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Challenges and Opportunities for Sexual Risk Reduction in Scottish Adolescents

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adolescents, focus groups, HIV prevention, Scottish adolescents, sexual risk reduction, STI prevention

Abstract

Sexually transmitted infections, HIV, and unplanned pregnancy challenge the health of Scottish teens. We conducted focus groups with teens ages 16-to-19, recruited from an urban youth café in Edinburgh to assess sexual risk taking and protective behaviors. A trained facilitator, using a semi-structured interview guide, led the groups. We taped and transcribed data verbatim for coding and theming. The teens revealed similar concerns despite differences in gender and/or sexual histories. Despite school-based sex education, sex was rarely discussed with peers or adults outside classrooms; the ability to practice communication and negotiation skills was minimal. Much risky behavior occurred in public spaces and was often linked to drug or alcohol intake. There was a glaring lack of teen planning for, or contemplating, future adult lives. Findings highlight the challenges these teens faced in practicing safer sex and limited opportunities to tailor intervention strategies to address the cultural realities of their lives.

Key words. adolescents, focus groups, HIV prevention, Scotland, sexual risk reduction, sexually transmitted infection prevention

Adolescents in Scotland: Challenges and Opportunities for Sexual Risk Reduction

Worldwide, adolescents still face ongoing negative health, and psychological and social repercussions from sexual risk taking behaviors (Bearinger, Sieving, Ferguson & Sharma, 2007; Hodgkinson, Beers, Southammakosane & Lewin, 2014; Hoffman & Maynard, 2008; Idele, et al., 2014). In Scotland, teens are challenged by many of the same negative outcomes of sexual risk behaviors (sexually transmitted infections [STIs], HIV, unintended pregnancy) as their U.S. counterparts (Centers for Disease Control and Prevention [CDC], 2016; Health Protection Scotland, 2017). Despite various sexual health interventions and programs in Scotland implemented over the past decade, evidence suggests that the incidence of STIs among young heterosexuals and unplanned pregnancies remain a problem in Scotland (Scottish Government, 2015). In fact, a news headline just a few years ago read, "Sexually transmitted diseases rocket across all age groups in Scotland" with STI rates jumping 46% in the past decade in those under 25 years of age (Scottish News, 2014). Across Scotland, there remains a need for interventions that can address increasing STI rates, especially for adolescents and young adults, as the peak age of STIs for females in the United Kingdom is 19-20 years and slightly older for males (20-23 years; Family Planning Association UK, 2011; Health Protection Scotland 2018). Although total numbers of HIV cases are small compared to the United States, with less than 10,000 documented cases (Health Protection Scotland, 2017), because STI exposure and HIV infection risks are clearly linked (CDC, 2017; Hayes, Watson-Jones, Celum, van de Wijgert & Wasserheit, 2010), these teens will face that continued threat as well.

The United Kingdom also has the highest rates of both teen pregnancy and abortion in all of Western Europe (Family Planning Association UK, 2011). Although the most recent Information Statistics Scotland (2017) report also shows that although overall teenage pregnancy

rates are declining, health disparities exist, with teenagers from the most deprived areas more likely to become pregnant at rates five times higher than those in the least deprived areas of Scotland (62.1 compared to 11.6 per 1,000 women).

Since the introduction of the Sexual Health and Relationship strategy in Scotland (Scottish Government, 2003), there has been a range of interventions, programs, and frameworks initiated over a decade with the most recent being the Sexual Health and Blood Borne Virus Framework 2015-2020 (Scottish Government, 2015). These strategies and programs have been introduced with the aim of improving the sexual health and wellbeing of people in Scotland across the lifespan. Yet, despite good progress in reducing hepatitis C infections, new HIV and STIs diagnoses remain a significant problem (Scottish Government, 2015). Sexual health disparities continue to negatively impact teens, especially those who are economically disenfranchised and Scotland documents an urgent need for translational science initiatives to move research evidence into practice (Heath Protection Scotland, 2017; National Services Scotland, 2015; Scottish Government, 2014).

Data suggest that the behavior of Scottish teens is similar to U.S. teens with average age of first sex at 16 years with nearly one-third of young Scottish adults reporting first sex occurred earlier, and less than 1 in 10 reporting contraceptive use at first sex; similarly, they also report less stable sexual partners and greater proclivity toward risk-taking and experimentation (Family Planning Association UK, 2011; Scottish Government, 2014). With these continued health issues, there remains a need to understand the challenges these teens face when it comes to exposure to, and ways to mitigate, sexual risks. U.S. derived evidence-based interventions (EBIs) may be useful for Scottish teens as well, and models such as ADAPT-ITT describe pragmatic steps to disseminate and adapt such interventions (Wingood & DiClemente, 2008).

