

Health educators' perceptions of a sexual health intervention for homeless adolescents

Lynn Rew^{a,*}, Aaron B. Rochlen^b, Christina Murphey^a

^a School of Nursing, The University of Texas at Austin, Austin, TX, United States

^b Department of Educational Psychology, The University of Texas at Austin, Austin, TX, United States

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Abstract

Objective: The purpose of this qualitative descriptive study was to explore the perceptions and experiences of health educators in providing a brief, street-based intervention to homeless adolescents.

Method: Qualitative data were collected via e-mail from a purposive sample of 13 male and female health educators who provided the intervention and analyzed using manifest and latent content analysis techniques.

Results: Five categories with two or more subcategories were identified in the data and included how the educators' views changed, how they felt homeless youth were similar to and different from other adolescents, positive aspects and challenges of providing the intervention, and suggestions for future interventionists working with this population.

Conclusions: The health educators' practice was strengthened over the course of providing the intervention through their positive experiences, changes in their perceptions, some of which were biased, and ability to confront the challenges that accompany working with this vulnerable population.

Practice implications: Health educators who work with this population should learn about the culture of homeless youth and characteristics of homeless youth that may influence their participation in a sexual health intervention. Moreover, they need to be non-judgmental, practice the intervention, be aware of their biases, and remain flexible.

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1. Introduction

Homeless adolescents are at higher risk than housed youth for contracting and transmitting sexually transmitted diseases. This finding has been attributed primarily to past experiences such as sexual abuse and early sexual debut as well as current behaviors such as having multiple sex partners, engaging in sex while under the influence of alcohol and other drugs, exchanging sex for survival needs, and engaging in sex with intravenous drug users [1,2]. One of the national health objectives set forth in *Healthy People 2010* is to “promote responsible sexual behaviors, strengthen community capacity, and increase access to quality services

to prevent sexually transmitted diseases (STDs) and their complications” [3, p. 25].

In addition to these national objectives, the American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS) (1994) included the recommendation that “All adolescents should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STDs (including HIV infection) and appropriate methods of birth control should be made available with instructions on how to use them effectively” [4, p. xxxi]. Despite the national objectives and AMA guidelines, education to promote sexual health in adolescents is a sensitive, and at times controversial, topic [5].

Although there are a number of street outreach programs that provide condoms and treatment for acute STDs throughout the country, few have included interventions to promote the sexual health of this segment of the population [6]. Moreover, despite the sensitivity and occasionally controversial nature of providing such interventions that has been described in the

* Corresponding author at: The University of Texas at Austin, School of Nursing, 1700 Red River, Austin, TX 78701, United States.
Tel.: +1 512 731 5763; fax: +1 512 328 9705.

E-mail address: ellerew@mail.utexas.edu (L. Rew).

literature [5], little is known about the impact on educators or researchers of providing such an intervention. Qualitative researchers have long been encouraged to acknowledge their biases prior to engaging in such research, but what about the biases of health educators that may be associated with intervention research, particularly when the intervention concerns a sensitive and controversial topic and when the recipients of the intervention are stereotyped, stigmatized, and marginalized? Moreover, is it possible that interventions benefit not only the priority population for whom they are developed but that those who provide the intervention benefit as well?

1.1. Purpose

In consideration of these unanswered questions, the purpose of this study was to explore the experiences of both male and female health educators in providing a brief, street-based, gender-specific sexual health intervention to homeless adolescents.

2. Method

2.1. Design and setting

The qualitative descriptive [7] analysis reported here took place in a university setting in central Texas. Health educators provided a sexual health intervention to homeless adolescents who sought social and health services from a street drop-in center in an urban setting [8]. The drop-in center was staffed with social workers and volunteers who provided structure and maintained the ground rules for behavior within this setting. The intervention consisted of eight 1-h sessions that were developed with input from the youth themselves [9]. The sessions covered topics based on social learning theory [10], the theory of reasoned action [11], and cross-sectional findings from this population [6]. A trained pair of health educators who were the same gender as the group participants led each session. To maintain intervention fidelity, these health educators followed a manual with detailed instructions including objectives, learning activities, time frame, and list of materials. A total of 285 homeless youth, ages 16–23 years, received the intervention in groups of two to eight participants per session. The majority of youth who received the intervention was male (58%) and European American (57%). Each participant received a payment of \$10 for each session attended as well as a snack and a small toiletry item such as a hairbrush.

