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Abstract: The current HIV/AIDS epidemic has revitalized interest in adolescent sexual behavior and led to exciting new lines of prevention research. Researchers have concluded that awareness of the risks associated with high-risk sexual behavior alone is not enough to change the behavior of adolescents. Cognitive behavioral skills interventions that directly teach adolescents new skills are now widely recommended as components of prevention efforts. Although social-skills training has often been included as a component of such interventions, we actually know little about how social skills and adolescent sexual behavior are related. This paper provides a conceptual framework based on social-learning theory for understanding the relations between social skills, high-risk sexual behavior, and many of the problems associated with adolescent sexual activity. The paper concludes with a call for renewed interest in heterosocial skills research and outlines possible directions for future investigation.

A recent Centers for Disease Control and Prevention (1995) monograph presents rather alarming statistics regarding the major health risks associated with adolescent sexual activity. AIDS is now the sixth leading cause of death among persons aged 15 to 24 years. Considering the 8-10 year incubation period between HIV infection and AIDS, a more accurate depiction of the HIV epidemic among adolescents may be indicated by the fact that 20% of individuals diagnosed with AIDS are in their twenties. Adolescents are at high risk for a range of other sexually transmitted diseases as well, such as gonorrhea and chlamydia, that are contracted by one in eight teens each year. In addition, adolescent birth rates remain quite high with more than one million teenagers becoming pregnant each year. Underlying these sobering statistics are dramatic escalations in adolescent sexual activity. For example, over 50% of students ranging from grades 9-12 have engaged in sexual intercourse, and 18% report having had four or more sexual part-
ners. Unfortunately, just over 50% of these sexually-active teens reported that they or their partner had used a condom at last sexual intercourse, while approximately 19% reported that they or their partner had used birth control pills during last sexual intercourse.

The current AIDS epidemic has stirred interest in the development of interventions aimed at reducing high-risk sexual behavior among adolescents. In light of increasing recognition that awareness of the risks associated with high-risk sexual behavior alone is not enough to change the behavior of adolescents, cognitive behavioral skills interventions are now widely recommended as components of prevention efforts (e.g., Jemmott, Jemmott, & Fong, 1992; Kelly & Murphy, 1992; Kelly, Murphy, Sikkema, & Kalichman, 1993; Kelly & St. Lawrence, 1988; Rotheram-Borus, Koopman, & Haignere, 1991). From a cognitive-behavioral perspective, effective intervention has at least two key ingredients. First, adolescents need to be “sensitized” to the risks associated with their behavior. This is accomplished through risk education designed to enhance the accuracy of personal vulnerability appraisal (Kelly & Murphy, 1992; Kelly et al., 1993). Second, once sensitized, adolescents need to learn to change the behavior patterns that place them at risk. Behavior change is facilitated by the direct training of skills, such as: (1) safer sex practices; (2) assertiveness to communicate safer sex commitments to sexual partners or to resist coercions to engage in high-risk behavior; and (3) self-management and problem-solving skills to anticipate and/or avoid high-risk situations (Kelly & Murphy, 1992).

The inherent interpersonal nature of high-risk sexual behavior is reflected in the prominent role of social-skills training in cognitive-behavioral interventions. A number of recent studies have shown that traditional social-skills training procedures can be adapted to teach specific interpersonal skills that help adolescents reduce the frequency of their engagement in high-risk sexual behaviors (e.g., Kipke, Boyer, & Hein, 1993; Schinke & Gordon, 1992; St. Lawrence et al., 1994). For example, St. Lawrence et al. (1994) conducted an intervention with 19 substance-dependent, sexually active, and conduct-disordered adolescents. The social-skills component involved three 90-minute sessions in which a group format was used to instruct the participants in the use of assertiveness and communication skills. After viewing a short film included to focus attention on partner negotiation and communication, the group leaders discussed and modeled specific social skills which were then practiced by the participants in triads. Group leaders shaped the desired skills during the practice sessions using selective attention, inattention, and praise. Pre/post role-play assessment indicated substantial improvements across the five targeted skills (i.e., acknowledges the other person’s viewpoint, specific refusal, provides rationale for refusal, states need for safety, proposes lower-risk alternative) and global ratings of effectiveness.