While there has been a global increase in evidence-based sexual risk reduction interventions across various age groups and genders, the utility of interventions for Scottish teens developed outside of the United Kingdom is unknown. Gaining increased understanding of the protective and risk taking behaviors of male and female Scottish teens will be helpful for identifying next steps for cultural tailoring interventions to increase their applicability in this population. The Health Improvement Project for Teens (*HIPTeens*) is recognized by both the CDC and U.S. Department of Health and Human Services as one such EBI for STI/HIV and teen pregnancy prevention (Morrison-Beedy et. al., 2012) and is a brief, theoretically-driven intervention with documented long-term, multiple behavioral outcomes. ADAPT-ITT and others programs suggest using focus groups with the target population as the first step (assessment) for formative work needed to modify interventions and approaches for new populations (Chandler, Anstey, & Morrison-Beedy, 2016; Childs & Knight, 2015; Schnall, Rojas, & Travers, 2015; Wingood & DiClemente, 2008). The purpose of our study was to describe sexual risk-taking and protective behaviors in male and female Scottish adolescents identified in focus groups and related challenges and opportunities for HIV/STI and pregnancy prevention interventions such as *HIPTeens*.

Methods

Participants

This study was approved by the institutional review board/ethics committee of the University of South Florida and Edinburgh Napier University. We recruited teen participants during the summer of 2017 from an urban youth community café located in downtown Edinburgh, Scotland. The café was similar to a community-youth agency site in the United States that serves area teens with after-school programs, activities, and a place for teens to connect in a

teen friendly site. The café serves downtown Edinburgh with 6-to-20 youth, ages 12-to-20, and predominantly from impoverished areas, served daily. Following face-to-face meetings with staff to inform them of the study purpose and procedures, we posted recruitment flyers at the site as well as announcements on the café's social network site. The principal investigator (PI) also spent time imbedding herself in the setting to connect with teens and was available, prior to focus groups, to answer questions and describe the study to potential participants. All potential participants came to the site to discuss the study but it is unknown whether they may have first heard about the study through a friend, the social media post, or through first-time contact while visiting the café.

Once interested individuals were provided with verbal and written study information, they were privately assessed for inclusion criteria and consented prior to the start of the focus group. Inclusion criteria included: (a) teens ages 16-to-19 years (16 is age of full consent for participants in the United Kingdom); (b) not currently pregnant; (c) interested in dating, or have sexual experience or interest in a heterosexual relationship; and (d) English-speakers. Following suggested approaches (Corfman, 1995), we did not include pregnant or lesbian, gay, bisexual, transgender, or questioning teens in this study as we believed the dynamics and disclosure during groups would be impacted by mixing more diverse groups of teens and, for the purposes of our study, we were discussing needs for recruitment to heterosexually-focused interventions. Only two teens who expressed interest did not meet eligibility criteria (i.e., heterosexual interest), and, therefore, were not enrolled. All others were able to attend one of the three focus groups.

Due to the "drop-in" nature of the recruitment site, we chose to recruit males and females to form mixed-gender groups on each of the recruitment evenings to have a sufficient number each time for active focus group discussions. We conducted groups weekly until data saturation

occurred which was at end of group three. Each group had six participants of mixed genders and ages for a total $N = 18$. We also had a mix of sexually-active and abstinent teens in each of the three groups. Details of participant characteristics can be found in Tables 1 and 2.

Measures

Demographic and risk behavior questionnaire. For each participant, we assessed gender, age, race, ethnicity, country of origin, education level, ever sexually active (vaginal, oral, anal), current contraceptive use, and ever tested for STI and HIV.

Interview script. We used focus groups to gather data on sexual risk taking and preventive behaviors in male and female adolescents. Following common procedures, a semi-structured interview script was used to guide the focus group discussions (Côté-Arsenault & Morrison-Beedy, 2005). We developed an evidenced-based intervention, *HIPTeens* (The Health Improvement Project for Teens; Morrison-Beedy, et al., 2012), recognized by the CDC and the U.S. Department of Health & Human Services, for HIV/STI and pregnancy prevention. In the past, our formative and intervention work has been guided by the Information-Motivation-Behavioral Skills Model (IMB; Fisher & Fisher, 1992) and we applied this to guide our approach to focus group questions. Open-ended questions addressed major theoretical constructs of information, motivation, and skills as they related to risk and protective behaviors. We also asked about recruitment and retention strategies for future intervention studies. To note, use of the IMB model was fluid and participants were given opportunities to share opinions and experiences beyond the IMB constructs. We began with broader questions and added probes (e.g., *help me to understand that better*) to elicit more in-depth responses as appropriate. These descriptions were further enhanced in depth and breadth by the group process that takes place within the groups (Morrison-Beedy, Cote-Arsenault, & Feinstein, 2001). See Table 3 for the

detailed interview guide.

