Adolescents With Psychiatric Disorders and the Risk of HIV

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ABSTRACT

Objective: To review literature relevant to human immunodeficiency virus (HIV)-associated risk behaviors among adolescents with psychiatric disorders and psychological influences on risk behaviors. **Method:** This report is based on review of 66 articles, which comprise all of the relevant literature in the English language. **Results:** Although the seroprevalence of HIV in adolescents with psychiatric disorders is unknown, studies indicate that adolescents with psychiatric disorders are at greater risk than their peers because of increased rates of unsafe sexual practices, impulsivity, self-destructive attitudes, cognitive immaturity, high rates of substance use, self-cutting behavior, and the sequelae of sexual abuse. **Conclusion:** Directions are proposed for the design of developmentally appropriate, clinically oriented HIV prevention interventions based on the relationships between psychological dysfunction, social stressors, and HIV risk behaviors. *J. Am. Acad. Child Adolesc. Psychiatry,* 1997, 36(11):1609–1617. **Key Words:** adolescents, human immunodeficiency virus risk, diagnoses.

Adolescents are at risk for acquiring human immunodeficiency virus (HIV) because of sexual and drug behaviors that are commonly initiated during this developmental period. A recent report estimates that adolescents younger than 22 years of age account for 25% of all new HIV infections and those younger than 26 account for 50% of new infections (Office of National AIDS Policy, 1996). Adolescents have emerged as an at-risk population in need of interventions designed to reduce HIV-associated risk behaviors. However, adolescents are not a homogeneous group, but rather a mosaic. Each subgroup may have a different profile of HIV-associated risk behaviors. One adolescent subgroup, understudied and in urgent need of HIV prevention interventions, is that of adolescents with psychiatric disorders. The relationships between psychological dysfunction, other stressors, and HIV risk behavior in adolescents is the focus of this review.

Review of the Literature

Several studies have attempted to quantify HIV-associated risk behaviors among adolescents with psychiatric disorders. DiClemente et al. (1989) found that known risk behaviors were prevalent among their hospitalized sample ($N = 44$): intravenous (IV) drug use (15%), sharing IV drug needles (15%), partner of an IV drug abuser (15.8%), sex partner of homosexual/bisexual male (15.8%), and having sexual intercourse with someone whose sex history is unknown (35%). In addition, a previously unrecognized HIV risk behavior was frequently noted: self-mutilation or self-cutting behavior (60%) and sharing of cutting instruments with peers (25%). Similarly, Baker and Mossman (1991), in a small sample of hospitalized girls ($N = 23$), found high levels of drug abuse (17% reported daily use of drugs), high-risk sexual activities (57%), and histories of sexually transmitted diseases (STDs) (17%). In a comparison study of adolescent psychiatric inpatients ($N = 76$) and school-based adolescents ($N = 802$), hospitalized adolescents were found to be almost twice as likely to be sexually active,

Accepted May 16, 1997.

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Research funded by grants from the Department of Psychiatry and Human Behavior, Brown University, and NIMH (R29 MH50416).

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almost twice as likely to report intercourse without condoms, and more than twice as likely to use IV drugs (DiClemente and Ponton, 1993).

No formal studies exploring the seroprevalence of HIV in adolescents with psychiatric disorders have been published to date. However, on the basis of inferences from seroprevalence studies conducted with other adolescent populations and adults with psychiatric disorders, it is likely that the rate of seropositivity in adolescents with psychiatric disorders is significant. HIV seroprevalence rates ranging from 0.2% to 2.2% have been found among adolescents in various settings, including an STD clinic (Quinn et al., 1988), medical outpatient clinics (D'Angelo et al., 1991), college campus health service clinics (Gayle et al., 1990), and Job Corps entrance clinics (St. Louis et al., 1991). HIV seroprevalence rates have ranged from 5.5% to 14% among adult psychiatric patients in New York City (Cournos et al., 1991; Empfield et al., 1993; Meyer et al., 1993; Sacks et al., 1992; Stewart et al., 1994; Volavka et al., 1992).