Intuitively, the social skills typically targeted in such interventions (e.g., assertiveness, problem solving, and communication skills) appear to be related to high-risk sexual interactions. Indeed, the modification of high-risk sexual behavior would seemingly require concomitant changes in social behavior. Engaging in safer-sex behaviors might require discussion with a sexual partner, resistance to coercive attempts to engage in high-risk behaviors, and the ability to avoid risky social situations (Kelly & St. Lawrence, 1988). We actually, however, know surprisingly little about how social skills and high-risk sexual activity among adolescents are related (Nangle & Hansen, 1993). To date, very little research effort has been dedicated to the identification and validation of possible targets of social skills training components of interventions aimed at: reducing high-risk sexual behavior of adolescents (Hansen, Giacoletti, & Nangle, 1995; Nangle & Hansen, 1993). The present paper provides a conceptual framework based on social-learning theory for understanding the relations between social skills, high-risk sexual behavior, and many of the problems associated with adolescent sexual activity. The problems associated with adolescent sexual activity outlined above (e.g., AIDS, STDs, unintended pregnancy) are posited to result, in part, from problematic heterosocial interactions (e.g., coercive interactions, lack of communication) between sexual partners that lead to high-risk sexual behavior (e.g., intercourse without a condom).

Consideration of the Existing Heterosocial Skills Literature

Unfortunately, despite the pivotal role of heterosocial skills, the existing literature has failed to address the social skills needed in sexual interactions. In fact, heterosocial interactions in general are notably absent from most adolescent social competence assessments (see Inderbitzen, 1994, for a review of such assessments). Current conceptualizations of heterosocial competence are limited to the problems associated with minimal dating among males who are typically college-aged. As such, assessment and treatment has almost exclusively focused on the conversation skills required for successful date initiation. The failure to address the social aspects of sexual interactions is particularly disturbing given the reports of adolescents that such interactions are the most problematic of all heterosocial situations (Conger & Conger, 1982; Knox & Wilson, 1983).

We thought it might be instructive to take a closer look at the existing be-
havioral heterosocial skills literature to examine trends and possible limitations. To do this, we reviewed three journals with well-established histories of publishing social skills intervention research (Journal of Consulting and Clinical Psychology, Behavior Therapy, Behavior Modification). The review included studies published in the past 25 years that specifically targeted heterosocial skills.

After reaching a peak in the late 1970’s, interest in heterosocial skills research has declined sharply in recent years (see Figure 1). In light of the HIV/AIDS epidemic and subsequent increasing interest in adolescent sexual activity, we would have expected to see a concomitant increase in heterosocial skills research. The declining interest is somewhat better understood when the content of the studies is examined and placed in an historical context. There was remarkable homogeneity across the 32 reviewed studies, including the use of college student participants (over 85% of the studies), reliance on predominately male participants (over 70%), focus on heterosocial anxiety (over 60%), reliance on role-play assessment methodology (over 80%), and a focus on assessment rather than treatment (over 75%).

These studies clearly reflected the literature’s almost exclusive focus on the problem of minimal dating among college males. The surge of interest in minimal dating in the 1970’s was the result of its relation to heterosocial anxiety rather than a direct interest in heterosocial dysfunction. Heterosocial anxiety was viewed as an ideal analog for anxiety research, because of its clinical relevance, the fact that it affected a large percentage of college students, its negligible demand effects, and the strong and not readily habituated physiological responses elicited by heterosocial interactions (Curran, 1977). We have thus been left with an inadequate conceptualization of heterosocial competence that is limited to the conversation skills needed for males to “get a date.”

The Relationship Between Social Skills and Sexual Activity: A Conceptual Model

The onset of puberty, changing nature of heterosocial interactions, and emergence of sexual activity have long been considered to be among the most challenging developmental transitions of adolescence (Hansen, Christopher, & Nangle, 1992). Interestingly, although the integral role of the physical changes of puberty is well documented (Berger, 1986), adolescent sexual behavior might be influenced more heavily by social expectations and the social significance of patterns of sexual activity than by actual biological factors (Ford & Beach, 1951; Miller, McCoy, & Olson, 1986).

