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The Role of Sexual Health Professionals in Developing a Shared Concept of Risky Sexual Behavior and HIV Transmission

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Abstract

“Risky sexual behavior” accounts for the majority of new HIV infections regardless of gender, age, geographic location, or ethnicity. The phrase, however, refers to a relatively nebulous concept that hampers development of effective sexual health communication strategies. The purpose of this paper is to propose development of a shared conceptual understanding of “risky sexual behavior.” We reviewed multidisciplinary HIV/AIDS literature to identify definitions of risky sexual behavior. Both the linguistic components and the social mechanisms that contribute to the concept of risky sexual behaviors were noted. Risky sexual behavior was often defined in a subjective manner in the literature, even in the scientific research. We urge a paradigm shift to focus on explicit behaviors and the social context of those behaviors in determining HIV risk. We also propose a new definition that reduces individual biases and promotes a broader discussion of the degree of sexual risk across a diversity of behavioral contexts. Sexual health professionals can

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strengthen practice and research initiatives by operating from a concise working definition of risky sexual behavior that is broadly transferable and expands beyond a traditional focus on identity-based groups.

Keywords

disease prevention; diversity; public health systems; health promotion; HIV/AIDS; patient education; prevention; program planning; sexual behavior

Introduction

The HIV/AIDS pandemic underscores sexual health as a critical area of practice and research. More than 35 million people live with HIV/AIDS, and approximately 1.5 million AIDS-related deaths occurred in 2013 (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014). In the United States alone, an estimated 1.1 million persons live with HIV/AIDS, and one in six are undiagnosed and unaware of their HIV infection (Centers for Disease Control and Prevention [CDC], 2013). People who do not know their HIV status account for more than 50% of all new HIV infections (CDC, 2008), and 88% of all HIV cases in 2010 were due to sexual contact, including male-to-male sexual contact (63%) and high-risk heterosexual contact (25%), and sex with a partner known to have or to be at high risk for HIV infection (CDC, 2012).

The World Health Organization (WHO) notes that “Accessible, acceptable, affordable and high-quality sexual health services are fundamental for achieving a sexually healthy society” (WHO, 2010, p. vi). Although effective HIV risk assessments and interventions are needed, sexual health professionals, including nurses, lack a shared conceptual understanding of “risky sexual behavior” (RSB; Boekeloo, 2014)—especially as it relates to increased risk of HIV transmission. For the purposes of this paper, we broadly view RSB as sexual behavior that increases one’s risk for unintended sexual health outcomes. But that definition is unhelpful insofar as the terminology surrounding sexual practices remains vague. The lack of a clear, shared concept of risk in relation to sexual behaviors may hamper effective sexual health assessment and the development of intervention initiatives. And, indeed, there are no nationally established competencies for the definition and assessment of RSB. As clinical competencies drive education and practice, the absence of such standards has substantial public health implications (Hewitt & Cappiello, 2015). Considering that sexual behaviors account for the majority of all HIV cases, adequately defining RSBs will provide an important contribution to HIV prevention.

In clinical practice, during assessment and education with clients about reduction of RSBs, screening errors may occur due to provider and/or client stereotypes and provider-client misunderstandings (Burgess, van Ryn, Dovidio, & Saha, 2007). For example, while current clinical guidelines call for routine HIV screening of *all* clients aged 13 to 64 (CDC, 2006), a dearth of open discussion, the presence of provider assumptions or biases, and discomfort discussing sexual topics by either or both parties can impede realization of these standards, especially with youth and older adults and in age or gender discordant clinical encounters (Goyal et al., 2013; Slinkard & Kazer, 2011). In a systematic review examining nurses’

preparedness to discuss sexual health issues, many nurses were found to lack preparation and willingness to engage clients in conversations regarding the client's sexual health needs (East & Hutchinson, 2013). With respect to provider-client misunderstandings, adolescents have been found to associate abstinence with refraining from heterosexual vaginal intercourse, while failing to perceive that anal and oral sex are "real sex" in the context of health care and disease prevention (Brawner, Gomes, Jemmott, Deatrick & Coleman, 2012; CDC, 2010).

