round of analysis began by identifying broad topic categories that pervaded responses to the two survey questions. Categories, based on the participants’ responses, were developed independently by the three analysts, and then collated by the lead analyst. These categories were then

reconciled into a categorization schema consisting of eight broad topic areas. Consensus was reached among the three analysts on this categorization, as well as for the conceptual definitions and the quotes illustrating the respective categories. During the second round of analysis, participants' responses were then independently coded by each of the analysts for fit into the eight thematic categories. Responses were kept intact (that is, individual topics or sentences were not separated from context of remainder of that participant's response). If appropriate to the content reflected in the quote, responses were coded into more than one category. Discrepancies were resolved in discussion so that all three analysts agreed on the data to be included under each thematic category. After the second round of analysis, categories were then merged from eight to five thematic categories by the lead analyst due to persistent overlap in content, and to improve the fit of the categories with the data. A third round of data analysis with the more parsimonious five-themed categorization schema revealed that saturation had been reached with all responses accounted for, and consensus achieved among the analysts on coding of the data into the merged categories. Lastly, age and racial and ethnic background of respondents were unblinded, and frequencies of responses for each of the categories were tallied.

Human Subjects

Prior to implementation of the study, human subjects review was obtained from the respective university and clinical setting institutional review boards, as well as the federal Office for Human Research Protections. A waiver of parental consent was requested due to the sensitive nature of the study. As participation in this study involved minimal risk, and particular attention was paid to the need for the adolescent's privacy, the request for a waiver of parental consent was granted (Santelli et al., 2003; Santelli et al., 1995).

Results

Five broad topic categories emerged from the data: personal readiness, fear, beliefs and values, partner worthiness, and lack of opportunity. Each of these themes will be described individually. The most frequently occurring theme, "Personal Readiness," was conceptually defined as one's sense of preparedness to engage in sex. Participants' responses suggested that being abstinent was related to one's perception of feeling developmentally ready to engage in intercourse. Illustrative quotes of this thematic category include the response of a 19 year old Latina adolescent — *"Feel that I am not ready to be that involved in that kind of serious relationship"* as well as a 17 year old black adolescent — *"I feel I am not ready emotionally, mentally or physically."* A 16-year-old white adolescent offered — *"I've never had sex, because I don't feel at this time in my life I am not mature enough, nor have mature feelings for someone."*

"Fear" in the context of this study was defined as worry or fright related to sex and/or potential consequences of sex. Respondents expressed both general and specific fears related to potential consequences of sex, inclusive of the potential risk of pregnancy and sexually transmitted infections, including HIV/AIDS. A 17 year black adolescent related, — *"I'm mostly scared and have been asked out a lot. I reject automatically because I think after a few dates it will come down to sex. I am deeply terrified for millions of reasons."* A 15-year-old American Indian noted — *"Because I don't want to risk getting an STD or pregnancy."*

The category of "Beliefs and Values" reflected a moral standard or ethical ideal from the respondent's perspective. Themes of religiosity, as well the import of a decision to have sex, were reflected in their comments. A 15-year-old black adolescent noted her religious beliefs as a reason to abstain from intercourse. *"... because I am a Christian."* A 16-year-old white adolescent reflected the importance of a decision to have sex — *"... no need to rush into something so important and so affecting of my life."*

The value of a potential partner, or “partner worthiness” was also a recurring theme in this sample of adolescent females. A 17-year-old black adolescent noted — *“Haven’t found the right guy, who I know that I can trust and respects and loves me in the same way that I love him.”* A 19 year old black young woman asserted, *“... most of the guys I have met are macho jerks with superiority-complexes”*

“Lack of opportunity” was also a theme that emerged for this sample of adolescent females. Not having the chance or circumstance to engage in intercourse was noted by fourteen of the respondents. A 15-year-old white adolescent related *“I’ve never had the ‘perfect’ opportunity...”* A 15-year-old black adolescent noted — *“I’ve never had a boyfriend before...”*