Studies have suggested that the following factors promote HIV risk behaviors in patients with psychiatric disorders: cognitive deficits (e.g., impaired judgment, problem-solving difficulties, problems with risk assessment), impulsivity, self-destructive tendencies (e.g., self-cutting behavior), history of drug use, history of sexual and physical abuse, poor interpersonal relationships, financial instability, affective instability, and adverse life circumstances such as homelessness (Baer et al., 1988; Carmen and Brady, 1990; Kalichman et al., 1994; Kelly et al., 1992; Steiner et al., 1992). Clinical reports also suggest that adults with cluster B Axis II personality disorders are more likely to engage in HIV-related behavior. One literature review found that poor impulse control and substance abuse, which often accompany personality disorder, are associated with needle-sharing and multiple sexual partners (Golding and Perkins, 1996). The precise role of many of these factors in promoting HIV risk and their relative importance have yet to be determined.

Risk Factors/Behaviors

HIV risk behavior exhibited by adolescents with psychiatric disorders might be the product of specific diagnoses. For example, teenagers with conduct disorder and attention-deficit/hyperactivity disorder have a tendency to be more impulsive in their actions and therefore may not use safer sex practices when encountering sexual interactions. Adolescents with a major depressive disorder may lack the self-esteem and assertiveness in order to consistently implement safer sex practices. Alternatively, HIV risk might be the product of increased distress and dysfunction inherent in all disorders. Data from the following studies are inconclusive, but they suggest a potential for both possibilities.

In a cross-sectional study of adolescent psychiatric inpatients ($N = 44$), those teenagers with conduct disorder or borderline personality disorder (63.6%) were more than three times as likely to be classified in the HIV "high-risk" category as were those with either schizophrenia (20%) or affective disorders (20%) (DiClemente et al., 1989). Another study found that female adolescent inpatients with conduct disorder tended to have higher levels of drug abuse, multiple sexual partners, and STDs compared with other adolescent inpatients (Baker and Mossman, 1991). These findings support the idea that risk behavior is not uniform across diagnostic categories and, although HIV risk has not been quantified according to diagnoses, most adolescents with psychiatric diagnoses are at increased risk for infection (Di Scipio, 1994).

Destructive risk-taking might also be an expression of subclinical, nondiagnosable depression. Adolescents who are depressed but do not meet full diagnostic criteria might be at increased risk for self-destructive behavior (Blatt, 1991). The co-occurrence of mood disturbance and various types of destructive behavior, including sexual promiscuity, is evidence for this relationship. In a study of 173 young African-American women from two health centers, Orr et al. (1994) found that those women with depressive symptomatology were significantly more likely than nondepressed women to report multiple partners (odds ratio [OR] = 1.7), an IV drug user partner (OR = 4.5), or a partner with an STD (OR = 2.4). HIV infection may even be overtly described as a form of suicidal behavior, suggesting that in some cases HIV risk may be consciously desired. In a case example, Frances et al. (1985) describe a man with a history of chronic suicidal thoughts and severe substance abuse difficulties who deliberately sought out sexual partners with acquired immunodeficiency syndrome (AIDS) in order to acquire HIV. He expressed a desire to die but had found it difficult to more actively take his own life.

In contrast are the more general findings from a longitudinal study that explored change in HIV-related high-risk behaviors in relation to knowledge, experiences, and mental health symptoms in adolescents (N = 602) (Stiffman et al., 1992). Using the Diagnostic Interview for Children and Adolescents and the National Institute of Mental Health Diagnostic Interview Schedule, Stiffman et al. (1992) found that a variety of psychiatric symptoms during adolescence were associated with risk behaviors during young adulthood (conduct disorder, r = .27; depression, r = .16). For example, youths with three or more symptoms of depression were 5.6 times more likely than their peers to engage in prostitution. IV drug use during young adulthood was predicted by several adolescent psychiatric symptoms, including suicidality (OR = 9.9), anxiety symptoms (OR = 11.1), and posttraumatic stress disorder (PTSD) (OR = 5.9). In addition, they found that general improvement in mental health symptoms over time was associated with less risk behavior during adulthood. However, because the study was not designed to test the efficacy of mental health interventions, it remains unknown whether psychiatric treatment leads to a decrease in HIV risk behavior. This review indicates that all adolescent patients with psychiatric diagnoses are at increased risk, although there are no data that compare inpatients and outpatients, or acute and chronic conditions.