In sexual health behavioral research, the limited operationalization of HIV risk (i.e., an exclusive focus on condom use) hampers the evidence base for applied HIV prevention science. That is, most behavioral HIV/AIDS researchers continue to focus solely on male condom use as an effective prevention tool (Crosby & Cates, 2012), even while the menu of available prevention options has expanded with emergent technologies such as treatment-as-prevention (TASP), pre-exposure prophylaxis (PrEP), microbicides, and female condoms (Cohen et al., 2011; Fava et al., 2013; Hosek et al., 2013; Weeks, Coman, Hilario, Li, & Abbott, 2013). In response to technological advances, clinicians and researchers who develop risk assessment and counseling tools should also consider strategies beyond the traditional (Coates, 2013). But to develop effective new strategies, health behavioral scientists must more clearly define how they understand and represent to their clients what sexual risk is and what behaviors contribute to it.

To elicit accurate information during sexual health assessments, one needs to know which questions to ask clients and/or research participants. A working definition of RSB that encompasses a broad range of sexual practices that increase HIV risk as well as social mechanisms that amplify that risk would offer a starting point. We begin this commentary by providing the evidence base and rationale for re-conceptualizing RSB. Second, we present themes from our critical review of the literature on social mechanisms highly correlated with increased rates of HIV transmission. Third, we propose a definition of RSB that is appropriate across a diversity of behavioral contexts and sexual health disciplines. Lastly, we discuss the relevance of this work to clinical practice. Our aim is to improve sexual health assessment and intervention through clear, unambiguous communication between health professionals and the public. We believe that sexual health professionals, including nurses, physicians, community health workers, health educators, and other social service providers, are well-positioned to lead this paradigm shift. We hope to strengthen practice and research initiatives by illuminating discrepancies among definitions that may influence clinical and scientific understanding of RSB.

The Evidence Base and Rationale for Change

Despite the frequent use of the term across various practice disciplines, health behavior theory, and research, RSB has not been conceptually analyzed in scientific circles. Instead, RSB is used nearly as loosely in scientific discourse as in everyday language, carrying with it myriad implied cultural, social, and scientific meanings (Hupcey & Penrod, 2005). The ambiguous language becomes problematic when attempting to assess an individual's risk and promote protective behaviors. Because precision in the language of scientific inquiry enables both theory building and practice application, a more exact definition of RSB would

be an advantageous starting point for sexual risk health assessment and education (Hupcey & Penrod, 2005).

A concise working definition of RSB and standardized assessment questions that align with current practice guidelines would facilitate the role of sexual health professionals in preventing sexually transmitted infections (STIs), including HIV. Upon critical review of multidisciplinary HIV/AIDS literature, however, we noted that a specific, shared definition is virtually nonexistent. The absence of a standard definition for RSB poses two potential threats to public health and the promotion of a sexually healthy society: 1) health care professionals are limited in their ability to conduct comprehensive sexual health histories and develop individualized risk reduction plans, and 2) the general public may inaccurately identify the risk of sexual practices, thereby increasing their susceptibility to HIV infection.

The CDC *Sexually Transmitted Diseases Treatment Guidelines* (2010) states that “effective delivery of prevention messages requires that providers communicate general risk-reduction messages relevant to the client and that providers educate the client about specific actions that can reduce the risk for STD/HIV transmission” (p. 2). What constitutes “safe sex” and “unsafe sex,” however, has historically been categorized in different ways with emphases falling divergently on condom use or multiple sexual partners (Slaymaker, Walker, Zaba, & Collumbien, 2004). Clarity in terminology is key to meeting clients’ needs during clinical exchanges. Yet misunderstandings and a breakdown in communication often occur in the client-provider relationship (Hayter, 2009). Clear definitions could reduce those break downs.