Most respondents, as exemplified in the following quotes, noted multiple motivations for abstinence. A 15 year old Latina adolescent related — *“I’ve never had sex because #1) I think that I am still too young. #2) It is really risky. I don’t want to get any STD’s or have a baby. And #3) I want to stay a virgin till I marry.”* An 18 year old black adolescent notes — *“I haven’t met anyone that has made me think about having sex with him; no one has met my personal standards. I’m afraid of lowering my standards because it lowers my self worth.”* A 15-year-old white adolescent further relates — *“I don’t think I’m ready, and I have not found anyone I care about enough to want to have sex.”*

Respondents expressed a variety of motivations for abstinence. Table 1 displays the rank order of reported motivations for abstinence, beginning with personal readiness, followed by fear, beliefs and values, partner worthiness, and lack of opportunity. When motivations for abstinence were examined for the younger adolescents (aged 15–16 years) as compared to the older adolescents (aged 17–19 years), personal readiness was the modal response for the younger adolescents, while fear was the reason most often cited by the older adolescents. (Table 1)

Responses on motivations for abstinence were examined for similarities and differences among racial groups. Black and white adolescents most frequently reported personal readiness, while Latina females cited beliefs and values. (Table 2) The second most frequent motivation reported by Black (61%) and Latina (73%) adolescents was fear, while only 25% of white females cited fear.

Discussion

With clarity, the young women of this culturally diverse sample articulated their reasons for sexual abstinence — personal readiness, fear, beliefs and values, partner worthiness, and lack of opportunity. “Personal readiness,” the most frequently reported motivation for abstinence for the sample as a whole, as well as for the younger adolescents (aged 15–16 years), may reflect the participants’ awareness of developmental influences on sexual behavior. Older adolescents’ (aged 17–19 years) modal response was fear, which may indicate their understanding of potential risks associated with sexual behavior. However, given the limitations of the study, one can only speculate about the underlying meanings of terms like “readiness” and “fear.”

Most respondents cited the adverse consequences of sexual intercourse — sexually transmitted infections and pregnancy — as reasons to be fearful. The disproportionate prevalence of HIV among minority communities may be one explanation why so many black and Latina adolescent young women cited fear as their motivation for abstinence. A 17-year-old Latina noted, *“Mother got AIDS through sex, scared of risk.”* “Beliefs and values” was a frequently occurring theme among 15–16 year old and the 17–19 year old adolescent young women. Specific to beliefs and values, religious convictions were a

motivator to abstain from intercourse, exemplified by one respondent who wrote, *“Because I am a religious person . . .”* Beyond religious beliefs, respondents noted issues of spirituality — *“I think it is something sacred.”* and moral standards — *“I need to feel real love in a relationship before I can have sex.”* as reasons to be abstinent. As part of primary health care services, assisting adolescent young women in examining sexual activity decision-making in relationship to their personal beliefs, values and future goals provides the opportunity for reflection that may change behavior (Centers for Disease Control and Prevention, 2011a).

Responses related to “partner worthiness” were also noted as a reason for abstinence. *“I’ve never . . . had a guy worth it”* and *“I am waiting for the right person to come along.”* exemplify this theme. A future orientation is depicted in the response of a 15-year-old Latina adolescent: *“...I don’t want to regret it in the future for sleeping with someone who would probably end up being nobody.”* This adolescent demonstrates an ability to look forward and has an appreciation that what she values in a partner today may change in the future. Exploration of what makes for a worthy partner could be a valuable exercise with adolescents.

Among the five themes identified, “lack of opportunity,” had the lowest rate (20%) of responses. Adolescents cited various reasons for why they had not had the opportunity to have sex; from parental restriction to absence of a relationship. However, lack of opportunity does not necessarily connote lack of desire. It would be interesting to explore in more depth how adolescent females view “opportunity” when deciding about sexual activity.

