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A qualitative study of how mothers and teenage daughters negotiate sex-related risk and independence

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Abstract

Concern across more economically developed nations has focused on the role of parental communication and monitoring in predicting risk-taking behaviour and health outcomes. However, explorations of how mothers and daughters negotiate risk remain under-researched. This paper presents the findings of a qualitative study examining mothers' and teenage daughters' perceptions of risk-related health concerns around sexual behaviour and the implications for health policy, nursing practice and future research. A purposive sample of seven young women aged 14–16 years and their mothers ($n = 14$) were recruited from low-income families living in the south-west of England.

Data were collected through longitudinal in-depth interviews and were analysed for thematic content using constant comparative methods. Findings highlighted how mothers and daughters understand risks associated with sex and relationships and their implications for safety. Mothers' concerns focused on their daughters' vulnerability to the risk of sexual threat, particularly after alcohol consumption. Within relationships mothers did not advocate abstinence but developed harm minimisation approaches to minimise the impact of risk taking and maximise opportunities for independence. Strategies based on trust and openness were preferred to expectations of rigid adherence in rule negotiation. Clinical significance lies in building on maternal expertise to develop community-based initiatives that have the potential to improve health and clinical outcomes for young women.

Keywords

Communication, daughters, health, independence, mothers, risk, sex

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Introduction

UNICEF (2007) recently published a comprehensive assessment of the lives and well-being of children and adolescents in economically advanced nations. This report highlighted the implications of a wide range of risky behaviours that impact on the overall well-being of children and young people. It recognised that young people may abuse drugs and alcohol, become involved in violence, live unhealthy lifestyles (smoking, over or under-eating) or become pregnant in teen years often because of the circumstances they find themselves in or as part of broader social contexts. However, the United Kingdom (UK) and the United States of America (USA) are placed in the bottom third of the rankings for five of the six dimensions reviewed. Children in these countries were more likely to participate in risky behaviours than children in 20 other industrialised nations (UNICEF, 2007).

In addition, social commentators, policymakers and researchers across these nations have focused on teenage–parent relationships in connection with a range of what have been perceived as deviant behaviours, such as young offending, substance misuse, smoking or early pregnancy (Jacobson and Crockett, 2000; Miller et al., 2001; Borawski et al., 2003). It is now well established that, although risk taking during adolescence is not fully understood, the associated outcomes reflect, to some degree, young people's unpreparedness and inability to cope with the pressures many of them are put under around the globe (UNICEF, 2007).

The research that informs this paper focuses on young women and risks associated with sexual activity. In the UK, the age of consent to any form of sexual activity is 16 years for both men and women (FPA, 2011). Sexual activity during teenage years is often associated with unsafe behaviours, with young people having more sexual partners than other age groups (Donaldson, 2008). The median age of first heterosexual intercourse in the UK has dropped from 17 years in 1990 to 16 years in 2000. However, 26% of girls and 30% of boys will have had sexual intercourse before the age of 16 (Wellings et al., 2001; Brook Advisory Service, 2005). It is generally accepted that early sex is often associated with unprotected sex, alcohol and drug consumption (Tripp and Viner, 2005). Consequently, over the last ten years young people have been increasingly diagnosed with sexually transmitted infections, including chlamydia, anogenital herpes and syphilis (Horton, 2005; Donaldson, 2008). However, for many young women unwanted pregnancy continues to be the main health risk associated with teenage sex. Women from poorer backgrounds or deprived communities are more likely to become teenage mothers and have often experienced low educational attainment, poverty or emotional difficulties, or are the children of teenage mothers (Cater and Coleman, 2006; Harden et al., 2006; Department of Health (DH), 2010b).