Psychological and Cognitive Influences on Risk Behavior

Psychological deficits that are present in many adolescents with psychiatric disorders, whatever the diagnosis, may make HIV risk behavior more likely. Potential psychological factors include poor judgment and cognitive impairment, impulsivity, low self-esteem, conflict concerning sexual orientation and sexual exploration, the need for peer acceptance, conflict in families concerning sexuality, and adverse life experiences.

In addition to the cognitive immaturity inherent during adolescence, those with psychiatric disorders frequently have significant cognitive impairments related to their disorders, such as problems with accurate judgment, risk assessment, and decision-making, as well as problems with information processing (Etemad, 1992; Platt and Spivack, 1972). These cognitive difficulties may be due to acute distress or may be of a long-standing nature and often result in HIV-related knowledge deficits. Adolescents with psychiatric disorders often lack accurate information about HIV/AIDS (Katz et al., 1995), suggesting that patients may be unaware of the degree to which their own behavior places them at risk for HIV infection (Kalichman et al., 1994; Kelly et al., 1992; Ponton et al., 1991). A frequent misconception among adolescents with psychiatric disorders, for example, is that HIV can be acquired through various modes of casual contact (e.g., sharing drinking glasses, being in close proximity to someone with AIDS, and using the same eating utensils) (Brown et al., 1997b). Frequent absences from school cause adolescents with psychiatric disorders to miss educational experiences focused on HIV prevention (Slonim-Nevo et al., 1995). Substantial deficits in practical understanding of AIDS and risk reduction measures have been found among chronically mentally ill adult outpatients in inner-city community mental health centers (Baer et al., 1988; Carmen and Brady, 1990). For example, Kelly et al. (1992) found that 43% of their sample of adult psychiatric inpatients believed that heterosexual women cannot get AIDS and 45% believed that a person's appearance signals whether he or she has HIV infection. Consequently, lack of developed judgment, coupled with misconceptions, or information that is not in a usable form, may contribute to HIV risk.

Sexual behavior of adolescents may be impulsive and spontaneous, rather than the result of calm decision-making (Kirby et al., 1994). Many adolescents with psychiatric disorders are impulsive, although the precise role of recklessness in the formation of sexual behavior for depressed or suicidal adolescents is unclear (Gabel et al., 1994; Roehrig and Range, 1995). In general, impulsivity increases vulnerability to transient and coercive relationships. It may be difficult for adolescents to understand how behavior performed now may have serious consequences in the future, and the cumulative risk of behaviors over time may not be appreciated. Impulsive behavior may be difficult to change because such actions reduce the anxiety stemming from unrecognized or otherwise intractable sources (Epstein, 1991).

Adolescents will practice safer sex only to the degree that they believe they can protect themselves when needed (Wulfert and Wan, 1993). Many researchers have suggested that lack of self-efficacy, the belief that a behavior can be performed, explains the frequent

discrepancy between individuals' HIV/AIDS knowledge and their continued unsafe behavior (Bandura, 1989). In fact, self-efficacy may have greater power in predicting condom use than other psychological constructs, such as other sexual attitudes, HIV knowledge, and perceived vulnerability (Brooks-Gunn et al., 1988; Brown et al., 1992; DiClemente et al., 1992; Wulfert and Wan, 1993).

To implement safer sex practices, adolescents must feel capable of performing several different actions under various realistic situations. For example, adolescents need to be able to refuse to engage in sexual intercourse, to request that a condom be used during sexual intercourse, or to negotiate substituting safer acts for high-risk behaviors. Adolescents with psychiatric disorders may lack the self-esteem and the self-confidence needed to acquire and use the necessary communication and assertiveness skills in order to protect themselves in real-life situations.

