DECISION MAKING:
FACTORS THAT AFFECT SEXUAL RISKS

One of the simplest things counselors can do to help clients change unsafe patterns of behavior is to help them understand the decision-making process and the fact that people are constantly in the process of making decisions, regardless of whether they are aware that this is happening. With the counselor’s help, clients can then look at factors that affect the decisions they make to better evaluate their risks and make changes to reduce those risks. This issue of PERSPECTIVES discusses the process of making decisions, factors that influence those decisions, and ways to better make decisions.

Research Update

Decisions related to engaging in HIV risk behaviors—or behaviors of any sort—are influenced by many factors. These factors include information and knowledge; self-perception and views toward risk; personal values and beliefs; skills, including communication skills; emotional responses; relationship dynamics; and substance use.

Factors that influence decision making overlap and interrelate. For instance, a person may have motivation to avoid unprotected sex but because of fear of a partner’s reaction, decide not to insist on condom use. Each factor affects each person’s decision-making in different ways. Two people may each have poor communication skills with partners, but each may make different decisions as a result: one person may feel motivated to improve his or her communication skills, while another may not see such a change as possible or even think in terms of change at all.

What Is a Decision?

A decision is a “choice among competing courses of action.” Decision theory summarizes the decision-making process, whether deciding what sexual behavior to engage in or what job to pursue, in three steps: first, a person takes note of all possible courses of action, for instance to have protected sex, to have unprotected sex, or not to have sex. Second, a person weights the advantages and disadvantages of each possible decision, for instance the decreased sensation that a person might experience from using a condom compared to the increased probability of contracting or transmitting an STD from not using a condom. Third, a person assesses the desirability or undesirability of various outcomes, for instance of remaining healthy or becoming infected with HIV or another STD.

This process describes a rational, conscious, and ideal process. Often, however, a person is not conscious of his or her decision-making process, perhaps because he or she has not seen a value to being aware of the
Three Steps of Decision Making

1. Person takes note of all possible courses of action

2. Person weighs the advantages and disadvantages of each possible decision

3. Person assesses the desirability or undesirability of various outcomes

Related Issue: Unprotected Sex And People With HIV

People who have tested positive for HIV have additional issues to consider when making decisions about sexual behavior. Unprotected sex with someone who is infected presents a possibility of becoming infected with another strain of HIV, one that could be more virulent or resistant to certain drug treatments.

A study that included HIV seropositive gay men who had unprotected anal intercourse found a variety of self-justifications for not using protection, including the belief that they had nothing more to lose and the idea that they were not responsible for the welfare of their partner. The study’s researchers suggested that underlying feelings of denial and anger may fuel such decisions.

Some people decide to engage in unprotected sex with HIV-infected partners and accept the risk of reinfection. They may do this because of uncertainties surrounding the dangers of reinfection or its probability, or because of the pleasure of unprotected sex and the fact that sex without condoms can symbolize trust, love, and intimacy. For some, having unprotected sex with someone else who is infected can be empowering and guilt-free since there is no longer a fear of contracting or transmitting HIV.

Anger, resentment, and depression can influence decisions to engage in unprotected sex. In addition, studies have shown that unprotected intercourse is related to the use of alcohol and other drugs among people who are infected, as well as those who are uninfected.

Despite these realities, prevention campaigns are seldom directed specifically at people with HIV. One campaign by an agency in Australia highlighted affirmative views of sexuality for people with HIV and dealt with issues such as sexual self-esteem.
Information

Without basic HIV information, a person is at a disadvantage in making decisions to avoid HIV infection. As researchers have learned more about the biology of HIV transmission, the safety of particular behaviors has become clearer. Studies suggest that most people, but not all, understand which behaviors are risky and recognize that some are riskier than others. While knowledge can lead to increased concern or guilt about possible infection, often it does not guide people’s behavior at the point of contemplating sex.\(^3\)

Skills

Decisions to engage in safer sex are strongly influenced by one’s sense of personal skills, both in practical areas, such as proper condom use, and in social aspects such as communicating with partners and being assertive in high-risk situations. Putting on a condom, especially when in a state of sexual arousal, can be difficult, and people who are inexperienced in using condoms may encounter problems that interfere with condom effectiveness or that discourage use. Similarly, negotiating and communicating about risks can be difficult. Many people are uncomfortable discussing sex and feel unable to initiate a discussion about it.

