

Adolescents living with HIV/AIDS: sexuality experiences

Adolescentes que vivem com HIV/aids: experiências de sexualidade

Adolescentes que viven con el VIH/SIDA: experiencias de sexualidad

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ABSTRACT

Objective: To analyze the experiences of adolescents living with HIV/AIDS about sexuality.

Method: Qualitative research carried out in a Specialized Care Service of a municipality, of Rio Grande do Sul, with 15 adolescents living with HIV/AIDS, in the year of 2014. A semi-structured interview was used. The data was analyzed using Minayo's operative proposal.

Results: The first affective interactions of adolescents were experienced through hooking up and dating, strongly influenced by the differential valence of gender in family constructions. The experiences of sexual relations were due to the affective dimension of the relationship and were not given without concern to the adolescents. Managing the condition of seropositivity in their affective relationships mobilized their daily lives.

Conclusion: The learning of sexuality extrapolates the access to information, resulting from the multiple experiences lived, the moment and the different scenarios in which they are inserted.

Keywords: Sexuality. Acquired immunodeficiency syndrome. Adolescent health. Nursing.

RESUMO

Objetivo: Analisar as experiências de adolescentes que vivem com HIV/aids acerca da sexualidade.

Método: Pesquisa qualitativa realizada em um Serviço de Atendimento Especializado, de um município do Rio Grande do Sul, com 15 adolescentes que vivem com HIV/aids, no ano de 2014. Utilizou-se entrevista semiestruturada. Os dados foram analisados por meio da proposta operativa de Minayo.

Resultados: As primeiras interações afetivas dos adolescentes foram experienciadas por meio do ficar e namorar, fortemente, influenciadas pela valência diferencial de gênero nas construções familiares. As experiências de relações sexuais foram decorrentes da dimensão afetiva do relacionamento e não se davam sem preocupação para os adolescentes. Administrar a condição de soropositividade em seus relacionamentos afetivos mobilizava o seu cotidiano.

Conclusão: O aprendizado da sexualidade extrapola o acesso às informações, decorrendo das experiências vivenciadas, do momento e dos distintos cenários em que elas se inserem.

Palavras-chave: Sexualidade. Síndrome da imunodeficiência adquirida. Saúde do adolescente. Enfermagem.

RESUMEN

Objetivo: Analizar las experiencias de adolescentes viviendo con VIH/SIDA sobre la sexualidad.

Método: Investigación cualitativa realizada en un Servicio de Atención Especializada de un municipio del Rio Grande do Sul, con 15 adolescentes viviendo con VIH/SIDA, en el año de 2014. Se utilizó entrevista semiestruturada. Los datos fueron analizados a través de la propuesta operativa de Minayo.

Resultados: Las primeras interacciones afectivas de los adolescentes se experimentaron a través del ficar y namorar, fuertemente influenciadas por las diferencias de género en las construcciones familiares. Las experiencias de relaciones sexuales se debieron a dimensión afectiva de la relación y no se dieron sin preocupación a los adolescentes. El manejo de la condición de seropositividad en sus relaciones afectivas movilizaba su vida cotidiana.

Conclusión: El aprendizaje de la sexualidad excede el acceso a las informaciones, derivándose de las múltiples experiencias vivenciadas, del momento y de los distintos escenarios en que se insertan.

Palabras-clave: Sexualidad. Síndrome de inmunodeficiencia adquirida. Salud del adolescente. Enfermería.

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INTRODUCTION

The evolution of the acquired immune deficiency syndrome (AIDS) in Brazil has multiple dimensions, involving social, cultural, political, economic, clinical and epidemiological aspects. After more than three decades, AIDS, in the country, has become a stabilized epidemic, concentrated in some vulnerable populational sub-groups. One example is the case of the infection by the human immunodeficiency virus (HIV) in the younger population, which has recently presented a tendency to increase⁽¹⁾.

As teenagers face the chronic malady that is AIDS, their daily lives become permeated by issues involving the anti-retroviral therapy, family relations, silence and the revelation of the diagnostic, orphanhood, sexuality, adolescence in institutions such as support houses, among others⁽²⁾.

