People between the ages of 13 and 24 comprise more than 18 percent of all diagnosed HIV cases in the United States. Despite this, the rate of HIV testing for young people is disproportionately lower than for adults between the ages of 25 and 40.

Several factors may discourage young people in particular from testing for HIV: they may believe they are too young to obtain testing without parental consent; they may not have convenient access to a test site; or, because they did not receive a thorough sex education, they may not be aware that they have reasons to test.

In the process of forming their identities, young people embark on a journey of experimentation and exploration that may lead them to engage in behaviors that put them at risk for HIV infection. Studies have shown that levels of awareness, knowledge, or concern about HIV and AIDS are often not indicative of actual behavior. According to a national study, 53 percent of high school students reported having had sex, and 86 percent had been taught about HIV infection in school. Only 54 percent of sexually active students, however, reported condom use during their last sexual intercourse.

Peer pressure, self-esteem, and the lack of adequate experience and judgment are often related to youth risk behaviors. The difficulties of youth may be compounded by the presence of other circumstances. The following sections examine youth homosexuality and bisexuality, homelessness, substance use, and gang activity.

**Homosexuality and Bisexuality**
Gay male youth who are sexually active are at higher risk for HIV infection than their heterosexual peers. Seventy-three percent of reported AIDS cases of men between the ages of 13 and 24 occur among men who have sex with men.

Many gay, lesbian, and bisexual youth are unable to find a positive and supportive peer environment. Partly as a response to feelings of social isolation, some young people, especially gay male youth, congregate in areas they perceive as “safe” places to have sexual contact. As a result, these young people may believe that the only environments in which they can find acceptance are those that
require sexual activity. Sex in these environments is often secretive and high-risk. Young people who engage in anonymous sex may also be at higher risk for HIV infection because their partners are often adult men who have sex with men, a group with a higher rate of HIV infection.

Because homosexuality is socially stigmatized, which sometimes results in homophobic violence, gay, lesbian, and bisexual youth often attempt to hide their sexual orientation and constantly monitor themselves in areas of daily life. Gay and lesbian youth sometimes distance themselves from peers for fear that any kind of intimacy may be misconstrued as a homosexual advance.

Homosexual youth may struggle to reveal intimate feelings because they fear rejection and ridicule, and are less likely to fully benefit from peer relationships, which are important elements of adolescent development. Personal interactions and relationships based upon false pretenses often result in low self-esteem and feelings of isolation. The stress of hiding sexual orientation may produce anger and resentment toward family, friends, and society as a whole. These feelings may lead to high-risk behaviors as a coping mechanism.

For young people, homosexuality may also present potential problems in family relationships. To avoid rejection, homosexual adolescents often distance themselves from their families. Poor family relations may contribute to the development of low self-esteem because a young person may feel unworthy of being loved, which in turn may lead to depression, suicidal tendencies, and an increased likelihood of participation in HIV risk behaviors.

The family of a homosexual youth who discloses his or her sexual identity may react in various ways, ranging from unconditional support and acceptance to complete rejection. In the latter case, parents may experience shock and denial, which may lead to violence and expulsion from the home.

Homelessness

There are an estimated 1.5 million to 2 million homeless and runaway youth in the United States. Compared to other young people, homeless youth tend to become sexually active at a younger age and to have more sexual partners. They are also more likely to use injection drugs and other substances, share needles, and have sex with partners who inject drugs. To sustain themselves, homeless youth often engage in sex work or “survival sex,” the exchange of sex for anything needed, including money, food, clothes, shelter, or drugs. Sporadic condom use increases the risk of HIV infection.

The lack of secure and stable environments causes physical and emotional vulnerability among homeless youth. In addition, these young people often lack the resources to obtain basic necessities such as food, shelter, and medical care. Untreated physical and mental health problems, meanwhile, may affect a young person’s functioning and decision-making abilities, and sexually transmitted diseases (STDs) may also increase the chances of HIV transmission.