This study expanded on our understanding of the reasons why young women may abstain from intercourse. There were many findings common to this study and existing research. “Personal Readiness” (Ott, Pfeiffer, & Fortenberry, 2006), “Fear” (Kaljee, et al., 2007; Loewenson, et al., 2004), “Beliefs and Values” (Doss, et al., 2007; Halpern, et al., 2006; Ott, et al., 2006; Paradise, et al., 2001; Rostosky, et al., 2003) and “Partner Worthiness” (Ott, et al., 2006) were themes common to this study and others. However, parent-adolescent relationship, a strong predictor of abstinence cited in the literature (Cox, 2007; DiLorio, et al., 2004; Haglund, 2006; Halpern, et al., 2006; Maguen & Armistead, 2006; Morrison-Beedy, et al., 2008; Resnick, et al., 1997; Velez-Pastrana, et al., 2005), was not explicitly expressed by the adolescent young women in this investigation. Perhaps, due to the nature of a pencil and paper questionnaire that did not allow for expansive answers, participants’ responses related to the complexities of parent-adolescent relationships and abstinence were constrained. “Lack of opportunity” was also an expressed reason for abstinence by study participants, and yet such motivators for abstinence were not seen in the literature. Related to the all of the previously discussed themes, more research is needed to explore the sexual decision making process for adolescents, particularly in the context of our increasing understanding of how adolescent brain development impacts risk behaviors (Weinberger, Elvevag, & Giedd., 2005).

Limitations

The limitations of this study should also be considered. The data were based on self-reports, which may be inaccurate due to socially desirable responding. Further limitations include the use of a small purposive sample of 70 adolescent young women. Although this sample of abstainers was representative of the larger overall sample of 254 adolescent young women and of the diverse clinic population from which it was drawn, the size and the non-probability sampling method limit generalizability of the findings. It is also unclear if the responses of these participants, who were predominantly urban dwellers and of low socioeconomic status, would be similar to the broader population of adolescent young women. Additionally, the use of a written questionnaire with open ended questions did not

allow for expansive expressions of rationale for abstinence. However, anonymity for the respondents does facilitate open and honest responses, concise as they may have been.

Implications for Clinical Practice

Adolescents consider health care providers to be one of their most valued sources of information on issues of sexuality (Sieving, Oliphant, & Blum, 2002). As such, clinicians who care for adolescents are ideal individuals to counsel and support patient choices for abstinence. Furthermore, there are promising studies that brief office-based, one-on-one interventions are efficacious in reducing sexual risk (Centers for Disease Control and Prevention, 2011a; Jemmott, et al., 2007). Motivational interviewing and behavioral skills-building are techniques used in these interventions; techniques that can be readily utilized in implementing the findings of this study. The additional insight and understanding gleaned from this research can guide interventions that inform, motivate and build skills that support an adolescent young woman's desire to be abstinent.

Norms about having sex influence initiation of sexual intercourse (Loewenson, et al., 2004; Santelli et al., 2004). Eliciting the thoughts, feelings and concerns about sexual intimacy and sharing why other adolescent young women have decided to abstain from intercourse may help to promote abstinence. Clinicians can also provide an opportunity for young women to reflect upon what personal readiness to engage in intercourse means in the context of their lives, as well as what constitutes a worthy partner. Whether an adolescent young woman is abstinent out of choice or circumstance, these discussions may enhance self-awareness and facilitate sexual decision-making consistent with her beliefs and values. Further, interventions that address adolescents' expectations and worries about sexual activity rather than lecturing or trying to scare them, can empower the adolescent to opt for abstinence after weighing the costs and benefits of delaying intercourse. Devising a concrete plan with the adolescent may move these discussions from the theoretical desire to practice abstinence to strategies that may delay first intercourse (e.g. not going to a boyfriend's home when there is no adult present, abstaining from alcohol and other drugs that impair judgment, negotiating with a partner for abstinence).