2.2. Sample

The sample for this analysis was 13 health educators (7 females and 6 males) purposefully drawn from a total population of 20 who had provided the street-based sexual health intervention. All health educators who provided the intervention were recruited by e-mail approximately 6 months following the conclusion of the intervention. Many of these providers were graduate students at the time of the intervention, some of whom had subsequently graduated and were

unreachable by e-mail. All who had accurate e-mail addresses ($n = 14$) were invited to participate and only one of these subsequently declined to participate owing to other professional responsibilities. The female educators ranged in age from 24 to 56 years ($M = 35.7$). All had baccalaureate degrees in psychology or nursing and all but one had post-graduate education. One had completed a PhD in nursing. Six of the female educators were Caucasian and one was Hispanic. The male educators ranged in age from 29 to 34 years ($M = 30.8$). All had baccalaureate degrees, five were enrolled in post-graduate education, and one had completed a PhD in social psychology. Four of the male educators were Caucasian, one was Hispanic, and one was Asian. Male and female educators were assigned to their respective gender-specific intervention groups. As we did not know the racial or ethnic make-up of intervention participants prior to the beginning of each session, we were not able to match on the demographic characteristics of educator to group composition. Only one male educator had previously worked with a group of homeless adolescents.

2.3. Data collection

Following approval from the institutional review board for the protection of human subjects, all educators were contacted via e-mail and invited to participate. Responses were anonymous, thus no signed consents were required. Each potential participant received a copy of the informed consent letter, and completion of the set of qualitative questions was taken as consent. After completing the questions, each participant received a book as a token of appreciation from the principal investigator.

For the purpose of this study, we developed four areas of interest to evaluate. These included (a) how the health educators' views changed from participating in the project; (b) their perceptions of similarities and differences of homeless adolescents versus housed youth; (c) benefits and challenges of working with this population; and (d) suggestions for future researchers. To collect information for these central areas of study, participants completed the following 11 questions via e-mail. Because the majority of health educators for the intervention were no longer employed by the researcher and had moved out of the city or state, the current project employed open-ended questions via e-mail rather than face-to-face interviews. Observations of the health educators' behavior during the intervention was also deemed impractical to insure the confidentiality and fidelity of the intervention itself:

1. Did your view of homeless adolescents change over the time that you were delivering the intervention and, if so, how?
2. What surprised you most about the homeless youth who participated in your groups?
3. What was your most positive response or reaction to being around these homeless youth?
4. What did you like most about participating in groups with this population?
5. What was the most difficult topic for you to convey to the homeless youth in your groups? Why?

6. What was your most negative response or reaction to being around these homeless youth?
7. What did you like least about participating in groups with this population?
8. In comparison to other adolescents with whom you have interacted, how similar or different was this experience?
9. What suggestions can you make to other health educators who might work with homeless adolescents?
10. How do you think you could have been better prepared for this experience?
11. What else would you like to say about your experience with homeless adolescents?

2.4. Data analysis

To reduce the original data, each set of written responses (the unit of analysis) was read and a written summary compiled independently by two of the investigators. These two investigators then met to discuss the condensed summaries and ascertain that the core of the responses was preserved [12]. Summaries were then analyzed using both manifest and latent content analysis techniques to search for commonalities and differences among responses [13,14]. Each researcher identified main themes (latent content) and categories (manifest content) for each question, and then combined findings from the questions to identify common themes and categories. Any discrepancies in the frequency or number of themes and categories were discussed until a mutual consensus was reached. Summaries, themes, and categories were then examined by two doctoral students not associated with the intervention study for confirmation of the findings. Member checks were done with a random sample of four of the health educator participants for further confirmation (two females, one of whom was Hispanic, and two males, one of whom was Hispanic and one of whom was Asian) [15,16]. Final confirmation of categories and subcategories was established by the third author who compared the summary of findings with original comments made by the participants. Categories and subcategories were retained if two or more participants' responses could be included.