The predominant influence of social factors is not that surprising given that sexual behavior is indeed social, as are many of the behaviors that precede, maintain, and follow it (Barlow, 1977).

The sexual behavior of adolescents, therefore, cannot be understood adequately apart from its social context. During adolescence, social interactions and relationships become increasingly complicated and adultlike (Hansen et al., 1995). The peer group expands and becomes more complex, more time is spent with peers, and the frequency and importance of heterosocial interactions increases (Csikszentmihalyi & Larson, 1984). There is a greater desire for close friends as adolescents turn to their peers for support formerly provided by the family, and the primarily same-sex interests and playmates of childhood give way to opposite-sex interests and friendships (Hansen et al., 1995).

Levels of Social-Skills Related to Sexual Activity

These dramatic changes in interpersonal interactions place many new demands on the social skills of developing adolescents. Social skills can be defined, rather generally, as the learned interpersonal behaviors that individuals use to obtain or maintain reinforcement from other people (Kelly, 1982). The increased frequency and importance of opposite-sex interac-
tions and emergent sexual activity require the development of a subset of social skills referred to as heterosocial skills. Heterosocial skills have been defined as the social behaviors necessary for initiating, maintaining, and terminating social and sexual relationships with persons of the opposite sex (Barlow, Abel, Blanchard, Bristow, & Young, 1977; Galassi & Galassi, 1979). These skills serve a variety of important functions for the adolescent, including the promotion of interpersonal competence and more adult-like social behavior, enhancement of status within the peer group, development of independence, experimentation with sex role behaviors and sexual activity, and courtship and mate selection (Damon, 1983; Kelly & Hansen, 1987). Sexual-interaction skills are a further subset of heterosocial skills, and can be defined as the heterosocial skills required for competent sexual interactions (Nangle & Hansen, 1993). It should be noted that sexual-interaction skills may include the social skills required for adolescents to abstain from sexual activity altogether. In this way, it may help to consider sexual-interaction skills to be the skills required for adolescents to enact their decisions regarding sexual activity in a competent manner. Of course, the process of making decisions regarding sexual practices has also been considered to be a dimension of social skill, referred to as problem-solving (Kelly & Murphy, 1992; Nangle & Hansen, 1993).

It is important to note that these levels of social skills are not necessarily viewed as independent dimensions of behavior. The extent to which there is overlap between the skills needed for social and heterosocial interactions is unclear, but assumed to be significant (Kelly, 1982). For example, global skills necessary for normal adolescent heterosocial interactions, as well as interactions with same-sex persons, are varied and include knowing how to initiate and maintain conversations, interpret and understand the affective states of others, assess peer norms and values, monitor the social impact of behavior, and match social behaviors to the demands of the situation (Conger & Conger, 1982; Kelly, 1982).

Conceptualizing the social skills associated with sexual interactions in terms of levels has the advantage of highlighting the situation-specific nature of social competence. The skills comprising competence in one social situation may not be the same as the skills required in a different social situation. An otherwise socially competent adolescent may have difficulties in heterosocial interactions, just as an otherwise heterosocially competent adolescent may have difficulties in sexual interactions. It is likely, however, that skills at each of the three proposed levels make related, yet somewhat independent, contributions to the engagement in high-risk sexual behavior. For example, more socially competent adolescents are likely to have greater exposure to a larger network of peers and adults. This enhanced exposure may lead to more opportunities to learn about sexual activity and form an appropriate support network. Conversely, less socially competent adolescents may be at increased risk as the result of having less exposure to learning opportunities and involvement in more deviant peer networks. Initial support for this hypothesis can be found in recently published studies indicating links between early engagement in sexual intercourse, substance use, and antisocial behavior among adolescents (Capaldi, Crosby, & Stoolmiller, 1996; Tubman, Windle, & Windle, 1996). The skills required for competent peer and heterosocial relations are thought to overlap significantly (Kelly & Hansen, 1987). Therefore, as the result of increased peer exposure and skills, more socially competent adolescents may be expected to have more opportunities to meet and form relationships with members of the opposite sex. Increased contact with members of the opposite-sex may then allow more socially competent adolescents to have more frequent opportunities to develop and refine their heterosocial skills. The enhanced heterosocial competence resulting from increased exposure may then contribute to the development of more competent sexual interaction skills. In addition, more socially and heterosocially competent teens may be more likely to select one another as relationship partners, thus further reducing their likelihood of engaging in high-risk sexual behaviors. These proposed interactions between the three levels of social skill remain largely speculative, however, and await further investigation.

