SEXUAL RISK BEHAVIORS: WHO IS VULNERABLE? AN EXTENSIVE LITERATURE REVIEW OF SEXUAL RISK PRACTICES AND THE DEVELOPMENT OF A PAMPHLET FOR AN AT-RISK COMMUNITY

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SEXUAL RISK BEHAVIORS: WHO IS VULNERABLE? AN EXTENSIVE LITERATURE REVIEW OF SEXUAL RISK PRACTICES AND THE DEVELOPMENT OF A PAMPHLET FOR AN AT-RISK COMMUNITY

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SEXUAL RISK BEHAVIORS: WHO IS VULNERABLE? AN EXTENSIVE LITERATURE REVIEW OF SEXUAL RISK PRACTICES AND THE DEVELOPMENT OF A PAMPHLET FOR AN AT-RISK COMMUNITY

Abstract

This study examined published research on sexual risk behaviors and the people who engage in them. Using current and past literature, an extensive review and analysis of attitudes, beliefs, and causes of sexual risk behaviors was done. Sexual risk behaviors were defined within the following models: medical, alcohol and drug, societal views, self definitions, and cultural definitions. The age groups studied were: adolescence (12-17), young adulthood (18-25), middle adulthood (26-50), and later adulthood (51 and older). Studies of homosexual men and women and heterosexual women and men were reviewed as well as a comparison of gender differences. Studies about religion and culture were reviewed, as well as health, psychological co-morbidity, and substance abuse. And, finally, a review of interventions used was examined. A critical analysis was done of 164 articles to determine themes, which emerged as gender, age, ethnicity, assessments used, procedures used, limitations within the articles, and sexual orientation. Finally, an educational pamphlet was developed to target the largest at-risk group, people between the ages of 18-25 years. Based on sexual risk behavior literature, this study examines the impact that risky sexual behaviors have on a person and society, and it also highlights the importance of accessible education. The electronic version of this dissertation is at OhioLink ETD Center, www.ohiolink.edu/etd.
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For my mother

Who has always supported me
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Sexual Risk Behaviors: Who is Vulnerable?

An Extensive Literature Review of Sexual Risk Practices
and the Development of a Pamphlet for an At-Risk Community

Introduction

Dr. Philippe Ricord was the first doctor to study venereal disease, primarily syphilis and gonorrhea in women (Dracobly, 2004). Dr. Ricord noticed the multiple ways in which a woman can contact venereal diseases, and he began investigating the ways in which oral and anal sex could contribute to the transmission of syphilis and gonorrhea. Although Dr. Ricord’s “cure” of mercury did not work, his understanding that many factors contributed to the transmission and infection of syphilis and gonorrhea made him a pioneer in the field of venereal research.

Today in the United States, every nine and a half minutes, a person is infected with HIV (cdc.gov), and the reported lifetime STD rates range from 12% to 25% (Abbey, Parkhill, Buck, & Saenz, 2007). In a 2008 study done by Mueller, Gavin, and Kulkarin, 93% of Americans supported the presentation of sex education in some form. However, research has shown that although abstinence-only programs have increased, they have been ineffective. The authors noted that early education can help prevent sexually risky behaviors later in life. Teaching people “how to say no” and providing education about birth control and STDs can help postpone sexual intercourse and increase the likelihood of safer sex. This paper focuses on sexual risk behaviors among multiple ages, sexes, ethnicities, religions, and sexual orientations in the hope of presenting the people who are most at risk. Also, it discusses education that promotes safe-sex practices that reduce risk
**Purpose of the Study**

The purpose of this study is to develop a better understanding of sexual risk behaviors by examining current and past research, community definitions, as well as attitudes and beliefs that have emerged about sexual risk behaviors. By collecting and analyzing data across the field of human sexuality and sexual risk behaviors, a more comprehensive picture of persons who are engaging in sexual risk behaviors is revealed. Once identified, it is possible to look further into the problem and ask why these groups of people are engaging in these risk behaviors and what can be done in terms of intervention to help prevent them from making these behaviors habitual? The purpose of this study is to bridge a gap in the research by comprehensively examining articles on sexual risk behaviors in hopes of learning what happens to people who engage in sexual risk behaviors. Also, this project will result in a pamphlet geared toward persons 18-25 years old who have been identified as one of the highest at-risk communities.

Understanding the prevalence of those who engage in sexual risk behaviors can help researchers and the health care communities educate people on risky behavior in hopes of decreasing risky sexual practices among all persons. Researchers are not alone in not having done a sufficient job of educating the at-risk community about the outcome of sexual risk behaviors, what happens after the studies are done, and how the research has affected the people. Because of limitations in the research, it is hard to hypothesize about the long-term effects of interventions for sexual risk behaviors.

Longitudinal studies have not comprehensively investigated sexual risk behaviors across age ranges. Therefore, it is important to study the gaps in the literature and locate
the age groups or demographic groups where research is lacking. No prospective studies related to sexual risk behaviors were found to follow a group throughout their lives. Studies that have shown persons to engage in risky behavior at age 15 have not longitudinally studied what happens to those persons when they are 25, 35, 45, or 55 years of age. To date, the research has focused on limited demographic variables, such as 18-25 year olds enrolled in college or persons over the age of 50 in nursing home settings.
Background

Why is Studying Sexual Risk Behaviors Important to Society?

Miller et al. (2004) stated that although sexual behavior has long been a focus of research investigation, research examining sexual risk behaviors and how they correlate with family, peer, and community has been lacking. Because sexuality is an important aspect of one’s life and can alter an individual’s familial, societal, and cultural environment as a whole (Askun & Ataca, 2007), studying risky sexual behaviors is important because they can threaten both physical well-being and social interactions. Many attitudes, behaviors, and concepts with regard to sex and sexuality are socially constructed (Askun & Ataca, 2007). These researchers noted that cultural sexual attitudes may include the general beliefs of a particular culture, personal decisions about when sexual intercourse is permissible, as well as individual attitudes concerning appropriate and inappropriate sexual behaviors.

According to Abbey, Parkhill, Buck, and Saenz (2007), approximately 19 million sexually transmitted diseases are diagnosed annually within the United States. Of those, almost half are contracted by people between the ages of 15 and 24. These researchers report that at least half of all HIV patients are age 25 years old and younger, and that the rates of transmission through heterosexual intercourse are increasing, particularly for young women. According to Quandango, Sly, Harrison, Eberstein, and Soler (1998), experts in public health, education, and risk-intervention have generally all agreed that women “need to assume a greater responsibility” for their sexual behaviors. However, this assumption depends on the women increasing communication with their partners and
discussing sexually related issues. Understanding the motives of people who engage in risky sexual behaviors may help provide insight into understanding the factors that contribute to and maintain an individual’s engagement in these behaviors (Miller et al. 2004).

Papaharitou et al. (2008) studied men and women over the age of 60 who were sexually active on an occasional or regular basis. They found that contrary to the notion that elderly individuals are not sexually active, they, in fact, maintain sexual interest and pleasure and their sexual interest/pleasure is associated with a range of personal, socioeconomic, and interpersonal factors. Winningham (2006) reported that approximately one in six people living with AIDS is over the age of 50. Papaharitou et al. (2008) does not address the importance of educating individuals in this age range; they reported only that the people are still engaging in sex. Winningham (2006) reported that persons in this age group are one-sixth less likely to use a condom during sex than are younger adults. Education is needed within this age group about risk behaviors.

**Sexual Risk Behaviors Defined**

Taking risks and experimenting with a variety of new activities can be considered healthy, depending on the activity. However, when “…the need for varied, novel, and complex situations and experiences and the willingness to take physical and social risk for the sake of the experiences…”(Gullette & Lyons, 2006, p. 24) becomes risky to individuals and those around them, they are no longer engaging in healthy exploration of new activities. The definitions for sexual risk behaviors will be a broad extension of the literature. I have blended many different definitions from published research and defined
various areas to further explain and explore the definition of sexual risk behaviors as an overall construct. The five sections that emerged are (a) the medical model, (b) the alcohol/drug model, (c) the societal model, (d) the self-report model, and (e) the cultural model. No research articles were found that used all five definitions as stated to define sexual risk behaviors.

*Medical Model*

Sexual risk behaviors have often been defined within the medical model as being restricted primarily to the act of intercourse and lack of condom use. An example of this definition is found in Huebner and Howell’s (2003) discussion of sexual risk behaviors as “…a history of sexual intercourse involving either multiple partners and/or no condom use” (p. 78). Coley, Medeiros, and Schindler’s (2008) definition did not extend much beyond Huebner and Howell’s, in that it added lack of reliable birth control and increased susceptibility to STDs, only.

Within the medical model, sexual risk behaviors are defined as having unprotected intercourse (vaginal and/or anal) that places a person at risk for a sexually transmitted disease (STD), HIV/AIDS or unintended pregnancy. Additionally, risk behavior is that engaged in by persons who knowingly have an STD or HIV/AIDS and participate in unprotected sex, which ultimately endangers both the individual and their partner (Vesely et al. (2004), Harris et al. (2006). Having multiple sexual partners or unprotected sexual intercourse outside of a mutual monogamous relationship can also pose a risk to both individuals for contracting an STD (Gullette & Lyons, 2006).
Kef and Bos (2006) stressed the importance of educating persons who have health problems and disabilities. The authors noted that while dating may occur less among people with physical disabilities, they are still sexually active and may have been poorly informed about general sex knowledge. In addition, Kaeser (1996) reported that individuals with severe or profound mental retardation (IQ scores between 31 and 50) were engaging in genital touching and intercourse but with little or no knowledge of safe sex and protection.

Within the mental illness arena, people with bipolar disorder who are exhibiting manic symptoms, such as increased energy, grandiosity, impulsivity, and poor judgment, may be more likely to engage in risky behaviors. Meade, Graff, Griffin, and Weiss (2008) reported that some mentally ill individuals engage in sexual risk behaviors that could put them at risk for HIV/AIDS, such as unprotected sex, multiple partners, and trading sex. The authors further stated that persons with mood disorders are more likely to be sexually risky than those with psychotic disorders, as persons who are manic may have increased sexual thoughts, sexual desire, and/or sexual activity.