With the negative connotations surrounding “risk” and in the absence of a clear, authoritative definition, RSB may come to imply deviance and immorality to many. Recall, for example, the terminology formerly used to describe HIV/AIDS risk groups as the “4 H’s”—hemophiliacs, heroin addicts, homosexuals and Haitians (CDC, 1983, p. 9). We posit that the metalanguage of RSBs may serve similarly to reinforce and perpetuate stereotypes and prejudices. Debates about the origin and subsequent trends in HIV/AIDS infection persist, with HIV theories ranging from government conspiracy to witchcraft. These beliefs and the stigmatizing ways in which AIDS has historically been defined result in distrust and misguided understandings about RSB. Given extensive documented evidence that HIV is transmitted sexually, we argue that definitions and messages need to be clear and encompassing, highlighting behaviors rather than identities and emphasizing that *anyone* engaging in sexual behavior is at risk, although measures can be taken to reduce this risk (WHO, 2010). Indeed, even in committed, mutually monogamous relationships evidence suggests that exposure may occur if one or both partners break the commitment (Blashill, Wilson, O’Cleirigh, Mayer, & Safren, 2014; Jones, Stephenson, Wall, & Sullivan, 2014; Walker, 2014). Normalizing risk through a carefully articulated definition of RSB means clarifying that sexual activity quite simply always carries some threat, not the stigmatized, deviant threat of past stereotypes but a serious, widely distributed risk that requires everyone’s attention.

Three decades into the HIV/AIDS pandemic, HIV risk perception remains low—even among individuals whose behaviors put them at increased risk (Beltzer et al., 2013; Ma et

al., 2013). As a health care community, if we continue to define RSB within contexts of high-risk *groups*, those outside the defined risk groups may fail to accurately recognize their risk of acquiring HIV, and those who identify with the high-risk groups may mistake the source of their risk. Defining *behaviors* that place an individual at risk for HIV may be the better approach (Mann & Tarantola, 1998). For example, men who have sex with men (MSM) are not at risk for HIV because of their sexual orientation but because of increased patterns of sexual behaviors (i.e., anal sex) that hold greater potential for HIV transmission. More specifically, rectal tissue is prone to abrasion during penetration (Draughon, 2012), and the protective humoral immune barrier in cervicovaginal secretions is absent in rectal mucosa (Baggaley, White, & Boily, 2010). Anal sexual behavior places individuals at increased risk for contracting HIV regardless of gender or sexual orientation. Thus, it is unprotected anal sex—not being a man who has sex with other men—that increases one’s risk of HIV. Sexual behaviors rather than culturally delineated sexual identifications influence risk (Beyrer et al., 2012). Equally important, because the typical prevention message is that MSM are at increased risk for the virus, women and heterosexual men engaging in anal sex may be misled to believe that their behaviors are free from risk, while MSM may not perceive that a range of other physical interactions available to them represent much less risky options—that, in other words, it is not sexual orientation but specific types of unprotected activity that defines their risk (Fortenberry & McBride, 2010).

Similarly, African-American and Latina women are not inherently more sexually at risk nor are Euro-American white women inherently less at risk because of their ethnic origins. In fact, there is no physiological association between ethnicity and heightened HIV risk. Increased rates of STIs among individuals with membership in culturally defined groups and a public health focus on these specific populations give the impression that there are inherent connections between sexual health risk and ethnic and/or racial identification and further contribute to objectification of these groups (Szymanski, Carr, & Moffitt, 2011). As HIV/AIDS has disproportionately affected racial and ethnic minority women and adolescents, many resources have been devoted to identifying and managing RSB in these populations. This is good in that it targets resources to a real need, but, without careful articulation, the message such efforts send could lead men and women who do not identify ethnically with these groups to underestimate the risks associated with their behaviors and again may cause men and women who do identify with the “risky” groups to mis-identify the source of their risk. The conundrum of risk attributed to certain groups and not others and the weighting of RSBs differently by gender, sexual orientation, age, and socioeconomic status (SES) has the potential to impede prevention efforts against the spread of HIV. Semantic and conceptual clarity are necessary to improve sexual health assessment and intervention. We posit that the current categorization of risk unhelpfully and perhaps dangerously implies group-based biases and reinforces historically stigmatizing associations.