3. Results

Five categories, each with two or more subcategories were identified. Overall structure of the findings is displayed in Table 1 along with corresponding frequencies of responses. The frequencies of response were retained to fully describe the patterns within the data [7]. Categories and subcategories are described below along with exemplars from the participants' written responses.

3.1. Views changed

The majority of both male and female educators stated that providing the intervention had changed their views of homeless youth. Responses varied from views changing only a little to views changing substantially. For example, a female

Table 1

Categories, subcategories, and frequencies of responses about homeless youth from health educators

Categories	Subcategories and types	Frequency of responses
Views changed	Sophistication of homeless youth	9
	Causes of youth homelessness	7
	Stereotypes refuted	6
	Resiliency of homeless youth	4
Comparisons	Similarities	6
	Differences	
	Face harder situations	8
	More independent, resourceful	7
	Limited future time perspective	6
	Open communication style	4
	Defensive, fatalistic	3
Positive aspects	Benefits of intervention	10
	Personal and professional growth	8
	Building relationships	6
Challenges	Resistance to specific topics	10
	Disruptive behaviors	7
	Environmental context	5
	Limits of role	4
Recommendations	Be non-judgmental	7
	Practice intervention	7
	Seek further exposure	5
	Be aware of biases	4
	Be flexible	4
	Establish rapport	3

wrote, "Yes, my view of homeless adolescents changed somewhat over the course of my work leading the intervention," while a male wrote, "Yes, my views did change substantially." Subcategories of how views changed were sophistication of homeless youth, causes of youth homelessness, stereotypes refuted, and resiliency of homeless youth.

3.1.1. Sophistication of homeless youth

Several of the participants commented about the unexpected level of sophistication and intelligence they observed in the homeless youth. As one female stated, "I realized that some of them were smarter than I expected," and one of the male educators stated, "I was surprised by the high level of sophistication and knowledge of many of the adolescents."

3.1.2. Causes of youth homelessness

Some of the health educators admitted they were ignorant about this population prior to meeting with them and this experience gave them new information about the number of homeless youth and the reasons they became homeless. Most of the responses were related to learning about experiences of abuse and neglect in the youth's homes and the lack of comprehensive social services. One of the females stated, "I was not previously aware of the degrees of childhood neglect and abuse in this group, or of the 'dead end' situation of foster care."

3.1.3. Stereotypes refuted

The majority of health educators admitted that their experiences in providing the intervention served to refute several of the stereotypes they had previously held concerning homeless adolescents. One of the male educators remarked, “I probably had stereotypes about homeless adolescents, viewing them as poor, unsophisticated, and aimless.” Another male noted, “I realized that my stereotypes were coloring my expectations of these individuals, who were often extremely intelligent and caring.” One of the female health educators stated, “I didn’t know anything about them and tended to think of them as a social stereotype of homeless people: slackers; people who should just go get a job like the rest of us do.”

3.1.4. Resiliency of homeless youth

Health educators expressed surprise to find the homeless youth to be resilient. As one male summarized, “I was surprised at how resourceful and resilient they were.” Another male said, “Sadly, many of these individuals survive in a very inhospitable and dangerous environment, which seems to have pushed them to develop innovative strategies to protect themselves and their friends.”

3.2. Comparisons to other adolescents

Although many of the educators identified characteristics of this population of youth that were quite similar to other adolescents (e.g., “I feel that the homeless adolescents and housed adolescents are similar in a lot of respects”), the majority also identified numerous ways in which they were different (e.g., “Their street knowledge and levels of independence is strikingly different”).