Hallfors et al. (2005) reported on the importance of screening for depression among young females, as depression may be a contributor to acting sexually risky. The authors noted that women who engage in high-risk behaviors and are also depressed should seek treatment for both depression and sexual decision making. Von Sadovszky, Vahey, McKinney, and Keller (2006) reported that while people go into encounters with positive emotions if they are planned, over half of the participants in their study (53%)
had negative or mixed emotions following an unplanned sexual encounter that was considered risky. In turn, this impulsive behavior could add to their depression.

Alcohol/Drug Model

Expanding the definition are those people under the influence of alcohol and/or drugs. A person under the influence may have casual sex with unknown partners and fail to use a condom, and potentially engage in other risky sexual practices (Dew, Elifson, Sterk, & 2007). Schafer, Blanchard, and Fals-Stewart (1994) hypothesized that those under the influence of a substance may have clouded judgment, lower inhibitions, and decreasing sensitivity toward pain during intercourse, which may lead to an infection and an STD.

In 2001, Sherman and Latkin reported that for those under the influence of drugs while engaging in unprotected sexual intercourse, the rates of HIV infection had not decreased extensively when compared to injection-related risk behaviors. In fact, in the wake of the HIV/AIDS epidemic, current researchers have focused extensively on the behavioral risk factors associated with substance abuse and HIV transmission (Schafer, Blanchard, & Fals-Stewart, 1994). Hendershot, Stoner, George, and Norri (2007) detailed a model whereby sensation-seeking individuals under the influence of substances were more likely to engage in risky behavior that could put them at risk for HIV/AIDS and STDs. Within the model, the researchers reported that two personality types emerged: (a) sexual sensation seeking, which was defined as “the propensity to attain optimal levels of sexual excitement and to engage in novel sexual experiences” and (b) sexual
compulsivity, which was defined as “a propensity to experience sexual disinhibition and under-controlled sexual impulses and behaviors” (p. 365).

Among adolescents, high risk sexual behaviors and their associations with drugs and alcohol abuse have caused a large concern within the health care system (Wagner, 2001). Wagner (2001) drew upon Zuckerman’s (1979) model of sensation seeking and reported that high school and college students who are high sensation seekers are more likely to engage in risky sexual behaviors, use drug/alcohol, drive recklessly, steal and engage in vandalism (p. 116). The author adds that the choice to engage in such behaviors was within an individual’s personal control. Wagner (2001) claimed that elements of self control, if studied, could be used in prevention and treatment protocols to help eliminate unwanted behaviors.

When looking at men who have sex with men (MSM), Torres and Gore-Felton (2007) report that associations exist between sexual risk behaviors and substance abuse, number of partners, and lack of social support. The authors also noted that anxiety and depression influence risk behaviors and, although few studies have examined the correlation between loneliness and HIV-related risk behaviors among this population, they hypothesized that feelings of loneliness may lead to the use of alcohol and drugs, multiple partners, and engaging in anonymous sex. All of these activities place them at risk for HIV (p. 64).

**Societal Model**

Furthering the definition, Miller et al. (2004) explained the importance of the cost of these behaviors to both the individual and society as a whole. Persons who are
engaging in risky sexual behavior and having unprotected sex may consequently have to
deal with unplanned pregnancy or abortion. An unplanned pregnancy, Miller et al. (2004)
suggested, could impact the individual’s academic success and employment, as well as
other aspects of their life (p. 1612).

Globally, adolescents may be faced with many problems with regard to sexual
risk behaviors and STDs, unwanted pregnancy, and substance abuse. For those who live
at the poverty level, obtaining knowledge about resources and education may be difficult
and, they may be more likely to unknowingly engage in such high-risk behaviors
(Gutierrez, Bertozzi, Conde-Glez, & Sanchez-Aleman, 2006). When correlating
sociodemographic factors with sexual risk behaviors, Peterson (2006) found that the
daughters of single, African American mothers were more likely to engage in sexual risk
behaviors than were daughters of single Caucasian mothers. Peterson (2006) highlighted
that of the 100 mothers studied, African American mothers were more likely than
Caucasian mothers to report living in poverty and having a lower level of education. Both
factors were related to increases in sexual risk behaviors among adolescent girls.

According to Sandfort, Orr, Hirsch, and Santelli (2008), the rates of adolescent
pregnancy may have declined over recent years in the United States, but adolescents are
still responsible for the highest population of females with unwanted pregnancies. The
authors continued to note that while the incidence of STDs has decreased, adolescents
continue to be among the highest of those infected. The authors’ concern regarding this
population’s at-risk status was attributed to the promotion of abstinence-only programs.
They believed that the “…promotion of sexual abstinence until marriage has become a
cornerstone of U.S. domestic and global practices” (p.155). The authors noted that the federal government guidelines regarding abstinence-only programs focus solely on knowledge of social, psychological, and health gains that can result when people abstain from sex (Sandfort, Orr, Hirsch, & Santelli, 2008). The authors noted that the theory behind abstinence-only programs was to help avoid STDs and unintended pregnancies. They found, however, that abstinence-only programs increased health risks. They suggested that education geared toward health and motivation would be more helpful in reducing short and long term health risk among adolescents.

Finding results that were contrary to those of American programs, Herlitz and Ramstedt (2005) reported on sex education programs in Sweden that were set into place “long before the AIDS epidemic…” (p. 220). The authors noted that Swedish sex education programs begin in primary school where students are taught the basic reproduction system. As students advance, they are taught “age-appropriate” information regarding contraception, STDs and HIV/AIDS. They learn where to locate regional health care clinics that they can visit if they have questions. One of the findings the authors reported was that sexually active adolescents between the ages of 16-17 were more likely to use condoms than were those who were a few years older, a behavior that is markedly different from that of American adolescents.

Self-defined Model

When defining sexual risk behaviors, it is imperative to understand that while the definition I am using is research-based, it is ultimately based on self-definition or self
report (Scandell et al., 2003). Therefore, the definition has emerged from the participants’ own reported behaviors.

Schrimshaw et al. (2006) reported that in a recent review of the literature regarding the reliability of self-reporting measures for sexual risk behaviors, only 15 articles were found. Scandell et al. (2003) reported that high sexual risk behaviors are underreported and that unprotected sex is over-reported. This happens mainly in face-to-face interviews, which is “a commonly used methodology in clinical and research settings” (p. 120).

A difference of opinion appears in the research regarding the optimal methodology for conducting interviews. Some researchers have chosen to do them online, while others have chosen to do phone interviews and others conduct them in person. All of these interview methods can influence the accuracy of self reporting. Nicolosi et al. (2006) studied sexual problems among the elderly using phone questionnaires. The participants were asked if they had had sexual intercourse over the last year and, if so, had they experienced sexual problems that were itemized on a provided list. The authors noted that they chose this methodology because they wanted to avoid the embarrassment that could happen during face-to-face interviews.

Gullette and Lyons (2006) utilized the Internet and sent emails to study college students between the ages of 18-43. Alcohol intake and risk behaviors were researched. The researchers acknowledged that using an online survey relied solely on self reporting; therefore, students might have over-reported or under-reported their behaviors. The authors also noted that a limitation inherent in this method was that students could
“…inaccurately recall sexual activities, such as using or not using a condom” (p. 30). Scandell et al. (2003) reported that college students tended to misrepresent their sexual histories when asked about them in order to appear less risky. Utilizing a self-report measure of sexual risk behaviors, the researchers found that one third of students who had previously tested positive for an STD did not disclose that test result to their partners.

In reviewing this research it is also important to distinguish that sexual risk behaviors may be different among each population. For example, unprotected sex within a monogamous relationship, such as marriage, may not be considered risky. However, unprotected sex with a stranger could be considered risky. Another consideration that should be made is that not every person who has sex while intoxicated is acting in a risky manner. However, the distinction is made by determining which behaviors the person engages in while intoxicated. For example, a person whose blood alcohol level is below the legal limit could engage in sexual intercourse with a stranger safely, by using a condom, which would be considered less risky than if that person had unprotected sex with a stranger.

*Cultural Model*

Quadagno et al. (1998) reported that African American women are less likely than American or Hispanic women to engage in sexual acts other than vaginal intercourse. Caucasian women are approximately 30% more likely to receive and give oral sex than African American women (Quadagno et al., 1998). The researchers stated that they believe that ethnic backgrounds do not differ in the incidence of vaginal intercourse, but anal intercourse appears to be higher among heterosexual Hispanic women.
Quadagno et al. (1998) explained that one of the reasons for this difference could be due to culture and the differences in the ways that people in Hispanic culture reinforce gender and sex versus the ways that people in European American culture do. When studying Hispanic women and men, Quadagno et al. studied men and women in America and therefore the sample consisted of persons who resided in America but could have been born anywhere. Quadagno et al. (1998) reported that within Hispanic culture, the value of “machismo” may contribute to the dichotomy among the genders. Given this, women are typically not allowed to discuss relationships and “sex is considered a private issue….‖ (Quadagno et al., 1998, p. 58). The authors noted that women learn about sex from their husbands and, therefore, their knowledge can be very limited. For example, Quadagno et al. (1998) reported that Hispanic women are not allowed to bring up subjects such as sexual behaviors or condom use. In situations such as these, culture plays a vital part in sexual risk behaviors. A woman may unintentionally engage in sexual risk behaviors because she does not know differently. When educating on sexual risk behaviors and health in such situations, culture should be an integral factor.

Contributors

Contributors are defined as anything that may cause or be involved in a person engaging in sexual risk behaviors. Unlike drugs and alcohol as contributors, a person’s experiences play a part and people may not be fully aware of the impact these experiences have on them. For example, Oswalt, Cameron, and Koob (2005) discussed the importance of anticipated regret with regard to sexual risk behaviors. The authors studied anticipated regret with college students and defined it as mainly having regret
after one’s first sexual experience. The researchers discussed the fact that if an individual engaged in a behavior that they regretted, they might have a higher emotional intensity with regard to the situation. Conversely, researchers stated that those who have less experience sexually and have not engaged in other risky activities, reported lower anticipated regret toward engaging in high risk behaviors, such as having unprotected sex (Oswalt, Cameron, & Koob, 2005).

Oswalt, Cameron, and Koob (2005) researched people from their early 20s to late 70s and asked them to reflect on sexual experiences or lack thereof with regard to premarital sex. The researchers found that about 40% had some regret about premarital sex, whereas only 8% regretted that they did not have premarital sex. When examined by gender, the subjects revealed that twice as many women regretted having premarital sex, whereas twice as many men regretted not having premarital sex.