Sexual risk behaviors, risky behavior, problem behaviors, risky sex, and unsafe sexual practices are common, often interchangeably used terms. The National Institutes of Health (2005) defined RSB in relation to HIV transmission as sexual contact, including oral, with an infected person without using a condom, and sexual contact with someone whose HIV status is unknown. Though most agree that unprotected sex is risky, debate continues to

arise elsewhere, especially over the perceived risks of penetrating versus non-penetrating sex and the risk of transmission in bonded partnerships, where condom use diminishes as trust develops over time (Hock-Long et al., 2012).

Social Mechanisms of Risky Sexual Behavior

An RSB definition with wide behavioral applicability may prove beneficial particularly to sexual health professionals who are developing strategies to reduce other undesired outcomes from sexual behavior, such as unwanted teenage pregnancy and the proliferation of other STIs. Effective interventions require an in-depth understanding of what constitutes RSB and how these behaviors increase the risk of contracting and transmitting disease. In addition to sexual practices that increase HIV risk (e.g., multiple sexual partners), some social mechanisms compound risk. It is equally important to acknowledge multi-level mechanisms (e.g., geographically and socially constrained sexual networks) associated with RSBs (Brawner, 2014). Although there are several well-known contributors to RSB, such as limited comprehensive sexual health education, our critical review of the literature indicated that three factors in particular are frequently linked with increased rates of HIV transmission: gender inequity, socioeconomic status (SES), and depression (Higgins, Hoffman, & Dworkin, 2010; Morokoff et al., 2009; Szanton, Thorpe, & Whitfield, 2010). These factors can influence actions taken by clients to avoid or reduce identified risks, and should be included in sexual health assessments during clinical encounters and research.

Gender Inequity

Power differentials influence interpersonal dynamics in sexual relationships and have the potential to affect communication about and negotiation of sexual activity (Alexander, Coleman, Deatrack, & Jemmott, 2012; Wyatt et al., 2013). Across the lifespan, the pervasive social construction of sexuality as a male-dominated arena creates a standard in which men may dictate when and where sexual encounters occur and whether or not condoms are used. Heterosexuality is structured in such a way that a man's societal power is often carried into intimate relationships, which may encourage a woman's sexual and emotional subservience (Shaw & Lee, 2001). Risky sexual behavior occurs within the context of "differing degrees of power within relationships and gender-differentiated norms for sexual behavior" (Hoffman et al., 2006, p. 52). To understand RSB, it is essential to investigate how gender inequalities in power are played out in sexual relationships and how this power differential may influence sexual risk.

One of the ways power differentials are enacted in sexual relationships is through intimate partner violence. Researchers in social science and public health have documented heightened risk for HIV transmission among people experiencing intimate partner violence (Dunkle et al., 2013; Teitelman, Tennille, Bohinski, Jemmott, & Jemmott, 2011). More specifically, women who report a history of intimate partner abuse may be at increased risk for HIV. Power differentials within relationships affect risk when a more passive member in a relationship feels unable to object to his or her partner's having multiple sex partners; unable to ask about past or current history of STIs; and unable to request changes to unsupportive, unhealthy patterns of interaction (Jewkes, Levin, & Penn-Kekana, 2003; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003). Theorists posit that intimate partner violence

negatively affects a woman's ability to control sexual activities (including condom use) with a known HIV-positive partner (Lichtenstein, 2005). Women experiencing intimate partner violence have also reported inconsistent condom use with partners with known HIV risk factors and coercion by their abusive partners to practice other sexual risk behaviors (Draughon, Lucea, Campbell, Paterno, Bertrand, Sharps, Campbell, Stockman, 2014; Dunkle et al., 2004; Wu et al., 2003). Lastly, structural factors such as inequitable gender norms deter HIV prevention strategies among women, even in the absence of violence, by serving as a barrier to condom negotiation and effective sexual communication (Brawner, Teitelman, Webb & Jemmott, 2013; Go et al., 2003). For example, condom coercion, a form of self-silencing, occurs when women are pressured to agree to have anal or vaginal sex without a condom when they wanted their sexual partners to use one (Teitelman et al., 2011). While we focus on women because the traditional patriarchal structure of western society often still results in their occupying a disempowered social position, men are not exempt from the deleterious effects of power imbalances in intimate partnerships. Violence and coercion put women and men at risk for HIV transmission, and men who are socially positioned to behave with passivity in a relationship can experience similar outcomes with women or with other men (Siemieniuk, Krentz, & Gill, 2013). Our intent, again, is not to point toward gender-based risk groups, but rather to highlight the relationship between traditional structures of gendered inequality and the socially normative behaviors linked to them that increase risk for HIV.