Little is discussed about the positive exercise of sexuality during adolescence, of its loving, intimate and experimental nature. It is mostly defined by the literature from the health field as natural and dangerous⁽³⁾. Experimenting with sexuality during adolescence is generally associated to issues such as unplanned parenthood, abortion, risk of sexually transmitted infections and HIV, among others.

Going through adolescence with HIV/AIDS affects in many ways the experience of sexuality, since it frequently starts being controlled, restricted and veiled. Experiences related to the sexuality of adolescents with this disease are entangled in paradoxes involving affective relationships, the revelation of the diagnostic to a partner, the stigma, the prejudice, reproductive issues, changes in body image, the desire to constitute a family, future plans, family perceptions regarding living with sexuality⁽⁴⁻⁷⁾, among others.

Hopes and needs of the adolescent with HIV/AIDS tend to be restricted by them or by people they live with, when compared to those of other adolescents their age. Even in highly vulnerable social conditions, adolescents will always be, on a certain degree, subjects of their own sexuality, which means that attempts to find mechanisms to control their sexual experiences are improper.

Given this context, this study aims to answer the following research question: How do adolescents living with HIV/AIDS experience sexuality? To answer it, this study looks into the experiences with sexuality of adolescents with HIV/AIDS.

METHOD

This is a qualitative, exploratory and descriptive study⁽⁹⁾, come from a PhD thesis⁽¹⁰⁾ presented in 2014. The setting of the study was the Specialized Assistance Services (SAE) in

a city in the countryside of the state of Rio Grande do Sul. In this service, adolescents with HIV/AIDS of the city and from some other cities in the region are cared for and can follow-up their cases. In addition, this municipality is the sixth with the most cases of aids in Brazil, considering cities with more than 100 thousand people⁽¹⁾.

Fifteen adolescents with HIV/AIDS who follow-up their cases at the SAE participated in the study. It should be highlighted that the number of subjects who participated in this research was achieved according to data saturation criteria⁽⁹⁾.

Inclusion criteria considered: people with HIV/AIDS, aged between 10 and 19 years old (according to the WHO's definition and the criteria adopted by the Brazilian Ministry of Health), who monitors the disease at the SAE. Adolescents with no previous knowledge of their diagnostic were excluded from the research, since that would risk breaking the diagnostic secrecy, which could lead to damages to the participants. Family members and professionals from the SAE were asked about whether the adolescent knew his or her diagnostic.

To choose participants, a search was initially conducted in the SAE's medical records. The first contact with the adolescents and their families took place through the professionals of the health service, which were informed about the study, and asked for permission so the study could be conducted.

Data collection was conducted with the use of a semi-structured interview, made up of the following questions: Are you dating or seeing someone? What is good and what is not in these relationships? Who clarifies your doubts about sexuality? Did your sexuality change after you found out about your health condition? Sociodemographic data collected included: age; educational level; type of infection; people with whom the adolescent lives; age in which they found out about their diagnostic; income, educational level and profession of the parents or caretakers.

Before the interview, adolescents above 18 years of age signed the Free and Informed Consent Form (FICF), whereas those younger than 18 years of age signed a Term of Agreement and their parents signed the FICF. Data collection was conducted in a place chosen by the adolescents, which was the SAE for 13 participants and their homes for two participants. In both places, the privacy of the participants was ensured. Interviews were recorded in a digital audio recorder and fully transcribed.

To analyze the data, the operative proposition of Minayo⁽⁹⁾ was chosen. Its first level refers to the exploratory stage, when knowledge was sought regarding the group under study. After that, the second moment, called "interpretative", was carried out in two stages: ordering and clas-

sification of data. In the ordering of data, the statements were transcribed and organized, and during classification, an exhaustive horizontal reading of the texts was conducted, as well as a cross-sectional reading, a final analysis, and the construction of the report with presentation of the results.