When expanding this theory to adolescents, Serovich and Greene (1997) reported that predictors of behaviors can be seen by determining the influences on “voluntary” behavior. The researchers described a person’s intent to engage in a behavior as being their attitude about the behavior as a whole and their perceptions learned from others, as well as whether they thought they should or should not engage in the risky behavior.

Shrier et al. (1996) summed up Schneider and Morris’ (1991) research by stating that individuals who engage in a multitude of risky behaviors may form “risk behavior syndrome” (p. 378). Individuals experiencing this syndrome are at risk for serious repercussion, not only physical but legal. In addition, Shrier (1996) reported that the earlier the onset of the problem behaviors, the more severe the behaviors became.
Rye and Meaney, (2007) reviewed the importance of the pursuit of sexual pleasure as a primary motive for engaging in sexual activity. The researchers stated that “uncommon [sexual practices] does not equal pathological” (Rye & Meaney, 2007, p. 38). The authors noted that most sexual behaviors can be found on a continuum from healthy to pathological. When the sexual pleasure has become a primary motivation and the individual does not account for the safety of themselves and their partner, then they may be engaging in risky sexual practices.

In considering the cultural influences within the United States, Serovich and Greene (1997) noted that in the case of HIV/AIDS, they believed that people’s attitudes toward risky behaviors as well as the collective attitude prevalent in their societies were important and could influence an individual’s actions. For instance, education given to adolescents surrounding STDs is generally geared toward abstinence, reduction of sexual activity, and number of partners. This three-part focus has neglected a critical component of education: understanding the attitudes that adolescents have toward risky behaviors. Serovich and Greene (1997) believed that it is critical to understand adolescents’ attitudes toward preventive measures, such as using condoms to help prevent HIV/AIDS. Because many adolescents get their information not only from peers but also from school, Somers and Gizzi (2001) argued that if students became isolated from school, they were more likely to engage in risky behaviors. Therefore, it is important to keep adolescents involved with their environments.

Schneider and Morris (1991) associated risky sexual behaviors with not using a seat belt, physical inactivity, and failure to use helmets or sunscreen. Schneider and
Morris (1991) also noted that problem behaviors may contribute to risky behaviors. For example, those who are at risk of being arrested are more likely to engage in severe risky behaviors. Oswalt, Cameron and Koob (2005) continued this relationship by adding that there is an association between sexual risk behaviors and smoking cigarettes and skipping school.

**Populations Examined**

I am exploring the demographics of participants engaging in sexual risk behaviors. Primarily, the questions include: What populations are at highest risk? Which is at the highest risk? What additional factors contribute to their actions and make them risky? Within this inquiry, the age groups examined are: adolescence (ages 12-17), college age or young adulthood (18-25), middle adulthood (ages 25-50), later adulthood, and elderly (ages 51 and over). Studying a broad range of ages allows better understanding of who is engaging in sexual risk behavior. Within this section, age is the primary focus, and any possible contributors that may influence an individual to engage in risk behaviors are included as well.

**Adolescence (12-17)**

Adolescence is a time of exploration that can involve sexual experimentation when people are not necessarily emotionally ready for the responsibilities that come with being sexually active. Morrison-Beedy, Carey, Feng, and Tu (2008) reported that almost one half of sexually active persons will acquire an STD by the age of 25, and those in their late adolescence are particularly vulnerable to Chlamydia and Gonorrhea. The authors reported that with the alarming rates of HIV/AIDS rising in today’s younger adult
population, it is assumed that they were infected when they were in their adolescence, since the time frame for diagnosis can be 5-10 years.

Lohman and Billings (2008) studied adolescent boys who engaged in sex from the age of 12 to 15 years old. The authors found that boys who were sexually active at that young age were more likely to have academic problems, have an increase of problems at school as well as substance abuse problems. The authors noted that adolescents having sex at such a young age could not only have long term affects on their health, but also could cause societal problems, such as unintended pregnancy.

Rose et al. (2005) reported that contraceptive use is very low among the adolescent population, and with the rise of early sexual activity, the result is a greater risk for both pregnancy and STDs. The researchers noted that when compared with older adolescents or people in their 20s, younger adolescents who decide to carry a infant to term have higher rates of premature delivery and lower birth rates. William, Connolly, and Cribbie (2008) stated that because one of the highest risks for early adolescents who are engaging in sexual activities is pregnancy—which can lead to both psychological and health risk for the adolescent—substantial efforts need to be made to intervene early on.

The consumption of drugs and alcohol within the population has contributed significantly to people engaging in risky sexual behavior (McHale & Newell, 1997). McHale and Newell (1997) reported that 50% of the participants studied engaged in unprotected sexual intercourse while under the influence. Sex education is vital for this population. Muller et al. (2008) reported that once people become sexually active, sex
education may have little impact within the age group in stopping sexual intercourse, but it can help with contraception use and condoms.

Young Adulthood/College (18-25)

People in college have been identified as the most at risk for engaging in sexually risky behaviors. Approximately 80-90% of college students report being sexually active and only one third report using condoms on a regular basis (Abbey, Parkhill, Buck & Saenz, 2007 and Eisenberg, 2001). Both Abbey, Parkhill, Buck, and Saenz (2007) and Eisenberg (2001) reported that college students are likely to have multiple sexual partners, averaging six or more partners. Moore and Davidson (2006) reported that even with a flooding of educational material regarding safe sex practices, some college women have not changed their sexual practices. The authors noted that “...being well-informed about sexual risk does not necessarily result in behavioral change” (p. 577). Moore and Davidson (2006) found that women wanted to have education about sexual health and risk behaviors that was more personalized to them as individuals, such as, personalized information about sexuality, reproduction, contraceptives, decision making, assertiveness and communication skills examples, as well as how to apply them individually within situations.

According to Gullette and Lyons (2006), college students may engage in unprotected intercourse, have multiple sex partners, attend “wild” parties, seek “novel” social experiences (i.e., join Greek organizations or experiment with drugs), and consume “large” amounts of liquor. The researchers also stated that women who engage in sexual risk behaviors have more negative attitudes toward using condoms, possess lower self
esteem, and use illegal drugs on average more than do women with higher self esteem (Gullette & Lyons, 2006).

Randolph et al., (2007) examined sexual pleasure and condom use among college students and found that both men and women reported that using condoms significantly reduced sexual pleasure. The researchers reported that men valued unprotected sex more and believed that using a condom reduced pleasure more often than did women. Interestingly enough, Flannery, Ellingson, Votaw, and Schaefer (2003) found that although college students are more likely to have multiple sex partners and not consistently use condoms “…they are more likely to have higher levels of sexual self-efficacy and use a condom if a partner requests it, and both practices are associated with lower risk of HIV infection” (p. 228). It may be likely that Chin’s (1999) theory about women’s schema and possible lack of strength which could lead to a woman not being comfortable discussing safe sex practices with her partner, can help illustrate the inconsistencies. Hypothetically, if college students felt more self efficacious about their own sexual ability, they might be more comfortable asking their partner to use a condom, in which case their partner could agree. However, it is also likely that students may lack self efficacy and are not comfortable asking about condom use.

Middle/Emerging Adulthood (26-50)

Research on middle or emerging adulthood is defined for the purpose of this paper as individuals between the ages of 26 to 50 years old. There is sparse research among this population, therefore any conclusions made of the emerging adulthood individuals sexual risk practices should be done with caution. Kaestle and Halpern,
(2007) researched this age population and examined what should be considered risky sexual behaviors within the context of a “loving relationship.” The authors noted the importance of examining the length of the relationship before defining their activities as risky. In the early stages of emerging adulthood, persons may be newly out of college, and the way in which they enter and view a relationship is different from the way they viewed relationships when they were in college. Kaestle and Halpern, (2007) stated that the emotional development for emerging adulthood relationships should occur within the first three to four months. During this time, emerging adults date and may fall in love and this time is often referred to as the “honeymoon” phase. Kaestle and Halpern, (2007) stated that sexual activity during this time is novel and, therefore, the couple could engage in risky behaviors at this time. The authors found that “…relationships of less than one month’s duration include more frequent fellatio but less frequent cunnilingus than longer term dating relationships” (p. 134).

Kaestle and Halpern, (2007) noted that additional research is needed in a broad range of areas because current literature on oral and anal sexual practices is limited. The researchers found that of 3,000 individuals surveyed by the National Health and Social Life Survey, 85% had engaged in vaginal sex in the past year, 69% of women had performed fellatio while 74% of men reported receiving fellatio, 75% of women reported receiving cunnilingus and 72% of men reported giving it and 16% of both men and women reported having anal sex. (p. 135).

When reporting on working with this population, Risen and Altof (1990) said that it is important to work with couples, because this is the time in life when most adults
choose a committed partner and could be unknowingly engaging in sexually risky behavior together. Furthermore, showing the couple how to have open dialogue about their previous sexual experiences is vital, because STDs can go undetected for years.

*Later Adulthood/Elderly (51 and over)*

Research on later adulthood or the elderly populations (persons over the age of 51) has shown that people in this group possess a desire to be sexually active. There is a lack of research among this population therefore any conclusions about the elderly sexual risk practices should be done with caution. Although labels such as “dirty old man” and “asexual” can often be associated with this population, when individuals want to continue to be sexually active, both men and women continued to report their desire to be sexually active as they aged (Nagartnam & Gayagay, 2002; Nicolosi et al., 2006). In the elderly population, specific sexual dysfunctions arise that may interfere sexual activity. Nicolosi et al., 2006, examined sexual activity and the prevalence of sexual dysfunctions among the elderly and found that 11% of men studied reported having delayed ejaculation and among women 13% reported inability to reach an orgasm. In addition, sexual functioning can be affected by health concerns which typically increase with age. For example, with someone who experiences a stroke, sexual behaviors may become very different from those experienced prior to the stroke, and they may be seen as unusual or inappropriate (Nagartnam & Gayagay, 2002).

Research has continued to show that unprotected sexual contact is the most reported form of HIV transmission within the elderly community, and older adults are one-sixth less likely to use a condom as compared to the younger generations.
Physiological changes that occur as women age contribute to the risk of being infected with HIV/AIDS. Women may experience a “…decrease in vaginal lubrication and estrogen deficiencies, which cause thinning of the vaginal walls…[and]…these physiological changes allow for microscopic tearing during sexual penetration and, therefore, provide a direct route for HIV transmission” (Winningham, 2006, p.1). Pratt and Schmall (1989) detailed the importance of educating the elderly about sexuality. In addition, Pratt and Schmall (1989) reported that education should be focused on all aspects of sexuality, such as touch, intimacy, body image, and affection, instead of the focus being mainly on genital sex. Also focus should be on safer sex practices.