In preliminary work examining this levels approach, we have just conducted two studies in which young undergraduate participants completed a battery of measures, including a behavioral role-play test, designed to assess specific dimensions of social skills and contraceptive/prophylactic behavior (Nangle, Hansen, & Grover, 1997; Nangle & Grover, 1998). Following the model described above, our assessment of social skills included: (1) global assertiveness and problem-solving ability; (2) heterosocial skill and anxiety; (3) assertiveness and problem-solving ability in specific heterosocial-sexual situations; and (4) self-reported difficulty and frequency of engagement in specific social behaviors associated with contraceptive/prophylactic use. The assessment of contraceptive/prophylactic behavior included the competency of specific method implementation and the consistency of use. In general, the results supported our hypotheses that social skills and contraceptive/prophylactic behavior were strongly related for both males and females. Among males, global assertiveness and heterosocial skill and anxiety were associated with the level of engagement in contraceptive-related social behaviors (e.g., discussing contraception with a pharmacist), which,
in turn, was related to the competence of condom use. A slightly different pattern emerged among the females. Although global assertiveness was significantly associated with heterosocial skill and anxiety, it was not related to engagement in contraceptive-related social behaviors or contraceptive/prophylactic use. Heterosocial skill and anxiety, however, were associated with both engagement in contraceptive-related social behaviors and the competence of contraceptive/prophylactic use. For both males and females, the level of engagement in specific contraceptive-related social behaviors was the best predictor of competent contraceptive/prophylactic use.

**Social-Skills Deficit Model**

The key assumption of this conceptual model is that the presence of social skills deficits increases the likelihood that adolescents will engage in high-risk sexual behavior that in turn increases their risk for the many health problems related to adolescent sexual activity. Following from the discussion above, such social-skills deficits may arise at any one of three proposed levels (i.e., social skills, heterosocial skills, sexual-interaction skills). Using a social-skills conceptualization, deficits may be explained in two different ways: (1) The skill was never learned or was learned inadequately, or (2) the skill was learned (i.e., in the repertoire of responses), but is used effectively only in certain situations because of prior reinforcement, punishment, or extinction of the behavior, or because of inadequate discrimination regarding when to exhibit the skill (Kelly, 1982). In addition, the use of a skill might be inhibited by cognitive influences and/or anxiety (Hansen et al., 1992; Nangle & Hansen, 1993).

Considering the mechanisms involved in their acquisition, it seems likely that many adolescents would never learn, or learn inadequately, the social skills associated with competent heterosocial-sexual interactions (Nangle & Hansen, 1993). Social skills are developed through a complex interaction of learning mechanisms including exposure to appropriate models, the consequences associated with the behavior, exposure to, and participation in, social activities, and cognitive factors, such as self-statements and attributional processes (Hansen et al., 1992; Kelly, 1982). Thus, social skills are largely acquired through direct learning opportunities. Skills are either initiated spontaneously, or after being acquired through seeing others use them, and then modified, or removed from repertoires, as the result of feedback provided by the consequences of social interactions.