Study Procedure

Prior to the start of the focus group, teens were screened individually by the PI in private areas of the center to assess inclusion and exclusion criteria for enrollment. We also reviewed general study and consent issues so they would understand the study protocol and be able to judge continued interest in participation. Once these and interest in study participation were confirmed, we gathered interested teens in a private room where they were provided a study consent to read, had any questions answered, and completed the anonymous demographic form. Once all teens had consented, voluntary participation was confirmed by a teen study advocate from the youth café who confirmed the teens' understanding of the study and desire to take part; this advocate was required by the institutional review board of the PI's home institution.

Once all teens had consented we began the group by reviewing ground rules (e.g., there are no right or wrong answers, speak one at a time, no judgment responses or nonverbals) and started the digital recorders for data collection. The group was conducted by a seasoned moderator who also took notes to augment data transcriptions. Each group lasted 60-to-90 minutes and participants received a gift card for local U.K. vendors for £20 GBP (approximately $25 U.S. dollars) at the end of the group. Following the focus groups, debriefing with other research team members and the moderator included discussions of group dynamics and interaction as well as broad themes arising from the discussions.

Data Analysis

We analyzed the brief anonymous quantitative sexual survey data using basic descriptive statistics in order to provide a foundation of understanding of the sexual experiences of participants as we then delved into further detail with focus group data to gain a more in-depth

understanding of their behaviors. The demographic and risk behavior data were summarized and tallied using descriptive statistics to describe the sample and provide context for transcription data.

All focus groups were digitally-recorded and professionally transcribed verbatim. Transcriptions were read multiple times in preparation for within-group and between-group analysis, which identified and summarized themes relevant to the purpose of the study. Transcription data were integrated with any field notes recorded during the groups pertaining to nonverbal and behavioral activities. This allowed a measure of data triangulation. Using conventional thematic analyses focusing on intentions, meaning, and context (Morrison-Beedy et al., 2001), we employed an open-coding scheme that allowed identification of themes, which were coded manually. Within- and between-group analysis continued until data saturation was evident when no new themes emerged and similar responses were noted by the third focus group. Although some direct questions were asked of participants (e.g., *where did you learn about HIV/STIs and pregnancy prevention?*) entire transcripts were reviewed in order to identify themes that emerged across the course of the focus groups, rather than just in reflections on one question posed to the teens.

Prior to data analysis, inter-rater reliability between coders was established by reviewing previously coded focus group transcripts until 90% inter-rater consistency was established. Data from the study were then hand coded and themes reviewed and confirmed by other team members using an iterative process with any coding discrepancies discussed and reconciled by consensus. After discussion between raters addressing three discrepancies, full agreement was reached for coding. We incorporated macro (between groups) and micro (within group) comparisons for data analysis. We established trustworthiness during the analysis in several

ways including: (a) providing an audit trail of what was done and why, (b) debriefing post focus group, (c) presenting rich descriptions of the study and data, (d) incorporating field notes into the analysis where indicated, and (e) using an independent transcriptionist with word-by-word transcription. Credibility of the study was established by including adolescents of both genders with diverse sexual experiences (including those with no or very limited experience) and dependability enhanced by: (a) use of a single trained moderator and (b) detailed interview guide.

Results

In total, 18 participants took part in three focus groups. Both genders and sexual experiences (abstinent or sexually active) were represented in each group. The average age of participants was 17.2 years with 61% being male and 39% female. Participants were predominately White (89%) and 11% Black; the majority were born in Scotland (83%). This reflects of the demographics of Scotland in general, and Edinburgh in particular (Live Population, 2018). Nearly three-quarters of the sample (72%) were sexually active. The majority of sexually active teens (n = 13) reported history of vaginal (92%) and oral sex (85%); 6 of the 13 reported anal sex (46%). We asked about various current contraceptive uses including pills, implant, intrauterine devise, rhythm, patch, long-term injectables, condoms, hormonal ring, and diaphragm; the only options endorsed were condoms and implants. The majority of the sample did not report having been tested for HIV or contraceptive use. See Tables 1 and 2 for descriptive sample characteristics.

