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# Addressing Unmet Sexual Health Needs among Black Adolescents with Mental Illnesses

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## Abstract

Despite advances in HIV epidemiologic and prevention research, adolescents with mental illnesses remain a historically underserved group with respect to human immunodeficiency virus (HIV)/sexually transmitted infection (STI) prevention resources. Black adolescents with mental illnesses in particular are a relatively underserved, hidden population in the field of sexual health. Strategies and guidelines are needed to account for underlying psychopathology among Black adolescents with mental illnesses in ways that current models have yet to address. In this paper, we propose several actionable mechanisms to better integrate HIV/STI and mental health related services and activities for sexual health promotion.

Historically, people dealing with mental illnesses were presumed to lack interest in sexual intercourse or intimate relationships (Thomas, 1988). Over the years, however, researchers demonstrated that not only were adolescents and adults with mental illnesses sexually active, but they were engaging in more sexual risk behaviors than their peers without mental illnesses (Elkington et al., 2013; Marengo et al., 2015; Meade & Sikkema, 2005). Additionally, increased prevalence rates of human immunodeficiency virus (HIV) have been documented among adults with serious mental illnesses when compared to the general adult population (Blank, Mandell, Aiken, & Hadley, 2002; Rosenberg et al., 2001). Similar

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discoveries were made among youth wherein those with mental illnesses reported increased rates of HIV risk-related sexual behaviors (Brown et al., 2010; Teplin et al., 2005).

In the United States, Black adolescents are at the epicenter of our national epidemic for HIV and other sexually transmitted infections (STIs; Centers for Disease Control and Prevention, 2014a, 2014b). Black adolescents seeking treatment for mental illnesses (both inpatient and outpatient) are at heightened risk because they engage in risk behaviors (e.g., having sex under the influence of drugs and/or alcohol) more frequently than their peers (Brawner, Gomes, Jemmott, Deatrick, & Coleman, 2012; Brown et al., 2010). Yet we lack clear, evidence-based strategies/guidelines to screen for and address sexual health and HIV/STI prevention needs in this demographic.

A growing body of research focuses on developing a better understanding of sexual risk behaviors in non-clinical samples of Black adolescents experiencing psychological *symptoms* (Elkington, Bauermeister, & Zimmerman, 2010; Turner, Latkin, Sonenstein, & Tandon, 2011). While the aforementioned research is greatly needed, there remains a paucity of data on the sexual health needs of Black adolescents receiving mental health treatment. Findings from Black adolescents seeking treatment for clinically diagnosed mental illnesses consistently demonstrate that this group tends to have earlier sexual debut and comorbid substance abuse issues, and is less likely to use condoms (Brawner, Davis, Fannin, & Alexander, 2012b; Starr, Donenberg, & Emerson, 2012; Woods-Jaeger, Jaeger, Donenberg, & Wilson, 2013). Given increased rates of risk behaviors, we hypothesize that those in need of inpatient or outpatient mental health services have unique psychoeducational needs and thus require specialized assessment and intervention strategies. For example, our data (published elsewhere) indicate that an adolescents' psychological state may influence his/her decisions about sex and relationships, and that teaching skills for coping mechanisms and emotion regulation are key to mitigating contextual factors (e.g., dysregulated expressions of sadness and anger) that contribute to HIV/STI risk. Further investigations are needed to better understand the nuances of these occurrences.

Behavioral interventions have proven to be successful for the general adolescent population (Protogerou & Johnson, 2014; Santa Maria, Markham, Bluethmann, & Mullen, 2015), yet we do not know if these same benefits translate to adolescents with mental illnesses. We do know, however, that sexual health promotion programs are most effective when they are tailored to the unique context of target populations (Airhihenbuwa, Ford, & Iwelunmor, 2013). We posit that without tailoring intervention content to the psychological factors that may drive HIV/STI risk behaviors among Black adolescents with mental illnesses (e.g., impulsivity, internalized stigma), the interventions will not be as effective. Thus, less attention to sexual health needs among Black adolescents with mental illnesses has significant public health implications for this understudied group. For example, standardized methods do not exist to screen for sexual health concerns (e.g., risk for HIV/STIs) and develop individualized risk reduction plans during mental health treatment encounters (Wright, Akhtar, Tosh, & Clifton, 2012). Moreover, many mental health treatment programs are not equipped to handle the sexual health needs of their clients (McKinnon, Wainberg, & Cournos, 2001; Solomon et al., 2007). In fact, it has been noted that some mental health providers are uncomfortable discussing sexual health topics with consumers (Quinn,

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Happell, & Browne, 2011). The continued lack of integration of mental and physical health services (including comprehensive sexual health assessment) further complicates matters and underscores missed opportunities to provide holistic care. The same holds true for the general population of adolescents with mental illnesses regardless of racial/ethnic background. However, with the growing HIV/STI epidemic among Black youth, we believe this underserved population warrants explicit focus.