Perception of Risk

Information, attitudes, and skills may be irrelevant for people who do not consider themselves to be at risk for infection through sex, or who feel themselves unable to avoid unsafe behaviors. In order for people to feel personally threatened by HIV, they generally must experience some anxiety or fear of infection. Without such fear, it is unlikely that a person will be motivated to initiate changes in risk behaviors. Too much fear, however, can be counterproductive if it results in denial, which can cause people to downplay risk or avoid thinking about prevention.

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Studies have found that people have a tendency to underestimate their vulnerability to adversity and to see themselves as luckier than others. In the case of HIV infection, people may acknowledge risks of behaviors but discount them by not seeing themselves or their partners as the “type” to become infected with HIV. This attitude has been found among both those who have a history of high-risk behavior and those whose risks are much less significant. Many young people who are just becoming sexually active and people who are in the process of sexually “coming out” are particularly likely to underestimate their vulnerability.\(^5\)

A number of other factors may affect perceptions of risk. In general, people are poor at conceptualizing risk when the probability of harm from a single incident is relatively low.\(^5\) Each sexual encounter that does not result in HIV infection might reinforce a sense of security or invulnerability despite the fact that the risks of each act are independent. This phenomenon can extend beyond a person’s own behaviors to the behaviors of friends and others. When people do not see friends becoming infected, they may further discount their own risks.\(^5\)

Beliefs and Values: Cultural and Peer Influence

Sexual behavior takes on different meaning depending on a person’s cultural identity, experiences, personal beliefs, and values. Beliefs and values are shaped by personal experience and are strongly influenced by the culture or cultures with which a person identifies: cultures both enable and constrain people through laws, norms, expectations, and habitual practices.\(^6\) Some cultural norms accept certain types of sexual expression and drug use, while others prohibit them. In some cultures, the explicit discussion of sexual behavior and homosexuality are taboo.\(^7\) In addition, personal beliefs and values may conflict with cultural norms and with other factors. For example, a woman whose male partner has been unfaithful may want to protect herself by using condoms during sex, but because her religious beliefs forbid condom use, she may be forced to reconsider her value system. Peer pressure and a need for attention may be especially strong for young people and lead them to engage in unsafe behaviors in order to “fit in” socially.\(^8\)

Personality and Development

A review of the literature demonstrates a significant correlation between “sensation-seeking” personalities and factors such as number of sexual partners and incidence of unprotected anal or vaginal sex.\(^9\) A sensation-seeking personality is characterized by a desire for novel and exciting sensations and a willingness to engage in, and even seek out, activities that others deem too risky. Sensation-seekers tend to either minimize their perceived risk or ignore danger associated with their behavior.\(^9\)

Sensation seeking is closely related to other personality traits such as adventurousness and impulsiveness. Impulsive people tend to act spontaneously, without planning or forethought, typically ignoring risk and not considering the consequences of actions.\(^9\) Like sensation-seekers, highly impul-
sive and venturesome people are more likely to engage in HIV risk behaviors. Developmentally, adolescent sexuality is particularly associated with risk-taking and impulsive behavior.\(^3\) Unprotected sex is common among sexually active youth ages 11 to 15.\(^10\)

**Relationship Dynamics**

Decision-making may be confounded by the interactions of sexual partners. While ideally both people in a relationship communicate and negotiate effectively, this may not occur. Rather than communicate or negotiate, partners often make assumptions about each other. For instance, one partner may assume, perhaps falsely, that since both partners tested HIV negative when the relationship began and since the relationship is monogamous, there is no possibility of infection.

In addition, some people are emotionally or economically dependent on their partners. Demands to use protection may drive their partners away. Women who are raising children and economically challenged, for instance, may be more focused on survival needs such as physical shelter or

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**Related Issue: Oral Sex Risks**

When deciding what behaviors to engage in, people often have difficulty with the subject of oral sex. This may be due in part to the fact that oral sex is a behavior that involves some level of risk, but is clearly much less risky than other behaviors, such as unprotected anal or vaginal sex.