Sexuality

When examining sexuality, I focused on heterosexual and homosexual populations separately and in relation to each other with respect to risky sexual behavior. Dew, Elifson, Sterk (2007) report the importance of studying homosexuality and heterosexuality separately. The authors found that both groups engaged in sexual behaviors that put them at risk for contracting HIV and hepatitis C, in addition to other STDs, but that homosexual men engaged in behaviors that put them at risk at an only slightly higher rate. Often when researchers examine the thinking behind sexual risk behaviors among men, homosexual men are thought to engage in more risky behavior. However, the Dew, Elifson, Sterk’s (2007) article highlighted the risks that both homosexual and heterosexual men take.
Heterosexual Men

When researching heterosexual male college students, Eisenberg (2001) found that older students and non-Caucasian students were more likely to report having multiple sex partners over the last 30 days. Consistent with the research, the Eisenberg study (2001) found that people with more partners reported less consistency with condom use. Interestingly enough, Eisenberg (2001) found that those who did report using a condom consistently, were under the age of 23. Those who were 23 years or older reported not only using condoms less consistently but also reported that they were engaging in the same-sex sexual practices (Eisenberg, 2001).

Catania, Coates, and Kegeles (1994) found that men who communicated about sexual health were more committed to using condoms and were more likely to have higher levels of sexual enjoyment with women. In their study, the authors found that heterosexual men often communicated their desire to wear a condom to avoid contracting HIV and genital herpes.

Homosexual Men

In a 2005 study, Stein, Rotheram-Bors, Swendeman, and Milburn reported that of the 250 homosexual male participants surveyed, the average number of reported partners within a three-month period was seven. In addition, nearly 25% of those individuals reported never using condoms during intercourse. Osmond, Lance, Pollack, and Catania (2007) queried men in Chicago, Los Angeles, New York, and San Francisco about their risky sexual behaviors in their past and categorized them into six different hierarchal categories:
No male sexual partners, no anal intercourse partners, anal intercourse with 100% condom use (protected partners), anal intercourse without 100% condom use but only with partners thought to have the same HIV serostatus as the respondent, unprotected anal intercourse in which insertive partner was HIV negative and the receptive partner was HIV positive or serostatus known, and unprotected anal intercourse in which the receptive partner was HIV negative and the insertive partner was HIV positive or serostatus known. (p. 1678)

Three trends were found: during the time of the study (1997-2002), 1) HIV infection increased; 2) risky sexual behaviors also increased, and a shift from avoiding anal intercourse or engaging in intercourse with a condom occurred; 3) partners asked about the HIV status of the other person in order to reduce the risk of transmission (Osmond et al. 2007).

When looking at MSM, Preston, D’Augelli, Kassab, and Starks (2007) reported that the risk among this community includes a preference for receptive anal sex, multiple unknown partners, unprotected sex, as well as possible substance abuse during intercourse. The researchers also addressed other important considerations within this community that may affect risky behaviors, including age, education, access to the Internet, and psychological well-being.

When working with homosexual men toward safe sex education, Griffen et al. (2006) reported that it is important to discuss continual use of the condoms as a protective measure for HIV. This education should include, but not be limited to, the dangers of “barebacking” (anal sex without a condom) and intravenous drug use. Stein,
Rotheran-Borus, Swendeman, and Milburn (2005) reported that when talking to homosexual men about drug use, focusing on coping styles and healthy peer relations should be a focus of treatment.

Heterosexual women

Chin (1999) suggested that a women’s sexual health to some extent depends on the health of her male partner(s). Given this, sexual interactions are critical and important to determine and examine how a woman thinks and feels when engaging in sex. Chin (1999) suggested looking at a woman’s schemata (her internal view of herself, self worth and self efficacy) to understand how she organizes experiences, provides meaning to sexual activities, and processes or interprets her actions. When related to risky sexual behaviors, if a woman’s schemata are not strong, she may not be comfortable inquiring about her partner’s sexual history, his HIV status, or asking him to use a condom. Chin (1999) stated that with regard to one-night stands, women with poor schemata may “guess” the extent of her partner’s safety visually rather than ask him.

When examining mutually shared conversations between partners that result in sexual scenarios or sexual scripts, Dworkin, Beckford, and Ehrhardt (2007) found that the analysis of sexual scripts were vital for safer-sex practices. The partners could communicate their needs, make decisions, and shape their own and the other’s actions in sexual negotiations. For example, the researchers found that 95% of women studied felt that the use of condoms did not ruin their “ideal” sexual scripts (Dworkin et al., 2007). When the researchers queried the women about asking the men to use a condom at the
time of penetration, 29% of women reported stopping and asking for her partner to put on a condom.

Also, many sexual risk behaviors are related to drug use or intoxication (Cooperman, Falkin, & Cleland, 2005). Therefore, an increase in HIV/AIDS infections has occurred. Women using recreational drugs could have a direction impact on their decisions to engage in sexual risk behaviors (Cooperman, 2005).

Homosexual Women

Morrow and Allsworth (2000) stated that the reporting of HIV among lesbian women is typically self identified and has only recently been studied. Of the 267 females studied (both lesbian and bisexual, 53% reported having had an HIV test at least once, two women reported being positive, and 9% of the women studied had not been tested. Although the risk remains unclear, the researchers note that lesbian women are at risk for the human papillomavirus (HPV) and anogenital warts, the same as heterosexual women.

When compared to bisexual women, lesbian women appeared to have fewer partners over the course of the year, but they had more partners who defined themselves as lesbian (having sex with females only) as opposed to bisexual (having sex with males and females). Bisexual women reported using dental damn during sex, whereas lesbian women were less likely to suggest safer sex practices.

A Comparison of Homosexual and Heterosexual

Dew, Elifson, and Sterk, in their 2007 study of homosexual and nonhomosexual male methamphetamine users, found that both heterosexual men and homosexual men put themselves at risk for contracting HIV, hepatitis, and other STD’s. The authors noted
that heterosexual men tended to engage in less risky behaviors than did homosexual men, however, nearly one half of the heterosexual males studied reported having had sex with someone who was a methamphetamine drug user. Among women, lesbian women reported safe sex practices more often than did heterosexual women (Mattew, Brandenburg, Johnson, & Hughes, 2003). Mattews, Brandenburg, Johnson, and Hughes (2003) reported that although lesbian women reported safer sex practices, the same safe sex education should be given to all women to decrease the risk of HPV.

Research on college campuses studied primarily heterosexual students who were sexually active. Research was limited to the sexual practices of same-sex sexual contact and opposite-sex sexual contact. Eisenberg (2001) reported that the “...bulk of the literature on college students’ sexual behavior employs samples of several hundred students, which would be unlikely to include sufficient numbers of students reporting same-sex sexual contact to conduct appropriate analyses...” (p. 576). Eisenberg (2001) also argued that research into individuals identified as lesbian, gay, or bisexual is limited and usually collected from support organizations or educational programs. This fact makes it difficult to appropriately analyze and generalize the findings. For example, Eisenberg’s (2001) research on the differences of sexual health practices among college students with same-sex versus opposite-sex partners found that “...female students reporting both-sex partners and males with both-sex partners and only same-sex partners were more likely to report multiple sexual partners than students with only opposite sex experiences” (p. 585).
Gender

A review was done of gender differences between men and women engaging in sexual risk behaviors. In a study by Fischtein, Herold, and Desmarais (2007), the researchers concluded that men thought about sex more frequently than did women, were more likely to engage in oral sex, and lost their virginity at a younger age. Specifically, those persons who were single, had higher education, and did not attend religious services on a regular basis were more likely to engage in risky sexual practices. The progression from thoughts of sexual activities and reality was not discussed. The researchers also noted a larger difference exists between the number of lifetime partners between males and females, with males reporting higher numbers of sexual partners than females. However, it is important to note that the researchers found that men and women may be using different strategies to determine the number of partners with whom they have had intercourse, and, therefore, this discrepancy may account for some of the gender differences within the literature.

When examining gender differences in other cultures, Rugpoo (2008) researched condom use among Thai couples and suggested it is vital to educate Thai women on safe sex practices and HIV. Rugpoo (2008) argued that this great need exists because of the extramarital affairs often engaged in by Thai husbands who frequent sex workers. Participants of the study felt that sex workers who looked cleaner (i.e., dressed as students) were safer to have sex with. Thai women may face barriers in using condoms with their husbands, as it could be seen as a stigma for a married person to buy condoms.
Also, her husband may disapprove of condoms and/or their cost. Consistent with Chin’s (1999) report, a women’s sexual health can depend on her male partner, and it is important to help educate both men and women on safe sex practices.

Culture

Because sexuality affects not only the individual but also the family, society and culture, it is important to understand and examine how cultures and religions view sexual risk behaviors. We turn now to an inquiry into the religious and cultural aspects that affect sexual risk behaviors.

Religion

Research done to date has shown that students who are sexually active may report lower levels of intrinsic and extrinsic religiosity (Zaleski & Schiaffino, 2000). Religious identification may protect individuals from engaging in sexually risky behaviors. Jones, Darroch, and Sing (2005) reported that greater attendance at religious services may be associated with the timing of an adolescent’s loss of virginity. However, if the adolescent was already sexually active, attending religious services appeared to have no association with decreasing sexual activity. Interestingly enough, Zaleski and Schiaffino (2000) discovered that students who reported high levels of religiosity, both intrinsic and extrinsic, were less likely to use condoms, and, therefore, they may represent a population at higher risk for unsafe sexual practices.

Among adolescents who reported believing in G-d, Goggin et al. (2007) also reported lower levels of sexual risk behaviors. The authors hypothesized that believing in G-d may protect against being sexually risky and these people may use their beliefs as
strength to draw upon. Conversely, Sinha, Cnaan, and Gelles (2007) reported on the importance of religion and risky sexual behaviors and found that African American and Latino males reported the highest rate of sexually activity. The lowest percentage was found in the Caucasian males group, but both African American males and Latino males reported being more religiously active than Caucasian males. When working with religious teenagers, it is important not to focus on whether or not they attend church or temple or believe in G-d. Instead, one should empathize with their behaviors and the support systems that they have, including church, family, and cultural group.