Sexual Orientation and Exploration

Adolescence has often been thought of as the time of sexual self-discovery and exploration, which may include same-sex behaviors (Hochhauser, 1989). The prevalence of same-sex experimentation during adolescence is not known because there are few recent studies (Rotheram-Borus and Koopman, 1992). In one study conducted in Minnesota public high schools in the late 1980s, 90% of males and 83% of females reported themselves as exclusively heterosexual, while 1% of 12th-grade males and fewer than 1% of 12th-grade females viewed themselves as mostly or completely homosexual. Ten percent of the teenagers were unsure of their sexual orientation, adding further support to the notion that sexual identity may take years to evolve and to be acknowledged (Emans et al., 1991).

Anal intercourse may occur as part of exploration for heterosexual teenagers, as well as for self-identified gay youth. Studies have reported that as many as 15% of teenagers (boys and girls) have participated in anal intercourse (MacDonald et al., 1990). The extent of sexual identity confusion and the prevalence of anal intercourse for adolescents with psychiatric disorders is unknown, but these behaviors carry clear HIV risks. In addition, sex initiation for gay teenagers often involves older, more experienced gay men (Remafedi, 1987), leaving the gay teenager in a situation with power and ability to ensure use of condoms during anal intercourse. Self-identified gay teenagers often experience significant psychosocial stressors, including anticipated negative reactions to self-disclosure of their gay identity, fears of rejection by their families and friends if their sexual orientation is discovered, and violent attacks by biased people (Rotheram-Borus and Koopman, 1992). Constricted social networks may leave gay teenagers feeling isolated because of their sexual orientation, potentially leading to significant mental health concerns and resulting in risk-taking behavior.

Interpersonal Factors

Some research suggests that peer group norms are one of the strongest predictors of safer sex. For example, the majority of adolescents believe that their peers do not support condom use, and these perceived peer norms have been found to predict condom use (Fisher et al., 1992). One study found that adolescents who perceived peer support for condom use were more than three times as likely to intend to use condoms than their peers (Brown et al., 1992). Walter and Vaughan (1993) also demonstrated the important influence of social factors on high school students' intentions to use safe sex behaviors and the occurrence of risk behaviors. Unfortunately for adolescents with psychiatric disorders, social relationships may not be positive, and peer norms may be in opposition to safer sex practices. Although no data address the quantitative importance of perceptions of peers among adolescents with psychiatric disorders, their social networks are less well developed, more complicated, and, often, higher-risk than those of their peers (McFarlane et al., 1995).

Although peers are a significant contributor to risk attitudes, the family remains important for teenagers. Among adolescents with psychiatric disorders, family functioning is sometimes disturbed, or a family member may be impaired by his or her own psychiatric disorder. Parents may be unable to provide a stable environment in which the adolescent may test the limits of behaviors. Inability to actively monitor adolescents' behavior may lead to increased experimentation. In addition, parents, with their own impulsivity, serve as models for risk behavior. In general, families with adolescents with psychiatric disorders have disturbed and distorted communication patterns. Thus, even if families are intent on expressing supportive attitudes, the message may be lost because of conflict and disrupted communication patterns.

All risk behaviors occur in the context of a community, in which teenagers are exposed to cultural stereotypes of male and female sex behaviors. For some adolescents with psychiatric disorders, this context is one of "community disintegration" (Fullilove et al., 1990). Poverty, lack of education, joblessness, hopelessness, and drug use promote self-destructive risk behaviors of all types. Gender stereotypes perpetuate aggressive male behavior and submissive female behavior, stereotypes that are in turn reinforced by the media and popular culture (Amaro, 1995). Adolescents with psychiatric disorders may be less able than others to evaluate and modify these stereotypes.