3.2.1. Similarities

One of the male educators commented that the homeless youth dealt with issues common to other adolescents, “surrounding wanting to be liked and included a desire to make friends and care for others.” One of the female educators added, “there is a lot of ‘drama’ that went on in their friendships and relationships. Both groups can be moody or smart-alecky when you’re attempting to interact with them. Both groups have the same needs regarding sexual health education and drug use.”

3.2.2. Differences

Five types of differences were identified. Homeless youth were viewed as (1) facing harder situations; (2) being more independent and resourceful; (3) having limited future time perspective; (4) acting defensive and fatalistic; and (5) having an open style of communication. In describing harder situations faced by homeless youth, one male wrote, “They would endure a great deal more stress and harmful situations.” As for being more independent and resourceful, a male educator stated the homeless were, “more independent and self-reliant,” and a female educator stated, “homeless adolescents seemed older in that they were more resourceful.” As for their limited time

perspective, homeless youth were described as “emotionally more like younger children often reacting selfishly with skewed perspective to time.” The comments about acting defensive and fatalistic all came from male health educators, one of whom wrote, “. . .homeless youth had developed a sense of fatalism. Believed had no control over experiences and it would be pointless to attempt to change.” Finally, concerning their open communication, a male educator wrote, “More authentic in expressing thoughts/feelings and spoke their minds (sometimes good and sometimes bad).”

3.3. Positive aspects of providing intervention

Three types of positive aspects of providing the sexual health intervention to homeless youth were identified: benefits of the intervention, personal and professional growth, and building relationships.

3.3.1. Benefits of intervention

Reflecting on their experiences, most of the health educators identified benefits of the intervention to the homeless adolescents. One female educator wrote, “Many of the youth expressed appreciation for the health information and the ‘refresher in sex ed’.” In response to what he liked most about providing the intervention, a male added, “The satisfaction of conveying information that is helpful in practical ways to participants. The session on STDs was particularly powerful. I recall one participant telling me after we showed those graphic pictures of individuals with STDs that he will never have sex without a condom again.”

3.3.2. Personal and professional growth

Several health educators noted that providing the sexual health intervention to homeless adolescents resulted in personal and professional growth for the educators themselves. Referring to the experiences and perspectives of the homeless youth, one male added, “It helped me gain perspective on my own life and experiences.”

Another male educator wrote, “It was a journey of personal growth for me.” A female educator summed up her perspective by stating, “Overall, it was a very positive experience and a great learning experience for me.”

3.3.3. Building relationships

Several of the health educators stated they enjoyed the relational aspect of working with homeless youth. Responding to the question of what they liked the most about providing this intervention, a male stated, “I enjoyed interacting with the adolescents and being able to communicate directly with them without reservations.” Another male wrote, “in general I found the authenticity and genuineness that most of the participants presented with to be wondering [sic] to see, although the level of trust necessary to reach this type of relationship took several sessions to develop.” A female said, “It was a great experience and I wished that I could have participated longer. They really opened up my eyes to this population and made me realize that they are real people.”

3.4. Challenges in providing intervention

Although most health educators were very positive about working with this population of adolescents, they all acknowledged a variety of challenges. These included resistance to some of the content of the intervention, disruptive behaviors, context of the environment, and limitations of their role as health educators.

3.4.1. Resistance to content of intervention

According to these health educators, various components of the intervention were more difficult than others to convey to the homeless youth in their groups. Four main topics were mentioned most frequently: future time perspective, self-efficacy, transmission and treatment of HIV/AIDS, and assertive communication. Future time perspective was mentioned by male providers while the other three topics were identified by the female providers. Regarding future time perspective, a male provider wrote, “I found it difficult at times to convey the topic of future time perspective to the homeless youth in the intervention. Because of their age, as well as the homeless status, many of the adolescents seemed to have a sense of time that differed markedly from myself.” Regarding the other difficult topics, female providers wrote, “Self-efficacy seemed to be one of the most difficult concepts for the leaders to get across,” and another noted, “Many of the female participants whole-heartedly believed that herpes could not be spread unless the infected partner had visible lesions and others believed that the Government did in fact have a cure for AIDS, but was keeping it from the people. This group did subscribe to conspiracy theories about HIV/AIDS.”