Yet, in caring for adolescent young women, it is important to note that intention to abstain from intercourse does not necessarily result in abstinence (Santelli, et al., 2011b). Unlike many risk behaviors such as cigarette smoking and drug use, sexual intercourse is an age-graded behavior with the expectation that people will eventually have sexual intercourse (Jemmott, et al., 2010). Discussions are crucial about use of a back-up method to prevent pregnancy and STIs if abstinence fails. Further, women of any age may experience sexual coercion which has implications for the ability to rely on abstinence to prevent pregnancy and STIs. Health care providers must be alert to these realities and ready to provide support and counsel (Santelli, et al., 2011b).

Conclusion

The current study yields an increased understanding of the motivations for abstinence as reported by a group of culturally diverse adolescent females. Further research is needed to understand the sexual decision-making process and barriers and enhancers to risk avoidance. Nonetheless, the first person voices of these adolescent females provide guidance in the development and refinement of gender and culturally sensitive sexual risk reduction interventions.

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References

- Bersamin MM, Fisher DA, Walker S, Hill DL, Grube JW. Defining virginity and abstinence: adolescents' interpretations of sexual behaviors. [Research Support, N.I.H., Extramural]. *Journal of Adolescent Health*. 2007; 41(2):182–188. [PubMed: 17659223]
- Brislin, R. The wording and translation of research instruments. In: Lonner, WJ.; Berry, JW., editors. *Field Methods in Cross-Cultural Research*. Newberry Park, California: Sage; 1986.
- Centers for Disease Control and Prevention. [Retrieved June 4, 2011] HIV/AIDS among Youth. 2008 Aug 3. from <http://www.cdc.gov/hiv/resources/factsheets/print/youth.htm>
- Centers for Disease Control and Prevention. [Retrieved January 7, 2012] Best Evidence Interventions. 2011a Aug 12. from <http://www.cdc.gov/hiv/topics/research/prs/print/best-evidence-intervention.htm>
- Centers for Disease Control and Prevention. [Retrieved January 7, 2012] CDC Fact Sheets. 2011b Aug 29. from http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- Centers for Disease Control and Prevention. [Retrieved January 7, 2012] HIV Mortality. 2011c Feb 28. from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/mortality/index.htm>
- Centers for Disease Control and Prevention. [Retrieved January 7, 2012] HIV Surveillance Epidemiology of HIV Infection. 2011d Apr 22. from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.htm>
- Centers for Disease Control and Prevention. [Retrieved January 7, 2012] HIV Surveillance in Adolescent and Young Adults. 2011e Jul 14. from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>
- Centers for Disease Control and Prevention. [Retrieved September 29, 2011] HIV Surveillance in Women. 2011f May 20. from <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/women/index.htm>
- Cox M. Maternal Demandingness and Responsiveness as Predictors of Adolescent Abstinence. *Journal of Pediatric Nursing*. 2007; 22(3):197–205. [PubMed: 17524964]
- DiLorio C, Dudley WN, Soet JE, McCarty F. Sexual possibility situations and sexual behaviors among young adolescents: the moderating role of protective factors. [Research Support, U.S. Gov't, P.H.S.]. *Journal of Adolescent Health*. 2004; 35(6):528.e511–528.e520. [PubMed: 15581534]
- Doss JR, Vesely SK, Oman RF, Aspy CB, Tolma E, Rodine S, Marshall L. A matched case-control study: investigating the relationship between youth assets and sexual intercourse among 13- to 14-year-olds. [Research Support, U.S. Gov't, P.H.S.]. *Child: Care, Health & Development*. 2007; 33(1):40–44.
- Downe-Wamboldt B. Content analysis: Method, applications, and issues. *Health Care for Women International*. 1992; 13(3):313–321. [PubMed: 1399871]
- Forhan SE, Gottlieb SL, Sternberg MR, Xu F, Datta SD, McQuillan GM, Markowitz LE. Prevalence of sexually transmitted infections among female adolescents aged 14 to 19 in the United States. [Research Support, Non-U.S. Gov't]. *Pediatrics*. 2009; 124(6):1505–1512. [PubMed: 19933728]
- Gamel C, Grypdonck M, Hengeveld M, Davis B. A method to develop a nursing intervention: the contribution of qualitative studies to the process. [Research Support, Non-U.S. Gov't]. *Journal of Advanced Nursing*. 2001; 33(6):806–819. [PubMed: 11298219]
- Haglund K. Understanding sexual abstinence in African American teens. [Research Support, Non-U.S. Gov't]. *MCN, American Journal of Maternal Child Nursing*. 2006; 31(2):86–92.
- Halpern CT, Waller MW, Spriggs A, Hallfors DD. Adolescent predictors of emerging adult sexual patterns. [Research Support, N.I.H., Extramural Research Support, Non-U.S. Gov't]. *Journal of Adolescent Health*. 2006; 39(6) 926.e921-910.