The research followed the precepts of Resolution n. 466 from 2012, created by the National Council of Health of the Ministry of Health, and was approved by the Research Ethics Committee of the Universidade Federal do Rio Grande do Sul, CAAE 15126813.4.0000.5347. To guarantee the anonymity of participants, the adolescents were identified by the letter A followed by numbers: A1, A2, A3 (...) A15.

■ RESULTS

Regarding the characterization of study participants, 10 of the adolescents were female, and five, male. All were infected via vertical transmission of HIV and were using antiretroviral medication. The participants were all in the age group from 11 to 19 years of age. Twelve of them had yet to complete elementary school, and from these, two were not frequenting school when data were collected. Three participants were in high school.

All adolescents came from working classes, with an income of up to one minimum wage per month. Considering the family structure of these participants, six adolescents had both parents deceased, and lost their family structure after that took place; also, six of them had a deceased mother and two of them had a deceased father. One teenager had no contact with his/her parents, and did not know whether they were alive. Due to this, which was reported by most as permeated by suffering and loss, six teenagers lived with their grandparents, especially maternal ones, two of them lived with the biological mothers, three lived with foster families. It stands out that, from the 15 adolescents, four had a father or mother in prison and six coexisted with parents or family members who made use of alcohol and/or other drugs. Most teenagers coexisted with their maternal and paternal brothers, but some of them only knew that these siblings existed.

Data analysis resulted in three categories: Affective interaction experiences, Sexual relation experiences, and Dilemmas lived to reveal the condition in affective relations.

Affective interaction experiences

Adolescents mentioned the fleeting nature of affective interactions, which are a possibility of self-knowledge and construction of autonomy.

I never did anything [sexual intercourse], just some kisses. I always get nervous when I'm about to kiss someone. I've been in love with a boy, but I'm liking another one now (A3).

I've been with many, I don't like to date. When I'm with a girl I don't see anyone else, so she can trust me. I like a girl, but she just wants to be friends with me (A8).

I've never kissed anyone, I'm a little shy. The first time I'll be nervous, because I don't know how it feels like. I like a girl from college, but I'm afraid to hit on her and find she doesn't like me (A7).

The first time I kissed someone I was twelve, I was really embarrassed. I didn't like to kiss him. He wasn't nice to me, he told everyone. After that I dated another boy, but I didn't had sex with him (A4).

The adolescents also understood "hooking up" and "dating" as different. Hooking up is seen as a type of affective interaction characterized by superficiality and the absence of commitment. Statements indicate that this type of interaction is a type of informal fun to these young people, when it comes to established codes for more serious relationships.

Dating is staying together for a long time. Hooking up, you hook up with someone today, someone else tomorrow. You take someone you're dating to meet your parents. It's good to have a boyfriend so you can have someone there in happy and sad times (A13).

When you hook up, you hook up once and that's it. When you date, it's everyday the same person and she always treats you with love. It's good to have a girlfriend so you can have someone who understands you. What's bothering is having to lie about what you have [AIDS], when you don't trust enough to tell (A1).

The nice thing about dating is feeling the love, having a partner to share the things in life. Hooking up isn't nice, because there's no love for them (A7).

Hooking up is better, because there's no responsibility or commitment. I'm hooking up with a girl, but I don't wanna date, I don't want a serious commitment. To have a girlfriend you need to trust her, you need to like the person. The responsibility is much bigger with a girlfriend (A10).

Dating was understood by the teenagers as a more serious relationship, which requires commitment and fidelity.

ty, where there is more physical intimacy, and knowledge about the other and the self, which can be followed by an initiation into sexual relations.

When you date you can have sex, when you're just hooking up you can't. The man needs to be faithful to the woman and the woman to the man. We need to trust our partner (A13).

Dating is much more different, you need more responsibility. When have a girlfriend she wants to have sex while you don't. When you're just hooking up, you only kiss and hug (A8).

Hooking up with a boy is no commitment, but when you date, it's different. My friend said that first she hooked up, than they started dating, than they had sex (A3).