Homeless youth tend to have low self-esteem and are often distrustful of adults, undereducated, and many have been victims of physical or sexual abuse, broken families, and abandonment. In their constant need to fulfill basic needs, homeless youth may have little concern for long-term health risks such as HIV. Homeless youth tend to adopt “street values” that
Homeless youth tend to adopt “street values” that encourage high-risk behaviors, and the likelihood of engaging in these behaviors appears to increase with the duration of the homeless experience.8

A study of “street youth” in four Northern California cities found that 61 percent of respondents had been sexually active within the previous 30 days, and only 23 percent of those who had engaged in heterosexual vaginal intercourse during this period had used a condom every time. Females in the study were about half as likely as males to use condoms with partners every time they had sex. Many of these young people did not recognize their own risks for HIV. Although 62 percent said they were concerned about contracting HIV, and 59 percent thought they were likely to become infected, only 27 percent considered their behavior to put them at risk for HIV infection.10

A study of Los Angeles street youth found that 70 percent were sexually active, and those who were had an average of 11.7 sexual partners in the previous 30 days. Street youth with multiple partners were more likely to have had an STD, to engage in survival sex, and to use drugs during sex. In addition, 30 percent of the participants reported injection drug use.11 An earlier study found similar results.12

Substance Abuse

Substance use is common among young people, and it can lead to increased risk for HIV infection. The use of alcohol and other drugs can lower inhibitions,13 and substance-using adolescents tend to engage in sexual activities that pose higher risks for HIV transmission.4 According to a national study, one-quarter of sexually active high school students reported substance use during their last sexual intercourse. In addition, two percent of high school students in the United States have injected illegal drugs.5 Substance abuse may also intensify feelings of loneliness and result in self-destructive behaviors.13 A study examining psychosocial predictors of HIV risk among adolescent drug abusers found that participants generally failed to perceive themselves as being at risk for HIV infection despite having adequate levels of knowledge about HIV transmission. Young people who abuse substances often show signs of psychopathology such as conduct disorder, impulsivity, and impaired attention and judgment that may contribute to high-risk behaviors.14

Gang Activity

Membership in a gang poses further risks for young people. A gang is a group of people who regularly encourage high-risk behaviors, and the likelihood of engaging in these kinds of behaviors appears to increase with the duration of the homeless experience.8

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Related Issue: Condom Availability in High Schools

Condom availability in public high schools is a controversial issue. Despite the fact that many high school students are sexually active and that condoms are the most effective way of decreasing transmission rates of HIV and other STDs for people who are sexually abstinent, opponents of high school condom distribution express fear that condom accessibility in schools may increase the rate of sexual activity among young people and undermine the role of parents in their children’s sexuality.20

A one-year study of a condom distribution program at a Los Angeles high school found that condom use increased when condoms were available, while the level of sexual activity among students remained the same. After making condoms available to students for one year, researchers found that the number of young men reporting condom use each time they had vaginal intercourse increased from 37 percent to 50 percent. Female students, however, showed little change in their rates of condom use with partners. The study showed no increase in either the percentage of students who engaged in sexual activity or in the percentage of students who had three or more sex partners.21

There was also evidence that condom availability in the school increased communication about safer sex among students. Sixty-two percent of students agreed that the availability of condoms at school made it easier to discuss condom use with partners. Some students who were not sexually active, meanwhile, obtained condoms for exploratory activities—such as putting them on their penises or fingers—that helped them become familiar with condoms and their proper usage. Researchers speculated that familiarity with condoms is likely to increase the chances of safer sex practices when a person becomes sexually active.22

Homeless youth tend to adopt “street values” that encourage high-risk behaviors, and the likelihood of engaging in these behaviors appears to increase with the duration of the homeless experience.
associate with each other, exclude nonmembers, and may engage in criminal and socially disruptive activities. In 1995, police departments in California reported 4,927 gangs and 254,618 gang members—the highest numbers nationally for both categories. Research indicates that juveniles with a history of criminal activity are at greater risk for HIV infection than other young people. Not all gangs, however, are involved in criminal behavior.

Young people often join gangs because they have low self-esteem, lack social cohesion in their lives, or have grown up in socioeconomically disadvantaged environments. Adolescents without support networks and those who have been victims of physical and sexual abuse are especially likely to join gangs. Gangs often have clear rules of discipline and punishment; such rules can be attractive to young people who lack this structure in their families.

Initiation into a gang, also called “jumping in,” frequently involves performing or subjecting oneself to criminal or violent acts. To symbolize loyalty, many gangs require members to have permanent markers on their bodies, such as tattoos or scarification patterns. A woman’s initiation into a gang may require her to perform sexual acts, especially “chain bangs” or “gang bangs,” which refers to sequentially having sex with several members of the gang. Gang culture promotes unsafe behavior, and anecdotal reports suggest that gang members use condoms less frequently than other young people when they have sex. In the context of a gang’s family-like structure and support system, gang members may view condom use as a sign of mistrust.