Adverse Life Experiences

Research on the effects of childhood sexual abuse has established that a history of abuse increases the risk for both current and later psychiatric problems, most commonly depression and PTSD (Mennen, 1993). For example, Brand et al. (1996) found that depressed sexually abused adolescent inpatients ($N = 24$) were significantly more likely to have a comorbid diagnosis of PTSD than were depressed non–sexually abused peers (46% versus 0%). Childhood sexual abuse has been associated at a later age with a range of disturbances in sexual behavior, including high-risk sexual activities, sex with many partners, and a tendency to reenact sexual victimization (Browne and Finkelhor, 1986; Green, 1993). One study found that adolescents with psychiatric disorders who had been sexually abused evidenced significantly higher rates of drug use (31% versus 13.8%) and more severe alcohol problems (22.8% versus 14.8%) than a matched group of adolescent inpatients (Hussey and Singer, 1993). Another project with adolescents in a psychiatric hospital found that girls with an abuse history reported significantly lower condom use self-efficacy, reported significantly more alcohol use, and exhibited significantly more difficulty using safer sex behaviors than their nonabused peers (Brown et al., 1997a). DiClemente et al. (1991) found that sexually abused adolescents were 1.6 more times likely to report self-cutting behavior than those who did not experience sexual abuse or trauma. Allers and Benjack (1991) found that more than 65% of a sample of 52 HIV-positive adults had been physically or sexually abused in childhood. In sum, the previously described studies suggest that a history of sexual abuse can often lead to problems in the expression of sexual behavior and substance abuse, both of which place the individual at higher risk for HIV.

Another group of adolescents who exhibit both increased rates of psychiatric disorders and greater risks for acquiring HIV because of their adverse life experiences are homeless adolescents. There are more than 1.5 million homeless adolescents in the United States, approximately 4% of whom (60,000) are estimated to be HIV-seropositive (Stricof, 1991). The most recent data indicate that young age is perhaps the strongest predictor of HIV seropositivity among homeless and runaway adolescents (Empfield et al., 1993). Depression, suicide attempts, and drug and alcohol abuse are commonly found in homeless and runaway youth, which increases their risk for acquiring HIV (Rotheram-Borus et al., 1991). Because of poverty, these adolescents often have sexual relations with multiple strangers in order to obtain money and/or drugs. For example, one study found that HIV infection in runaways was associated, in declining order, with homosexual/bisexual activity, prostitution, having had another STD, and "crack" cocaine use (Stricof et al., 1991).

Co-Occurring Factors

Although few adolescents inject drugs intravenously, the use of illicit substances (e.g., marijuana, cocaine) and alcohol is even more prevalent among adolescents with psychiatric disorders than among their peers. DiClemente and Ponton (1993) found that adolescent psychiatric inpatients were 2.5 more times likely to abuse substances than a school-based sample. Substance abuse is, in turn, associated with sex exchange for drugs (20% of sample) or sex with IV drug users (20%). Nine percent of the adolescent psychiatric inpatients reported IV drug use, compared with 3.7% of nonhospitalized peers. Needle-sharing places all at high risk for HIV.

Research has also focused on the relationship between ethnic minority status, psychological distress, and substance abuse. A recent study suggested that psychological distress is an important risk factor that predisposes adolescents toward drug and alcohol use, especially for Hispanic adolescents and other ethnic minorities (Alva, 1995). Alcohol use was found to be positively related to measures of psychosocial stress, anxiety, and depression in a sample of Hispanic adolescents in California ($N = 171$).

In addition to the direct transmission of HIV, drug and alcohol use is a cofactor in sexual risk-taking. These

substances lower the threshold for risk behavior, therefore increasing the likelihood of participating in risky sexual practices. For example, one telephone study of 1,152 adolescents found that, among those who were sexually active, 44% indicated that they were more likely to have sex if they were drinking (Strunin and Hingson, 1992). Among adolescents with psychiatric disturbances, substance abuse can compound their emotional disturbances, indirectly resulting in the increased likelihood of participating in risk behaviors. In a study of 100 adolescent psychiatric inpatients, the only statistically significant predictor for unplanned sexual intercourse was drinking alcohol (Aruffo et al., 1994). Windle et al. (1992) found that the strongest predictor of suicidal ideation and suicide attempts among 224 eighth and tenth graders was the combination of sexual and drug risk-taking.

