P A C T S 2

Parent, Adolescent and Child Training Skills 2

Avoiding Risky Sex in Adolescence

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Parent, Adolescent and Child Training Skills 2
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Introduction

Risky sexual behaviour refers to practices such as having vaginal, anal or oral sex without a latex condom with a partner who may have a sexually transmitted disease (STD) or who may carry the human immunodeficiency virus (HIV). Risky sexual behaviour may lead to unintentional teenage pregnancy (UTP), infection with an STD or HIV infection. HIV infection, in turn, can lead to the acquired immunodeficiency syndrome (AIDS). For some youngsters who engage in risky sexual behaviour, the long-term outcome is problematic or fatal. The prevention of risky sexual behaviour and the promotion of safe sex are, therefore, of central concern to professionals in the fields of health, education and social services. Safe sexual behaviour refers to sexual practices where the risks of UTP, STDs or HIV infection are minimized. Safe sexual behaviour includes abstaining from sex, or using latex condoms when having sex, when it is unclear whether or not the sexual partner has an STD or is HIV positive.

Aims

The aims of this guide are to provide the practitioner with a description of risky sexual behaviour, an explanation of associated risk and protective factors, guidance on the prevention of such behaviour and an overview of what we now know about the development of successful prevention programmes.

Objectives

After studying this guide, practitioners should be able to:

- describe the main physical and psychological changes that occur during adolescence that are relevant to the development of sexuality;
- describe risky sexual behaviours and related risk and protective factors;
- answer parents' and teenagers' questions about risky sexual behaviour and its prevention;

- conduct a preliminary assessment of an adolescent or group of adolescents potentially at risk for engaging in risky sexual behaviour;
- contribute to a programme that aims to prevent risky sexual behaviour;
- respond constructively to an adolescent who has engaged in risky sexual behaviour;
- be aware of the limitations of our knowledge base relating to the prevention of risky sexual behaviour in adolescence;
- be aware of further readings beyond the brief account provided in this guide.

Part I: Development and sexuality

Adolescent development

Adolescence, the period between the dependency of childhood and the relative independence of adulthood, is marked by significant physical and psychological changes and it is within the context of these that adolescent sexuality emerges.

Psychosocial development in adolescence

The establishment of a clear sense of identity – that is, a sense of *who I am* – is the major concern of adolescence and the way in which this challenge is managed may render the adolescent more or less vulnerable to risky sexual behaviour. Marcia (1981) has found that adolescents may cope with the task of identity formation in four distinct ways and has termed these foreclosure, identity diffusion, moratorium and achieving a clear identity.

Foreclosure

With foreclosure, vocational, political or religious decisions are made for the adolescent by parents or elders in the community and youngsters accept these without entering into prolonged decision-making about their own identity. This may happen where youngsters are expected to join a family business, take over the running of a family farm, or strictly adhere to a clearly defined religious or ethnic lifestyle. These adolescents tend to endorse authoritarian values and are unlikely to engage in risky sex.

Identity diffusion

With identity diffusion the youngster makes no firm commitment to personal, social, political or vocational beliefs or plans. These teenagers devote themselves to seeking excitement and fun and drift from situation to situation without establishing a long-term plan or a coherent view of their identity. Some become disenchanted and socially withdrawn. There is a high probability

that those who endlessly pursue excitement and fun will engage in risky sexual behaviour.

Moratorium

In cases where a moratorium is reached, the adolescent experiments with a number of roles before settling on a clear identity. Some of these roles may be negative (e.g. delinquent) or non-conventional (e.g. drop-out/commune dweller). However, they are staging-posts in a prolonged decision-making process on the way to a forming a stable identity. During this moratorium state, adolescents may engage in sexually risky behaviour as part of the roles with which they experiment.

Achieving a clear identity

Where adolescents achieve a clear identity after a successful moratorium, they develop a strong commitment to vocational, social, political and religious values and usually have good psychosocial adjustment in adulthood. Where a sense of identity is achieved following a moratorium in which many roles have been explored, the adolescent avoids the problems of being aimless, as in the case of identity diffusion, or trapped, which may occur with identity foreclosure. Youngsters who have achieved a clear sense of identity are probably far less vulnerable to engaging in risky sexual behaviour than those who have not done so. However, this state is commonly not achieved until later adolescence.