From the statements of the adolescents it can be seen how they operate within the different models of masculinity and femininity in their experiences involving sexuality, which reinforces stereotypes regarding the theme. These elements can be better noticed in the several different forms in which they signify girls' and boys' affective relations, showing unbalanced evaluations of gender worth. In the following dialogues, that is easy to see:

Girls like serious relationships, boys not so much. Boys hook up with many girls to show to the others, to become known as men. The girls fall in love and want commitment earlier (A5).

Boys want to be seen as studs. In high school there are many like that. They keep asking me who I hooked up with, I make it up, say that I hooked up with a girl there, so I'm not the only one who never hooked up with anyone (A7).

The boys don't like it serious. The more girls they hook up with, the more sex they get to have. The girls don't like just hooking up, because that's not fun. They are more affectionate, they fall in love more (A11).

Gender distinctions originating from the approach to sexuality of parents and grandparents, when it comes to issues involving sexuality, can be extracted from the statements. In the family of the teenagers, the differentiation of conducts and controls is made clear, as female sexuality is more restricted, limited, forbidden and denied, whereas there is much more incentive for the masculine sexuality to be free and experimented with. This polarity in guidance relative to sexuality can be seen in the following statements:

It is different with the boys. To us they say: Take care of yourselves, girls. To them is: put a condom so you don't catch a disease. The parents don't say no to the boys, only to the girls (A2).

The boys can do anything and we can't do anything. We have to have limits, there's always a little talk to explain, you need to be alert, attentive. I have a friend who dated everyone and grandma said: that's terrible, she's so pretty and she's like that. Then I asked: to the boys it's not bad at all, just because their men? I don't agree with that (A1).

With the girls it's different, because they're girls. Their grandma tells them: You have to take care not to get pregnant. The grandma is always suspicious about them, but with me it's fine (A10).

The statements show a repressive posture permeating the dialogue between parents or caretakers and the teenagers, which can, sometimes, lead to conflict or even intimidate teenagers to seek guidance from their families when it comes to issues related to sexuality. This description can be seen as follows:

I'm not dating because my dad won't let me, he says I'm too young. I kiss boys at school in secret, because he doesn't really let me go out (A12).

I started dating without telling my mom, but my sister told her. When my mom saw me talking with him on the phone she got my phone and broke it, so nervous she was, and grounded me (A11).

When I met a boy, my older sister argued with me and told me not to talk to him again. [...] I lied to her many times. I want to tell these things, but I don't, because I'm afraid she'll fight with me and hit me (A4).

The adolescents are going through their first affective interactions by finding boyfriends or girlfriends and, as they say, "dating". Sexuality, to them, is a long path they traverse, permeated by caresses, a slow revealing of one's own body and that of his or her partner, talks, doubts, fears, and the discovery of new feelings and sensations. It is continuous, as they learn based on the experimentation of the many dimensions that permeate it, and by the interiorization of social, family, and gender values.

Sexual relation experiences

Eleven teenagers stated that they had never had a sexual intercourse, and that they would choose to have this

first experience when they reached what they considered to be the right moment. This right moment would be one in which they felt love and trust in their relationships. The issue of trust was mentioned as a way to keep their diagnostic a secret, and also, especially in the case of the girls, to keep their virginity in secret, away from public eyes. They also said that, if their first sexual experience takes place in a situation where all of these conditions are true, it will be possible to experience it in a more relaxing way.

It needs to be with someone special, that's part of my life, that likes me, that supports me in happy and sad times (A13).

The first time must be with love, friendship. It can't be just sex. If there's no love I'll be more nervous and if there is I'll be more at ease (A7).

I broke up with my ex because he wanted to have sex and I didn't. I thought it wasn't the time yet, I was afraid he'd tell everyone I was a virgin (A1).

The first time I'll be very anxious. I need to like him. You need love, passion and trust to tell about the disease (A6).

Gender issues are also present in the statements of the students when it comes to sexual intercourse initiation, and are highly relevant in the decisions that surround the start of this practice. Women and men have different motivations for starting their sexual lives, which originate from the construction of their identities as men and women, as based on gender roles, as can be noted ahead.