People are often clear that they want to do what is necessary to avoid high-risk behaviors, but are less certain about their resolve to avoid relatively low-risk behaviors. This uncertainty, conflicting reports among researchers and providers, and the lack of quantifiable information about oral sex risks, may also lead people to want even more information about the risks of oral sex than about the risks of other behaviors. This sidebar outlines oral sex risks.

The California Department of Health Services, Office of AIDS, reported the following in a 1996 statement: “There is some risk of HIV transmission from unprotected oral sex. This risk is small and certainly far less than the transmission risk from unprotected anal receptive sex, unprotected anal insertive sex, or unprotected vaginal sex.”\(^16\)

According to a review of research on the subject, cited cases of oral transmission are relatively few, and the cases that do exist often involve complicating factors and ambiguity about whether oral sex was the actual cause of transmission.\(^17\) One study found that the risk of oral transmission of HIV is less than one percent of the risk for anal transmission.\(^18\) In addition, an analysis of risk assessment data from HIV test counseling sessions of more than 50,000 men who had sex with men in 1994 and 1995 found no association between increased HIV seroprevalence and oral sex and no statistically significant difference in seroprevalence rates between people who used condoms during oral sex and those who did not.\(^19\)

While reported cases of HIV transmission through oral sex have appeared to be from the insertive partner to the receptive partner during fellatio, researchers consider oral sex with women to be a risk behavior because HIV can be found in vaginal secretions and menstrual blood. In either form of oral sex, researchers state that the presence of sexually transmitted diseases or open wounds or cuts in the mouth can increase transmission risk.

Prevention messages emphasize the importance of not brushing teeth or flossing before engaging in oral sex. These activities may open the gums, creating a passageway into the blood for any HIV that may enter the mouth in semen or vaginal secretions. As an alternative to brushing in order to freshen breath before sex, educators suggest using mouthwash or chewing gum.

Studies and anecdotal reports show that most people who engage in oral sex do not use protective barriers, which can reduce the risks from oral sex. For people who engage in oral sex without barrier protection and want to reduce risk, the Office of AIDS recommends not allowing a male insertive partner to ejaculate into the mouth, or switching to less risky sexual behaviors.\(^16\) Nonetheless, most researchers emphasize that unprotected oral sex instead of unprotected anal sex is clearly a risk-reduction strategy.

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financial support than with possible infection with HIV.\(^7\)

Shame associated with discussing sexual behavior can make discussion difficult. People who are not able to assert their needs may devalue themselves and feel other peoples’ thoughts are more important than their own.

The ability to clearly communicate with a partner is a good predictor of safer behavior.\(^{11}\) A person’s decision to use condoms or other protective barriers may be significantly influenced by his or her perceived ability to negotiate safer sex. Studies find, for example, that gay men who feel unable to negotiate safer sex are more likely to engage in risky sexual behavior than those who feel able to negotiate safer sex.\(^{12}\)

**Other Life Issues**

Potential infection with HIV can be a relatively minimal concern for people facing more pressing concerns—such as hunger, poor health, homelessness, drug addiction, and vulnerability to physical or sexual abuse. This may also be true for some people who rely on sex work as their main source of income.

**Implications for Counseling**

When a counselor understands the process and factors of decision making, he or she can better understand a client’s thought process and factors that may be influencing it. For instance, counselors can consider the extent to which a client is making decisions based on his or her personal beliefs or values, perceptions of his or her health or the health of others, economic concerns, pressure from family, or sense of self-efficacy in using condoms.

The counselor’s job is to make sure the client has accurate information to make conscious decisions, and to help the client understand and feel responsibility for his or her decisions. Helping the client gain an awareness that he or she engages in a process of decision making, and exploring what this process is for a particular client is important. Clients may not be aware that a process has preceded a decision to engage in a particular behavior. They may believe that decisions are made for them by others or that decisions are made without thought or feeling. Understanding the factors that affect a client in making and implementing a decision may help the client sort through challenges in maintaining a commitment to protected sex and gain a greater sense of control over behavior.

Clients can learn about their decision-making processes by examining the behaviors they have engaged in and then reflecting on the thought process that preceded the behavior. Counselors can help in this by using basic counseling techniques such as actively listening, addressing contradictions, and modeling appropriate behavior. It is important to keep in mind that the counselor’s role is a limited one. Ultimately, clients make their own decisions; the counselor’s role is to help them become aware of the process. The counselor can discuss influences on the client’s process but must avoid colluding with clients who might be seeking to have someone else—perhaps the counselor—take responsibility for their decisions.