DISCUSSION

Adolescents with psychiatric disorders frequently engage in HIV-related risk behaviors. Impulsivity, self-destructive attitudes, the sequelae of sexual abuse, and cognitive immaturity are some of the many factors that directly determine these risk behaviors. Other significant barriers to safe sex behaviors are indirectly related to general factors found in adolescents with psychiatric disorders. Such factors include low self-esteem, poor self-efficacy for safer sex practices, distorted cognitions, and disordered family functioning. Despite the barriers to safe sex behaviors, the context of clinical psychiatric care creates the opportunity for change by assessment of these behaviors and integration of intervention strategies into treatment planning. In fact, brief behavioral and social skills training for adult psychiatric inpatients has been shown to have a significant impact on HIV risk behaviors (Mueser et al., 1990), and two pilot interventions for adolescents resulted in safer attitudes (Brown et al., 1997a; Slonim-Nevo et al., 1991). The focus of this discussion is the management of sexual risk behavior in the context of clinical care. Because there are many factors in common to all risk behaviors, these intervention ideas are also relevant for delaying the onset of sexual intercourse and for other risk behaviors such as self-cutting and IV drug use. The review of factors related to risk behaviors suggests that there are four areas that commonly need to be addressed for adolescents with psychiatric disorders: personalized concern about the threat of HIV, dysfunctional cognitions regarding risk behavior, sexual communication skills, and high-risk peer group norms.

Personalized Concern. Adolescents often perceive HIV as a remote and unlikely threat or that HIV only threatens "homosexual males and drug addicts." Clinicians can dispel these misconceptions in order to increase personalized concern. The threat of HIV becomes more personal for adolescents when people with AIDS appear more familiar. Adolescents begin to feel more susceptible to HIV when they learn of HIV-positive heterosexual teenagers or of the infection of professional athletes and celebrities. Since many adolescents are impulsive, drawing attention to the long-term consequences of HIV provides an incentive for restraint. HIV also feels more real if the adolescent is given the opportunity to visualize the opportunistic diseases and the fearful course of deterioration characterized by final stage AIDS. Although scare tactics used in isolation ultimately fail to deter risk behavior, increasing appropriate anxiety about the threat of HIV may be an important first step to changing behavior (Brown et al., 1997b). These basic prevention techniques may be used in school programs; however, adolescents with psychiatric disorders may be absent or inattentive because of other concerns.

Attitudes about sexual relationships may cloud realistic appraisal of safe behavior. Both male and female adolescents commonly share the misconception that the degree of affection in relationships equates with safety: "My boyfriend is safe because he loves me, so we don't use a condom." Intimacy may be especially important for adolescents with psychiatric disorders, who may feel estranged from their families or who may, in their sexual behavior, act out conflicts from other relationships. If the use of a condom is perceived as erotic and increases the intimacy of the relationship, safer sex practices are promoted. Misconceptions regarding HIV testing are also prevalent. In fact, HIV testing experiences may actually increase a sense of false confidence for some, since negative test results relieve anxiety about infection. Because HIV testing in the medical setting often lacks in-depth counseling, intervention by the clinician is needed to discourage patients from using the test experience to rationalize further risk-taking.