Earle et al. (2007) reported that religious women in the United States are more likely to feel guilty about masturbating and less likely to engage in premarital intercourse. Findings from both Jones, Darroch, and Sing (2005), and Earle et al. (2007) suggested that religious commitment was associated with the age of sexual intercourse for the first time, and was related to the number of partners these subjects had over their lifetimes as well. McCree (2003) suggested that African Americans are among the most religious “population subgroups” and the religious involvement that is fostered in that community may help to modify negative behaviors.

Ethnicity

Age, education, and marital status may affect verbal and nonverbal communication regarding sex. Quadango et al. (1998) suggested that men who are younger, married, and/or cohabiting with women are more likely to initiate conversations about sex. The researchers noted that in situations where women are economically dependent on their partners or in cultures where males typically dominate, women did not
generally discuss sexual desires or risk, and usually did not even know about the activities that men participated in that were putting them at risk. In fact, in Rugpoo’s (2008) study of Thai women, it was reported that they under-reported their husband’s sexual risk practices because they did not know about them.

According to Wang et al. (2007), after two years of a virtual eradication of sexually transmitted diseases (STDs), China saw an “explosion” of STDs. Sexually transmitted diseases have increased more rapidly in females than males, and Wang et al. (2007) hypothesized that this increase may be associated, in part, with the loosening of governmental control over the population movement. Migrant women who are unable to find jobs may frequently turn to sex work to make money. Migrant men who are relatively wealthy may, therefore, have “…increased opportunities to engage in high risk behaviors…” (p. 58) with sex workers. Chinese students in rural China reported feeling that attitudes toward sex were changing from a more traditionally conservative view to a more liberal view (Lonn et al., 2007). However, the students reported that they still felt that sexual activity prior to marriage was viewed as morally wrong in their society as a whole, especially by members of the older generation. Although the younger generation responds to strong influences from Western countries, students reported not being comfortable talking to their parents about HIV/AIDS, due to embarrassment and their parents’ lack of education (Lonn et al., 2007).

Jermott, Jermott, and O’Leary (2007) reported that while only 12% of women in the United States are African American, 67% of women who were diagnosed with AIDS in 2004 were African American. Among this population, Jermott, Jermott, and O’Leary
(2007) also noted that the rate of Chlamydia is 10 times higher and the incidence of Syphilis is 25 times higher among African American than among Caucasian women. Ickovics et al. (2002) speculated that reasons for the disproportional rates may be due to feelings of powerlessness and helplessness. According to the researchers, feelings such as these may lead to women having “…a short term view of the world and the consequences of behavior due to more violent and chaotic environment, higher rates of prostitution due to economic strain and denial of vulnerability to AIDS risk” (p. 339-340).

Ickovics et al. (2002) reported on the importance of examining ethnicity when researching sexual risk behaviors in a community. The researchers noted that in the African American community, cultural values emphasize gender relations, family structure, and social/economic survival. These factors must be considered when discussing and exploring sexism, racism, and oppression in this community. Ickovics et al. (2002) also suggested that if minority women live in poverty, they could be at risk for engaging in risky sexual practices. The researchers noted that “…poor minority women may be overwhelmed by the number of life stressors they experience, and AIDS risk may be of relatively low concern when compared to the need for shelter, food, employment, and safety that demand immediate attention….the stress that many poor minority women experience, and the manner with which they cope with that stress, may be related to AIDS risk behaviors” (p. 340).

When comparing ethnic differences among women, Farmer and Metson (2006) found that Latina women reported using condoms less than did Caucasian women. Of Latina women who did use contraceptives, 10% always used a condom, and 58% never
used one, whereas, 17% of Caucasian women always used condoms and 47% never did (Farmer & Metson, 2006). Gutierrez, Bertozzi, Conde-Glez, and Sanchez-Aleman (2006) reported that 17% of all births in Mexico in 2003 were of women under the age of 20. In Mexico, adolescents living in poverty have become susceptible to sexual activity leading to unwanted pregnancy, as well as alcohol and tobacco use (Gutierrez, Bertozzi, Conde-Glez, & Sanchez-Aleman, 2006).

When comparing two European studies on sexual risk behaviors, it is possible to see the similarities and differences that emerge (Askun & Ataca, 2007; Herlitz & Ramstedt, 2005). In Sweden, radical measures were taken to help with the prevention of HIV/AIDS. The Swedish government implemented mandatory sexual education programs starting at primary school. It was discovered, however, that despite these extreme measures, risky sexual practices did not decrease and people did not adopt safer sexual practices. It can be concluded that neither Western nor European counties have figured out the best possible sex education programs.

In contrast, Turkish society has maintained a viewpoint whereby men control sexual behavior. It appears that urban communities seem to be separating from this viewpoint and the younger generation, while still holding some of their families’ views, are starting to make their own decisions about their sexual practices. Askun and Ataca (2007) found that 67% of college students at a Turkish university reported never having had intercourse. The researchers noted that a total of 52% of men and 81% of women reported that they were virgins. Also, only 11.4% of women reported that they had had intercourse, while 67.8% of men reported that they had engaged in intercourse.
When discussing sexual risk behaviors, it is important to understand someone’s cultural background and the topics that they may or may not be comfortable with. As noted, individuals from some countries and cultures are very open and willing to discuss sex, while others are more reserved. When educating people, it is important to not only discuss the facts, such as STD rates and the importance of using a condom, but one must be mindful of those people in the room who are sensitive. Jermmott, Jermmot, and O’Leary (2007) stated it best by saying that brief, culturally sensitive, cognitive-behavioral skill building interventions are the best teaching tool for HIV/STD prevention and safe sex education.

**Comorbid Disorders**

Health problems, psychological conditions, and possible substance abuse are all important factors that could contribute to a person’s probability of engaging in sexually risky behaviors. All three factors can be vital in understanding why people are engaging in sexual risk behaviors and determining what can be done to mitigate the negative outcomes of their actions.

**Health**

Sandfort, Orr, Hirsch, and Santelli (2008) reported that the timing of an individual’s first sexual experience is related to the subject’s long-term sexual health. The researchers determined that having sex at an early age can be associated with HIV/AIDS and STDs, whereas those individuals who do not engage in sex until later in life were at lower risk. In addition, Russell, Golub, Cohen, and Mayer (2007) reported that identification and treatment of asymptomatic STDs are critical to the prevention of new
infections. The researchers noted, however, that people are often unaware that they are infected, and, therefore, they are less likely to be tested, seek treatment, or modify their risky sexual behaviors. The researchers concluded that this avoidance of testing and treatment may be one reason for the increase in STDs.

**Psychological**

When studying depression and sexual risk behaviors, Perdue, Hagan, Thiede, and Valleroy (2003) hypothesized that depression may predispose a person to a risky situation, such as engaging in high risk sex with a great number of partners, whereas, specific behaviors, such as unprotected sex, may be influenced more by immediate factors, such as fear of being rejected sexually or being intoxicated. When studying this phenomenon in women, Sterk, Theall, and Elifson (2006) found that over time, women who continued to experience high levels of depression and anxiety (after treatment) were more likely to engage in drug use as well as high risk sexual behaviors. Interestingly, women who continued to experience higher levels of anxiety were also more likely to report higher levels of sexual risk behaviors more frequently.

Among demented patients, sexual desires may not decrease, although their functioning in other areas may. Mayers (1994) detailed that a person with dementia who may not be able “….to move a spoon from a bowl to his mouth and must be fed may retain the capability to move his hand to the thigh of his caretaker, engage in sexualized stroking, and proceed to move his hand upward in a highly directed and sexually aggressive manner” (p. 217). Women, on the other hand, may tend to cuddle, kiss or climb on males’ laps or into their beds in a quest for affection (Mayers, 1994). In an
optimal situation, patients would be able to discuss and determine the health risk of the behaviors they will possibly be engaging in, including finding out if their partner(s) may have an STD. However, given that that is not a possibility for most patients with dementia, it then becomes the responsibility of the staff in the health care setting to keep the patients safe.

Substance Abuse

Torres and Gore-Felton (2007) discussed the implications that emotional pain may have on men who have sex with men and reported that alcohol and drug abuse has been associated with this community and could result in an increase in the number of incidents of unplanned sexual intercourse, indiscriminate sex, unprotected anal sex, as well as a greater number of sexual partners. Among heterosexual men and women, a link has also been found between substance use and sexually risky behaviors. Alcohol and drug use has been shown to cloud judgment, disinhibit the user, and decrease pain sensitivity during intercourse. These factors, it has been hypothesized, affect HIV transmission (Schafer, Blanchard, & Fals-Stewart, 1994). Alcohol and drug use may affect particular individuals differently. In fact, Schafer, Blanchard, and Fals-Stewart (1994) report that individuals under the influence of drugs are less likely to use condoms with new sexual partners than are those under the influence of alcohol.

Among women who smoke cigarettes, Saules et al. (2007) found an association between cervical cancer, sexual risk behaviors, risk awareness, and health. It was found that women who smoke cigarettes “reported a higher frequency of talking with health care providers about the benefits of testing for sexually transmitted diseases” (p. 210). In
addition, women who are at risk for cervical cancer (i.e., smokers) are aware of the general risk factors but “fail to define themselves accurately as being a member of an at-risk group [therefore suggesting that] prevention efforts may miss their target” (p. 208).

*Interventions*

It is important to understand not only the sexual risk behaviors, but, also, the interventions and therapies that are being utilized to help this community. Bogart et al. (2007) researched cognitive strategies used during recall of information by people who may have engaged in risky sexual behaviors. These researchers used two main strategies: (a) enumeration, in which the event is recalled and counted separately, and (b) estimation, which is based on the perceived frequency at which the behavior may have occurred. The researchers emphasized the importance of understanding the strategy being utilized, as this strategy may have influenced the self-report of risk behaviors and ultimately the intervention/treatment. It was found that enumeration may be more accurate than estimation, because individuals could often recall the details of a sexual event, especially if asked to examine them in a shorter time frame.

*What was not Studied*

In this broad overview it is important to know not only what is included in the research review, but also what is excluded. Fetishism, sadomasochists, bondage, and dominatrix have been excluded, because they are their own communities, possessing their own norms and rules. The sexual risk behaviors common to these populations differ from those of the general population, specifically, those who do not participate in such activities. Therefore, it would have been hard to generalize about either group. Sex
workers have also been excluded, as they too have their own norms within their community and it is difficult to generalize about their practices. Finally, persons who have suffered from acts of violence, such as rape or sexual abuse have been excluded. Studies that research risky behaviors among these populations have been excluded because they lie beyond the scope of this paper.