In this comment, we highlight the importance of addressing unmet sexual health needs among Black adolescents with mental illnesses. First, we provide a brief snapshot of sexual health among Black adolescents, with reference to differences among those with mental illnesses. Second, we demonstrate that sexual risk behaviors can be viewed as psychopathologic behaviors wherein some Black adolescents with mental illnesses use sexual intercourse to mitigate psychological distress. Third, we present findings from current HIV/STI prevention programs delivered in mental health treatment settings. Lastly, we propose ways to better integrate HIV and mental health related services and activities for optimal HIV/STI prevention. It is important to note that we acknowledge that Blacks (e.g., individuals of African descent) are not a monolithic group. Shared experiences from their racial identification, however, may include steadfast resilience in the face of discrimination and significantly poorer health resources and outcomes (Jones, 2000). We believe that these unifying factors can be used as a resource to foster gender and cultural pride when working with this demographic.

## SEXUAL HEALTH AMONG BLACK ADOLESCENTS

Cognitive changes that occur during adolescence include a shift from a thinking style that is childlike and concrete to an expanded ability to think conceptually, make connections, and understand consequences (American Academy of Pediatrics, 2002). During this time, adolescents begin to make important decisions about planning for the future, romantic relationships, and experimentation with drugs and alcohol. Sexual curiosity and experimentation are critical components of normal adolescent development (Santrock, 2006). Issues arise, however, when adolescents are confronted with unintended consequences of sexual activity, such as HIV/STIs. Low risk perception, high STI rates, substance abuse and lack of awareness are all documented HIV risk factors for youth (Centers for Disease Control and Prevention, 2013).

Many HIV-positive individuals acquire the virus during adolescence or young adulthood (Idele et al., 2014). In fact, in 2010, adolescents aged 13 to 24 accounted for 26% of HIV diagnoses (Centers for Disease Control and Prevention, 2012). When stratified by race/ethnicity, Black adolescent males aged 13 to 24 were diagnosed with HIV at a rate more than three times that of Hispanic/Latino adolescent males and 11 times that of White adolescent males (144.9 vs. 41.4 and 13.1 per 100,000 respectively; Centers for Disease Control and Prevention, 2012). Additionally, Black adolescent females aged 13 to 24 were diagnosed with HIV at a rate more than six times that of Hispanic/Latino adolescent females and 20 times that of White adolescent females (38.4 vs. 6.4 and 1.9 per 100,000 respectively; Centers for Disease Control and Prevention, 2012). Although the seroprevalence of HIV among adolescents with mental illnesses remains unknown, HIV-

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infection rates among adults with mental illnesses have been found to range from 1% to 23% (Carey, Weinhardt, & Carey, 1995; Cournos & McKinnon, 1997; Rosenberg et al., 2001; Scott & Happell, 2011)—which is higher than the general adult seroprevalence of 0.6% (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2004).

Similarly, STI rates follow a trend of inequity. Adolescents aged 15 to 24 accounted for 68% of all reported Chlamydia infections in 2013, with the highest rate among Black adolescents (Centers for Disease Control and Prevention, 2014b). Chlamydia was reported at a rate five times greater among Black adolescent females aged 15 to 19 when compared to White adolescent females (6,907.6 vs. 1,383.3 per 100,000) and 9.5 times higher among Black adolescent males aged 15 to 19 compared to White adolescent males (2,109.6 vs. 221.3 per 100,000; Centers for Disease Control and Prevention, 2014b). Gonorrhea, syphilis, and human papillomavirus (HPV) demonstrate similar disparities among Black adolescents (Centers for Disease Control and Prevention, 2010).