Dysfunctional Cognitions. Attitudes about safe sexual behavior are related to general self-destructive attitudes,

low self-efficacy, and prior abusive experiences. For the overtly self-destructive, HIV may be used as another weapon for self-injury. Self-destructive attitudes and suicidal tendencies in general are addressed in the treatment setting. The connection between self-destructive attitudes and patients' sense of risk-taking in sexual relationships needs to be explored in similar detail (e.g., "What is appealing about taking risks with sex?"). For others, promiscuity and high-risk sex are related to dysfunctional thinking about relationships, intimacy, and sexuality (Di Scipio, 1994). Distorted cognitions are found across the spectrum of psychiatric disorders and are not exclusive to affective disorders. Clinicians can assist patients in identifying their maladaptive thoughts. Particularly prevalent are dysfunctional thoughts about the futility of prevention and about expectations in relationships (e.g., "He might leave me if I don't have sex without a condom, and I would die"). Also common are distorted cognitions about control in relationships and generalized male and female roles in relationships. The power to dictate sexual behavior is often possessed by the more aggressive partner on the basis of distorted assumptions (e.g., "If I let him do what he wants, he will love me more"). Moreover, earlier sexual abuse is sometimes revealed in the context of safe sex discussion and role-play, especially when participants are asked to provide examples of aggressive pressure lines or to play the role of a passive partner.

Communication Skills. Even when adolescents with psychiatric disorders are concerned about HIV and can identify their own dysfunctional thinking, they need practice to be clear and consistent and to use assertive responses to pressure lines in simulated situations. Clinicians can improve patients' efficacy for safe sexual behavior by using role-play exercises in a therapeutic group or in individual treatment. It is helpful to review basic communication techniques, such as the elements of aggressive, passive, and assertive communication. Strategies for role-playing include asking the patient to play the aggressor in a sexual scenario, then to simulate a more passive partner, or to reverse roles, playing the opposite gender. Developmentally and culturally relevant role-play scenarios can be tailored with patients' assistance ("What would your friend's partner really say?"). These scenarios help teenagers to confront fears about partner rejection and to learn how to persuade older, coercive partners to use condoms ("If you love me as much as you say, then you *will* use a condom"). The clinician can also help the patient cope with violence, feared or actual, arising from conflict around using a condom by reviewing conflict resolution techniques with the patient. Both in groups and individually, practicing coping strategies enables patients to apply their safe intentions in the real world.

Peer Norms. Both risky and safer sex behaviors occur in the social context of sexual partners, peer activities, and perceptions of accepted cultural behavior. HIV education discussions and group sessions in the clinical setting present the opportunity to reshape perceptions of peer expectations and norms. Clinicians can help identify patients' misconceptions about their peers ("They are all having sex, so I don't want to be the only virgin!") and clarify the extent of high-risk attitudes. Clinicians can suggest alternative, safer strategies and discuss possibilities for other peer groups that might support safer norms. Group sessions may be one basis for renewed support in dealing with the sensitive topics of sexuality and relationships. Individual treatment can address these issues by eliciting information about the patient's needs in relationships and motives for participating in risky behaviors with peers. The subjective attitudes and ritualized behaviors of specific adolescent peer subgroups, such as "runaways" who depend on survival sex, "artists" who engage in body piercing and self-tattooing, and "junkies" who share needles, should also be explored. For example, the peer group characteristics of adolescent homosexual behavior must be understood within a specific sociocultural context (e.g., same-sex behavior among inner-city Latino males). Alternative strategies can be found for the expression of impulsive, aggressive, and thrill-seeking urges. By being aware of patients' friends and peer norms, the clinician can better understand the dynamic interaction of psychopathology and high-risk social activities.

Conclusion

HIV prevention relates to many of the sexual concerns of every teenager in treatment, whether it be sexual relationships with peers, history of sexual abuse, or issues of romance and attachment related to sexual behavior. Dealing with the practical skills concerning sexual communication provides a window into understanding the patient's general dysfunctional attitudes, sense of self-esteem, and prior relationships. HIV prevention should be provided in individual and group treatment settings, especially for patients with poor

social supports and little exposure to social skills education. There is a need for additional research on the factors that make adolescents with psychiatric diagnoses at greater risk for sex with multiple unsafe partners, prostitution, self-cutting, IV drug use, and other HIV-related risk behaviors and for interventions specifically designed for these patients. Although HIV prevention is a formidable task, the clinician's encounters provide an important opportunity to make a meaningful investment in the future of our patients.

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