Adolescent sexual risk-taking in a psychosocial context: Implications for HIV prevention

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Adolescents bear a disproportionate burden of the HIV/AIDS epidemic in the United States. In 2009, fully 39% of all HIV infections in the U.S. occurred among young people under the age of 29, despite the fact that this group comprised only 21% of the population (Centers for Disease Control and Prevention [CDC], 2011a). Approximately 12,000 adolescents and young people aged 13-24 were diagnosed with HIV in 2010 (about 26% of all those diagnosed that year), second only to individuals aged 25-34 (CDC, 2012). Racial and ethnic minority youth are at particular risk, experiencing persistently higher rates of sexually transmitted infections (STIs), including HIV, than their white peers (Mojola & Everett, 2012). In 2009, African American youth accounted for a staggering 65% of all new HIV infections reported among individuals aged 13-24, although they represent just 14% of the population (CDC, 2011a). The prevalence of HIV among adolescents is likely even higher than CDC estimates would suggest, as STIs often go undiagnosed among young people until symptoms become evident, which may not occur for many years (Walcott, Meyers, & Landau, 2008). In addition, adolescents may lack access to adequate HIV testing and health care, or they may not seek out proper care, believing themselves to be invulnerable to contracting HIV (Cates, Herndon, Schulz, & Darroch, 2004). As a result, many individuals diagnosed with HIV/AIDS later in life will have actually contracted the disease during their adolescent years (DiClemente et al., 2008).

The most common method for HIV transmission among adolescents is high-risk sexual contact (DiClemente et al., 2008). Sexual risk-taking has been defined in the literature in a variety of ways; however, engaging in unprotected sex, having multiple sexual partners, and an earlier age of first sexual intercourse have all consistently been shown to increase the risks of contracting HIV and other STIs (Walcott et al., 2008). In the CDC’s 2011 Youth Risk Behavior Survey (YRBS), which assesses a variety of health-risk behaviors among 9th to 12th grade students, 47% of adolescents surveyed reported sexual intercourse at least once, while more than 15% of adolescents reported four or more lifetime sexual partners. Additionally, 40% of adolescents in the YRBS had failed to use condoms during their last sexual encounter (CDC, 2011b). While studies suggest that the majority of adolescents typically do report using a condom during their most recent sexual encounter, many also fail to use condoms consistently, greatly increasing their overall chances for HIV transmission (Walcott et al., 2008).

Of particular concern is the fact that HIV rates have remained consistently high among adolescents despite decades of research and advances in educational programming and treatment, indicating that new approaches to HIV prevention with this population may be needed. Much of the prevention work in schools and through community organizations targeted at adolescents has focused on individual-level factors, including increasing self-efficacy and teaching specific cognitive and behavioral skills for preventing HIV such as increasing condom use and limiting the number of total sexual partners, factors which are indeed important (Lightfoot, 2012). However, research suggests that many young people do not perceive themselves as being directly at risk for STIs and HIV, and may therefore fail to respond to interventions designed to change attitudes or beliefs. Moreover, perceived susceptibility to HIV does not necessarily result in the reduction of sexual risk-taking behaviors (Kershaw et al., 2005). Many adolescents
continue to engage in sexual risk-taking despite knowledge of the risks involved, implying that health protection may not be the most important motivating factor informing sexual decision-making for young people (Cooper, Shapiro, & Powers, 1998).

A focus on psychosocial and contextual factors may help to explain why interventions focused solely on individual factors have not altered adolescents' sexual risk behaviors at desired rates. As further support for this notion, HIV infection rates remain significantly higher among African American youth in spite of recent research indicating that African Americans actually tend to use condoms at greater rates overall than white individuals (Reece et al., 2010). This finding implies that the increased risk for this population is not primarily the result of individual risk behaviors. Understanding contextual community factors and designing prevention efforts that take into account the effects of social forces such as poverty, racism, sexism, and homophobia may be particularly important when working with low-income and minority youth, who tend to have experienced historical oppression and unequal access to power and resources in society (Bowleg, Lucas, & Tschann, 2004).

Living in poverty is one social factor that drastically increases adolescents’ risk of contracting HIV. Because rates of HIV tend to be higher in lower income communities than in wealthier communities, each unprotected sexual encounter becomes inherently more “risky.” (Corneille, Tademy, Reid, Belgrave, & Nasim, 2008). In addition, living in poverty brings exposure to multiple and chronic stressors, including higher rates of substance use, psychological distress, exposure to interpersonal and community violence, lack of parental communication and monitoring, and inequitable access to resources such as health care and education. These factors may, directly and indirectly, increase sexual risk-taking among adolescents, resulting in an earlier age of sexual initiation, greater number of sexual partners, and inconsistent condom use (Lightfoot & Milburn, 2009).