**Implications**

This direct learning process would appear to pose a number of difficulties for developing adolescents. The need for competent sexual-interaction skills now arises earlier than ever before, as adolescents are becoming increasingly sexually active at younger ages (Brooks-Gunn & Paikoff, 1993; Miller & Moore, 1990). By the age of 15, about 30% of boys and 25% of girls have had sexual intercourse (Miller & Moore, 1990). We also know that the majority of the social interactions of young adolescents are with same-sex peers. For example, Csikszentmihalyi and Larson (1984) found that high-school freshman spent 44% of their time in same-sex groups and 4% in opposite-sex dyads, whereas seniors spent 21% of their time in same-sex groups and 24% in opposite-sex dyads. Taken together these data suggest that young adolescents are becoming sexually active prior to having much exposure to heterosocial interactions. Thus, for many adolescents, opportunities to learn competent heterosocial and sexual-interaction skills directly are rather limited. In addition, even when such opportunities do arise, the operant, “trial and error” learning process can place adolescents at high risk. The single failure of an adolescent to resist a partner’s coercive attempt to have intercourse without a condom can result in exposure to the HIV virus and/or unintended pregnancy.

For young adolescents, the majority of opportunities for learning these social skills stem from indirect learning experiences with parents and same-sex peers as the primary socialization influences (Nangle & Hansen, 1993). When adolescents get information regarding sexual activity directly from their parents, they tend to engage in intercourse less frequently, have fewer sexual partners, begin sex at a later age, and be more likely to use contraception (cf. Treboux & Busch-Rossnagel, 1990). The emergence of sexual activity, however, coincides with increased demands for independence. The influence of peers increases, as the influence of parents stays the same or even decreases. Interestingly, although parents and peers appear to influence the sexual attitudes and behavior of nonvirgin adolescents, peer approval appears to more directly influence the sexual behavior and attitudes of nonvirgin adolescents (Treboux & Busch-Rossnagel, 1990). The dominant influence of peers on sexually-active teens is unfortunate as the prevalence of health problems associated with adolescent sexual activity suggests that peers are not the most appropriate education agents. Lack of basic information regarding physiology, STDs, and contraception are believed to be common problems within the teenage population (Select Committee on Children, Youth, and Families, 1988).
The acquisition of competent sexual-interaction skills is further complicated by the existing contingencies. Adolescents, just as many adults, tend to be influenced more heavily by the immediate positive consequences of engaging in a behavior than by the possible delayed negative consequences (Berger, 1986). The positive consequences of sexual activity, such as physical arousal, intimacy, and peer group approval, are more immediate, whereas the possible negative consequences, such as STDs and unintended pregnancy, are often more removed in time. Sexual intercourse is not only highly reinforcing physiologically, it is a peer-status gaining behavior among adolescents as well (McCabe, 1984). It is likely that even less competent sexual interaction skills often result in the reinforcing outcomes associated with sexual activity (Nangle & Hansen, 1993). For example, coercive verbal requests to not use condoms may be reinforced by engagement in unprotected sexual intercourse. Similarly, adolescents engaging in sexual activity may be more likely to inhibit initiating requests for the use of condoms because of concerns that doing so will interrupt the flow of the interaction and lessen the chances for sexual intercourse. The failure to exhibit the sexual-interaction skill is then reinforced by the subsequent engagement in sexual intercourse.

Adolescents who have acquired competent sexual-interaction skills may fail to exhibit them in certain situations because of exposure to differential reinforcement or punishment of the skills, or because of inadequate discrimination regarding when to exhibit the skills (Kelly, 1982; Nangle & Hansen, 1993). In the above cited example, decisions to initiate requests for using condoms are likely to be inhibited because of the reinforcing properties, and the fear of being punished by the removal, of opportunities for sexual intercourse. An additional complication is that the possible responses of partners to the enactment of competent sexual-interaction skills may be quite varied. For example, some partners may reinforce disclosures regarding STDs with praise for honesty, whereas other partners may punish such disclosures by withdrawing from intimate contact. Cognitive limitations may make it even more difficult for adolescents to identify or discriminate situations in which a given sexual interaction skill is needed. Adolescents may not be able to comprehend the probabilities of the more distal negative consequences of sexual activity or may believe that they are immune to the consequences of their sexual behavior and that only other people get pregnant or contract the HIV virus (Hansen et al., 1992; Nangle & Hansen, 1993). Such cognitive limitations may place adolescents at increased risk, as recent evidence indicates that perceived susceptibility to AIDS is negatively related to engagement in high-risk sexual activity (Catania, Kegeles, & Coates, 1990).