Socioeconomic Status

In the United States in 2012, 46.5 million individuals were living in poverty, a 2.5% increase from the previous five years (DeNavas-Walt, Proctor, & Smith, 2013). Low SES is believed to increase HIV risk through its association with reduced access to quality medical care and education (Harawa et al., 2004). Several researchers have demonstrated associations between SES and high HIV prevalence (Auerbach, Parkhurst, & Cáceres, 2011; Parkhurst, 2010). In geographic mapping studies, researchers have also discovered increased rates of HIV prevalence and high-risk behaviors in low-income neighborhoods (Brawner, Reason, Goodman, Schensul, & Guthrie, in press; Nunn et al., 2014). Community stressors associated with living in poverty are associated with HIV risk behaviors (Kalichman et al., 2005). Marginalization, including poverty, perpetuates a cycle of disempowerment and subjects the individual to additional risk behaviors in the absence of appropriate interventions (Marin, 2003). Just as gender, race, and ethnicity are not causal agents of HIV transmission, SES alone is not a definitive risk factor. However, factors associated with low SES, such as poorer quality of health care and lack of access to resources (Rubin et al., 2010; Szanton et al., 2010), need to be taken into account when attempting to understand RSB.

Depression

Depressive symptoms are associated with intimate partner violence victimization and aggression (Volpe, Hardie and Cerulli, 2012). With established links between intimate partner violence and HIV risk, it is essential to assess the relationship between depression and the decision-making power that sexual partners have in relationships. A growing body of knowledge suggests a strong positive correlation between depressive symptoms and RSB,

including but not limited to having sex with multiple partners, having a greater number of lifetime partners, having unprotected sex, having sex while under the influence of drugs and/or alcohol, and having sex with injection drug and cocaine users (Brawner et al., 2012; Chen, Thompson, & Morrison-Beedy, 2010; Lennon, Huedo-Medina, Gerwien, & Johnson, 2012). Adolescents with mental health diagnoses are at even greater risk of HIV exposure because they practice the same risky behaviors as their school-age peers, and at greater rates (Brawner et al., 2012; Brown et al., 2010; Donenberg, Emerson, & Mackesy-Amiti, 2011). Depression may affect an individual's likelihood of engaging in RSBs when sex is used as a means of mitigating distress (Alvy et al., 2011). The disorder may also compromise motivation to change adverse behaviors if psychological and/or emotional needs are being met by the behaviors (e.g., experiencing loneliness/isolation as a depressive symptom, looking to sexual partners for attention) (Brawner et al., 2012). It is important to be cognizant of the role of depression and other psychiatric disorders in RSB, as they may alter an individual's ability to advocate for and follow through with measures to decrease sexual risk.

Proposed Definition

Given the widespread use of the term RSB, it is important that the concept encompass the behaviors that it purports to represent. Building on the extant literature, the National Institutes of Health (2005) definition of risky sexual behavior, and drawing insights from Cooper, Shapiro, & Powers's (1998) definition of "risky behavior," we propose the following definition of RSB related to HIV transmission:

Any sexual behavior that increases the probability of exposure to HIV, including but not limited to unprotected genital contact (oral, anal, or vaginal), with or without penetration, orgasm, or ejaculation; concurrent sexual partners or multiple sequential sexual partners; sexual activity under the influence of drugs and/or alcohol; sexual activity in exchange for emotional support or material goods (e.g., money, drugs); and/or sexual activity with a partner of unknown HIV status.