Health-promoting interventions that aim to reduce adolescent sexual risk-taking behaviours rely on multidisciplinary approaches with significant input from a wide range of nursing disciplines. In England, sexual health nurses, school nurses, public health nurses and health visitors are involved in a plethora of policy-related activities, including: the Healthy Child Programme from 5 to 19 years (DH, 2009); Progress and priorities – working together for high quality sexual health: Review of the National Strategy for Sexual Health and HIV (MedFASH, 2008) and Healthy Lives, Healthy People (DH, 2010a), aimed at reducing the impact of risk-taking behaviours, including those related to sexual activity during adolescence. These policy initiatives recognise the case for primary prevention and building resilience during a child's early years. In terms of resilience, the

family can be the creator of the conditions for social exclusion or the means by which it is resisted (Coleman and Hagell, 2007). Supporting parents is crucial if they are to successfully navigate their children through this period of transition, build resilience, and encourage good sexual health and healthy relationships.

This paper reports on the findings from a qualitative study that investigated mothers' and teenage daughters' experiences of negotiating independence, in terms of their understanding of, and responses to, risk-related health concerns. It also highlights the implications of these findings for health policy, nursing practice and future research.

Background research into parental monitoring and risk-taking behaviours

The clear message from the literature is that children are less likely to become involved in risk-taking behaviour if they have parents who actively monitor and supervise them. This is in marked contrast to those who have parents who take a more 'laissez faire' approach (Ary et al., 1999; Stattin and Kerr, 2000; Pettit et al., 2001). A significant number of studies have explored the relationship between parenting behaviours and adolescent risk involvement (Griffin et al., 2000; Cottrell et al., 2003). These studies conclude that, in families where parents actively and closely supervise and monitor their children, there are significant associations with lower levels of alcohol and illegal drug consumption, higher rates of condom use and lower levels of teenage pregnancy (Jacobson and Crockett, 2000; Miller et al., 2001; Borawski et al., 2003). While the parent–child relationship is generally perceived as the most important determinant for effective parental monitoring, a range of socio-economic factors are linked to poor parental monitoring and supervision. These include socio-economic status (Pettit et al., 2001), low educational attainment (Crouter et al., 1999), poor marital relationships (Cottrell et al., 2003) and child maltreatment (Gilbert et al., 2009). Mental health and risk-taking behaviours in children and young people who have been abused have been shown to include anxiety, depression, post-traumatic stress, dissociation, oppositional behaviour, suicidal and self-injurious behaviour, substance misuse, anger and aggression, and sexual symptoms and age-inappropriate sexual behaviour (Gilbert et al., 2009). The presence of family difficulties, for example domestic violence, parental mental health problems, separation and divorce, can impact on the quality of family relationships, in particular parents' ability to offer support and young people's potential involvement in risk-taking activity (Pearce, in Coleman and Hagell, 2007).

Clearly, while the multiple sources of data from parents and children give important information about how the family context informs young people's development, there remain serious limitations to work within this field: not least that much of the work examining such associations has been based on young people's perceptions of parental monitoring and young people's views of their parents' perceptions of adolescent risk behaviour (Cottrell et al., 2003). Few studies have measured parental monitoring from a parental perspective or by recording actual adolescent risk behaviours. This view is supported by Cottrell et al.'s (2003) own survey of 270 parent–adolescent dyads on parental monitoring, which demonstrated that parental perceptions of monitoring efforts differed considerably from those of their children. Similarly, parents believed they had greater levels of information about their adolescents' whereabouts and activities than

those reported by the adolescents themselves. This research attempts to overcome these limitations by exploring health risk-related negotiations from both perspectives, using methods that allow more in-depth probing of the apparent differences in perception between mothers and their children over time.

Methodology

The sample

A purposive sample of seven dyads of young women aged 14–16 years and their mothers was recruited through a number of local schools within the south-west of England. Eligibility criteria included any young woman aged 14–16 years at the time of recruitment who lived with someone in a mother–daughter relationship. This encompassed biological and foster mothers and stepmothers, but only those in biological relationships volunteered to take part. Consistently with quota sampling techniques, the target population was recruited to represent a range of family types and ethnic backgrounds. Recruitment took place through schools. In some instances, young women volunteered after seeing flyers in schools; their mothers subsequently agreed and contacted the researcher. In other schools a flyer was sent directly to mothers of year groups 10 and 11 pupils, who then telephoned to volunteer.