Psychosocial development of gay and lesbian adolescents

A significant minority of youngsters have gay or lesbian sexual orientations. For gay and lesbian youngsters there are two significant developmental transitions that may occur during adolescence: self-definition and 'coming out' (Laird and Green, 1996). The first process – self-definition as a gay or lesbian person – occurs initially in response to experiences of being different or estranged from same-sex heterosexual peers and later in response to attraction to and/or intimacy with peers of the same gender. The adolescent typically faces a dilemma of whether to accept or deny the homoerotic feelings he or she experiences. The way in which this dilemma is resolved is in part influenced by the perceived risks and benefits of denial and acceptance. Where adolescents feel that homophobic attitudes within their family, peer groups and society will have severe negative consequences for them, they may be reluctant to accept their gay or lesbian identity. Attempts to deny

homoerotic experiences and adopt a heterosexual identity may lead to a wide variety of psychological difficulties, including depression, substance abuse, running away and suicide attempts. In contrast, where the family and society are supportive and tolerant of diverse sexual orientations, and where there is an easily accessible supportive gay or lesbian community, then the benefits of accepting a gay or lesbian identity may outweigh the risks, and the adolescent may begin to form a gay or lesbian self-definition. Once the process of self-definition as gay or lesbian occurs, the possibility of 'coming out' to others is opened up. This process of 'coming out' involves coming out to other lesbian and gay people; to heterosexual peers; and to members of the family. The more supportive the responses of members of these three systems are, the better will be the adjustment of the individual.

Gay young men are at particular risk of HIV infection. If the process of 'coming out' to themselves and their families is managed well, there may be less danger of them resorting to risky sexual behaviour and so placing themselves at risk.

Physical development in adolescence

Adolescence is a time of rapid physical and psychological development (Alsaker, 1996; Coleman, 1995). Adolescents develop primary sexual characteristics (menstruation in women and the capacity to ejaculate in men) and secondary sexual characteristics (auxiliary hair, breasts and voice changes). The average age for the emergence of primary sexual characteristics is about two years earlier in girls than boys. In the US and the UK the average age of the onset of puberty is between 10 and 11 years for girls and between 11.5 and 12.5 years for boys. The physical changes of puberty last about two years. Most commonly, puberty begins in boys with the growth spurt and in girls with the growth of pubic hair and breasts.

The timing of the onset of puberty affects satisfaction with body image, although this association is probably mediated by associated changes in height and weight. Early-maturing adolescents constitute 10–20 per cent of the population and at a psychological level early maturation affects boys and girls differently. Early-maturing boys are more satisfied with their bodies and feel more attractive, whereas early-maturing girls tend to be dissatisfied with their bodies because maturation is associated with weight gain. Early-maturing girls develop more conduct problems than late-maturing girls because of involvement in networks of older deviant peers. In the long term, these conduct problems abate. However, for girls, early maturity may leave a legacy in the form of being less educationally advantaged than their later-maturing counterparts. Early-maturing girls also show more heterosexual behaviour than their

female peers, but early-maturing boys do not show this increased level of sexual behaviour. Hormonal changes in adolescence have effects on some boys and girls, with raised testosterone levels contributing to male aggression and dominance. In girls, higher oestrogen levels are associated with positive moods and increased activity, while lower levels are associated with poorer moods.

A hundred years ago the average age for the onset of puberty was about five years later than is currently the case. This secular trend probably reflects a change in nutrition, health care and living conditions. The fact that youngsters are entering puberty earlier means that greater demands are being placed on them to manage their emerging sexuality responsibly.

Sexual behaviour in adolescence

In the UK, the National Survey of Sexuality and Lifestyles has led to a number of important findings about adolescent sexuality (Wellings *et al.*, 1994). The majority of boys and girls masturbate, although there is wide variability in the frequency with which boys and girls masturbate. During adolescence the majority of adolescents engage in some degree of sexual activity, usually within the context of brief romantic relationships. This activity varies and may include kissing, sexual fondling, mutual masturbation, oral sex and intercourse. The average age of first sexual intercourse has declined over the past 20–30 years from age 21 to 17 years for women and 20 to 17 years for young men. One in five youngsters under 16 years are sexually active. Those from working-class families and those of lower educational level have sexual intercourse on average two years earlier than middle-class youngsters with higher educational aspirations. Youngsters with strong religious affiliation and those of Indian origin report delaying first experiences of sexual intercourse until later in life.