- Jemmott JB 3rd, Jemmott LS, Fong GT. Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescents. [Randomized Controlled Trial Research Support, N.I.H., Extramural]. *Archives of Pediatrics & Adolescent Medicine*. 2010; 164(2):152–159. [PubMed: 20124144]
- Jemmott LS, Jemmott JB 3rd, O'Leary A. Effects on sexual risk behavior and STD rate of brief HIV/STD prevention interventions for African American women in primary care settings. [Randomized Controlled Trial Research Support, N.I.H., Extramural]. *American Journal of Public Health*. 2007; 97(6):1034–1040. [PubMed: 17463391]
- Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization. 2009 AIDS Epidemic Update. 2009. Retrieved from Online website: http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf
- Kaljee LM, Green M, Riel R, Lerdboon P, Tho LH, Thoa LTK, Minh TT. Sexual stigma, sexual behaviors, and abstinence among Vietnamese adolescents: implications for risk and protective behaviors for HIV, sexually transmitted infections, and unwanted pregnancy. [Research Support, N.I.H., Extramural]. *Journal of the Association of Nurses in AIDS Care*. 2007; 18(2):48–59. [PubMed: 17403496]
- Loewenson PR, Ireland M, Resnick MD. Primary and secondary sexual abstinence in high school students. [Research Support, Non-U.S. Gov't]. *Journal of Adolescent Health*. 2004; 34(3):209–215. [PubMed: 14967344]
- Maguen S, Armistead L. Abstinence among female adolescents: do parents matter above and beyond the influence of peers? *American Journal of Orthopsychiatry*. 2006; 76(2):260–264. [PubMed: 16719645]
- Morrison-Beedy D, Carey MP, Cote-Arsenault D, Seibold-Simpson S, Robinson KA. Understanding sexual abstinence in urban adolescent girls. [Comparative Study Research Support, N.I.H., Extramural]. *JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 2008; 37(2):185–195.
- National Campaign to Prevent Teen and Unplanned Pregnancy. [Retrieved December 13, 2011] Fast Facts Teen Pregnancy in the United States. 2010a. from http://www.thenationalcampaign.org/resources/pdf/FastFacts_TeenPregnancyinUS.pdf
- National Campaign to Prevent Teen and Unplanned Pregnancy. [Retrieved November 20, 2011] Linking Teen Pregnancy Prevention to Other Critical Social Issues. 2010b. from <http://www.thenationalcampaign.org/why-it-matters/pdf/introduction.pdf>
- National Campaign to Prevent Teen and Unplanned Pregnancy. [Retrieved November 20, 2011] Teen Pregnancy and Education. 2010c. from <http://www.thenationalcampaign.org/why-it-matters/pdf/education.pdf>
- National Campaign to Prevent Teen and Unplanned Pregnancy. [Retrieved November 20, 2011] Teen Pregnancy and Other Health Issues. 2010d. from <http://www.thenationalcampaign.org/why-it-matters/pdf/health.pdf>
- National Campaign to Prevent Teen and Unplanned Pregnancy. [Retrieved November 21, 2011] Teen Pregnancy, Poverty, and Income Disparity. 2010e. from <http://www.thenationalcampaign.org/why-it-matters/pdf/poverty.pdf>
- National Campaign to Prevent Teen and Unplanned Pregnancy. [Retrieved November 11, 2011] Teen Childbearing Cost Taxpayers \$10.9 billion in 2008. 2011. from <http://www.thenationalcampaign.org/costs/pdf/counting-it-up/press-release-national.pdf>
- Ott MA, Pfeiffer EJ, Fortenberry JD. Perceptions of Sexual Abstinence among High-Risk Early and Middle Adolescents. *Journal of Adolescent Health*. 2006; 39(2):192–198. [PubMed: 16857530]
- Paradise JE, Cote J, Minsky S, Lourenco A, Howland J. Personal values and sexual decision-making among virginal and sexually experienced urban adolescent girls. [Comparative Study Research Support, U.S. Gov't P.H.S.]. *Journal of Adolescent Health*. 2001; 28(5):404–409. [PubMed: 11336870]
- Pearlin LI, Menaghan EG, Lieberman MA, Mullan JT. The stress process. *Journal of Health and Social Behavior*. 1981; 22(4):337–356. [PubMed: 7320473]
- Pearlin LI, Schooler C. The structure of coping. *Journal of Health and Social Behavior*. 1978; 19(1):2–21. [PubMed: 649936]