It needs to be someone I'm dating. Before it happens, first, I need to trust him and see if he likes me. If we're close (A1).

The boy has [sexual intercourse] for the sake of it, to do it in quantity. The girl does it because she likes the guy. It is different for the girls, their parents try to protect them more, the boys don't even tell their parents (A5).

The boy really wants it [sexual intercourse], because he's a man, he's a macho, he needs it. In school there are some guys who say with how many girls they did it, to show they're more man (A8).

Honestly for the boy to have sex it doesn't matter if he's just hooking up or dating, to me you don't need to be dating. If you're just hooking up it's fine. You don't need to have a commitment to the girl so you can have sex, you just need to feel attracted (A10).

The involvement in affective relationships worried the adolescents who participated in this study, which reflected a type of care for the other. In their statements, they reveal awareness of how important it is for them to use condoms so as not to infect their partners, and of the need to talk to them about their health condition. In addition, they highlighted the consequences that pregnancy could have on their lives, and all the responsibilities that come from it. The following statements support this description:

I have HIV, so I have the responsibility of using a condom. I can't give it to anyone else. I don't want her to get pregnant, if I'm studying I'll have to stop studying and start working. You need to have a commitment to the kid (A7).

I didn't want to be with him anymore, because I'm afraid of everything, of doing something wrong, that the condom will break and he'll catch it too, the HIV (A1).

I'd use a condom for her not to catch it, because I'm worried for her. I think that first of all, if you trust, you must tell it [about the HIV], because it's no use telling after you already did it (A5).

Sometimes I remember, sometimes she remembers, one of us always remembers. She asks me to do it without a condom, but I won't. I'm afraid that the condom will break. I don't want her to get sick with aids. I'm always thinking about that when we're doing it [sexual intercourse] (A14).

It was found that the adolescents had an internalized knowledge about the connection between sex and the risks of contracting some sexually transmissible infection, since they seemed to be quite aware of the need to protect themselves from other infections.

I'll wear a condom, because she might have other diseases. The one I have can be coupled with the one she has and become worse (A8).

At a party, for instance, I'll never know if she has some disease. The first time you look at a person you can't tell who has a disease and who doesn't. If I wear a condom and she has a disease, I won't catch it (A7).

You need to use it to protect yourself from other diseases, like gonorrhea and syphilis, and protect from pregnancy (A14).

Additionally, some teenagers mentioned the difficulties they or other friends who had never had sexual in-

tercourse have when managing the use of the condom during sexual relations. Such difficulties are related to the belief that both the masculine and the feminine method diminish sexual pleasure. The next statements exemplify this description:

The boys don't like to use condoms, I imagine it can be tight because of the elastic. But, with me, if they don't use it, it won't happen (A12).

It's not that they forget, they don't use it [condom] because they don't want to and that's it, because they think it's annoying to have that on their parts. Women's condoms are weird to use, that things is too big, bigger than the one for men. I think it's uncomfortable (A13).

They say it bothers, that it's tight. My friend told me that when she told him to put it on [the condom] he said he wouldn't, that he'd rather not, because it's annoying (A3).

Another meaningful issue was the fact that, though the teenagers know about the condom and recognize their importance, they do not use it in every sexual relation. This may come from an understanding of sex as something spontaneous, of the difficulty of bargain between genders, the lack of communication between partners and the establishment of stable relationships Follow below some statements that signal these findings:

Me and my boyfriend, we didn't use condoms. The first time we had sex he already knew about the HIV. We don't talk about it, he doesn't talk about, doesn't give me space to do so. He knows about the risks, but he doesn't like it, says pleasure is less. He didn't do the test, he says he's not prepared (A2).

Only once I didn't use it [condom]. I know I have to, but its bothering, because it makes the relationship colder. You need to start everything again when you stop what you're doing to put it on (A14).

Teenagers stated that their sexual initiation cannot be understood simply as their first sexual relationship, but as a path they are going through — a path that is not linear and has its own rules to be respected or refuted, with setbacks and advances, experimentation and choices. It was possible to identify that they were subjected to social norms that direct the construction of sexuality, largely influenced by gender relations.