Data saturation in thematic responses emerged by group 3 when no new themes emerged. Predominant themes included: (a) we really don’t talk about how to "talk about" sex, (b) private behaviors occur in public places, (c) common concurrent use of substances especially with

anonymous encounters, and (d) limited future time perspective of these teens. Participants cited involvement in the study as a way to pass empty time and participation incentives suggested as a primary approach to facilitate recruitment and retention as they unanimously reported the lack of employment and opportunities for youth as a major concern for Scottish teens.

No Discussion About How to "Talk About" Sex

During the focus group it became readily apparent that these Scottish teens believed they discussed sex to a far lesser degree with either partners, peers, or adults than they perceived their U.S. counterparts did. This issue likely arose because the PI was from the United States and explained why she had come to the United Kingdom – to develop and tailor programs for teens incorporating a Scottish perspective. As one male said - "you Americans are always talking about sex. Blah, blah, blah, it doesn't matter who you're with, you keep going on about it." And a girl chimed in – "It's always all about that. It is in every bloody movie, video and song. Is that all you ever think about?" A male in another group laughed when he said "You just aren't going to find that here, all that open sex talk. We are way more private, even with our friends. The topic just doesn't come up with us like that." Several teens chimed in agreement when one girl said, "All these details…it's really a taboo topic. No one is gonna be chatting with their friends about using protection or getting tested. Too personal."

Knowing that the groups perceived Americans as much more open (overly so, in fact) about sex discussions, when asked about negotiating safer sex practices or discussing contraception or STI/HIV testing with partners, the participants made it very clear that although they learned the facts about contraception, STI and HIV transmission, and prevention, it was strictly a fact-based education. "We may know how to put a condom on and where to go get treated if we got some infection but that's way fuckin' different than bringing it up with

someone." As one male said,

> We never talk about how to 'talk about' sex and all these things. If you pull out a condom and the girl says, "OK," then that's as much as you're going to say. You be in the middle of things but for sure not bringing it up before.

Another girl complained,

> In our school they should've done that with us. I would like to know how you can actually bring it up without getting in a jam because you did. I think about maybe saying something before but then he might think I'm dropping my panties easy just 'cause I brought it up.

Another young man described how teens learn to use condoms, "They would show us videos but they didn't actually make us do it (practice with them); it was like 'cheers mate, carry on.' But actually how you would discuss such things with the person, no…not having it." Most in the groups agreed that, "What we need are communication skills. Just to be comfortable and not be afraid to speak up if you want to use a condom or whatever. Also consent to make sure they're (partners) OK with it as well." Many others affirmed the need to broach the consent issue with partners yet felt a lack of preparation and skills to do so.

Despite efforts across Scotland focused on sexual health, the dismaying purveying attitude in these groups was that relying on a person's self-reported risk was considered sufficient to allay any fears of most teens when it came to their personal risk with a new partner. As one young man said,

> If a girl tells me their (her) sex history, I don't know. Every time they've told me about their history, I've trusted them. Even if I didn't, then a friend would know enough about them to tell me if they was lying about (it); they would tell me.

This sentiment was identified in all three groups. One girl said,

> I think the only person I've been with could have had something but when he told me everything was OK, I believed him. He didn't ever bring up that he had been tested. I trusted his say on that then. I didn't think too much about it.

This passivity in making sexual decisions was evident in all groups. Many males echoed this response from one member, "If your partner says 'use something' then OK but if nothing is said then fuck it, just plow through. Most none of us would say anything and then, yeah, afterwards regret it." As one male said, "No news is good news. If none of your chums brings up something bad about the girl. She must be clean."

In all the groups, the teens concluded, for the most part, that they could not have conversations about sex and reducing risk with their parents. "I don't know anyone who is talking to their parents about this. They'll just be like, 'Just, if you do, be safe about it, but don't tell anybody.' Really just don't talk about it." As one male summed it up at the end of his group "As we be saying, no one is talking about how to talk about all this sex stuff." Being able to talk about sex-related issues in future interventions was also discussed. For the most part, teens wanted such programs provided in same gender groups but identified this as probably most beneficial for females. The challenge with all-male groups was what was termed "lad culture": "If we get a bunch of us lads together, then it's not really serious and we're getting carried away," and, "Boys might act more serious if the groups was mixed but girls might feel more comfortable if it was just all girls."