Given the demographic characteristics of the schools contacted, all of the participating families who volunteered and were subsequently recruited relied on a relatively low income (at the time of the study or in the recent past) and were English speakers. Only one family was from an ethnic minority. However, the participants did live in a diverse range of family forms, including two single-parent households, three reconstituted families and two intact nuclear families. By ensuring that particular characteristics are present within the sample it is possible to argue that a range of experiences are included within the study. In addition, it indicates that attempts have been made to eliminate some potential biases (Hek et al., 2002). While the sampling was not aiming to be representative, it sought to acknowledge the diversity among families.

Data collection

Three rounds of semi-structured interviews approximately 10 months apart (42 interviews in total) were undertaken at participants' homes. Participants were interviewed individually and interviews were audio recorded with consent from participants. The first round of interview questions was designed to establish a rapport with participants and gain biographical insights into the family. The second round of interviews focused in more depth on the context of mother–daughter relationships and particularly on negotiations around risk-related health issues. The final round of interviews expanded on the major themes to emerge from the first two interviews and encouraged participants to reflect on their hopes and aspirations for the future.

Data analysis

In keeping with the aim of this study to derive rich descriptions, data were analysed from multiple perspectives using different analytical methods. As Rich and Ginsburg (1999)

suggest, analysis begins with the limitations of data collection and evolves throughout the study. This data analysis was not a technique but part of what Crabtree and Miller (1992) describe as an iterative process. Analysis of the first round of interviews shaped the questioning in subsequent rounds. Within the content analysis, attempts were made to seek contradictions and diversity as well as patterns within the totality of the interview and field data recorded (Burgess, 1997). Informed by grounded theory and using the method of constant comparative analysis, it was possible to move back and forth between conceptual speculation identified within the literature, data collection and analysis, and personal reflection. Management of data from the 42 interviews was supported by specialist computer software, which allowed consistent and comprehensive treatment of the large amounts of data (Rich and Ginsburg, 1999).

Ethical issues, safety and consent

To access students in school settings in the UK, researchers do not have to undertake the equivalent of a National Health Service Research Ethics Application required for health-related research. Access is through direct negotiation with the Head Teacher, who acts in loco parentis. Formal ethics approval for the study was sought and granted by an Ethics Committee at the University of the West of England, Bristol. Information prior to involvement, consent and confidentiality adhered to a number of ethical, child protection and values policies developed by the National Children's Bureau (NCB, 2003) and in accordance with the Nursing and Midwifery Council (NMC) Code of Professional Conduct (2008). Written consent was gained from mother and daughter prior to the first interview. Safeguards were explained and particular attention was paid to information about child protection issues and the right to withdraw. Accessible written information was left with participants along with contact details in case further clarification was required. Participants were informed about data storage and management processes, including password protection, anonymity and maintaining confidentiality between the family members taking part.

Results

It is not possible to report on all the findings from the study here. Of particular relevance for this paper are the findings around risk perception and risk taking, particularly in relation to sex and relationships, and the practical negotiations that took place within the dyads to facilitate independence and maintain good communication within relationships.

Daughters' perceptions of risk awareness and maternal monitoring

Daughters expressed awareness of various aspects of risk and risk taking around a range of issues including: sex, violence, alcohol, drugs, being out and about, smoking and being away from the protection of the home environment. Awareness of the impacts of risk taking on their health and safety led some to avoid the activity. For some, friends' experiences were employed as a cautionary tale; the following quote highlights this in relation to fears of early pregnancy and drug taking:

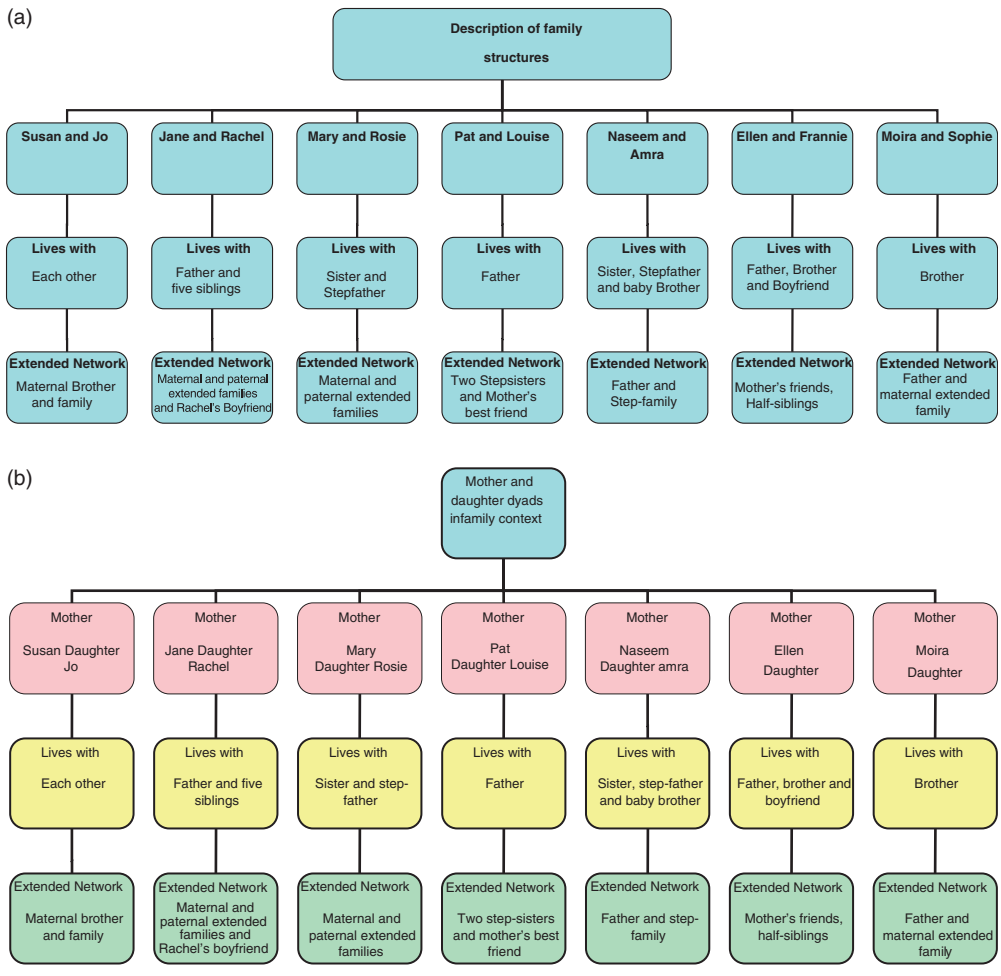

Figure 1. Summary of family biographies and social support context. In the diagram above mother is followed by daughter

> My best friend Lara thinks a baby is going to sort everything out, her life's really hard but it isn't, she's only young and she's got no money, her boyfriend is dropping out of jobs and getting new ones so he's never got a stable job and they are both living in separate houses at the moment (Rachel, daughter at interview two).

Educational input at school on drugs, alcohol, and sex and relationships had clearly raised this individual's awareness. Nevertheless, it was the role of maternal monitoring and how this impacted on limiting their freedoms that dominated discussions with daughters. Daughters articulated a real concern about their mothers' fears for them and genuinely wanted to respond to these concerns because they cared about their mothers and the relationship. Nevertheless, daughters also reported they needed to respond to maternal risk anxiety in order to maximise their freedoms and privileges. A range of parental

monitoring strategies were described by daughters, including rules about time keeping, staying in contact by mobile phone, arrangements for getting home and sanctions for rule breaking. Mothers were said to undertake more specific monitoring of particular behaviours, including asking about sexual activity, alcohol and drug consumption and boyfriends. In the following quote Rachel clearly understands the need to respond to her mother's concerns, although she herself appears distant from them:

> Well, my mum said I can drink, but she normally gives me a drink so she knows how many I've had . . . She thinks I should keep on my mobile in case there are emergencies, or in case I need to ring them or she needs to ring me. Yes my mum makes sure that I get a lift home by someone because she wouldn't let me get a taxi or a bus. She doesn't mind me getting buses down there but it's on the way back (Rachel, daughter at interview one).

Mothers' perceptions of risk awareness and monitoring

Mothers felt that there were plenty of things to worry about in caring for a teenage daughter. However, they clearly worried about different things, to different intensities, at different times. This depended on the activities daughters were involved in or the nature or quality of the mother–daughter relationship at any particular time. For example, anxiety was higher when the relationship between mother and daughter was fraught with conflict, or mothers felt daughters were being secretive, than during periods when communication between them was improved. Of particular note were mothers' fears over the threat of sexual violence while their daughters were under the influence of drugs or alcohol. Awareness was high that daughters might have their drinks 'spiked with drugs' in bars or while intoxicated be offered lifts home by men who were looking for sex. Mothers worried this could lead to assault or rape, as illustrated by the following quote:

> I think she's got sense, if a bloke came along and tried to pick her up she is sensible and she'd say go away. But it does worry me, I suppose I sound too over protective but it does worry me they could just grab her (Jane, mother at interview three).

Other areas mothers reported worrying about included sex and relationships, substance misuse, school attainment, future employment, and physical and mental health. Mothers often reported worrying over maintaining the quality of their relationships with their daughters.

Many maternal worries and fears about risk were interwoven and felt highly personal, but at the same time appeared universal:

> Yes, it is the same worries, it doesn't matter what the culture they are. Everybody has got the same worries about their child's safety and what they get involved with and what they do outside (Naseem, mother at interview one).

This quote reflects a key consideration: maternal fear and anxiety associated with their daughters' increasing independence. Mothers suggested this was characterised by their daughters spending less time in the family home and more time with friends, some of whom they did not know or approve of. There was also less certainty about where they were or the activities they were involved in. However, the feelings expressed most strongly were connected with the emotional struggle of coming to terms with their daughters' increasing move away from maternal monitoring, support and advice.

Daughters' experiences of risk taking through sex and relationships

Four of the young women said they had become involved in sexual activity around their fifteenth birthday. Motivations for having sex were complex: in the initial interviews young women reported they would 'do it' when they were ready, when they wanted to, because of love and not because boys were pressurising them into it. By the second and third interviews young women appeared less willing to talk about the types and levels of sexual activity they were involved in, although they were happy to talk about the practicalities of contraception. Daughters understood the importance of contraceptive barrier methods, but also talked about the difficulties of persuading boys to use them. The four who said they were involved in sexual activity were using oral or injectable contraception without the additional protection of condoms, but expressed varying degrees of uncertainty about their partner's commitment to the relationship, or of limiting sex solely to that relationship. This is illustrated below:

> Yes and I think that's why Mat, the boy I've just finished with, he never went out with me either because he wanted sex and I wouldn't do it without a condom and he started getting funny with me and the next day he finished with me (Louise, daughter at interview three).

By the third set of interviews six out of the seven interviewed identified feelings of uncertainty around sexual activity that were connected to being unable to persuade boys to use condoms, feeling coerced into sex when they were not ready, 'being or feeling used' sexually, being naked in front of boys and not liking or feeling uncertain of their bodies. In some instances having a boyfriend limited the level of risky behaviours, as it reduced the numbers of nights out drinking large amounts of alcohol and exposure to casual sexual encounters.