Dilemmas lived to reveal the condition in affective relationships

Adolescents have described the need to trust in order to reveal their diagnostic, as can be seen in the following statements:

I'd need to know them very well to tell. If I got married, then I would tell, because it's a matter of respect, not fooling others. I'd have to trust a lot and it'd need to be someone I trusted a lot, that knew what the disease was, because it's not a monster (A12).

I needed sometime to tell. At first we hooked up a lot, kissed and dated a lot, and then I decided to tell. I always froze when I wanted to tell, when I told him I felt a lump in my throat. I told him my biological parents died when I was little. I opened up with him, I talked about HIV. He was the only one I told (A3).

I didn't tell my boyfriend yet, because we just met. You need to love and trust to tell. I'm afraid that if we break up he'll tell everyone. I never trusted anyone enough to tell (A9).

The prejudice, sometimes experienced, sometimes internalized, represented by the stigma, is reflected in the revelation of the diagnostic to affective and/or sexual partners. Therefore, adolescents face the challenge of imagining their future lives with the fear of been abandoned. The statements below exemplify this description:

People are very prejudiced, because they don't know, they don't know, people who don't have it don't know. It's on TV all the time, but they don't pay attention (A12).

If my mother in law had not meddled and told her [the girlfriend] I'd have. You need to have trust, courage and luck, because maybe she'll break up with me and tell everyone. Maybe I'll start to be alone (A14).

To tell, you must be dating and very seriously. Sometimes, we don't really know the girl when we're just hooking up and she may go around telling everyone. I'd be afraid she'd leave me because of it, because she'd be prejudiced against me (A10).

Some adolescents, on the other hand, found partners that supported them, which was shown by the incentive to correctly use the medication and by an acceptance of their health condition, as the next statements show:

I was afraid to tell the boy I was dating, but I didn't want to lie to him. I was always open to him. He said: I'll help you to take your medicine right the best I can. He gave me a lot of support, always told me to take care of myself (A3).

I told him and he accepted me as I am. I told him when we started dating. I was very afraid to tell him, that he'd do something to me, he'd do something bad to me (A2).

A worrying situation identified in this study were situations in which the family revealed the diagnostic to the partners of the teenagers. This situation was reported with discontent and revolt by the adolescents, as shown below:

It was my mom who told my girlfriend. She went to her parents' house [the girlfriend's] and the first thing she said was: he has HIV. She said that even knowing that nothing would change, that she liked me and she'd support me (A14).

My stepfather told him [the boyfriend]. I didn't want him to know like that. When he found out I was afraid he'd leave me. Luckily my boyfriend accepted it. (A11).

Managing this health condition in affective relationships is one of the issues that defined these teenagers' daily lives. Even when dating, most adolescents chose not to immediately reveal their diagnostic, afraid of rejection. Some, however, found partners that gave them support.

■ DISCUSSION

The adolescents' statements highlighted different forms of relationship they experienced in their daily lives, characterized as "hooking up" and "dating". These modalities, clearly distinguished for the teenagers, may develop both in relationships based on mutual fidelity and the feeling of trust, and in those which are basically instant and ephemeral, without continuity or further development in the lives of these adolescents.

Such affective interactions signal, especially, the will to relate in a personal way and be open to experimentation⁽¹¹⁾. It is through these interactions that adolescents that live with HIV/AIDS confront their limitations and act according to the opportunities presented to them, in a continuous process of knowing oneself and the other, as well as of building autonomy⁽¹¹⁻¹²⁾.

In the affective relations characterized as hooking up, it is not common for a bond to be established between the teenagers, which, mostly, are separated afterwards with no perspective of doing it again⁽¹³⁾. Dating, on the other hand,

seems to occupy a more profound dimension in the lives of these adolescents, since, in addition to kisses and hugs, this experience leads to commitment and to the experience of sexual initiation⁽¹³⁾.