Private Behaviors Occur in Public Places

The teens in these groups also discussed where sex was taking place for them and the majority of their friends. Living in a densely populated urban capital, the teens talked about

where opportunities for sex arose. Many said they and their friends often have sex in public areas of the city. They all seemed to know what areas of parking lots, parks, and other public spaces were used by many teens as places to have a "quickie." One male said,

> Aye, tourists and business people would never know that while they're eating dinner at a restaurant or watching birds in the park or driving by on those tourist buses that there's a lot of us having sex in out-of-the-way sections of those spots.

And a girl quickly said, "And some right under their noses on park benches and behind the bushes right where they be walking." One male described in detail,

> About for 3 months, me and a group of my friends used to go to the park literally 5 minutes down the road. In this park there was this little path and there was a bit for you to sit. Nobody could see you when they were walking past except if they were walking across the bridge. We could drink and have sex there without anybody seeing. That went on for months. Sometimes we'd get there and the spot was already taken by another group doing the same.

Each group was in consensus that most adults were oblivious that teens were having sex in very close proximity to public venues. "Folks think that that would be uncommon for us, something rare, but in fact it's common." When asked if having sex in their own homes was common there was a general outcry: "Not in me own home or me own bed!" Many echoed one young man who said, "There's no privacy and my parents are home;" and another blurted out "Bloody hell - who does that in their own house?" As a few commented, "Maybe in a car if someone has one, but not your house." When asked how these "public area sex encounters" impacted decision making for safer sex and condom or contraception use, most laughed at what one male said, "It doesn't cuz you ain't be thinking ahead to bring it up or have something with

you!" A girl stated that in these situations, "The guys be thinking with their heads but it's the one on the wrong end! These outside situations just put you in a bad spot but they are never discussed in our school talks on sex."

However, one young man did say he tried to carry condoms with him so he could be prepared for a "tussle in the park," largely because his older brother gave him some (condoms) and told him to carry them. But as another described, "When you're out in these spots, you don't really think about it (protection) until after it's over." As another said, "We all know we should, but then it's the fact that, in the moment, it's forgotten about; we're not in the mood and stuff … we're just willing to risk it."

In two separate groups, individual females brought up the issue of safety with these encounters. Despite being hesitant to describe situations in detail, it became apparent that they struggled personally with this issue, "You can end up somewhere back in the trees and the next thing you know he's pushing you down and there's not a body around. So what are you supposed to do then?" Later that girl mentioned when referring to this event ,"It was so scary, who's thinking about pregnancy or other stuff then, not me." Another girl reacted "Me and my friends had too much bad happening in places that you think, 'How can it be?' We are bloody near in sight of everyone but still ending up in a bad place with this guy." Two other young women concurred that sex acts taking place outside were fairly common, "We don't really have cars. People be doing it outside the front door, around the corner." As the males in the groups echoed, "If it's just a one-off, then high chance it is not happening in the house. It's outdoors or wherever you can go quick." Another teen remarked, "People are not naked for sex, it's just a bit of trousers down and that's enough. So being prepared for this quickie is just not on our minds." There was general consensus among the young men in the groups similar to what one said,

"Take the sex if you can get it and worry later."

Concurrent use of Substances Enhances Risk

The teens also talked about substance use with sex and reported that Ecstasy was common as were pill parties where teens threw a mix of whatever pills they could bring (e.g., oxy, valium, bennies) in a container at parties and then grabbed a mix to take. It was in similar social situations where drug use was encouraged or expected that these teens said their decision making regrading sexual choices became almost non-existent. One male commented, "Once all the drugs come out it's hard to say you'll end up any place good as far as sex is concerned." A girl in another group stressed, "Lots of times you end up with someone you don't know and don't want to remember, much less remember to use protection." As one male said, "You're not thinking about getting a girl pregnant, cuz in that party group you figure she's using something so you don't have to worry." Another girl voiced concern about decision making in such situations and worried,

> When this comes up you never been taught a way to say no besides, "no," like they tell you at school to do. What we really need is how to say it other than just, "N – O," like to both the drugs and the sex, not just hope for the best.

The groups concurred, "The drugs and alcohol are not brought up in the same discussions as the sex talks in school. They be like different topics." Around the group everyone was shaking their heads in agreement. When this issue was brought up in other groups, there was also concurrence, "Getting the sex talks is only about sex, not never connecting it to anything else you gonna be dealing with."

Safety issues came up again when the discussion centered on concurrent use of drugs and alcohol. One young lady recalled a personal situation that ended badly.