3.4.2. Disruptive behaviors

The male health educators identified more disruptive behaviors of the males in their classes than did the female educators. One of the males noted that “some of the participants were disruptive, e.g., interrupting each other, quarreling with one another” while another added that it was “sometimes hard to get them to settle down and pay attention to the task at hand.” Another put it this way, “crowd control was an issue at times when there were members of the group who did not like each other.” The only female educator who commented on disruptive behavior of the female clients wrote, “The kids were mostly cooperative during groups, however when I ran into them outside of this setting some were rude and hostile.”

3.4.3. Environmental context

For some health educators, the drop-in center itself presented unfamiliar and unpleasant challenges. Female educators commented that “if there were guys in there that were new to the drop-in or had never seen or met me before, I would have to endure lewd sexually explicit comments as I walked to the back,” and “I was very hesitant and nervous during the first few weeks. I always made sure I was going with another health educator because I didn’t feel comfortable being there alone.” Male educators expressed a different challenge in the context of the drop-in environment. One of them wrote,

“especially during the summer, the drop-in was sometimes an extremely hot and/or smelly environment to spend a large portion of the day.”

3.4.4. Limits of role as health educator

Some of the health educators expressed frustration at the limits of their role as health educator. One of the nurses wrote, “The heartbreaking frustration of comprehending some of the extreme fragility of their situations coupled with my inability to render ongoing care.” Referring to seeing youth argue with each other, one of the males wrote, “Although I would not have felt comfortable intervening during these episodes, it did feel quite awkward and uncomfortable at times to not be in a position to help... in managing crisis situations.”

3.5. Recommendations for other health educators

Although the health educators received training and ongoing supervision of their work while providing the intervention, when they had time to reflect on this experience, they offered several recommendations for other professionals planning to work with this population. The recommendations were to: be non-judgmental, practice all components of the intervention, seek further direct exposure to the population prior to working with them, be aware of one’s biases toward the population, be flexible, and establish rapport with the youth and staff.

3.5.1. Be non-judgmental

The educators cautioned future health educators to be non-judgmental when working with this population. In offering his recommendations, one male wrote, “Spend as much time as you can with the adolescents just talking to them, and letting them know you are not there to judge them or condemn them.” One of the females added, “Keep an open mind and check your judgments at the door.”

3.5.2. Practice components of intervention

Several of the health educators made specific recommendations about practicing delivery of the intervention, particularly through role-playing. One said, “Role-plays would have been helpful in order to practice interacting with the adolescents who were so forward and brash.” Another wrote, “The role play was especially helpful for rehearsing the material and how to teach it. I went over everything a second time with my first teaching partner, someone with a psych background, but I cannot remember her name. The rehearsals helped me to learn the material and to prepare responses to questions and other situations.”

3.5.3. Seek further exposure to population

Although some of the health educators had previous experience working with homeless adolescents and were immediately comfortable providing the intervention, others felt it was a disadvantage not to have had such previous experience. A female recommended, “To have been exposed to this population beforehand in some capacity, although it was easy to get used to them quickly.” Another female wrote, “The training I received

was fairly comprehensive. It would have been nice to learn more of the street kid lingo. I also think it would have been good for me to learn more about the slang associated with drugs. The more we use the kids' verbiage [sic], the more effective."

3.5.4. *Be aware of biases toward population*

One of the male health educators stated that others might have difficulty working with this population "because of preconceived notions of their lifestyles and attitudes." Commenting on this aspect of their own preparation for this intervention, another male wrote, "I think that the training that we experienced was extremely helpful in allowing me to begin to examine my biases and assumptions with homeless youth. I would strongly encourage other health educators to undergo similar guided exercises in order to limit the amount of stereotyping and negative attributions that would negatively impact relationships formed with homeless adolescents and the ability of group facilitators to relate to participants in a way that fostered a safe, healthy environment."