The experience of a sexual relation is understood by adolescents with HIV/AIDS as a passage rite for their adult lives, and the ideal moment would be related to the "feeling" of maturity. For that to take place, the sexual initiation of these adolescents makes them the writers of their own actions, requiring responsible attitudes, decision making, and consequently, the taking of responsibility for decisions, all of which puts them in a universe where they are more mature. Such findings corroborate the results of a research conducted with Canadian adolescents who live with this condition⁽¹²⁾ and consider more maturity needed to experience their first sexual relationship.

Among teenagers who live with HIV/AIDS, sexuality also presents itself as one of the spheres where the acquisition of individual autonomy in relation to the family of origin takes place. In this stage, representations, values and behaviors regarding sexuality and the gender roles are structured, as boys and girls start to experiment affective relations that make their connections go beyond the confines of their families⁽¹²⁾.

It can be noted that, within the families of these adolescents, sexuality is understood from a reproductive dimension. The boys are stimulated to act more liberally regarding their sexual initiation, while the girls are kept away from this knowledge and are stimulated to preserve their virginity. It is important to highlight that the different behavior of parents or caretakers when it comes to the education of girls and boys directly interferes in the way in which their identities are being built, as well as in the posture they assume in relation to sexuality.

Such disciplinary discourses, focusing on gender issues, have also been noticed in a research conducted with adolescent girls in the south of Brazil⁽¹⁴⁾, in which teenagers reported that their families treated sexuality very differently when talking to boys than they did when talking to girls. That implies in a higher level of control and regulation exerted by parents to adolescent girls, in addition to giving less freedom to them in daily activities.

Sexuality is still a very repressed theme in society, and the repression in the education about the theme, since childhood, results in "knots" that entangle and make its experience increasingly more difficult. Adolescents showed fear of talking to their parents or caretakers about their affective relations, which leads them to hide facts, to not talk about their doubts, and to hold themselves from certain experiences⁽¹⁵⁾.

That said, when parents do not recognize the experiences of their children with sexuality, they waste opportunities to talk to them about the theme, clarify doubts and provide open spaces for communication⁽¹⁶⁾. Additionally, censoring or being indifferent to the sexuality of these adolescents can increase the chances of unsafe sexual practices, since there is no guidance or the little there is, is based on inadequate information that makes the teenagers vulnerable.

This vulnerability is increased when related to another aspect brought to discussion by the adolescents in this study, according to which not all of them use condoms in all sexual relations, although they are aware of the risks to which they are exposed. This indicates that they understand the information they were given through the lens of social and cultural influences, leading to actions that are different to those proposed by, among others, the health services. Therefore, it is evident that the use of these pieces of information depends, among other factors, on the affective involvement of the moment, on the access to methods, as well as on the level of liberty and autonomy people have in this age group^(4,17).

A similar study indicated that, although teenagers who lived with HIV/AIDS were aware of the importance of the condom, they felt tempted not to use it. To these adolescents, the spontaneity of the relation and the moment itself are factors that make the use of the method more difficult. In addition, they felt that the use of the condom limited intimacy, creating a distance between them and their partner, as well as working as a constant reminder of their health condition⁽¹²⁾.

In regard to the aspects related to revealing the diagnostic to affective partners, this was shown to have a high complexity for the teenagers. If, on one hand, they recognize it as necessary to protect their partner from the possibility of being infected by the virus, on the other, revealing their condition and being discriminated is a possible outcome that would bring them suffering. The result of this process is that they only tell when they feel they can trust the relationship. Thus, the threat that discrimination represents and the stigma regarding their condition ends up delaying the decision of revealing the problem to the partner. It is interesting to note that, considering the knowledge of teenagers, they assume that those who love them will not abandon them when they reveal their condition.

Considering that, divulging this information is not a simple act. On the contrary, it is a careful analysis of when and to whom reveal it, and depends on previous preparations of a personal decision⁽¹⁸⁾. International researches, consonant to this, revealed that divulging to partners that

one has HIV/AIDS is a complex and challenging issue^(5,7). Adolescents feel trapped between the desire to share the secret, the guilt for hiding the truth, and the fear of being rejected^(5,12,19). A study has shown that feelings of trust and attachment, for teenagers, develop with time and are essential elements to discuss the condition of HIV⁽¹²⁾.