> There is a high risk, especially for females when they're just so drunk that they get forced into things. I do know a few people that has happened to and it has happened to me as well. That's when I stopped doing all that stuff and going drinking with my friends. I didn't leave my house for weeks. It is really risky, especially for females drinking with other people. Even if you don't wanna do it, you can end up getting forced into it when you've been drinking.

The concurrent use of drugs and alcohol at parties posed a risk to these teens with many echoing the comment made by one young man, "Every party be having alcohol or drugs, whether it is Ecstasy or people even slip in Viagra for a fun surprise. And no one is really talking about that when we get the sex talks." Another young man spoke about frequently having sex under the influence of alcohol and his lack of using condoms during those episodes, "Maybe being sober actually would help…You just put it in the back of your mind and don't think about it. …Later, I get tested. I normally get tested after the relationship and (shows fingers crossed)." Other teens in all three groups responded similarly that one got tested after the fact, "Just so we can, you know, say we are in the 'all clear' and dodged it." The assumption was that they were not infected and, therefore, others they had sex with were in the "same boat."

Limited Future Time Perspective

Participants were specifically asked about their future plans, what they envisioned for themselves and what they might be doing. The vast majority responded, "I never think about the future." Others agreed when one male said, "I have no idea, probably the same as I do now – nothing." In another group a girl commented, "Thinking about years from now…I would never think that far ahead. I want to have money but how to get it, I don't know." Comments across groups were similar to this, from a male who said, "There ain't nothing to do, no jobs, nothing,

so why think about anything different happening?" Only one girl responded that she wanted to go on to school to be a social worker. Several boys responded that they hoped they would have a job but as many reported, "There nothing much, maybe a restaurant or a shop, not many choices." As one described his situation, "Me dad's home not working, and me brothers are home not working so I'm just another;" this sentiment was echoed by several others across the groups. In fact, of the 18 participants, only one of those 17 years and older was still in school with most of the 16 year olds expecting it would be their last year of school (supported by "yes" to participant comments and nonverbal confirmations during focus groups discussions).

Recruitment and Retention Strategies for Future Studies

Although these teens had limited input regarding recruitment and retention strategies other than the often cited, "Money is always good," a few did confirm what one said, "Doing something good for others my age would be a good thing," thus, enrolling in a study was seen as positive by several participants. Interestingly, several of the participants brought up the need for teens attending a risk-reduction intervention to be provided an "official certificate" as it might be recognized by potential employers if, "It said we took part in something that taught us social skills or communication. It would help us get a better job." Another male said, "An actual certificate that could be recognized by employers that you weren't just sitting around, then I feel more people might want to do (an intervention) program."

Discussion

We sought to gain a better understanding of sex-related protective and risk-taking behaviors in Scottish adolescents. The findings from our focus groups highlight both the challenges these teens continued to face in practicing safer sex as well as opportunities to tailor intervention strategies to address the cultural realities of these teens' lives. Importantly, many of

these findings hold the potential for applicability to other cultural groups of teens.

One predominant theme identified during our study was their limited communication skills needed for negotiation of risk preventive and avoidance behaviors, as well as the lack of opportunities to develop and practice skills in a setting where proficient feedback was available. The importance of integrating multiple opportunities for role play scenarios in risk reduction interventions can never be stressed enough. Developing refusal skills, whether that be for alcohol or unprotected sex for example, while at the same time providing opportunities to continue the social relationship or engagement with the potential partner is imperative. Too often, if teens are provided skill training in communication it is to learn simply to say, "No," and that will not work in every situation. What teens need are a "menu of options," some that may be appropriate for one partner or situation but which need to be modified for another partner or situation (Morrison-Beedy, 2012). Learning assertive communication techniques, basic negotiation skills, and doing so in an affirmative but non-confrontational manner are skills that teens can apply across various life situations outside sexual scenarios as well.

A somewhat unexpected finding in these urban-residing teens in Scotland were the number of sexual experiences that took place in very public places such as parks, restaurant patios, and entertainment venues. Most of these encounters were both rushed and unplanned, a "quick trousers down," which left little opportunity for romantic pleasure or protection. Although the teens recalled numerous times when they or their friends had these encounters, few, until these focus groups, had given thought about preparing for these somewhat common "public" occurrences. Integrating intervention strategies that allow teens to develop scenarios that fit their reality are important aspects of increasing intervention efficacy. Certainly for these Scottish teens, role plays describing bedroom scenarios with parents out of the house or driving around

town in cars would not be a fit for their life experiences.