Mothers' perceptions of sex, relationships and boyfriends

Mothers' concerns centred on a number of sub-themes: daughters starting sexual relationships too early (due to peer pressure), unplanned pregnancy and sexually transmitted disease, the threat of sexual violence and daughters keeping secrets about sex and relationships. The failure of daughters to share information led to fears that they might not get the support and advice they needed to protect them. Mothers said they wanted their daughters to talk about sex with them and were happy to help them access sexual health services. On the one hand mothers wanted to support their daughters in safer sex activity, but on the other they saw sexual involvement in itself as naive or potentially risky. Sex was something mothers would have preferred their daughters not to be involved in, but if they were then they wanted to provide comprehensive support and advice. Perceived naivety was often articulated in terms of daughters' failure to understand what boys were 'really like around sex', particularly in terms of the lengths they would be prepared to go to secure sex:

> Yes, boys yes, they just use them, use the sweet talk that's it and they take advantage and they get pregnant and then their life gets destroyed, they can't study, they can't relax (Naseem, mother at interview one).

Mothers articulated a level of conflict between discouraging risk taking and at the same time wanting to minimise the impact of sex-related risk behaviours. In this extract a mother

focuses on the types of open communication that she believed needed to happen to prevent unwanted pregnancy:

> I think more people end up with unwanted pregnancies or having to go through terminations or whatever because suddenly they're in a situation and things get out of control and they are not prepared. I said to her long before you get to the situation where you want sex, I would prefer you to be managing the situation. Because it's not particularly ideal, if they come home and they're pregnant and she's got visions about her future (Ellen, mother at interview one).

There were times when mothers were resigned to the fact their daughters were not sharing the full story about their sex lives. Nevertheless, overall, mothers appeared to feel that excessive probing for information would be experienced as nagging or nosiness and therefore counterproductive. Information from daughters that was unsolicited, or advice or help that was spontaneously requested, was seen as a more reliable and productive way of communicating.

Negotiating independence and freedom: Mothers responding to the differences

From a maternal perspective three things were key to keeping daughters safe: monitoring, risk management strategies and developing practical responses to minimising risk. Monitoring was connected to knowing where their daughters were, who they were with and the activities they were involved in, while management strategies focused on keeping in touch (usually by mobile phone), setting boundaries (including rules about time keeping, getting home and the consequences if broken), responding to conflict (although relatively rare, conflict had to be confronted when daughters were involved in rule breaking) and giving advice around risky behaviours (including harm minimisation strategies and accessing relevant support services).

More important than the strategies themselves was that they were part of the ongoing relationship. In relation to successful negotiation within the dyads, key findings were connected to the concepts of openness, trust and harm minimisation. Mothers preferred to know the sorts of risky activities their daughters were involved in and, even though they disapproved, wanted to provide information, support and advice to minimise the potential impact of risk-taking behaviours.

> I'm more flexible than her father is, that doesn't mean that I always agree with what she does . . . But it does mean that I prefer to know what she is doing rather than her feed me a pack of lies that she is staying with her friend and then if something happened and I needed to contact her where is she, you don't know, you've got no idea who her friends are or anything (Ellen, mother at interview two).
>
> I thought OK, she's 14, I don't like the idea of it, but you hear of it so much and I have told her straight, if ever she does feel like she wants to *have sex* then speak to me first. I said I would much rather take you down to the doctors and put you on the pill and do whatever I have got to do rather than have babies we don't want (Pat, mother at interview two).

These mothers were mostly empathetic with the feelings associated with adolescence. Rules were set, but mothers were democratic in their implementation. Negotiation took place around a host of issues, including money, going out, sex, alcohol and drug taking, having friends home, staying over, boyfriends, appearance (including body piercing, tattoos), job and careers, and school attainment. Negotiation, openness and flexibility

were believed to be the most effective approach to managing risk and maintaining good relationships with daughters. This is illustrated eloquently in the following quote:

> Yes, I like to know that she is in, she is in on time, I am starting to give her a bit of leeway with times . . . it is getting a bit later, because I am trusting her, so if she gets my trust then she will get extra time (Jane, mother at interview three).