Be respectful of each person’s process of making decisions, and validate processes the client feels have been effective up to this point. Some clients may say that making decisions about sex or other behaviors is a tormenting process; others may not see that they have choices. When a client expresses difficulties in making decisions about engaging in potentially harmful behaviors, explore how this client feels and help him or her consider the possibility of changes in his or her process of making decisions.

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**A Counselor’s Perspective**

“It’s important for me to help clients recognize that if they make decisions to engage in unprotected sex they’re not committed to these. They can change these at any time.”

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**A Counselor’s Perspective**

“Clients are sometimes amazed and feel a lot of power when they realize they can have control over their actions. I can help them see the control and choices they have.”

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**There Are No Absolutes**

In making decisions, clients need to understand that while risks are significantly affected by a person’s behaviors and precautions, any sexual behavior can involve some degree of risk. Help clients understand the distinction between the possibility and probability of infection from any particular behavior. Most sexual behaviors involve a possibility of infec-
However, the probability of infection varies greatly from one behavior to another, and depends in large measure on the protection a person uses. Without becoming an “oddsmaker,” help clients understand the idea of relative risk.

Moving from Decision to Action

Decisions can involve any level of commitment. A client may, for instance, be ambivalent about a decision to use condoms. It is important to assess the level of a client’s commitment—the extent to which he or she believes the decision will be carried through. Some people may make decisions about acceptable risks but have little ability to carry out the intended behaviors. For example, in the moment of sexual activity, feelings may overwhelm the resolve to have protected sex. Or, a person may overestimate his or her abilities to negotiate with a partner for safer sex.

Explore with the client any obstacles he or she may foresee. The counselor can then work with the client to overcome these by helping to build the client’s skills, encouraging the client to reflect on his or her decision-making process and talk with supportive friends, and providing referrals for follow-up counseling. For instance, if the client is confused about conflicting beliefs, the counselor can acknowledge this conflict and ask the client to consider it further. The counselor might refer the client to follow-up sources for supportive counseling to resolve this conflict. If communication skills are an issue, the counselor can engage in role-play scenarios of possible verbal interactions with partners or refer to follow-up counseling.

Help clients recognize that if they make decisions to engage in unprotected sex, they can change these at any time. A client may, for instance, believe that because he or she has engaged in unprotected sex with a partner in the past, it is not possible for him or her to change this behavior with this partner in the future.

Negotiation with Partners

People are more likely to engage in safer behaviors if there is a conscious “buy-in” by both partners to engage in protected behaviors. This mutual commitment is an affirmation for another person’s decision to engage in safer behaviors. Counselors should help clients to consider how the “buy-in” might occur and how to proceed if it does not.

Counselors can help clients affirm both their commitments to themselves and possible conflicting thoughts and feelings that might arise if a partner does not share those commitments. It is important to remind clients that a partner does not have to think the same way as the client. But, the partner must be willing to do what the client wishes in terms of harm reduction and the client must feel secure with the partner’s intention.

A discussion of ongoing committed relationships often includes explicit discussion of the terms of the relationship—for example,

References
6. Gendin S. Riding bareback: Skin-on-skin sex—been there, done that, want more. POZ. June 1997; 64-65.
whether the couple is committed to monogamy or has an open relationship. It is important for partners to understand the terms of the relationship and all aspects of the relationship that affect each other’s risks. For instance, for partners in an open relationship, it is important for both partners to understand the risks of sex that occurs outside the relationship. When clients in ongoing relationships are considering foregoing condoms, counselors can encourage them to use the infection “window period” as a time during which to consider this option.

When Decisions Imperil Safety

When clients make decisions that imperil themselves—for example, entering a relationship and deciding to engage in unprotected vaginal or anal sex based on the belief that the partner is negative—counselors need to make sure clients understand the significance of their decisions and the possible consequences. They should address the contradiction between risk and what the client is doing, clarify the client’s personal beliefs and values and how he or she feels about these, and ask about the sense of personal responsibility the client does or does not feel.

As always, it is important to keep in mind that what the client expresses as his or her limits regarding risk may be different from the counselor’s own limits. The counselor must remain aware of his or her comfort or discomfort in discussing risks with clients, especially when risks the client is willing to take conflict with those of the counselor.