Dealing with the chronic, concurrent exposure to alcohol and drugs while addressing sexual risk was a major need for these Scottish teens. On a licensed premise, teens ages 16 and older can drink beer, wine, or hard cider if purchased by an adult and can purchase any alcohol at age 18. Age limits for drinking and purchasing alcohol vary by country in the European Union, with many starting at age 16 (ProCon.org, 2016). Our findings highlight the ongoing pressure teens face in peer social situations to drink or use drugs and engage in sex. Interventions that integrate these scenarios during motivational enhancement and skill building strategies would be welcomed, and essential, to address risk in teens.

These teens came from economically-disenfranchised areas of urban Edinburgh. Most, if not all, had left or planned to leave school by age 17. Except for one teen, the universal comments surrounding their plans for the future or envisioning next steps in life were restricted, minimal, or absent. A challenge exists for interventionists to devise engaging strategies to broaden or elongate future time perspective in these teens, knowing an intervention cannot change their day-to-day lives and histories. Even more urgent would be to provide approaches that address the very real experiences these teens have for "living life to the fullest now" and focusing on immediate gratification rather than choosing behaviors that may have more long-term positive benefits.

Overall, despite the occasional comment from a participant regrading attempts to practice safer sex or make informed choices, the focus group discussions predominantly brought out a propensity to participate in risk behaviors with a "fingers crossed" approach, to rely on "no news is good news" in regard to potential partner risk or HIV/STI exposure, and "to plow through" in risk situations and "hope for the best" in scenarios involving public sex venues, concurrent

substance use, and lack of discussion or planning around sexual behavior choices. Safety in such situations was also a concern especially for the females in the groups. Addressing consent issues and helping teens identify triggers to unsafe situations as well as strategies to employ (e.g., buddy system, avoiding secluded areas) are important components needed in interventions. Despite the efforts directed to teens in Scotland to reduce sexual risk behaviors, just as in the United States, there remains gaps between provision of the facts and knowledge acquisition to focus on programs that build motivation and the skills need to reduce risk.

Following ADAPT-ITT recommendations (Wingood & DiClemente, 2008), modifications to the U.S.-tested *HIPTeens* intervention or others are needed to fit the reality of life for these urban Scottish teens. Certainly, role play scenarios that include bedroom scenes or home parties will need to be changed to reflect less private situations such as ones that are set in public settings such as a park. Although alcohol and drug use put both U.S. and Scottish teens at risk, the legal drinking age differences should be integrated into discussions in the intervention. The discomfort many of these teens had with talking about sexual situations may mean that skill building communication exercises should begin at a more introductory level, incorporating opportunities for teens to brainstorm many lay terms for different sexual experiences (e.g., for vaginal sex teens may brainstorm fucking, making love, screwing, knocking boots, getting laid) may build comfort levels so skill building can progress. Motivational exercises in *HIPTeens* to promote future time perspective development in teens will likely need to be repeated within the intervention allowing Scottish teens time to contemplate future plans throughout the intervention. Additional future goals added to the take-home materials that match the reality of these teens focused on employment options that fit the Scottish reality rather than a U.S. college focus will be needed. Providing Scottish participants with a completion certificate or similar document may

be valuable to this population rather than just ceremonial.

Limitations

We made significant effort to ensure trustworthiness of the findings and add rigor to our study. However, limitations include findings which are based on this small sample from one recruitment catchment in Edinburgh, Scotland. Clearly, because only teens who were aware of this setting and utilized it for social networking were included in the study the representativeness of all adolescents cannot be assumed. However, the mix of genders and sexual experiences of participants with data saturation by group three provided insight into various sexual risk and protective behaviors of these teens. The focus of the groups was to round out our understanding of nuanced cultural differences that may exist for Scottish teens and to appreciate the context of that environment when it comes to sexual health choices. These experiences may be different for teens from other socioeconomic status or cultural groups within Scotland and a different view may have been obtained if the focus groups were restricted to homogenous same-gender or like sexual-experienced participants. However, within and across all groups in our study, differences among participants in gender or sexual experience did not seem to pose a challenge to all the teens speaking out, asking questions, and presenting their perspectives. Although the participants provided very detailed personal descriptions and asked relevant questions during the groups attesting to the validity of the data, results may still have been different if the facilitator had been from the same cultural background.