## SEXUAL RISK BEHAVIORS AS PSYCHOPATHOLOGIC BEHAVIORS

To preserve the health and viability of future generations, it is imperative that we understand the contextual nuances of sexual risk behaviors among Black adolescents with mental illnesses. Initial studies of adolescents receiving mental health services indicate that they typically have low self-esteem, significantly greater cognitive deficits, negative attitudes about prevention and decreased perceived vulnerability to HIV/STIs (Brown, Danovsky, & Lourie, 1997). We posit that sexual risk behaviors are, at times, psychopathologic behaviors. Psychopathology is traditionally defined as the study of mental disorders (Oxford Dictionaries, 2016). Clinically, however, the term can also be used to indicate behaviors or experiences that signify that an individual has a mental illness. We see sexual behaviors as more than just coping strategies, but as psychopathologic behaviors that can be evidence of underlying psychiatric concerns—particularly in developmentally inappropriate sexual displays such as those seen among survivors of childhood sexual abuse (Jones et al., 2012). In other words, psychiatric symptoms such as guilt, emotional lability and anxiousness can cause individuals to engage in maladaptive behaviors that they might otherwise avoid in an effort to mitigate distress (Brawner, 2012). Calls have been made to conduct additional research in treatment-seeking populations to better understand psychopathologic symptoms and personality constructs (Krueger & Markon, 2006). Thus we maintain that the psychosocial sequelae of mental illnesses necessitate targeted HIV/STI risk reduction strategies that account for unique psychopathology in treatment-seeking populations (e.g., sexually active Black adolescents with mental illnesses receiving outpatient mental health treatment).

Psychological symptoms linked to sexual risk behaviors include depression, anxiety, and post-traumatic stress, and are often the result of exposure to violence or secondary to mood disorders, Attention-Deficit/Hyperactivity Disorder, or psychoses (Hall, Kusunoki, Gatny, & Barber, 2014; Miron & Orcutt, 2014; Sarver, McCart, Sheidow, & Letourneau, 2014; Voisin, Hotton, & Neilands, 2014). Among Black adolescents and young adults in particular, depressive symptoms are predictively associated with multiple sex partners (Khan et al., 2009), a well-documented contributor to HIV seroconversion (Boily, Alary, & Baggaley,

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2012). Moreover, this demographic is also more likely to have a history of STIs than their counterparts who are not experiencing depressive symptoms (Khan et al., 2009; Lee, O'Riordan, & Lazebnik, 2009). It is important to note that the presence of an STI increases the risk of HIV acquisition two-fold (Fleming & Wasserheit, 1999). Comorbidities like alcohol and substance abuse also contribute to the psychopathology, and further increase the chance of HIV/STI risk-related sexual behaviors such as multiple lifetime partners, more frequent sexual intercourse, unprotected sex, and relationship violence (Carswell, Hanlon, Watts, & O'Grady, 2014; Mason, Campbell, Zaharakis, Foster, & Richards, 2014; Sarver et al., 2014).

Externalizing disorders (i.e., Conduct Disorder) affect an adolescent's ability to negotiate peer norms that encourage risk behaviors, while internalizing disorders (i.e., Major Depressive Disorder) affect self-efficacy and ability to negotiate safer sexual behaviors like condom use (Brown et al., 2014; Joppa et al., 2014; Sarver et al., 2014). Cognitive deficits, such as impulsivity, limited appraisal of risky situations, and poor judgment are also associated with increased risk of HIV and STI infection (Brown, Danovsky, et al., 1997; Crepaz & Marks, 2001; Donenberg et al., 2005). Emotional lability among adolescents with mental illness may supersede impulse control and motivation to avoid adverse behaviors, thus contributing to the use of HIV/STI risk-related sexual behaviors to self-soothe and alleviate distress (Brawner, 2012).

Black adolescents with mental illnesses are at even greater risk of HIV exposure because they engage in HIV/STI risk-related sexual behaviors at higher rates than other adolescents (Donenberg et al., 2005). For example, Brawner, Davis, Fannin and Alexander (2012a) demonstrated that while clinically depressed and non-depressed Black adolescent females held similar positive attitudes toward condoms, there were stark differences in condom use frequency. Loneliness, fear of abandonment and motivation to use sexual intercourse as a stress reliever may explain these differences (Brawner, 2012; Brawner, Gomes, et al., 2012), as well as the effects of racial and ethnic discrimination (Tobler et al., 2013) and internalized stigma (Elkington et al., 2013).