- Pulerwitz J, Amaro H, De Jong W, Gortmaker SL, Rudd R. Relationship power, condom use and HIV risk among women in the USA. [Research Support, Non-U.S. Gov't]. *AIDS Care*. 2002; 14(6): 789–800. [PubMed: 12511212]
- Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, Udry JR. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA*. 1997; 278(10):823–832. [PubMed: 9293990]
- Rostosky SS, Regnerus MD, Wright MLC. Coital debut: the role of religiosity and sex attitudes in the Add Health Survey. [Research Support, Non-U.S. Gov't Research Support, U.S. Gov't P.H.S.]. *Journal of Sex Research*. 2003; 40(4):358–367. [PubMed: 14735410]
- Santelli, J.; Kowal, D.; Wheeler, E. Abstinence, Noncoital Sex, and Nonsense: What Every Clinician Needs to Know. In: Hatcher, R.; Trussel, J.; Nelson, A.; Cates, W.; Kowal, D.; Policar, M., editors. *Contraceptive Technology*. Twentieth Revised Edition ed.. New York: Ardent Media, Inc.; 2011a. p. 101-112.
- Santelli, J.; Kowal, D.; Wheeler, E. Abstinence, Noncoital Sex, and Nonsense: What Every Clinician Needs to Know. In: Hatcher, R.; Trussel, J.; Nelson, A.; Cates, W.; Kowal, D.; Policar, M., editors. *Contraceptive Technology*. Twentieth Revised Edition ed.. New York: Ardent Media, Inc.; 2011b. p. 101-112.
- Santelli JS, Kaiser J, Hirsch L, Radosh A, Simkin L, Middlestadt S. Initiation of sexual intercourse among middle school adolescents: the influence of psychosocial factors. [Comparative Study Research Support, U.S. Gov't, Non-P.H.S.]. *Journal of Adolescent Health*. 2004; 34(3):200–208. [PubMed: 14967343]
- Santelli JS, Rogers AS, Rosenfeld WD, DuRant RH, Dubler NL, Morreale M, Schissel A. Guidelines for Adolescent Health Research A Position Paper of the Society for Adolescent Medicine. [Position Paper]. *Journal of Adolescent Health*. 2003; 33:396–409. [PubMed: 14596961]
- Santelli JS, Rosenfeld WD, DuRant RH, Dubler N, Morreale M, English A, Rogers AS. Guidelines for adolescent health research: a position paper of the society for adolescent medicine. *Journal of Adolescent Health*. 1995; 17(5):270–276. [PubMed: 8924431]
- Sieving RE, Oliphant JA, Blum RW. Adolescent sexual behavior and sexual health. [Research Support, U.S. Gov't, P.H.S.]. *Pediatrics in Review*. 2002; 23(12):407–416. [PubMed: 12456893]
- Uecker JE, Angotti N, Regnerus MD. Going most of the way: "technical virginity" among American adolescents. [Historical Article Research Support, N.I.H., Extramural]. *Social Science Research*. 2008; 37(4):1200–1215. [PubMed: 19227698]
- Velez-Pastrana MC, Gonzalez-Rodriguez RA, Borges-Hernandez A. Family functioning and early onset of sexual intercourse in Latino adolescents. [Research Support, N.I.H., Extramural]. *Adolescence*. 2005; 40(160):777–791. [PubMed: 16468671]
- Villarruel AM, Jemmott JB 3rd, Jemmott LS. A randomized controlled trial testing an HIV prevention intervention for Latino youth. [Erratum appears in Arch Pediatr Adolesc Med. 2006 Nov;160(11): 1187]. [Randomized Controlled Trial Research Support, N.I.H., Extramural]. *Archives of Pediatrics & Adolescent Medicine*. 2006; 160(8):772–777. [PubMed: 16894074]
- Weinberger, D.; Elvevag, B.; Giedd, J. The adolescent brain: A work in progress. 2005. Retrieved from Online website: <http://www.thenationalcampaign.org/resources/pdf/BRAIN.pdf>
- World Health Organization. Women's health fact sheet. 2009. Retrieved from Online website: <http://www.who.int/mediacentre/factsheets/fs.334/en/index.html>