Although openness meant different things to different people and within relationships or contexts, there was a significant amount of overlap between mothers' accounts. The possibility of discussing intimate issues, including risk-related issues, was seen as key to maternal attempts to keep their daughters safe or minimise harm. Both the willingness of daughters to share information about their lives and the desire of mothers to listen were seen as crucial to maintaining that dialogue. Mothers were sometimes uncomfortable with what they heard and on occasion disapproved of particular activities or behaviours. However, they also valued the frankness of the dialogue with their daughters. Interestingly, while openness was viewed as a key component of the relationship, secrets and the occasional lie by daughters were viewed as inevitable and were not seen to undermine openness and trust. In essence, trust shaped negotiated strategies around risk.

Discussion

The data from this study are consistent with other international studies in the field that highlight the problematic nature of simplistic and deterministic accounts of monitoring and supervision by parents and traditional positivistic accounts of adolescent risk-taking behaviour (Lewis et al., 2006; Stace and Roker, 2005; Solomon et al., 2002). This extends the work of Stace and Roker that explains monitoring not in terms of the amounts parents do but as part of the ongoing relationship. It is important to note that maternal anxiety was context-specific. Nevertheless, mothers reported that, rather than the risks associated with drug or alcohol taking, it was the additional vulnerabilities to sexual threat that dominated their concerns.

Mothers and daughters had significantly different perceptions of risk and its management, using many of the management strategies highlighted in previous work (Langford et al., 2001; Lewis et al., 2006), including keeping in touch by mobile phone, boundary setting, responding to conflict, and giving advice and support (Langford et al., 2001; Stace and Roker, 2004; Lewis et al., 2006). On the other hand, daughters co-operated and showed concern for their mothers' fears, both for the sake of the relationship and to maximise their opportunities for freedom. Mothers developed practical strategies based on a harm minimisation approach that understood daughters' risk taking to be a normal aspect of developing independence. This represents a departure from abstinence debates centred on the belief that parents can and should keep young people away from risk, even when families live within socially deprived communities that make it very difficult (see Blake and Frances, 2001, for discussion of abstinence programmes in the USA). Sex in particular was an area of contested risk; although mothers would have preferred it was not taking place, they wanted to advise on contraception. Most importantly, both mothers and daughters saw responding to risk through the negotiated relationship, based in trust and openness, as the key to maintaining constructive dialogue.

Policies and practice that aim to reduce sexual risk taking in young people through promoting sex and relationships education, safer sex and planned pregnancy

(Medical Foundation for Aids and Sexual Health, 2005; DH, 2007; National Institute for Health and Clinical Excellence, 2007; Medical Foundation for Aids and Sexual Health, 2008; DH, 2009) often focus on developing professional services, or improving access to care. Such policies tend to be based on the belief that young people need to access services independently of their parents in order to maintain confidentiality and that improving the uptake of services militates against risk and its consequences. For young women the focus is often on improving access to sexual health, contraceptive and abortion services, particularly for those living in deprived communities. These initiatives are clearly important, but can fail to recognise that parents are providing monitoring, support and guidance on an ongoing basis with little help from professionals.

Consistently with previous studies, mothers describe their role as anxiety provoking, emotionally demanding and often unsupported. Nurses working in health visiting services, school nursing services, and sexual health and drugs services understand the issues facing families and young people during adolescence. Significant focus has been on improving young people's access to sexual health services, through developments such as You're Welcome quality criteria: making health services young people friendly (DH, 2007) and the introduction of school-based and school-linked services (Ingram and Salmon, 2010; Owen et al., 2010). Nevertheless, the research here demonstrates that more can be done to increase professional support for mothers who are faced with responding to the everyday realities of young people involved in complex risk taking across a broad range of behaviours, including sex.