Anxiety may also contribute to the inhibition of social skills in interactions associated with sexual activity. Adolescents may be negatively reinforced for not discussing sex with professionals, parents, and peers by the avoidance of anxiety. Social interactions with potential sexual partners are likely to be heavily influenced by the presence of anxiety. The exact prevalence of heterosocial anxiety in the young adolescent population is not currently known, but it is likely to be quite high given the reports of over 30% of college men and women that it is a significant dating problem (Arkowitz, Hinton, Perl, & Himadi, 1978). Problems associated with heterosocial anxiety are only exacerbated in sexual interactions as such interactions tend to be ambiguous, engender fears of negative evaluation based on performance or appearance, and induce high levels of self-disclosure and awareness (Leary & Dobbins, 1983). Compared to less heterosocially anxious peers, adolescents with high levels of heterosocial anxiety tend to be less sexually experienced, less willing to engage in oral sex, and more apprehensive about sex (Leary & Dobbins, 1983). They also tend to have fewer sexual partners and a higher incidence of sexual dysfunction than less anxious adolescents (Leary & Dobbins, 1983). As expected, degree of heterosocial anxiety is also inversely related to the frequency of discussion regarding contraception, ability of partner to communicate effectively, and the use of more effective contraceptive methods (Bruch & Hynes, 1987).

Conclusions and Future Directions

It is fitting to begin our suggestions for needed research with a call to behavioral researchers to revisit the construct of adolescent heterosocial competence. The construct must certainly be expanded beyond the limited consideration of the conversational skills required in date initiation. As discussed in this proposed conceptualization, heterosocial skills include the social behaviors necessary for initiating, maintaining, and terminating social and sexual relationships with persons of the opposite sex, and subsume the more specific dimension of social skill referred to as sexual-interaction skills. Expanding our conceptualization and rekindling research interest will allow for the development of a literature base that enhances our understanding of the complex relations between social skills and high-risk sexual interactions among adolescents. Such a literature base would prove invaluable in the continued development of effective social-skills training components of cognitive/behavioral interventions aimed at preventing high-risk sexual activity.

The most significant obstacle to expanding our conceptualization of heterosocial competence to include sexual interactions will most likely be the
development of data collection procedures that are sensitive to the unique methodological and ethical issues inherent in assessing heterosocial-sexual interactions. A number of assessment procedures developed for use in the existing heterosocial skills literature appear to warrant further investigation, including self-ratings of anxiety or skill, self-monitoring, and peer ratings (e.g., ratings by significant others) in the natural environment (cf. Nangle & Hansen, 1993). A number of the studies we reviewed used self-report questionnaires designed to assess the level of anxiety or skill typically experienced by the participants when engaging in heterosocial interactions and/or during specific role-play scenarios (e.g., Farrell, Mariotto, Conger, Curran, & Wallander, 1979; Wessberg, Mariotto, Conger, Farrell, & Conger, 1979). A particularly promising procedure appears to be self-monitoring (e.g., Dodge, Heimberg, Nyman, & O’Brien, 1987; Himadi, Arkowitz, Hinton, & Perl, 1980). For example, Himadi et al. (1980) had participants record their social interactions for a one-week period using a diary format. In addition, peer rating forms were completed by two opposite-sex acquaintances of each participant. Heterosocial skills researchers also made advances in the development of role-play procedures. One of the more widely used procedures was the “Pizza Parlor” role play (e.g., Cole, Howard, & Maxwell, 1981; Fischetti, Curran, & Wessberg, 1977; Little, Curran, & Gilbert, 1977). For example, Little et al. (1977) asked heterosexually-anxious males to imagine that they and their female partner had just been out on a first date to a movie and were at a pizza parlor afterwards. As they awaited their orders, the participants were instructed to ask a female confederate out on a next date. The subsequent interactions were videotaped and evaluated in terms of degree of interpersonal skill and anxiety by female research assistants who were trained to attend to behavioral indicators of both skill and anxiety. The participants also rated the degree of interpersonal skill and anxiety they had exhibited during the role-played interaction. Although these studies did not address high-risk sexual interactions, the methods used do serve as models for the further development of procedures capable of assessing high-risk sexual interactions. Despite the promise of these methods, however, further development and evaluation will be needed as existing evidence indicates that both self-ratings and self-monitoring suffer from high reactivity and low reliability, whereas the psychometric properties of peer assessments are unknown at this time (Hansen et al., 1992).