Future Research

Further research with other diverse groups of teens in Scotland can provide additional insight into the themes identified in this study and may provide more in-depth conceptualization of the challenges and opportunities that are present in Scotland for risk reduction interventions

for teens. In addition, although we had both males and females in each group, there were almost twice the numbers of males versus females, with the seven females spread across the three different groups. Thus, although we heard some comments that may have highlighted differences between motivations or skills in males and females (e.g., the issue of safety), we did not have sufficient data saturation to analyze based on gender. Future work is needed to address gender differences and similarities, and the same is true for sexually-active and abstinent teens.

Conclusion

Similar to U.S. teens, many of the Scottish teens in our study were participating in multiple sexual and substance-use risk behaviors. Unlike in the United States, these teens emphasized that, despite sex education in schools, sex was rarely discussed with peers or adults outside required classroom lectures; the ability to practice communication and negotiation skills was minimal. Despite the ready availability of contraception and STI/HIV testing and related health care needs in this national health system country, teens admitted they lacked the skills to plan, discuss, or negotiate safer sex practices. Similarly, the connection between substance use and sex risk were not made readily apparent in education programs nor by the teens themselves. Prevalence of anonymous and unplanned sex lead to “capturing the moment” resulting, most often, in unprotected sex. There was a glaring lack of teen planning for, or contemplating, their future adult lives. The adolescents in our study revealed similar concerns despite differences in gender or sexual histories. Focus groups were employed in this formative study to gain insight into the sexual experiences of Scottish adolescents and the risk-taking and protective practices that impacted their sexual health. Ultimately, the challenges they identified in this descriptive study could be used to design and tailor sexual risk reduction interventions and provide opportunities to advance programs that work to build motivation and the skills needed to reduce

HIV/STI and unplanned pregnancy exposures.

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Key Considerations

- Scottish teens, particularly those from economically-disenfranchised areas, continue to need evidence-based sexual risk reduction interventions.
- Focus groups conducted with sexually active and abstinent teens revealed common threats to healthy sexual decision-making across genders.
- There was a clear gap in teens' communication and negotiation skills for healthy sexual choices and lack of opportunities for them to "talk about how to talk about sex."
- It was common practice for these teens to engage in high-risk sex behaviors in a wide array of public areas rather than at home or in private.
- Despite substance use and sex risk behaviors being so intertwined in these teens' everyday lives, these topics were rarely linked in sexual health education programs.
- The ability or desire to think beyond immediate gratification in sexual situations was a challenge for most of these teens whose future time perspective was limited or absent.

Table 1

*Focus Group Participant Demographics (*N *= 18)*

	Male (*n* = 11, 61%)	**Female (*n* = 7, 39%)**	***M***
Age (years)			17.2
16	4	3	
17	4	1	
18	1	0	
19	2	3	
Race			
White	10	6	
Black	1	1	
Ethnicity			
Hispanic	2	0	
Non-Hispanic	9	7	
Marital Status			
Single	11	7	

Table 2

Sexual History of Participants

	Male (*n* = 11)	**Female (*n* = 7)**
Never sexually active	2	3
Sexually active	9	4
Ever vaginal sex	8	4
Ever oral sex	8	3
Ever anal sex	4	2
Ever STI diagnosed		
Yes	5	3
No	6	4
Ever HIV tested		
Yes	2	2
No	9	5
Contraception		
Yes	4	3
No	7	4
Condoms	4	3
Implants	0	1

Note. STI = sexually transmitted infection.

Table 3

Focus Group Interview Guide

Teens are faced daily with different health choices. Some of these may include the prevention of HIV, STIs, and teen pregnancy but there are other health behaviors as well.
How important are those related to sexual risk compared to others?
We know that teens are provided, at times, a lot of information on how to prevent HIV, STIs, and teen pregnancy.
In regard to the information you receive, do you think you receive:
Enough
Not enough
Just the right amount
Where do you get this information primarily?
Are there areas that you would like more information?
In addition to information, teens need the skills to carry out those preventive behaviors. What do you think are the most important skills to carry out?
The least important skills?
And the most challenging to carry out?
Why are these skills challenging to carry out?
Teen lives are very busy and complex right now. How motivated are you and your friends to practice HIV, STI, and pregnancy prevention?
What issues or behaviors are more important to you?
What seem less important to you?

There are programs developed specifically for teens to help reduce their risk in sexual situations.

What things would make you or your friends want to participate in such a group?

What things would be challenges for you or your friends to participate in?

Are there any unique Scottish perspectives we would need to know about if we wanted to develop a program for Scottish teens?

Are there any other thoughts or ideas that you would like to share with us?

Note. STI = sexually transmitted infection.