Methods

Data Collection

Over 300 articles were reviewed from searches across the following databases: Ohiolink, Proquest, Ebsco, Google Scholar, and PsycINFO. Article selection and inclusion was then narrowed to 164 articles based on terminology search criteria. These terminology search criteria included the following descriptors: sexual risk behaviors, sexual behaviors, risk behaviors, and risky behaviors. In addition, these four main searches were combined with the following topics: adolescents, elderly, couples, women, heterosexual males, heterosexual females, homosexual males, health, depression, bipolar, addiction, alcohol, drugs, health factors, disability, ethnicity, culture, therapies, and interventions. Searches also included the terms, condom errors, chlamydia, gonorrhea, STDs and sexual risk behaviors, STDs and sex, and safe sex practices.

Summary of the data

Inclusion/Exclusion Criteria

A critical analysis was conducted to determine the inclusion and exclusion of each article. They were analyzed for their appropriateness for the research question. Articles
that were chosen included: studies, literature reviews, empirical articles on sexual risk behaviors and other topics, such as general risk behaviors. To determine an article’s appropriateness, inclusion criteria were established. First, the article needed to address either the topic of sexual risk behavior or risk behaviors with an examination of sexual practices. Next, the article needed to study the topics of this paper, such as adolescent sexual risk behaviors who live in China. Some articles, however, were too broad in scope, such as research on the behavior of adolescent sex workers, college students’ risky drinking and driving behavior—which included the topic of risky sexual behaviors—and articles on sexually transmitted diseases with no discussion of risk behavior. Each article was then analyzed with regards to demographic information, sexual orientation, limitations, and strengths. Based on this examination, the inclusion/exclusion criteria followed the terms mentioned above exactly.

**Methodology**

Articles were first coded to determine categories they met within the study. The number of codes an article could receive was not limited. The categories (referred to as covariates) were: college students, culture, gender, heterosexual women, heterosexual men, homosexual men, homosexual women, MSM (also known as men who have sex with men but do not identify themselves at homosexual), adolescents, articles studying primarily measurements, middle adulthood, elderly, substance abuse, psychological disorders, health, therapies, religion, and miscellaneous (literature review). Not all 164 articles reviewed were used in the text of this study; however, 164 articles were utilized to determine the overall percentages of the codes that emerged. This allowed for a better
understanding of the research. Articles are referenced in Appendix B excluding websites that were used to collect data for the pamphlet. Only non-literature review articles were coded. Coding was determined by the categories mentioned within each article. The codes were used to establish an understanding of how thoroughly each covariant had been examined within the literature to date.

Nine categories were established to examine the articles more closely. Sex, age, ethnicity, assessments, procedures, limitation, heterosexual, homosexual, and covariates were all entered into an Excel database. Within the categories, various choices were available. For example, under the category “sex” either male, female, both, or not stated could be selected. These options came directly from the articles. Upon emergence of a new term the database was updated to maintain consistency and accuracy.

Within sex, the categories were: male, female, both, or not stated. Age was entered as the authors stated the ages in the articles, then categorized based on how the ages were presented in the paper. The categories consisted of adolescents, 12-17; young adults, 18-30; middle adults, 31-55; later adulthood/elderly, 55+; and a new category of multiple age ranges. This category was needed since some articles included a broad range of ages. The category of “not stated” was also included for articles that did not report the age of the participants. Age ranges as reported in this study differ from age ranges reported variously in the articles studied, because as more articles were reviewed the age ranges broaden making it more complex to determine exact age ranges, which is why multiple age ranges was added.
Ethnic categories were developed directly from the research articles, as follows: Caucasian, African American, Hispanic, Asian, Not stated, All (only Caucasian, African American, Hispanic, or Asian subjects), Caucasian and African American solely, Caucasian, African American and Hispanic solely, Caucasian and Hispanic solely, primarily Caucasian, Hispanic and African American solely, and, Caucasian, Hispanic, African American, and Native American. I acknowledge the fact that ethnicities often do not fit into clear cut categories and that much diversity is involved. For example, using the term Asian can be misleading, because the reader does not know which Asian culture is being referenced. People from China, Japan, and Korea consider themselves “Asians,” but they are also from different cultures, just as the people born in America of “Asian” decent are culturally different from a native-born Asian. However, the terms used were pulled directly from the research articles, and, therefore, if distinctions were made in the participants’ sections, they would have been noted in the data sheets.

Assessments used within each article varied tremendously, and, therefore, it was difficult to categorize all of the assessments into a few categories. All assessments utilized were documented into the Excel spreadsheet, placed into 12 categories, and examined. Due to the board range of assessments chosen, even within a single study, the assessment category was determined by the primary assessment used. For example, if an author created a survey and used multiple questionnaires, these would be placed under the multiple questionnaires category because those surveys were their main assessment. This categorization was determined by the authors’ descriptions of assessments and how they were utilized in the study. The categories developed were as follows: “multiple
questionnaires” describing any article that had chosen to use more than one questionnaire in the methodology section, assessments created by the authors, medical only surveys solely utilized in college classes, computer-assessed interviewing programs, models that used both standardized interviewing and medical procedures, surveys, questionnaires that specifically stated that demographic information was a component of the questionnaire, self-reporting measures, interviews, self-administered assessments, and semi-structured interviews.

Procedures within this paper were defined as the methods or methodology in which the researchers used to assess the participants. Within the procedure section, all the articles’ procedures were placed into the data spread sheet as they were detailed by the authors. Following examination, the articles were placed into 11 categories that were then analyzed. These categories consisted of computer-assisted surveys, in-home interviews, small groups, paper-and-pencil questionnaires, research-assisted questionnaires, structured interviews distributed to students during classes, interviews, not-discussed questionnaires (self administered), and self reports.

After categorization occurred, the limitations sections of the articles reviews were analyzed in two ways. First, a review of the authors’ limitations were noted and detailed. Second, any information that was omitted (such as a limitations section) was noted in the limitations section and categorized into nine major themes. The themes that emerged were: self report, cross-sectional research, cross-sectional and self-report research, authors who did not mention the assessments used in the articles, no limitations section in
the article, findings which were not generalizable, restricted to testing students who were at school on the day of testing, self report, and a small sample size.

Sexual orientation was charted using the terms *heterosexual* and *homosexual* in individual columns. Within each column, a choice of Yes, No, or Not Stated was given. The gender was not needed because it was detailed next to the columns in the covariates sections. Sexual orientation was never assumed and may account for the large percentage of *not stated*, which will be addressed in the integration section.

*Integration of Articles*

**Gender**

When reviewing the category of gender, it was found that a majority of articles included both men and women (60%) in addition to often including adolescents and college students. When examined further, studies that sampled both genders and adolescents made up 26% of the articles reviewed, while college students were the focus of 22% of the articles. Most articles including both men and women made no gender related distinctions in their findings. When studying adolescents and college students, authors tended to avoid questions on sexual orientation. A total of 28% of college student articles, and 39% of articles on adolescents, did not state or ask about sexual orientation. Of the articles reviewed, the highest percentage that researched heterosexual females were college-specific (7%). This was followed by articles that researched substance abuse and stated that their participants were heterosexual (4%). Figure 1 displays the percentage of gender differences among the 164 articles examined.
Age

Regarding the age of participants, the category “multiple age ranges” was found to be most prominent. A total of 27% of the articles studied multiple age ranges as defined by this paper. A common age range was adolescent (age 16) to late 50s. This broad age range brings into question the generalizability of the data.

Sterk, Theall, and Elifson, (2006) studied African American women between the ages of 18 and 59 who used drugs. The aim of the study was to reduce HIV infection for women who were HIV negative, but were at risk because of their intravenous drug use. The large age range in the study was not addressed. Yet, women in their early 20s may respond differently from women in their 50s.

When examining other variables, the largest populations studied were, again, adolescents and college students—11% and 32% respectfully. However, the most
surprising results were that 11% of the articles reviewed did not state the ages studied. Kaeser (1996) researched perceptions that people who are profoundly mentally retarded engage in sexually risky behaviors. When discussing demographics, including age, in his methods section, Kaeser (1996) stated “. . . there was no attempt to learn the age of persons, their race, gender, or place of residence” (p. 311). Figure 2 illustrates the age-range- percentages among the 164 articles examined.

![Age Ranges](image)

**Figure 2 – Age percentages of articles researching sexual risk behaviors**

**Ethnicity**

Thirty-three percent of articles reviewed did not state the ethnicity of participants. This finding was unexpected because without knowing the ethnicity, a reader cannot infer differences among cultures. Caucasian, African American, Hispanic, and Asian ethnicities were the populations most often studied (22%) and most frequently among adolescents. Two groups, one consisting of Caucasian, African American, and Hispanic
individuals, and the other, Caucasian and African American individuals, were the next most prominent ethnicities studied. Combined they accounted for 9% of the studies reviewed. Among the total articles reviewed, ethnicities among the participants were limited. When expanded over multiple age ranges, only Caucasian, African American, Hispanic, and Asian ethnicities were found in 4% of the articles, and Caucasian, Hispanic, African American, and Native American made up 3% of the articles reviewed. Figure 3 displays the percentage of articles that included ethnicity information among the 164 articles reviewed.

![Figure 3](image-url)

**Figure 3- Ethnicity percentages among articles examining sexual risk behaviors**

**Assessments**

Multiple questionnaires, containing three to four variables each, were the primary assessment instruments used among thirty-seven percent (37%) of the articles examined. For example, Huebner, and Howell (2003) studied multiple variables, such as
sexual risk taking, parent-adolescent communication, parental monitoring, and parenting styles. Similarly, Kiene, Tennen, and Arneli, (2008) assessed for condom-use attitudes, self-efficacy of using condoms, condom-use behavioral intentions, and sexual behaviors. Results were often reported as correlations between the various target dimensions assessed. Generalizability was often limited due to a lack of statistical significance, related to methodological difficulties with sample population, size, or assessments used.