By shifting the focus from groups to specific behaviors, the message is clear that *all* individuals who are sexually active—regardless of race/ethnicity, gender, sexual orientation, marital status, etc.—are at risk for acquiring HIV. Just as universal precautions (e.g., gloved hands when in contact with bodily fluids) are automatically and uniformly performed for infection control, providers should automatically and uniformly conduct sexual health assessments for all clients. While the proposed definition assists to clearly identify behaviors that increase HIV risk, in attempting to understand RSB and adequately describe levels of risk, health care professionals and educators should also attend to the role that social mechanisms play in the sexual decision-making process of clients. Broader social and structural concerns, including the role of social norms and networks, should be considered in communications with clients and in the development of programs and interventions (Latkin et al., 2013).

The proposed definition moves toward a more precise and coherent understanding of RSB, one that we hope will a) encourage providers to engage all clients in sexual health dialogues without defaulting to group biases (i.e., no longer avoiding assessments in age or gender

discordant encounters); b) prompt clinicians and researchers to include non-traditional risk factors in their sexual health assessments (e.g., transactional/exchange sex); and c) clarify for the general public that all forms of sexual activity bear some degree of HIV risk—although actions can be taken to reduce that risk. The flexibility offered by this new definition allows for broader discussion and operationalization of RSB and has the potential to reduce the subjective assignment of risk based on biases against groups. Additionally, this definition is widely applicable across a diversity of behavioral contexts. For example, traditional classifications do not include exposure risks associated with non-penetrating genital contact or account for the importance of knowing a sexual partner's HIV status. Further, to reduce the threat of further stigmatizing individuals and their behaviors, we suggest using the terminology *sexual risk behaviors*, or *HIV risk-related sexual behavior* in lieu of RSB.

Relevance to Clinical Practice

The relevance of this work to clinical practice is three-fold: 1) transdisciplinary sexual health professionals have an opportunity to be at the forefront of clarifying RSB by modeling consistent, behavior-based definitions and messaging for other health professionals and the general public, 2) educators are in a position to improve training programs and curricula so that clinicians are better able to address clients' sexual health needs, and 3) providers are urged to uphold their responsibility to engage *all* clients in sexual health discussions, while remaining cognizant of their own unconscious biases. Although there is room for improvement, we would be remiss not to commend the providers who are already leading the charge to promote sexual health for *all* clients.

Everyone deserves the opportunity to be engaged in dialogue with providers about their sexual health. Providers, however, hold stereotypes (e.g., race, age or gender biases), typically outside of conscious awareness, and these shape clinical decisions, interpretations of behaviors and symptoms, and interactions with clients (Burgess et al., 2007). It is time to move past individual biases, cultural taboos, and stereotypes, and repudiate preconceived notions about particular groups. A shared understanding of RSB and a concise working definition can strengthen research and practice initiatives by providing an objective starting point.

We propose a paradigm shift to focus on behaviors and the social context of those behaviors as they relate to HIV risk. Focusing on a broader range of sexual practices that increase HIV risk and the social mechanisms, such as gender inequities, socioeconomic status, and depression, that amplify risk will improve sexual health assessments and intervention strategies (Brawner et al., 2013). Without a clear definition of RSB, the effectiveness of risk-reduction and abstinence promotion education intended to reduce HIV transmission is hampered. Using a shared definition with broad applicability in a variety of behavioral contexts may improve outcomes in clinical practice, research, policy, and public education. The promotion of comprehensive sexual health assessments for everyone normalizes health promotion behaviors such as routine HIV testing.

By bracketing or eliminating individual biases and historically stigmatizing norms, clinicians will be better able to offer individualized plans of care that meet the needs of clients, with particular attention to relationship context and emerging options for prevention. Information about newer technologies such as the female condom and TASP could be added to clinical and research protocols for sexual health management. Based on our review of the literature and our experiences as sexual health professionals, we created a list of sample questions for clinical and research assessments to explore contextual factors associated with sexual transmission of HIV (see Table 1). These questions are not exhaustive by any means, but rather are intended to highlight the contextual nuances necessary to comprehensive sexual health assessment. We acknowledge that some of the items are very direct and may make providers or clients uncomfortable; however, we contend that such information must be elicited to fully understand a client's sexual health promotion and risk reduction needs. In support of a forthright approach, the literature consistently demonstrates that, once provider-client rapport is established, clients are receptive to in-depth conversations about their sexual health with providers (Boekeloo, 2014; Goyal et al., 2013; Slinkard & Kazer, 2011).