Recent government publications (DH, 2009, 2010, 2011) have re-emphasised the role of health visitors, sexual health nurses and school nurses in working directly with communities to build capacity for health-promoting activities and militate against inequality. It is timely for nurses to engage more proactively in building on maternal expertise to develop community-based environments and initiatives that prevent some of the stressful and difficult situations that can emerge during adolescence. Nurses are in an ideal position to signpost to services early and prevent mothers feeling isolated in their endeavours. Building resilience in young people and their families is key. This means supporting maintenance of good mother–daughter relationships as arguably one of the most important components of limiting the impact of risk-related activity during adolescent sexual development.

Significant efforts were made to present all aspects of the research process from the analytical framework to the final analysis. It was hoped that making these processes explicit and transparent would maximise the reliability of the data. Nevertheless, there are inevitably limitations that need to be acknowledged as part of a reflexive and rigorous research process. Definitions of risk were shaped by findings from the literature review, which highlighted policy concerns around particular risk-related behaviours and the parental role in minimising risk through supervision and monitoring. Given that the findings of this study suggested daughters held different perceptions of risk from those of mothers and those contained within dominant policy debates, it is possible that their perceptions and experiences were marginalised within the research. This limitation could have been further compounded by the use of semi-structured interviewing. Pre-determined questioning may have made it difficult for daughters to challenge inherent adult assumptions about risk embedded within the research. Further research in this area needs to focus more centrally on risk management from the perspective of young women as opposed to the adults who surround them.

Conclusions

The impact of risky behaviours on the overall well-being of children and young people is a key focus of policy and practice initiatives in health and social care across advanced nations, particularly for those living in deprived communities. This research demonstrates that complex negotiations between mothers and daughters around health-related risk are based in trusting and open relationships and focus largely on harm minimisation and maximising opportunities for independence. Mothers and daughters clearly have different perceptions of risk and appropriate responses to it. Supporting the development of trusting relationships and open communication within families is perhaps the most effective way to minimise the impact of risk-taking behaviours for young women during the adolescent period. It is essential that nurses and other professionals working within communities have a comprehensive understanding of the subjective and complex negotiations which take place within families, if they are to support mothers to effectively protect, educate and support their teenage daughters through the challenges of risk taking in adolescence. Further research in this area needs to focus more centrally on risk management from the perspective of young women as opposed to the adults who surround them.

Key points

- Mothers' anxieties about risk taking appear to be context-specific and dependent on a number of factors; the most dominant concern is the degree to which particular risks heighten daughters' vulnerability to sexual threat.
- Daughters often did not perceive their own behaviours as risky, but were prepared to negotiate with mothers around monitoring. This was a genuine attempt to help alleviate maternal anxiety but also an opportunity to maximise independence.
- Mothers tend to take a harm minimisation approach to risk taking around sex rather than expecting abstinence. The data suggest that both mothers and daughters attempt to maximise freedom and maintain close relationships, while also recognising that negotiation is most successful when relationships are based on trust and openness.
- Nurses, and other health and social care professionals, promote numerous interventions that aim to reduce adolescent risk-taking behaviours. However, through an improved understanding of how risk is negotiated between mothers and daughters, nurses can build on maternal expertise to develop community-based initiatives that have the potential to improve health and clinical outcomes for young women.

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Conflict of interest

None declared.

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Debra Salmon For the last ten years, Debra's research has focused on the needs of 'hard to reach groups' in the areas of violence and abuse; sexual health and drugs and alcohol using mixed methods approaches. Expertise in health service evaluation has focused on primary prevention including the role of drama in sexual health education for 'hard to reach young people' and the development of sexual health services for young people in a wide range of settings. Debra also has significant experience of developing approaches that creatively engage participants within the research process including dissemination through a range of mediums. Current projects include the Single Parent Advancement and Learning Opportunities Participatory Research Project, funded by BIG LOTTERY and A Five Year Follow up Study of the 'Bristol Pregnancy Domestic Violence Programme' and the introduction of Routine Antenatal Enquiry.