Planning plays a role in first sexual experiences, with more than half of youngsters discussing having sex with their partners before the first sexual experience. For boys, first sexual experiences tend to be motivated by curiosity, whereas for girls the primary motivation is being in love. Half of women in later life regret that they had their first sexual experiences so early, but few men express such regret. Homosexual experimentation is common in adolescence but attraction to members of the same sex is confined to under 10 per cent of the population (Coleman and Roker, 1998). About a quarter of teenagers use no method of contraception. The younger a teenager is, the less likely he or she is to use contraception. Up to 50 per cent of sexually active youngsters under 16 use no contraception. The condom is the most popular method of contraception, with more than half of youngsters using this method and about a fifth using the contraceptive pill.

Outcomes associated with risky sexual behaviour

Unintentional teenage pregnancy, sexually transmitted diseases and HIV infection are the principal negative outcomes of risky sexual behaviour. Each of these outcomes, in turn, may have negative consequences for health, well-being and development.

Unintentional teenage pregnancy

From a biological perspective, early pregnancy is not harmful to either the mother or the child. However, complications during teenage pregnancy are common and teenage pregnancy may have many negative consequences in the socio-economic and psychological domains (Coleman and Roker, 1998; Coley and Chase-Lansdale, 1998). Complications of teenage pregnancy include higher risk of anaemia, toxaemia, and hypertension; low birth weight; higher risks of perinatal mortality; and higher risks of spontaneous abortions in subsequent pregnancies. At a socio-economic level, girls who have children early in their teens tend to drop out of education early, have poorer employment prospects and are more likely to become dependent on welfare subsidies and live in poverty. They tend to leave home earlier and are more likely to live in subsidized housing. The stresses associated with parenting may lead to the development of depression or anxiety disorders.

The relationships between teenage mothers and their children tend to be more problematic than those of their older counterparts. While teenage mothers are as warm as older mothers, they are less sensitive, verbal and responsive to their children and provide a less stimulating home environment. These parent–child difficulties in some instances lead to poor outcomes for the children of teenage parents. Children of teenage mothers are more vulnerable to abuse and neglect, to developmental delays, to educational underachievement and to behavioural problems.

The majority of fathers of children from teenage pregnancies have little or no contact with their children or partners and provide little or no financial support. Typically contact diminishes over time and less than a quarter of teenage fathers see their school-age children regularly. The greater is the conflict between the teenage mother and the male partner, the less is the contact between the partner and the child. For the children of teenage mothers, sustained involvement of the father is associated with better long-term adjustment. Truncated father involvement is associated with poorer long-term adjustment than no father involvement whatsoever. Most relationships between teenage mothers and the fathers of their children are short

term and teenage mothers are more likely later in life to become separated or divorced.

From the foregoing it is clear that UTP has many negative consequences for the young mothers and their children.

Sexually transmitted diseases

Sexually transmitted diseases in adolescence include chlamydia, genital warts, gonorrhoea, herpes, syphilis, vaginitis, hepatitis B and HIV infection leading to AIDS (which is dealt with under its own heading below). All of these conditions may be contracted during vaginal, anal and oral sex with someone who is infected. Most of these conditions cause discomforting symptoms, especially genital discomfort. Some STDs – such as chlamydia, gonorrhoea, syphilis and vaginitis – can be cured. Others – such as herpes and genital warts – cannot. With some STDs symptoms may never appear, or may disappear after a time, yet the person is still a carrier of the disease and can transmit it to another partner during vaginal, anal or oral sex. Characteristics of common STDs are given in Appendix 1.