The identification of the most problematic heterosocial-sexual situations for adolescents is a fundamental assessment issue in need of further examination. Thus far, the identification of targeted social behaviors in programs aimed at reducing high-risk adolescent sexual activity has been based largely on clinical intuition. While we do know that adolescents find the interactions surrounding sexual activity to be the most problematic of all social situations, we do not know what specific types of interactions they find most troubling. Warzac, Grow, Poler, and Walburn (1995) conducted a study designed to identify contexts that place adolescents at risk for unwanted sexual activity. In the first part of the study, sexually-active female adolescents identified 59 contexts associated with unwanted sexual activity. These contexts were subsequently rated by a new sample of female adolescents according to how common and difficult each was for them. Unsupervised activity where alcohol was present and feeling an obligation to engage in sexual activity emerged as high risk contexts. Similar methods could be used to identify contexts that place adolescents at risk for unprotected intercourse, etc. The development of more relevant training scenarios may enhance intervention effectiveness and generalization of learned skills (Warzak et al., 1995).

The validation of target behaviors will require further efforts to define “competence” in various heterosocial-sexual situations and the subsequent development of criterion measures. In the existing heterosocial skills literature, competence has been defined as the ability to initiate dating relationships, and the most widely used criterion measures are self-reports of dating frequency. As we expand the conceptualization of heterosocial competence, it becomes much more difficult to define and assess competence in particular interactions. For example, until quite recently, competence in the contraceptive literature was defined as the ability to prevent unintended pregnancies and sole reliance on the pill was viewed as quite competent (e.g., Heinrich, 1993). However, the advent of HIV and other STD’s has called this notion of contraceptive competence into question, and resulted in an increased interest in the use of condoms (e.g., Kelly et al., 1993). Even when competence has been defined, how to best assess it remains a significant challenge. The majority of existing studies on contraceptive behavior have relied on global self-reports of whether the respondent has ever used contraception or used contraception at first or last intercourse. These global self-reports have a number of limitations, including the failure to control for frequency of intercourse or number of sexual partners, inability to discriminate between adolescents who inconsistently use contraception and those who use contraception reliably, inability to discriminate between the use of specific contraceptive methods, and failure to identify specific targets for intervention (Nangle & Hansen, 1993). Thus, adolescents grouped using such measures are likely to show important within-group differences. For example, contraceptive “users” might vary in their consistency of use, frequency of sexual
activity, number of sexual partners, methods used, etc. Such within-group variability limits the degree to which links between specific social skills deficits and contraceptive behavior can be found.

The problems associated with sexual activity have clearly become one of the major health risks faced by adolescents. The current HIV/AIDS epidemic has revitalized our interest in adolescent sexual behavior and led to exciting new lines of prevention research. As a result of this new line of inquiry, we have come to the consensus that awareness of the risks associated with high-risk sexual behavior alone is not enough to change the behavior of adolescents. Cognitive behavioral skills interventions that directly teach adolescents new skills are now widely recommended as components of prevention efforts. Although social-skills training has often been included as a component of such interventions, we actually know little about how social skills and adolescent sexual behavior are related. The lack of an adequate literature base has led to the selection of target behaviors based primarily on clinical intuition. Such failure to demonstrate that target behaviors are indeed related to successful interpersonal outcomes has long been a weakness of the adolescent social skills literature (Hansen, Watson-Perzel, & Christopher, 1989). The design of more effective and generalizable social skills training components of prevention efforts will require a greater understanding of the relations between social-sexual interactions and problematic outcomes.

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