Sexual health professionals can also play a pivotal role in ensuring that adequate sexual health education is grounded in empirical knowledge of HIV transmission. Given the significant impact of HIV/AIDS, ensuring that HIV prevention education is offered in a variety of settings, including clinical, will be crucial in turning back the epidemic (Jones, Baker, Gelaude, King, & Jemmott, 2013). Diversification of delivery can be accomplished through curricula development for degree programs, as well as through the development of training programs for community health workers. School teachers, health educators, victim advocates and social workers can all be trained to deliver sexual health information, and nurses in particular are uniquely suited to teach health-technical and interpersonal skills (Borawski et al., 2015).

CONCLUSION

Significant public health challenges, such as HIV/AIDS, require clear client-provider communication to distinguish between risk and protective behaviors. To successfully implement sexual health assessments and interventions, it is critical that language is unambiguous and fully understood. Despite relevance to clinical practice and research, the conceptual development of RSB is limited, and a widely shared understanding of "risky" sexual practices does not exist. In this commentary, we explored clinical and scientific thought regarding "risky sexual behavior" and proposed a new definition that has wide applicability across a diversity of behavioral contexts.

As there is no cure for HIV/AIDS, prevention remains a pivotal tool to decrease the rampant spread of this devastating virus. During the past three decades we have seen the stereotyped face of HIV/AIDS change from that of the homosexual White male to racial and ethnic minority MSM and women. We believe that, between migration of people, a global economy, and a lack of behavioral change, we will see a fading away of population-based assumptions about HIV. In order to reduce risk behaviors among all people regardless of group or identity, we submit that clarifying definitions, creating uniform public messaging, and encouraging provider adherence to established guidelines is a necessary first step. From

there, sexual health professionals, including nurses, physicians, community health workers, health educators and social service providers, can better lead the way in supporting behavioral change. While all may not agree with the proposed definition or the conceptual understanding we have advanced, and while some may have additional questions they deem necessary to consider in screening clients, we hope we have made a strong case for the need to establish a clearer, more encompassing, more uniformly shared and less biased conceptual basis for RSB.

Future research should consider the following questions: How does an individual come to determine whether or not a particular sexual behavior or action is “risky”? What inter- and/or intra-personal factors cause providers to differ in their perceptions of clients’ sexual risk behaviors? Should we eliminate the term *at risk group* from our descriptive epidemiology of HIV? How can sexual health professionals affect an individual’s sexual decision-making process? These questions will hopefully incite collective and scholarly debate about the merit of how the term RSB is articulated in the literature, prevention messages, and other educational activities. Ultimately, such questions advance our clinical practice and the state of the science by clarifying the meaning of risk for given populations. Additionally, those working to decrease rates of unintended sexual health outcomes, such as unwanted teenage pregnancies, may find that a shared definition has wider applicability to their respective areas of focus.

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Table 1

Example assessment questions to explore contextual factors associated with sexual transmission of HIV