Table 1

Motivations for Abstinence among Adolescent Young Women by Age

	# of Responses Total Sample Ages 15–19 Years N=70		# of Responses Middle Adolescence Ages 15–16 years N=39		# of Responses Late Adolescence Ages 17–19 years N=29	
	n	%	n	%	n	%
Personal Readiness	43	61.4	30	76.9	9	31.0
Fear	41	58.6	24	61.5	15	51.7
Beliefs & Values	34	48.6	19	48.7	14	48.3
Partner Worthiness	23	32.9	14	35.9	9	31.0
Lack of Opportunity	14	20.0	7	17.9	7	24.1

- Due to missing age data, numbers of respondents do not add up to total sample.
- Percentages are > 100% as respondents expressed multiple motivations for abstinence.

Table 2

Motivations for Abstinence among Adolescent Young Women by Race & Ethnicity

	# of Responses Total Sample		# of Responses Black, Not Latina		# of Responses White, Not Latina		# of Responses Latina		# of Responses American Indian		# of Responses Asian	
	n	%	n	%	n	%	n	%	n	%	n	%
# of Respondents	N=70		N=31		N=16		N=15		N=2		N=1	
Category												
Personal Readiness	43	61.4	21	67.7	11	68.8	8	53.3	0	0.0	1	100.0
Fear	41	58.6	19	61.3	4	25.0	11	73.3	2	100.00	0	0.0
Beliefs & Values	34	48.6	12	38.7	8	50.0	12	80.0	0	00.0	0	0.0
Partner Worthiness	23	32.9	10	32.3	8	50.0	4	26.7	0	0.0	0	0.0
Lack of Opportunity	14	20.0	6	19.4	6	37.5	0	0.0	1	50.0	0	0.0

- Hispanics/Latinos can be of any race.
- Due to missing race and ethnicity data, numbers of respondents did not add up to total sample.
- Percentages are > 100% as respondents expressed multiple motivations for abstinence.