## HIV/STI PREVENTION INTERVENTIONS FOR ADOLESCENTS WITH MENTAL ILLNESSES

The majority of successful HIV/STI prevention interventions are based on cognitive and behavioral determinants of sexual risk (Mavedzenge, Luecke, & Ross, 2014). These models may not adequately address the risk mechanisms of adolescents who have psychiatric, cognitive, behavioral, and/or emotional deficits. Further, empirical investigations on the generalizability of traditional HIV/STI prevention programs to adolescents with mental illnesses is virtually nonexistent. While research on adults cannot be generalized to adolescents without significant evidence, we can learn from the successes and shortcomings of the adult literature to inform interventions for adolescents. Behavioral interventions for adults with mental illnesses demonstrated increased condom use, decreased number of sexual partners, and increased HIV knowledge post behavioral interventions (Carey et al., 2004; Kalichman, Sikkema, Kelly, & Bulto, 1995; Senn & Carey, 2008; Weinhardt, Carey,

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Carey, & Verdecias, 1998). Despite issues with smaller sample sizes and limited racial/ethnic diversity, these studies demonstrate that targeted, psychoeducational interventions can be used to decrease sexual risk behaviors among persons with mental illnesses.

Even though increased rates of sexual risk behaviors are well documented among adolescents receiving mental health treatment, very few studies have specifically looked at delivering HIV/STI risk reduction interventions to this demographic. Only four published studies are available for HIV prevention programs designed for adolescents in inpatient and/or outpatient mental health treatment (Brown et al., 2014; Brown, Reynolds & Lourie, 1997; Ponton, DiClemente, & McKenna, 1991; Thurstone, Riggs, Klein, & Mikulich-Gilbertson, 2007). Collectively, the results of these studies indicated decreases in HIV transmission myths, increases in intentions for condom use, and improved self-efficacy. With the exception of Brown et al. (2014), the samples were predominantly composed of non-Black participants. Further, interventions that focus on gender and cultural pride have been successful for Black adolescents (DiClemente, Wingood, Rose, Sales, & Crosby, 2010), yet a comparable model does not exist in the published literature for those with mental illnesses. Thus it remains unknown what effect a theoretically driven, gender and culturally relevant, psychoeducational skills-building HIV/STI prevention intervention targeted to Black adolescents with mental illnesses would have on their sexual risk behaviors. We posit that while other intervention models have proven to be successful, the aforementioned targeted intervention would achieve the greatest effect.

Biomedical, behavioral and structural HIV prevention interventions have also proven to be successful for adolescents (Pettifor et al., 2013), but to our knowledge no published studies were specifically developed or adapted to address the sexual health needs of Black adolescents with mental illnesses. Internationally, bundling HIV/STI prevention with mental health treatment for adolescents has been considered (Edwards, Britton, Jenkins, Rickwood, & Gillham, 2014; Flisher & Dawes, 2009). Previous interventions have documented success; however, additional randomized controlled trials are needed to supplement this dearth of research to address HIV/STI risk reduction needs among Black adolescents with mental illnesses. Although adolescents with mental illnesses may benefit from HIV prevention strategies targeted to a broad range of adolescents, future interventions should also be tailored to address their affective needs (Hall et al., 2008). Thus, in addition to the aforementioned factors, it is important that interventions for Black adolescents with mental illnesses specifically address psychological concerns, including emotion regulation (Sales, Lang, Hardin, Diclemente, & Wingood, 2010). For example, emotions (e.g., fear, insecurity) play a significant role in shaping sexual behaviors that increase risk for HIV/STIs as emotions drive heuristics for one’s balancing of perceived benefits versus risks of sexual practices, such as condom use (Gutnik, Hakimzada, Yoskowitz, & Patel, 2006). Additionally, the influence of social and structural drivers of the HIV/STI epidemic (e.g., social capital, concentrated disadvantage) on individual behavior must be acknowledged (Brawner, 2014). A comprehensive intervention that addresses the psychopathology of mental illnesses through a social determinants approach may best facilitate knowledge and skill acquisition to prevent HIV/STIs in a context that is relevant to the daily lives of Black adolescents with mental illnesses. The paucity of research on HIV/STI risk among

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adolescents with mental illnesses—not just community dwelling adolescents experiencing psychological symptoms—makes it difficult to develop this area of science.