It is interesting to note that fearing rejection leads to isolation and suffering, in addition to delaying the revelation to current and future partners and making it more difficult. In consideration to that, the fear of the stigmatization and discrimination associated to HIV is described as some of the most relevant factors that prevent people from divulging their disease to sexual partners. Dealing with the risk of losing a partner in the context of an affective relationship involves risk management, not only of the potential transmission of HIV, but especially for the possibility of rejection^(5,7).

It can be understood from the statements that some adolescents have ventured to reveal their diagnostic to their affective-sexual partners, filled with fear regarding rejection and desiring affective experiences with no secrets or omissions. Teenagers mostly wish for the revelation of their diagnostic to their partner to take place with affection, love and support.

Additionally, one cannot ignore how worried the adolescents are about having their diagnostic revealed to their partners by their families⁽²⁰⁾. According to their statements, the adolescents did not ask for any help in revealing their diagnostic, meaning that the relatives disrespected their autonomy and liberty, violating their right to keep their diagnostic a secret.

This can be a result of the preoccupation of relatives or caretakers with the "problems" that result from sexuality, understanding the beginning of sexual-affective experiences as an imminent risk. Their preoccupation with the reproductive lives of teenagers are tightly related to issues such as transmitting the disease. Therefore, they understand that revealing this condition to the partners of the teenagers is paramount, and therefore, increase the distance between themselves and these adolescents, wasting an opportunity to talk to them about the many constructs that are involved in the learning of sexuality in this stage of one's life.

Towards this end, it would be interesting for nurses to invest in spaces of dialogue that incorporate both affective partners and the family of these adolescents, to support them in their dilemmas and anxieties. In addition, nurses should establish channels of communication about the issue of sexuality with the other instances involved with the care and education of adolescents, such as school, for instance.

In order to approach the theme of sexuality with adolescents, the nurse needs to understand that this conversation is not the mere explanation about organic sexual development, and should also include the experiences of these teenagers. In this occasion, the role this professional can have in health education practices with this public is highlighted, especially when it comes to stimulating their autonomy.

■ FINAL CONSIDERATIONS

Learning about sexuality is not only accessing information about it. It results mostly from different experiences, and from the different moments and settings in which they take place.

The first affective interactions described by the teenagers were experienced through “hooking up” and “dating”, and are possibilities for acquiring self-knowledge and building autonomy. These relationships were considered as highly different by the adolescents, and were strongly influenced by the values attributed to gender differences.

Sexual relations result from the affective dimension of relationships in which liking and trusting were present. Gender issues interfered in interesting ways in the decisions that surround the initiation of this practice. Getting involved in such practices was not without worries for some adolescents, as they feared infecting their partners. Such issues deserve a careful look, since they generate doubts, fears and uncertainty for the teenagers.

Managing this health condition in affective relationships is one of the issues that defined these teenagers' daily lives. Even when dating, most adolescents chose not to immediately reveal their diagnostic, afraid of rejection. Others, however, found partners that gave them support.

Conducting this study meant dealing with several challenges, since the theme is complex and polemic, difficult to be discussed with this group. The limitations of this study include the difficulty to approach the theme, which is delicate, since talking about sexuality can lead to the manifestation of feelings such as shyness, unease and embarrassment.

In the sphere of assistance, health professionals are suggested to be more sensible when welcoming these patients, in order to bond with them and improve the spaces of attentive listening, making them free from prejudice and moral condemnation of experiences related to the sexuality of the teenagers that have this condition. When it comes to teaching, this study suggests the inclusion of sexuality as a cross-sectional theme in the syllabuses of health-related courses. Additionally, with regards to this research, new studies on the theme are suggested, that contemplate other regions of the country, from a perspective that goes

beyond the biological dimension, since this theme, when considered in its broader influences, has effects on the cultural identity and on the experience of sexual roles.

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