In addition to unsafe sex, widespread drug use in gangs also increases the risks of HIV transmission. For some gang members, drug trafficking is their primary source of income. Despite the dangers posed by gang membership, gangs often provide a sense of safety and may be important to survival for some young people.

Implications for Counseling

Adult HIV test counselors may find it useful to perceive working with young people as a cross-cultural experience. Young people experience life differently from adults, and it is important for counselors to “let go of” the idea that they intuitively understand young people. Counselors cannot necessarily apply the approaches they use in working with adults to counseling young people.

Creating Safety

Creating a counseling environment in which a young client feels safe may be more important than providing specific information or even than giving an HIV test or disclosing a test result. An adult counselor may be the first adult willing to listen to a young person and answer his or her questions in a direct and respectful way.

Counselors can help young clients become comfortable enough to talk about areas of their lives—such as sexual risk behaviors or substance use—that they might not otherwise discuss. Counselors can then respond with open minds to learn more about the roles of various behaviors in clients’ lives. In any session, focus first on listening to a client’s disclosure; only after this, explore issues of making changes in risk behaviors.

Explain to clients that the purpose of a test counseling session is to provide a forum in which they can discuss risk behaviors and related thoughts and feelings without being judged. Also explain the meaning of confidentiality, and, as it applies, anonymity, without assuming that clients have the same understanding of these terms as counselors.

Creating a safe environment also depends on test-site policies, which often prohibit bicycles or skateboards—primary transportation methods for young people—and to provide services only during school hours. Indeed, most institutions that serve a general audience were established to serve adults. It is important for administrators of programs targeting youth, therefore, to consider whether or not their policies and procedures suitably accommodate young people.

Maintaining Counselor Roles

The basic roles of test counselors are to provide an environment in which clients can discuss risks and receive help in decreasing unsafe behaviors, to facilitate HIV testing, and to provide support, referrals, and linkage to additional services. When working with young clients, it is especially important for counselors to stay within their roles.

Some adult counselors may feel a desire to be liked by young clients and, to achieve this, may try to appear “hip” to the issues of young people. Others may take on strict parental roles. Both of these approaches may jeopardize the...
counselor’s credibility. Adult test counselors cannot be surrogate parents for young clients or take on the roles of friends or peers.

There may be circumstances in which a young person looks to a counselor for advice. It may be appropriate to provide direction in these situations, but only if the counselor clearly explains that his or her role is not to tell a client what to do, and that the counselor is not responsible for the client’s decisions. In addition, avoid telling young clients what they “should” or “should not” do. The messages young people receive from adults often dictate that they should not only avoid engaging in risk behaviors, but that they should also not discuss these behaviors.

For peer counselors working with other young people, there may be occasions in which it is relevant to acknowledge similarities in experiences as a result of being young, but recognize that the experience of each client is unique.

**Psychological Development**

Young people are experiencing a time of enormous change and growth. The following are some issues unique to the psychological development of young people:

- **Experimentation and Exploration.** Young people experiment for several reasons, including curiosity, peer pressure, and the desire for thrills and adventure. Realize that experimentation and risk-taking are not inherently bad; they are integral to the experience of being young. Learn the extent to which young clients evaluate the risks associated with various behaviors. With information about a client’s attitude toward risk-taking, a counselor can work with him or her to develop skills that help distinguish between personally acceptable and unacceptable risks.

- **Perceptions of Time.** Young people’s perceptions of time may differ from those of adults. A week may seem to be a much longer period to a young person than it seems to most adults. This is relevant because a young person may consider a sexual relationship to be lifelong after only a few days, and as such he or she may be more willing to engage in unprotected sex in the relationship. In addition, a young person may become decreasingly committed to safer sex without recognizing this change is occurring. While respecting a client’s perception of time, counselors can point out the distinction between a period of a few days, weeks, or months from that of a lifetime. To illustrate that change often occurs unexpectedly, a counselor may ask a client to relate an attitude, belief, or other aspect of life from six months ago that the client did not expect would change but which, in fact, has.