3.5.5. *Be flexible*

Both male and female educators recommended being flexible. A female wrote, "Be flexible, and be persistent." One of the males stated, "Make sure you are flexible in your approach to working with this population."

3.5.6. *Establish rapport*

Those who provided the intervention also reflected on the importance of treating the homeless youth with dignity and respect. As one of the female leaders said, "Building rapport and making them feel safe are key components to working effectively with this population. Also, letting them know that the health educators are there to learn from them as well seemed to help build rapport with the adolescents."

4. Discussion and conclusion

4.1. *Discussion*

As researchers, we focus on how our interventions are designed to help vulnerable or at-risk populations. The findings from this study provide new information for health educators and community providers planning to work with homeless youth. One theme emerging from this analysis is that the health educators in this study held a number of biases and stereotypical views of homeless youth that were significantly challenged and/or modified by working directly with them. They became more adequately aware of the sophistication of these youth, the causes of their homelessness, and strengths that have been identified in previous studies [6,17]. While they noted several similarities with other adolescents, they also identified a number of important differences. Not surprisingly, they found that these youth faced harder situations and, consequently, were more resourceful than other adolescents. They also noted that homeless youth had a limited future time perspective, which supports many observations made by others who have worked with this population, most notably Fest who elaborated on the concept of time [18]. Fest

asserted that understanding the concept of time as it applies to street-dependent youth is of utmost salience. He added that because the majority of these youth have come from troubled and often abusive and traumatic backgrounds, the past is something to block out of memory. Similarly, many of these youth have little to hope for in their futures, thus the present becomes all-important.

A second theme was that the impact of working with this population was positive and meaningful to the health educators who provided the intervention. Several health educators described personal and professional growth that far exceeded their expectations. Several of them were committed to continuing to practice and conduct research with this population. Our findings also underscored many of the challenges that need to be addressed by service and healthcare providers. Some challenges were associated with presenting specific topics as part of the sexual health intervention while other challenges were part of the environmental context and setting.

Recently, Kidd shared a great deal about his personal experience as a researcher in observing and interviewing homeless adolescents in New York City and Toronto, Canada [19]. He wrote that he had to conquer his fears and realize that they were "based on ignorance" as he found these youth to be friendly and not unlike other people (p. 232). Findings from these health educators echo these sentiments. As some of our educators expressed feeling some degree of hopelessness or despair about the future of these youth, so too wrote Kidd, "a form of hopelessness, or a reaction to what can seem impossible: How can any real change come of this?" (p. 233).

Our overall interpretation of the qualitative responses from these health educators was that providing the intervention had affected them in unexpected ways. This was relevant in the number of stereotypes refuted, the clear description of how their views had changed, and how the experience had impacted them personally and professionally. Such findings not only point to the importance of engaging in an open discussion of expectations and biases toward populations being studied, but in how participating in the process of research can be an important and positive professional experience. Not only does our research give us information about what works and what does not work with particular populations, but it also provides valuable insights about how social research is really a reciprocal process, benefiting both provider and client.

4.2. *Conclusion*

Findings from this study indicate that providing an intervention to homeless youth has benefits for the providers including the chance to learn about another cultural group, refutation of biases, and opportunities for personal and professional growth.

4.3. *Practice implications*

Health educators provided a number of specific suggestions for providing an intervention for homeless youth. These suggestions addressed both logistical features of the setting and

methods for conducting this type of research as well as the personal awareness that their personal beliefs might be challenged and career goals modified. Paramount among their suggestions were being non-judgmental and practicing the intervention prior to implementation. Owing to the level of sophistication of these youth and to the recognition of preconceived ideas about this population by the health educators, these two recommendations are salient for future intervention studies with this population. Similarly, becoming more familiar with the unique language and appearance of the homeless youth population, characteristics of the setting for the intervention that included unfamiliar sensations, being flexible, and establishing rapport are other important characteristics for health educators to develop. The concept of time as it relates to issues of previous maltreatment and a feeling of hopelessness about the future is also an important element to consider when preparing health educators to intervene with homeless youth.

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