## INTEGRATING HIV AND MENTAL HEALTH SERVICES FOR HIV PREVENTION

It is imperative that we develop a better understanding of factors that contribute toward HIV/STI risk-related sexual behaviors, such as psychiatric correlates of behavior. We propose several actionable mechanisms to better integrate HIV/STI and mental health related services and activities for sexual health promotion. First, sexual health professionals can lead the charge to develop clinical guidelines for the assessment of HIV risk-related sexual behaviors during *all* mental health treatment encounters (Brawner, Alexander, Fannin, Baker & Davis, 2015). Currently, a “gold standard” to assess and meet the sexual health needs of clients in mental health treatment does not exist. Given that such standards drive clinical education and practice (Hewitt & Cappiello, 2015), it is crucial to move forward in this direction. Standardized questions, with individualized probes, can then be used to conduct comprehensive sexual health histories. We will also have to advocate for information gathering during the initial intake, as well as at all subsequent follow-up assessments. This will likely require additional provider training to ensure that they are comfortable talking to youth about sexual health topics, and to provide a safe space to acknowledge and repudiate unconscious biases about adolescent sexuality (Boekeloo, 2014).

Second, both sexual health and mental health researchers should continue to conduct studies to generate data and identify unique, unmet HIV/STI risk reduction needs in the target demographic. These data can then be used to develop gender and culturally relevant, developmentally and psychologically appropriate HIV/STI risk reduction programs to engage Black adolescents who are in inpatient and/or outpatient mental health treatment. Theory-based HIV/STI prevention interventions that are psychologically tailored and developmentally appropriate are needed for adolescents to reduce sexual risk behaviors (Montanaro & Bryan, 2014). Through rigorous randomized controlled trials, investigators can design and disseminate manualized curricula for comprehensive HIV/STI risk assessment and prevention programs to be delivered in mental health treatment settings. While proven effective programs are available for the general adolescent population, challenges remain in identifying the best ways to help them access these services (Mavedzenge et al., 2014). A variety of inpatient and outpatient treatment settings—including residential treatment programs and day programs—can be targeted to engage youth currently receiving mental health treatment and address their unmet sexual health needs.

Third, in an ideal world, all agencies would be able to co-locate HIV prevention services with mental health treatment; however, we acknowledge the challenges posed by limited resources (Whiteford et al., 2014). Where co-location is not feasible, we suggest innovative pairings between mental health agencies and AIDS Service Organizations (ASOs), or comparable community-based sexual health providers, for service provision. Health educators and case managers from the community agencies could then maintain scheduled

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hours in the mental health programs to offer free and confidential HIV testing, as well as behavioral risk reduction counseling. Based on agency capacity and client preferences, risk reduction education and counseling can be done in small groups or individual sessions. Mental health case managers are also capable of delivering HIV prevention messages, and their practice may become enhanced through the process (Tennille, Solomon, & Blank, 2010). Collaborative efforts between primary care and mental health providers are essential, in addition to family involvement, to prevent unintended sexual health outcomes (e.g., unwanted teen pregnancies) in this demographic (Brown et al., 2014; Brown et al., 2013). Advancements have been made with integrating HIV services into substance abuse programs (Murphy et al., 2014), and these models can serve as evidence-based practices for the mental health system.

## CONCLUSION

As noted by the World Health Organization (2010), “Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries” (pg. 1). While all adolescents with mental illnesses deserve targeted attention and services (Patel, 2007), enduring sexual health disparities in Black America substantiate particular focus on Black adolescents with mental illnesses. Given disproportionate HIV disease burden among Black adolescents, alongside increased sexual risk behaviors among Black adolescents with mental illnesses, culturally relevant and situated interventions are essential. Partnerships with stakeholders in nontraditional settings embedded within the community (e.g., inpatient and outpatient mental health treatment programs) can enhance sexual health dialogue and prevention efforts with underserved groups. However we move forward, the time has come to inform mental health policy toward the standardization of sexual health assessment and intervention in mental health treatment settings. Given that adolescent health is imperative to public health, this topic is timely, innovative and bears great significance.

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