HIV infection

Infection with HIV has devastating long-term biological and psychological consequences. At a biological level, HIV infection may evolve into AIDS, which, even with aggressive treatment, is ultimately a fatal condition (Brown *et al.*, 2000). Rapid HIV tests have been developed that provide results on the same day as the test, unlike earlier tests, which required a three-week delay before results were available. The duration between HIV infection and the development of AIDS is variable. Of HIV-infected children and adolescents, 13–23 per cent develop progressive encephalopathy, which is characterized by impaired brain growth, progressive motor dysfunction, and loss or plateauing of developmental milestones, with deficits in IQ and language tests. Some youngsters with AIDS suffer extreme discomfort, including pains in the head, chest and abdomen and peripheral neuropathy. Antiretroviral drugs halt the onset and progression of AIDS and improve the health of adolescents with AIDS. What was once an acute lethal condition has now become, as a result of the availability of antiretroviral treatment, a chronic subacute condition.

Adolescents who are HIV positive or who have developed AIDS experience considerable emotional distress and show significant emotional and behavioural problems associated with the diagnosis, the response of others to the diagnosis, and the difficulties of living with a chronic illness. Adolescents who find they are HIV positive and who later develop AIDS face multiple

stresses, including: loss of health; having to disclose their diagnosis to family and friends; family conflict; social ostracism; loss of social support; difficulties securing appropriate medical care; repeated hospitalization; aggressive medical treatment; chronic ill health; and poverty. In response to these multiple stresses they may develop emotional and behavioural problems that reflect involvement in the following grief processes, which typify experiences of loss:

- shock;
- denial or disbelief;
- yearning and searching;
- sadness;
- anger;
- anxiety;
- guilt and bargaining;
- acceptance.

There is not a clear-cut progression through these processes from one to the next (Stroebe *et al.*, 1993). Rather, at different points in time, one or other process predominates and there may also be movement back and forth between processes.

Epidemiology

Unfortunately, UTP, STDs and HIV infection are surprisingly common problems.

Unintentional teenage pregnancy

Birth rates for 15–19-year-old women in the mid-1990s in the UK were 32 per 1000 and in the US they were 57 per 1000 (Nitz, 1999). The UK has the highest rate of teenage pregnancy in Europe (Coleman and Roker, 1998). About two-thirds of pregnant adolescent girls have abortions. About a third of adolescent mothers go on to have repeat pregnancies within two years (Nitz, 1999).

Sexually transmitted diseases

Rates of STDs among adolescents are difficult to determine. In the US only the reporting of gonorrhoea and syphilis is mandatory (D'Angelo and DiClemente, 1996): in the early 1990s, for 15–19-year-olds, the rates of gonorrhoea were 882 per 100,000 for males and 1044 per 100,000 for females, while the rates of syphilis were 18 per 100,000 for males and 35 per 100,000 for females. Also in the US, community surveys show that the rates

of chlamydia are 5 per cent among college students and 11 per cent among inner-city adolescents (Rosenthal *et al.*, 1994).

HIV infection

In the late 1990s, there were more than 7 million cases of AIDS reported worldwide and 1 million of these were youngsters (Brown *et al.*, 2000). While exact prevalence data are unavailable, it is estimated that for every one reported case of AIDS there are three HIV-positive young people. Thus, there are 3 million young people worldwide who are HIV positive. HIV and AIDS initially proliferated among homosexual males and intravenous drug abusers. However, in Europe and America, HIV infection rates are currently increasing most rapidly among heterosexuals and young people in ethnic minorities. In many African countries the prevalence of HIV infection is about 10 per cent and life expectancy has dropped dramatically, from 60 to 43 years, as a result of AIDS-related deaths.

Theories about sexually risky behaviour

Numerous psychological theories have been constructed to explain how sexually risky behaviour develops and how it may be modified so that youngsters engage in safer sexual practices. Two of the more comprehensive theories deserving elaboration are the behavioural–ecological model of sexual behaviour (Hovell *et al.*, 1994) and the AIDS risk-reduction model (ARRM) (Catania *et al.*, 1990).

Behavioural–ecological model of sexual behaviour

The behavioural–ecological model argues that risky and safe sexual behaviours are determined by proximal and distal antecedents and consequences within youngsters' social–ecological systems, and also by a range of background predisposing factors (Hovell *et al.*, 1994). The model, which is outlined in Table 1, is supported by a large body of empirical research. It offers a framework for a range of preventive measures to reduce the incidence of risky sexual practices within communities. Strategies based on the behavioural–ecological model include:

- targeting groups with high-risk profiles on background, distal and proximal antecedent variables;
- family interventions and parent training to improve parent–child co-operation and communication and parental supervision;