Demographic information is always necessary to describe a sample, and was often included as part of the questionnaires used to secure data on the chosen topic of research (13%). For example, Kalichman, and Cain (2004), studying gender differences among persons receiving services at STD clinics, included demographic information, such as age, years of education, income, gender, and ethnicity. In addition, they measured sexual compulsivity, alcohol use outcome expectancies, substance use, and sexual behaviors. Including demographic information in such articles allowed the authors to conclude that their sample over-represented African American people who had a history of sexually transmitted diseases. This overrepresentation needed to be considered when the results were interpreted. Demographic information collected is a very important aspect of assessment because it allows the reader to better understand the sampled population as well as the generalizability of findings. Figure 4 illustrates percentages of various assessment methods reported among the 164 articles examined.
Figure 4 – Percentage of assessment methods used in articles examining sexual risk behaviors

Procedures

Surprisingly, only 7% of articles noted that the creation of their own survey was a crucial part of their approach to assessment. While authors who used multiple questionnaires may have created their own, they did not emphasize its importance, a situation illustrated by Stacy, Stein, and Longshore (1999). They described the development of four scales to specifically measure what they defined as “past drug use.” The authors used their own assessments to define past alcohol use by calculating the number of 12-ounce cans or bottles of beer, six-ounce glasses of wine, or one-ounce drinks of hard liquor consumed during a “typical” week, during the past year. Creating their own assessment tools can allow the researchers to study exactly what they wish; however, the tool can lack the reliability and validity that standardized measures presumably have.
Additionally, Gebhardt, Kuyper, and Dusseldorp (2006) created their own measurement of condom usage when subjects were having sexual intercourse for the first time. The authors created a 20-item questionnaire focusing on cognitive preparations and motivations for sex and condom use. However, they did not address the issues that could arise from a self-created assessment instrument.

An unexpected result was that self-reported data was often considered to be a limitation (29%), while other noted in other researchers work to be a strength. Champion, Shain, Piper, and Perdue (2001) reported that utilizing self report measures when examining minority women with STD’s yielded results twice those of researchers who had used surveys and other questionnaires. However, the authors acknowledged that while self reporting was a strength of the study, it was also a limitation because self reporting is difficult to standardize. Gebhardt, Kuyper, and Dusseldorp (2006) also noted self reporting as a potential limitation because questions are of a retrospective nature and caution should be used when interpreting. When examining the procedures identified in the articles, the most notable finding was the significant use of either self administration and/or interviews to collect interview data. Choi, Wojcicki, and Valencia-Garcia (2004) detailed the process of self administration by giving the subjects a standardized questionnaire that followed the completion of an interview. In addition to the self administered questionnaires the participants were given condom training for 10 minutes, and they also received a one-month supply of condoms and a diary to document their condom use. This methodology showed the importance of utilizing questionnaires and teaching as a procedure.
In contrast, Bogart, Walt, Pavlovic, Ober, Brown, and Kalichman (2007) used only interviews at inner-city STD clinics. They relied on audio taping and transcriptions to collect information from patients who recalled sexual behaviors. They found that 12 interviews were unable to be recorded due to taping malfunctions and those interviews were lost to data collection. Relying solely on audio taping as the method of data collection was a limitation of the researchers and therefore their results had to be interpreted with caution.

The method of assessment distribution was another important consideration within the articles reviewed. Four percent of the articles discussed distributing assessments in high school and college classrooms. Huebner and Howell (2003) detailed giving a 174-item anonymous questionnaire during high school by administering the survey on one day, to all students present who had parental consent. No attempt was made to address limitations that may arise when assessing students in classrooms. Shrier, Emans, Woods, and DuRant, (1996) stated that when sampling students during class, researchers may be underestimating the true prevalence of students who are sexually risky, because risky behaviors are associated with poor school attendance and dropping out of school. This consideration should be made when interpreting studies where the researchers assessed only students at school. Figure 5 displays the percentage of articles that discussed procedure methodologies used among the pool of articles examined.
Figure 5 – Percentage of methodology procedures used in articles examining sexual risk behaviors.

Limitations

Twenty-nine percent of the articles reviewed did not mention limitations in their studies. This omission is believed to be problematic because it does not address the potential generalizeability of findings. It is helpful when authors acknowledge limitations of their studies so that potential problems can be recognized and discussed. For example, when studying the influence of religious affiliation on sexual initiation and condom use among people in Zambia, Agha, Hutchinson, and Kusanthan (2006) found that religious affiliation’s influence on the risk of HIV infection was minimal. The authors did not include a limitations section in their articles, which would have been important because their sample consisted mainly of Seventh Day Adventists, Jehovah’s Witnesses, and New Apostolic Church members. Such persons may have had their own religious considerations that were not discussed. Furthermore, because of the limited nature of the
religious sample, the results cannot be generalized to other religions or secular groups.

Similarly, Jones, Darroch, and Singh (2005) discussed religiosity within the United States but only among persons affiliated with fundamentalist Protestant churches. Although the researchers did discuss other limitations within their study, they did not discuss the homogeneity of the sample.

Similarly, Catania, Coates, and Kegeles (1994) studied the distribution of HIV and other STDs including HIV and STD risk behaviors among heterosexual men and women and their correlates across social strata. The authors discussed that the labeling of a person’s sexual past may place them at risk for HIV. However, with regard to this specific finding, the authors did not explicate differences that labeling might cause among the sexes, ethnicities, or ages. The authors noted that the self reporting of condom use with HIV and STD infections appeared to be valid; however, self reporting and perhaps under-reporting is commonly considered to be a limitation in articles discussing sexual risk behaviors. Additionally, Dew, Elifson, and Sterk (2007) and Gullette and Lyons (2006) all agreed that using self reporting as a measurement—while the practice is considered acceptable and was used in both studies—should be noted as a limitation. Gullette and Lyons (2006) noted that when relying on self reporting, it is important to understand that behaviors may be over or under reported or reported inaccurately. When recalling sexual activity, people make mistakes, especially when reporting condom use.

In light of this problem, 29% of articles reviewed discussed the limitations of self reporting as an assessment tool. For example, Hallfors, Waller, Bauer, Ford, and Halpern (2005) noted that self reporting can be misreported, and suggested utilizing computer-
assisted interviewing to increase accuracy. Using laptops to collect sensitive material, such as sexual activity, substance abuse, and depression, these researchers collected detailed and presumably accurate and self-reported data from a sample of adolescents. They suggested that candidness was possible because the teens were not asked to answer the questions while facing an interviewer. Hendershot, Stoner, George, and Norris (2007) also used computer-assisted assessments to research sensation-seeking as a predictor of HIV risk and sexual risk behaviors in adolescents. They noted that self reports of sexual risk behavior may be inaccurate. Additionally, within the adolescent populations sampled, drinking-incidence could be higher than in the general population. With that said, the use of computer-assisted programs allowed the researchers to conclude that drinking alcohol before sex may predispose an individual to sexually risky acts. This finding did not differ among genders. It should be noted, however, that authors may not know all the limitations of their studies and could refer to the inability to generalize the result within the discussion. Figure 6 illustrates in percentages the kinds of limitations reported by the authors among the 164 articles examined.
Sexual Orientation

Authors commonly did not state sexual orientation of participants unless they were specifically researching a particular orientation. Almost half of the articles reviewed did not state whether the sample was heterosexual (43%), and over half did not state whether the population studied was homosexual (50%). Often, in articles such as Farmer and Meston (2006) that researched condom use as well as self efficacy and attitudes among an ethnically diverse college sample, demographics included, sex, age, and ethnicity, but excluded sexual orientation. These authors noted that the majority of the people sampled were sexually active and in relationships. However, nowhere in the article was the specific sexual orientation of the participants noted. Omitting data on
sexual orientation is a limitation within articles that studied sexual orientation, as this fact may be an important aspect of sexual risk behaviors.

Pinkerton, Abramson, and Holtgrave (1999) developed a model delineating cost differences in condom use between heterosexual and homosexual men. They calculated the cost of a condom and compared that number to the medical cost for individuals in the at-risk population. The researchers found that if high risk heterosexual men were to use one additional condom, the saving of HIV-related medical care cost would decrease by an estimated $40 million. In contrast, the authors noted that homosexual men are at greater risk than are heterosexual men, presumably because of the likelihood of increased anal sexual activity. The authors hypothesized that a condom which initially costs approximately $.25 would cost society $270.00 if a man was to have unprotected sex 50 times, because of the health care needed for him. These findings are important because they illustrate that sexual risk behaviors are problematic and expensive, regardless of sexual orientation. Dew, Elifson, and Sterk (2007) noted that both heterosexual and homosexual men put themselves at risk for contracting HIV, hepatitis C, and other STDs, although homosexual men may be at greater risk. More research is needed that includes sexual orientation as the research in sexual risk behaviors continue. Figure 7a (heterosexual) and 7b (homosexual) displays the percentage of articles that examined sexual orientation among the 164 articles examined.
Covariates

When analyzed, 22% of the articles studied youth. When examined more closely, 70% of the articles studied mainly youth while 15% studied youth and culture. For example, Christianson, Johansson, Emmelin, and Westman (2003) studied adolescents who may have been infected with Chlamydia in Sweden. Their results suggested that the term *youth* implied immortality, in the minds of young people, and the concept of “it won’t happen to me” was common among this population as well. Therefore, these young people may have been more likely to engage in risky behavior. However, one must note the cultural morals in Sweden; the authors wrote, “Scandinavia is known for its liberal attitudes toward sexuality. Love and intimacy between young people are discussed openly, and mostly accepted” (p. 44). In addition, the authors noted that sexual intercourse before marriage is common in Sweden, and sex education classes have been
mandatory in schools since the mid-1950s. Such attitudes differ from other cultures, such as those in conservative segments of America. Noting the country and its morals is important when interpreting data.

In considering the covariants, the next largest category researched was college students. A total of 15% of the articles reviewed studied people attending college. People in college comprise a unique population of young adults who are at higher risk for engaging in high risk sexual behaviors (Flannery, Ellingson, Votaw, & Schaefer, 2003), and this fact could be attributed to biological, psychological, and environmental changes that occur as one transitions to college (Schneider & Morris, 1991).