- **Sexual Identity.** Young people may be sexually active with partners of the same or opposite sex without identifying themselves according to sexual orientation. A young person who identifies as heterosexual may be disturbed by an incident in which he or she engaged in homosexual behavior. Frame this as experimentation and explain that any one experience will not necessarily change a person’s overall sexual orientation. Young clients may also express confusion about their sexual identity and may express interest in members of both sexes. Normalize these desires and, if the client chooses to act on them, discuss this decision and ways to minimize risk. For young people who state that they engage in sex with members of the same sex, or identify as homosexual or bisexual, assess the extent to which they believe they receive appropriate emotional support from family and friends. Explore the role of community support services and provide referrals for lesbian, gay, and bisexual youth support organizations.

**A Counselor’s Perspective**

“Many of my young clients who are gay have never known anyone with HIV or AIDS. I think this contributes to their belief that HIV is not a serious risk.”

**Friends and Group Membership.** In choosing friends and relating to peers, young people often make decisions that appear to bring them harm. Do not judge or discount these choices. Instead, focus on specific behaviors, related harmful effects, and the role of relationships in this context. Focus not only on the risks, but also on related benefits. In some cases, a young person may perceive group membership—such as gang affiliation—as necessary for survival. Group membership may also fulfill important needs, such as a sense of belonging, acceptance, or power. Acknowledge these needs and consider how a person might fulfill them without also engaging in HIV risk behaviors.

**Sexual Activity**

For a young person, sex can be especially overwhelming because

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<th>Test-Site Access</th>
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<td>Clients 12 and older can access state-funded HIV counseling and testing sites without parental consent if the counselor determines that the client can consent to the test. Be alert to the possibility that parents or other adults may accompany a young person to a test site and coerce a person into testing. When an adult visits the test site with a young client, recognize that the counselor’s only interest is in serving the client.</td>
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of the power and confusion it brings. Recognize that young people may have many reasons for engaging in sex, and explore these reasons. In some cases, a young person may engage in sex even if it is not in itself pleasurable for him or her. Sex may be a novelty that entices a young person, or sexual activity may be the result of pressure from friends, partners, or others. Be aware that there may be differences in psychological and physical development between young people, and this may affect the balance of power in relationships.

When young clients say they are sexually active, ask them to explain specifically what they mean by this. While test counselors may consider sex to involve penetrative behavior involving the penis, anus, or vagina, clients may consider kissing, “petting,” or masturbation to also be sex. In addition, heterosexual clients who engage in anal, but not vaginal, sex may believe that only vaginal intercourse is sex, and, therefore, do not consider themselves to be sexually active.

With clients who are and wish to continue to be sexually active, it is important to respect their choices, while also discussing related HIV risks. Help clients understand the reasons for practicing safer sex by exploring their values related to health and survival. Explore the client’s ability to communicate his or her desire to engage in or abstain from sex and to negotiate for condom use. Also evaluate clients’ knowledge of birth control methods and ways of accessing these. For clients who have uncertainty about the proper way to put on a condom, use a model to demonstrate.

For young clients who desire to have receptive or insertive anal sex, be prepared to educate them on proper and safer ways to engage in these activities. Counselors must be able and willing to discuss sexual behaviors with young clients.

Confusion about whether or not to be sexually active is common among young people, especially among those who have never had sex or those who have only recently become sexually active. Discuss the issues surrounding this confusion and explore any benefits the client may see in being abstinent or sexually active. Reinforce any client’s decision to be abstinent, and help him or her maintain their commitment by exploring any pressures they may feel to be sexually active. When clients report that they engage in sex despite not wanting to, explore the reasons for their behavior and work with them to find alternatives.

Beyond the risks of HIV, discuss the even greater risk of other sexual behaviors with young people who are abstinent or who are not practicing safer sex.

References
18. Interview with Nancy Netherland, Director of Prevention Services, the YMCA of San Francisco. February 1998.
Case Study

Carol is a 17-year-old female client who is testing for the first time. She reports a history of not using condoms during vaginal sex. She states that she believes she is "safe" in not using condoms because she only engages in sex with boyfriends. In the past six months, she has had four boyfriends at different times and had sex with each. She is testing because she and her current boyfriend recently attended a presentation in high school about HIV and testing.

Counseling Intervention

Begin by validating Carol’s decision to seek HIV counseling and testing services. Note that this is a sign that she is taking responsibility for her health and the well-being of her boyfriend. Ask Carol to summarize her knowledge of HIV. Fill in any gaps in information, explain and clarify points as appropriate, and answer any questions Carol may have.