Sexual risk-taking in adolescents often occurs in conjunction with other risk behaviors, including substance use and delinquency, which tend to be more common in low-income communities (Walcott et al., 2008). In general, adolescents are in a developmental process of learning impulse control and emotion regulation skills; poor impulse control and emotional regulation are associated with risk-taking of all kinds, including alcohol or drug use, risky sexual behavior, or these behaviors used together as means of coping with negative emotions. Many adolescents use substances to cope with or avoid the experience of distressing internal states; substances may in turn also contribute to increased anxious and depressive symptoms (Elkington, Bauermeister, & Zimmerman, 2010). In a longitudinal study focused on drug and alcohol use disorders among adolescents, researchers found that youth who were being treated for significant alcohol and drug problems were far more likely than their non-treated peers to engage in high risk-sexual behaviors throughout adolescence and into young adulthood (Tapert, Aarons, Sedlar, & Brown, 2001). While risk-taking is common in adolescence, and is associated with the normal developmental goals of asserting independence and autonomy, such experimentation generally does not lead to chronic risk-taking behavioral patterns (Black, Ricardo, & Stanton, 1997). The risk for long-term negative consequences from these activities appears to increase particularly when risk-taking occurs earlier in adolescence and when youth grow up in low-income communities (Black et al., 1997). In order to best address HIV risk among adolescents, sex education programming should occur in combination with substance abuse prevention programming to prevent long-term patterns of risk-taking into adulthood.

Psychological distress, including symptoms of anxiety and depression that may arise from living in a chronic stress environment, represents another important psychosocial factor that has been linked with sexual risk-taking and substance abuse among
adolescents. In a longitudinal study of 850 primarily African American high school students, researchers found that substance use mediated the relationship between psychological distress and sexual risk-taking, including increased sexual activity (both frequency of sexual intercourse and greater number of partners), and decreased condom use (Elkington et al., 2010). This study also demonstrated a trend toward increased sexual risk-taking by adolescents over the eight years of the study, confirming that HIV/STI risk remains a real and critical concern for this population (Elkington et al., 2010). A study by Seth et al (2009) found similar results with a sample of African American female adolescents. Psychological distress, which was endorsed at a clinical level by almost half of the girls in the study, was related to inconsistent condom use, having sex while intoxicated on alcohol or drugs, and having fears about communicating directly with male partners, among other problematic outcomes (Seth et al., 2009). Mental health professionals should be aware of the connections between psychological distress, substance abuse, and sexual risk-taking among adolescents and be particularly sensitive to these HIV risk factors in assessment and treatment of youth.

Communication between parents and children is an important avenue through which values and attitudes around sexuality are transmitted and this may be an advantageous area for potential safer sex intervention. Parenting practices have generally been regarded as one of the most significant predictors of adolescent sexual behavior, including factors associated with sexual risk, such as age of first intercourse, rates of condom use, and number of sexual partners (Kapungu, Holmbeck, & Paikoff, 2006). Increased parent-adolescent communication around sex has been shown to be related to more accurate knowledge about sexual consequences and reductions in sexual activity (Kotchick, Dorsey, Miller, & Forehand, 1999). In a qualitative study on sexual health among urban adolescent girls, parents and family members, along with peers, school, and the media, were identified by girls as the most influential forces in shaping their views on sexuality (Teitelman, Bohinski, & Boente, 2009). Poverty, and associated high levels of parental distress, may compromise parental monitoring and control and lead to disconnection between parents and children (Baptiste, Tolou-Shams, Miller, McBride, & Paikoff, 2007). A lack of monitoring may be especially problematic for young people living in poor urban environments, as risks to health and safety are prevalent. Monitoring by parental figures may give adolescents a greater sense of self-worth and strengthen the desire to protect themselves by engaging in safer sex behaviors (Baptiste et al., 2007). Family interventions that assist parents in communicating effectively with their adolescents around sexuality and safer sex decisions, and that encourage increased parental monitoring, may actually help to delay the onset of sexual activity and reduce rates of unprotected sex among adolescents (DiClemente et al., 2008).

Exposure to sexual violence, either through childhood sexual abuse or in dating relationships, represents another psychosocial factor that may significantly increase adolescent HIV risk behaviors. In one study, adolescents who reported experiences of childhood sexual abuse also reported higher rates of sex without condoms, more sexual partners, and increased chance of using alcohol and drugs prior to sex (Voisin, 2005). Youth who have been sexually abused as children are also more likely to have experienced other forms of abuse including physical and emotional abuse, which appear to contribute to sexual risk-taking over and above the effects of childhood sexual abuse (Jones et al., 2010). Further, experiences of interpersonal violence, including dating violence, have been shown to predict sexual risk-taking, even after taking into account poverty, parenting styles, and demographic factors (Rodgers & McGuire, 2012). Teitelman et al (2008) found that young African American and Latina girls who had experienced intimate partner violence (including physical and/or emotional abuse) were significantly less likely to use condoms consistently than girls who had not experienced such abuse,
putting them at greater risk for HIV and STI exposure. Interventions around dating violence and gendered power dynamics in relationships may therefore play an important role in promoting sexual health and lowering HIV risk.

Overall, while HIV prevention efforts to date have been instrumental in reaching at-risk adolescent youth, offering information about the epidemic and cognitive and behavioral skills-based tools to avoid HIV infection, innovative psychosocial approaches may be necessary to begin to decrease HIV rates among adolescents, particularly among minority and low-income youth. While interventions designed to increase sexual self-efficacy may be useful in reducing HIV infection, incorporating efforts to prevent or treat substance abuse, alleviate psychological distress, increase parenting skills, and reduce interpersonal dating violence, may render these intervention techniques more effective. This integrative approach may be particularly useful in light of the well-documented finding from the HIV-prevention literature that behavioral change rarely stems solely from increased knowledge about the consequences of sexual risk-taking (Turk & Hocking, 2005). A psychosocial approach may help to highlight broader contextual factors that increase risk and those that serve as protective factors, promoting sexual health and resiliency among adolescents.

REFERENCES


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