Question	Rationale
* Are you currently having sex? And this includes contact of the vagina/penis, rectum/butt and/or mouth?	This question probes current engagement in all types of sexual intercourse (i.e., anal, oral, and vaginal sex). This allows the provider to conduct an accurate sexual health assessment and intervention, and to discuss specific behaviors that may result in higher risk for HIV/STI infection.
* Do you currently have more than one person that you are having sex with? <i>(Probe for sequential and concurrent partners, including “orgies” and “trains.”)</i>	This can explore whether clients have more than one concurrent partner, their condom use and other influential factors involved (e.g., familiarity with main and/or casual partners).
* Do you use condoms consistently with your partner? If yes, what influences you to use condoms? If not, what influences you not to use condoms? <i>(Probe for condom use by partner type [e.g., casual, steady and main partners].)</i>	This question can explore reasons for noncondom use (e.g., trust, length of relationship, afraid to ask for condom), and provides a basis for comprehensive risk reduction education.
* Have you ever had a sexually transmitted infection, like crabs, syphilis or gonorrhea? <i>(probe for treatment and disclosure to sexual partners)</i>	STI history is associated with increased risk for future STIs, including HIV, and may provide insight on risk patterns. Probing treatment history and disclosure is also necessary for accurate sexual health assessment and intervention.
* Do you engage in sexual behaviors with men or women or both? <i>(Probe for vaginal, anal and oral sex, as well as mutual masturbation.)</i>	Asking about behaviors instead of sexual identity/orientation addresses difference in risk profiles based on behaviors that increase risk for HIV transmission (e.g., anal sex), not social groups. With knowledge of specific behaviors, providers can target intervention strategies (e.g., recommendation for dental dams versus female condoms).
* What do you do to protect yourself against STIs and unwanted pregnancy?	This question allows providers to assess any myths clients may have or potential practices that could increase risk (e.g., doubling condoms or pulling out).
* Recently, have you had sex with your partner without a condom, even if you wanted to use one?	This question helps to probe for sexual partner coercion. Given the links between sexual relationship power dynamics and increased risk for HIV, it is important to have an understanding of clients’ autonomy in sexual decision making with their partners.
* What do you know about your partner’s sexual history?	Some people do not have conversations with their sexual partners about that person’s past. Therefore, it is important to assess risk factors among sexual partners as these risks directly affect the client’s risk.
Do you feel safe/comfortable talking to the people you have sex with about what you like and don’t like sexually? <i>(Probe for differences based on partner type, length of relationship, etc.)</i>	This question allows the provider to elicit information about perceived control over sexual decision-making and sexual partner coercion. Probing for specific behaviors (e.g., partner communication about HIV testing, HIV status, condom use, etc.) will also help individualize risk reduction plans.
When you are feeling sad or angry about your relationship, are you more or less likely to use protection with your partner?	This question allows the provider to probe whether the mental/emotional status of the client influences his/her engagement in certain behaviors (e.g., no condom use).
At this time, or in the near future (e.g., next 1, 3, or 6 months), do you want to get pregnant/have a baby? <i>(Probe for timing, conception plans and strategies to prevent HIV and other STIs.)</i>	Desires and intentions to have children often hinder consistent condom use, thus increasing HIV risk. Talking with clients about their conception plans helps personalize risk reduction strategies in a manner that suits their current lived experience (e.g., condoms are not used, but both partners commit to be mutually monogamous and routinely get tested together). Further, it serves as a reminder for them about HIV/STI risks associated with unprotected sex.
What is most important to you about having sex with your partner: a) economic security, b) physical pleasure, or c) emotional connection? <i>(Probe: If you want (insert a, b, or c), how do you protect yourself if your partner wants to do something sexually that you don’t want to do?)</i>	This question allows providers to assess if clients engage in sexual activity with their partners with exchange motivations (e.g., for economic security). This is important to assess given that this can possibly influence engagement in unwanted sexual behaviors (e.g., hesitant to ask partner to use a condom because of presumed economic or emotional repercussions).
Have you ever had sex with someone who was incarcerated/locked up for more than 24 hours?	Inmates in jails and prisons across the United States are disproportionately affected by multiple health problems, including HIV and other STIs. This question will allow the provider to assess whether the client has knowledge of the HIV/STI status of any previously incarcerated partners.

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Question	Rationale
Do you talk to any of your partners about your other partners? Do you talk to any of your partners about <i>their</i> partners?	This question allows providers to probe about whether the client has any awareness that their sexual partners may have other partners. This also provides an opportunity to communicate about the risk of engagement in concurrent partnerships.
What types of things do you and your partner(s) do to turn each other on? <i>(Probe for different types of sexual behaviors, as well as mutual masturbation.)</i>	Asking about behaviors used to promote sexual arousal provides a comprehensive picture of sexual acts engaged in with partners. While mutual masturbation does not have inherent HIV risk, it may advance to vaginal, anal or oral sex.

* Note: Questions marked with an asterisk represent the items we recommend asking at every client encounter.

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