Understanding the factors that affect a client in making and implementing a decision may help this client sort through challenges in maintaining a commitment to protected sex and gain a greater sense of control over behavior.

Case Study

Steve, a 25-year-old gay man, has tested four times. His results have all been negative and he says he always uses protection during anal sex, and values this fact. He says he is testing now because he has recently entered a new relationship in which he and his partner have discussed and are committed to monogamy. In further discussion, he reveals that his new partner has asked him to test and Steve says that if they both test negative, they have decided to have unprotected sex with each other. He continues by saying that he and his partner actually have had unprotected anal sex on a couple of occasions. He says they have done this because his partner is “so sure” that they are both negative. Steve seems anxious after revealing this and wants the counselor’s opinion.

Counseling Intervention

Steve’s experience of unprotected anal sex with his partner is complex. This behavior has put Steve and his partner at potential risk for infection and it contradicts his statement of valuing and always using protection during anal sex. This suggests the need for the counselor to assess Steve’s self-efficacy and self-esteem and his sense of his ability to assert what he wants and needs in his relationship with his partner.

Acknowledge Steve for seeking a test and bringing his concerns to the counseling session. Let him know that the test counseling session can help him make decisions and implement behaviors that are comfortable for him. Ask him how he felt about engaging in unprotected anal intercourse with his partner and give him a safe place to discuss his feelings. Avoid focusing on past processes or choices in a way that might engender guilt in Steve; the objective is not to manipulate him but to help him understand his process so he can do things differently.

As Steve reveals more about his process, emphasize points in the process that may have not worked well and suggest that Steve consider what this may mean in terms of his ability to pursue what he wants sexually or in other areas of the relationship. Deciding which sexual practices are comfortable and then acting on those decisions will be easier if Steve can see that he deserves to have his needs met. If he expresses fear of losing his partner or of coercion, explore what Steve has experienced that leads him to this fear, and then explore how these feelings affect him.

If Steve appears to be asking for specific advice, be wary of succumbing to this. Rather, focus on helping Steve see and make choices and, if it appears that he needs more support in moving forward, link him to an appropriate referral for this.
Test Yourself

Review Questions

1. True or False: A person who makes a decision to engage in safer sex will always follow through on that decision when having sex.

2. A person with a “sensation-seeking” personality is characterized primarily by a tendency to a) lack knowledge of risks; b) seek activities that others deem too risky; c) act cautiously and only after careful reason.

3. True or False: People always become motivated to change risk behaviors if they fear becoming infected with HIV.

4. People who acknowledge their risks but discount them by not seeing themselves as the “type” to become infected with HIV a) are immune to the virus; b) incorrectly underestimate their vulnerability to HIV; c) are heterosexual.

5. True or False: Because women are often socialized to express their feelings, they will have few challenges negotiating risks with male partners.

6. Which of the following are reasons some people do not use condoms: a) shame associated with talking about sex; b) emotional or economic dependence on partners; c) lack of communication in the relationship; d) all of the above.

7. True or False: For some people infected with HIV, having unprotected sex with someone else who is infected can be empowering and freeing.

8. A report from the California Department of Health Services, Office of AIDS states that HIV transmission risk through unprotected oral sex is a) small; b) impossible to assess; c) about the same as the risk from unprotected vaginal sex; d) non-existent.

Discussion Questions

1. How can counselors be sure that clients are making decisions on their own and not based on pressure from partners?

2. What guidance can counselors provide to clients who test positive and want to negotiate safer sex with partners who also have HIV?

3. How can counselors respond in the risk assessment session to clients who state that they have committed to using condoms, but find themselves engaging in sex without condoms?

4. How can counselors respond when clients who engage in high-risk behavior state that they are aware of their risks and are willing to accept them?

Answers to Test Yourself

1. False. In some cases, people may discard their decisions and logical processes when actually engaging in sex.

2. b.

3. False. While anxiety or fear may influence a person’s decisions, this is not always the case.

4. b.

5. False. While the expression of feelings and emotions may prepare some women for intimate relationships, there are numerous challenges, such as power dynamics within relationships, that may affect a woman’s ability to negotiate risks with a partner.

6. d.

7. True.

8. a.
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