In light of this, Eight percent of the articles examined health risks that are affecting this population. Both Saules et al., (2007) and Flannery, Ellingson, Votaw, and Schaefer (2003) examined different health risks associated with college students as a result of engaging in sexual risk behaviors. Saules et al. (2007) found that women who smoked reported multiple sex partners, lack of condom use, excessive alcohol use, and abortion. Flannery, Ellingson, Votaw, and Schaefer (2003) reported on health risks associated with anal sex and noted that within the sample studied, 26% of the women reported having an STD. These authors highlighted health concerns regarding anal sex and stated that “anal intercourse is associated with hepatitis B, infection, anorectal human papilloma virus, and cancer in women” (p. 229). They stressed that anal sex behaviors be incorporated into sex education classes because of these health risks. Figure 8 displays the covariate percentages that studied the overarching themes among each of the 164 articles examined.
When writing the pamphlet, I targeted age, gender, sexuality, and other variables, toward the population that was determined as being the most at risk for engaging in high risk sexual behaviors. It was clear that persons between the ages of 18-25 were at the highest risk to themselves and to their sexual partners, and, therefore, more education is needed in this group. Because college can be a time of transition and emerging independence (and this independence includes biological, psychological, emotional, and environmental changes), a person can become at risk for engaging in sexual behaviors that they are not emotionally or physically ready for. For example, Gullette and Lyons (2006) found that when both men and women who are 18-25 use alcohol, they were less likely to use condoms and are less likely to be tested for HIV/AIDS.

Over 25,000 cases of AIDS were reported in one year for persons between the ages of 20 and 24 (Parsons et al., 2000). In 2006, 28% of all newly reported cases of HIV/AIDS were individuals who were likely infected during their college years (Gullette
& Lyons, 2006). Mis-information, or lack of information, exists. Parsons et al. (2006) reported that college students were embarrassed about asking how to use condoms and where to obtain them. They thought that condoms could be ineffective and unnecessary, which could lead to their having unprotected sex.

College campuses and health care centers allow for a platform of interventions regarding sexual behaviors (Eisenberg, 2001). Therefore, it is important to work toward developing materials that are not only educational but allow for the facilitation and ease of discussion with health care providers. Although this research refers to this age group as college age (possibly assuming that everyone is in college), this pamphlet is designed to reach all persons who are between 18 and 25 and is not limited only to persons who are in college.

In developing this pamphlet, I researched the ways in which written material, such as pamphlets, can effectively educate a general, though targeted, audience. Fredam, Damus, and Merkatz, (1999) stated that documents can reinforce information that people have been taught verbally. Green (1998) reported that the use of pamphlets can contribute directly to the knowledge of individuals by emphasizing healthy choices with regard to sex education. In addition, Green (1998) reported that many individuals get the bulk of their information from peers, not their parents, and written materials are another practical way of educating people. In order to grab the attention of younger adults, Fredam, Damus, and Merkatz, (1999) suggested that pamphlets must relate to individuals through text and illustrations referring to age and culture. They must be easy to read, well organized, and attractively illustrated.
When developing my pamphlet, I began searching for stock images in iStockphoto.com and Dreamstime.com to find images that would intrigue younger adults. Stock images were purchased from the two sites and rights are included to use at my discretion. My searches included the words, *sex, sexual activity, sexual intercourse, regret, college, love, drugs and alcohol, homosexual men, homosexual women, gay, lesbian, condoms, and birth control.* Images were chosen based on emotional reaction and common usage by the target audience. Real persons were chosen as illustrations, because they were believed to be more personal than drawings. I looked at people’s faces and body language to determine possible emotional reactions to the image. Paul, Redman, and Sanson-Fisher (2003) advise that the use of color and images allow for a pamphlet to be more relatable. I also believe that having an emotional reaction to an image is more likely when the reader is able to read the material and relate to it.

Paul, Redman, and Sanson-Fisher (2003) noted that effective pamphlets contain short words and sentences, and use messages and headings that will grab attention. Fredam, Damus, and Merkatz, (1999) reported that pamphlets should be written at a sixth grade reading level. Although the research often refers to this population as “college students,” this pamphlet is geared toward *all* persons between the ages of 18-25. It is also important to incorporate today’s language and communication style in the pamphlet. With the use of cell phones and texting, people’s communication has become shorter and written “in code.” The use of vernacular language known to this population will draw attention to the pamphlet’s validity. Such text words as *OMG, WTF,* and *IDK* have been chosen because they are widely known to this age range and are relatable.
The pamphlet is designed in six sections. The cover is intended to grab the attention of the reader by using common text words and images. The four inside leaflets are divided into subsections that focus on the following topics: heterosexuals, homosexual men and women, STDs, testing, and conversation starters. The back page contains a list of testing sites. As well, legal rights are explained, with a statement that credits the references and stock images used to create the pamphlet. Details in the sections include cross-over information: For example, dental dam, a protection barrier used during oral sex with women is discussed in both the heterosexual and homosexual sections. The pamphlet was also designed in such a way as to try and attract all sexual interest, such as making the images seamlessly merge together. For example, when opening the pamphlet, images of a heterosexual couple are across from images of a lesbian couple and two males in bed. The reasoning behind this choice was that both heterosexual men and women and homosexual men and women would initially see an image that is relatable.

Unfortunately, it is impossible to discuss everything regarding sexual health and risk behaviors in a pamphlet. Therefore, certain people and sexual acts are not discussed. The focus is placed on most harmful practices, pertaining to the health of both the at-risk population and the general population as well, specifically, oral sex with a man, oral sex with a woman, what to look for if you think you have an STD, barriers used for safer sex and how to use them, anal sex safety, oral sex safety, questions to always ask your partner, and where to get tested.
Discussion

This study is intended to help the research and clinical community, myself included, to develop a practical and deeper understanding of sexual risk behaviors. An examination of current and past research, community definitions and attitudes, as well as beliefs that have emerged about sexual risk behaviors, was done in order to gain a comprehensive overview of the people who are engaging in sexually risky behaviors. Throughout this paper, several at-risk populations are identified in hopes of reducing sexual risk behaviors. This pamphlet was developed to reach the college-aged group, deemed to be at the highest prevalence rate for engaging in risky sexual behaviors.

Filling in the gaps in the research, which includes the addition of longitudinal studies, would help to determine the risk behaviors that people engage in throughout their lives. Currently, the research has focused on limited demographic variables. A collective examination of these variables expands and deepens the research communities’ understanding of persons engaging in sexual risk behaviors.

With this research, a contribution to the research community has been made by identifying who we can help to reduce risky sexual behavior. In addition, it will help establish an understanding of both the addressed and unaddressed populations within the current psychological literature, helping to reveal further research needs and related interventions.

A pamphlet has been developed for people between the ages of 18 and 25 to help educate them further on sexual risk behaviors. People who are 18-25 are the most at risk because almost 80-90% of those in college are engaging in sex and one third of them are
not using condoms. With the rising rates of HIV, the pamphlet is designed to communicate effectively with 18-25 year olds and educate them on the importance of safe sex.

Sex does not affect only the two individuals engaging in the act. Being sexually risky-impacts one’s life, family, society, and our culture. Because this study focuses on sexual risk behaviors, it is suggested that future research should continue to focus on people who engage in risky behaviors and explore prevention interventions. Research should continue to examine the risk of STD and HIV/AIDS transmission and should explore effective ways of educating persons using various interventions, such as pamphlets and/or lectures. Risky sexual behavior may never be eradicated, but with research and education, hopefully we can teach people to be safer and reduce the risk of harm.
References


Dreamstime.com retrieved on 4/14/09


Istockphoto.com retrieved on 4/14/09


APPENDIX A

Dissertation Pamphlet: We All Have Things To Say
We all have things to say...

OMG...

IDK...

WTF...

Anal Sex Safety
Anal sex without a condom or “barebacking” or “raw” is very risky... using condoms with lubrication can make you ready for safer sex!

Oral Sex Safety
Dental dam for women...
Dental dam is a piece of latex used to cover the vagina
Use a condom if you do not have a dental dam by cutting off the tip of a condom and cutting up the side of a condom or plastic wrap

Also Try!
Kissing
Dirty talk
Mutual masturbation
Fantasies
Toys (make sure you use a condom or wash them with soapy water)

Always Ask...
- Have you had vaginal, and/or anal sex with other people?
- If so, how many?
- When were you last tested?
- Have you ever had an STD?
- If so, which ones?
- Do you have HIV/AIDS?
- How can we both remain safe?

Get Tested!!
Call the CDC-information hotline
1-800-232-4636
www.plannedparenthood.org

This brochure is not intended to substitute for you health professional’s opinion or care.
Images were retrieved from Istockphoto and Dreamstime.
References for information provided in dissertation and through use of national pamphlets
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### OMG...

- **Oral sex with a man**
  - Cover the penis with a new condom each time.
  - Use Polyurethane condoms if allergic to latex.

- **Oral sex with a woman**
  - Cover genital with dental dam.
  - Make sure no fluids leak out from the barrier.

- **Vaginal/Anal sex with a woman**
  - Cover the penis with a condom each time.
  - Use lubrication.

### IDK...

#### Every 9 ½ minutes someone in the United States will be infected with HIV

*If you think you have an STD look for...*

<table>
<thead>
<tr>
<th>Women</th>
<th>Men and Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual pain or discharge</td>
<td>Sores, bumps, or blisters near genitals, anus or mouth</td>
</tr>
<tr>
<td>Pain between belly button and vagina</td>
<td>Pain/burning when urinating</td>
</tr>
<tr>
<td>Unexpected bleeding</td>
<td>Itching in/around your genitals</td>
</tr>
<tr>
<td>Pain during sex</td>
<td>Swelling in your throat, flu like symptoms</td>
</tr>
</tbody>
</table>

### BTW...

<table>
<thead>
<tr>
<th>Barsriers</th>
<th>Use Them...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>Vaginal sex, anal sex, sharing dildo/vibrator</td>
</tr>
<tr>
<td>Dental dams (can use condom or latex cut into a square piece)</td>
<td>Oral sex with women Anal contact</td>
</tr>
</tbody>
</table>

- Make sure to use plenty of lube with your condoms and dental dams.
- To get more information about condoms and free samples visit:

### Things to know...

- Condoms fit all penis sizes.
- Saying a condom “reduces pleasure” is NOT a reason to not use one. A condom is better than a STD!!

### SAFE SEX:

**Look closely at your partner’s genitals for signs of rashes, sores or discharges before engaging in sex**

### BTW...

- When drunk and/or high people are less likely to use condoms and have an increase of STD and HIV infection.
Appendix B

Articles reviewed that met specified criteria
Articles Reviewed Meeting Specified Criteria