Assess Carol’s comprehension of her own risk by asking her to identify any past or planned behaviors that she considers to involve risk. Ask Carol how she feels about condoms now that she is informed about her risk. If she says that she is not ready to commit to condom use with partners, explore her reasoning for this, and in a supportive manner, address any issues that arise. Discuss other ways Carol may reduce her risks.

If Carol says she does not want to make any changes, acknowledge her decision to test as a major step toward behavior change. Seeking HIV testing reflects a recognition of risk and is a significant process for a 17-year-old. Working with her in a stage at which she is thinking about behavior change may encourage her to adopt a new behavior in the future.

If Carol says she is ready to commit to condom use, work with her in developing a realistic plan of action. If possible, arrange to meet with her for the disclosure of the test result to discuss progress in implementing this plan. Conclude the risk assessment and intervention by reviewing her previous risk and ways she may lower it.

Take note of any psychological, social, or medical referrals that Carol may find beneficial, and conclude the session by providing and explaining any appropriate referrals, such as a youth sensitive clinic or a young women’s service agency that provides counseling support for young people.

A young person with HIV is more likely than an adult to be isolated from supportive people. Discuss where the client has found support in the past and help him or her determine the usefulness of these sources. Locate support groups specifically for HIV-positive youth and other relevant programs specifically for youth, and provide linkage to these.

Referrals

Young people often require different types of referrals than adults. For instance, young people may benefit from referrals to youth-service organizations, youth social groups, or other special-interest activities. Referrals that provide support and foster the exploration of a young person’s feelings, values, conflicts, and desires are especially valuable. In addition, when providing referrals and facilitating the linkage of services, counselors may need to be more pro-active and directive with young clients than they are with adults.

Learn about referrals to make sure they are age-appropriate and culturally sensitive. Young people may be naïve about receiving referrals, and it may be necessary to explain the value of follow-up services. Recognize that support services may be especially important for young clients. In anonymous test-counseling settings, counselors may explain the value of a confidential setting, which can allow for a stronger counselor-client relationship and may be vital in helping clients gain access to services.

For more information on counseling young people, refer to the Young People & HIV issue of PERSPECTIVES, (Volume 3, Number 3) June 1993.
Test Yourself

1. People between the ages of 13 and 24 comprise what percentage of all diagnosed HIV cases in the United States? a) less than 1 percent; b) 3 percent; c) 18 percent; d) 65 percent.

2. According to a national study, what percentage of sexually active high school students reported condom use during their last sexual intercourse? a) 90 percent; b) 76 percent; c) 54 percent; d) 20 percent.

3. True or False: Poor family relations have no effect on a young person’s likelihood of developing high-risk behaviors.

4. True or False: Gang members may view condom use as a sign of mistrust.

5. Homeless youth are more likely than other youth to engage in which of the following behaviors? a) become sexually active at a younger age; b) have more sexual partners; c) use injection drugs and other substances; d) all of the above.

6. According to a national study, what percentage of sexually active high school students in the United States reported substance use during their last sexual intercourse? a) 6 percent; b) 25 percent; c) 65 percent; d) 90 percent.

7. True or False: Researchers suggest that condom distribution programs in high schools can increase communication about safer sex among students.

8. True or False: Researchers in one study have found that adolescent drug abusers generally failed to perceive themselves as being at risk for contracting HIV despite adequate levels of knowledge about HIV transmission.

Discussion Questions

1. Some adult counselors report feeling intimidated about counseling young people because young people’s experiences are so different from their own. How can counselors respond to such feelings?

2. Some adult counselors may find themselves taking on a parental role when counseling young clients. How can counselors assess whether this is occurring and deal with it if it happens?

3. Is it sometimes appropriate for counselors to be more directive in their counseling of young clients compared to older clients? If so, when might this be? If not, why not?

4. What can counselors do to create a “safe,” non-judgmental environment for young clients to discuss their risk behaviors and the context in which these occur?

5. When counseling young people, feelings often arise for counselors related to their own experiences of youth. While “normal,” this can potentially interfere with the counseling session. How can counselors recognize when this is occurring and respond to it?

Answers

1. c.
2. c.
3. False. Young people experiencing turbulent family relations often have low self-esteem. As a result this may lead to depression and participation in high-risk behaviors.
4. True.
5. d.
6. b.
7. True.
8. True.
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