MORTALITY AWARENESS AND RISK-TAKING IN LATE ADOLESCENCE

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The relationship of mortality awareness to sexual, drug, and athletic risk-taking by male and female college students was measured using two questionnaires. Regression analyses of Study 1 data revealed: (a) significantly greater sexual risk-taking among males \( (n = 68) \) than among females \( (n = 119) \) \( \beta = -0.20, p < .01 \); (b) a significant negative relationship of mortality awareness to sexual risk-taking in males, \( \beta = -0.36, p < .01 \); and (c) no relationship of mortality awareness to reported drug use or athletic risk-taking. Regression analyses of data from Study 2, which included only male subjects \( (n = 40) \), revealed that initial mortality awareness was significantly related to sexual risk-taking \( \beta = -0.33, p < .05 \), but that manipulated awareness of death did not affect willingness to take sexual risks. It was suggested that mortality awareness may reduce the taking of risks that present nonsalient consequences, and that the consequences of risky sexual behavior may be less salient for males than for females.

The emotional torments undergone by Goethe's young Werther and by Salinger's Holden Caulfield exemplify the adolescent's belief in the uniqueness of his own emotional experience. At a somewhat different level, this belief in personal uniqueness becomes a conviction that he will not die, that death will happen to others but not to him. (Elkind, 1967, p. 1031)

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There is abundant evidence that individuals in their teens and early twenties engage in more risky behaviors than older adults. In this country, adolescents aged 16–19 are at the highest risk for experiencing fatal or serious-injury automobile accidents (Tonkin, 1987); in fact, car accidents are the leading cause of death among people aged 16–24 (Arnett, 1990a). An estimated 30% of sexually active adolescents are afflicted with a sexually transmitted disease other than AIDS (Biglan et al., 1990), and an estimated 20% of current AIDS victims were infected during adolescence (Henggeler, Melton, & Rodriguez, 1992). Currently, two out of three teenagers say they have started drinking alcohol by the ninth grade (Goleman, 1993), and adolescents have the highest rate of use of almost every type of illegal drug (Arnett, 1992).

Yet why young people so commonly engage in behaviors that endanger their lives and well-being is unclear. Although environmental factors, such as poverty and lack of family support, have been linked to adolescent involvement in risky activities (Biglan et al., 1990; Furby & Beyth-Marom, 1992), much evidence indicates that college students, who are relatively privileged, also take chances with their lives and health. For instance, there is a high rate of unsafe sexual activity among undergraduates: Strader and Beaman (1989) found that although over 90% of a sample of sexually active college students knew that condom use reduces HIV transmission, only 40% had ever used one; and in a study by DiClemente, Forrest, and Mickler (1990), 37% of sexually active heterosexual college students reported never having used condoms, and only 8% reported using them every time they had intercourse.

One explanation of youthful risk-taking focuses on adolescent egocentrism: Elkind (1967) theorizes that an adolescent's belief in personal uniqueness can cause feelings of invulnerability to negative outcomes. He suggests, for example, that an adolescent female may fail to use contraceptives because she believes that pregnancy is a threat to others, but not to her. Although this theory is intuitively plausible, there is actually a greater amount of evidence that adults are prey to illusions of invulnerability than that adolescents are (Quadrel, Fischoff, & Davis, 1993). Moreover, although some studies indicate a relationship between youthful egocentrism and youthful risk-taking, others do not: for example.
Arnett (1990b) found that adolescent females who engaged in sex without contraception tended to estimate their chances of becoming pregnant under those conditions as lower than did adolescent females who consistently used contraception; Moore (1991) and Zuckerman (1994), however, found that there was an overall tendency for sexually active adolescents to accurately perceive their risk of contracting AIDS as greater when they were, in fact, taking sexual risks, such as engaging in unprotected intercourse or having multiple partners.

Elkind proposes that, at a deeper level, adolescents feel invulnerable to the most dreadful possible consequence—death—and take risks because they believe they are immortal. Research results to date, however, indicate the absence of a relationship between risk-taking by young or mature adults and attitudes toward death. Alexander and Lester (1972) found that parachute jumpers and college student controls reported equal amounts of death fear. Berman (1973) found no relationship between death anxiety and cigarette smoking, in a college student sample. McDonald (1976) found no relationship between reported risky-choice preference and death anxiety. Warren (1981–82) compared death fear, death acceptance, and other death attitudes among groups of subjects who were employed in mortality-related occupations, involved in death-defying activities, or uninvolved with death—and found no differences. Finally, Thorson and Powell (1990) discovered no relationship between death anxiety and self-reported participation in risky behaviors such as motorcycle riding and scuba diving.

It is possible, however, that because many individuals simply do not think about death during the course of their daily lives, mortality-related affect has little influence on their behavior. To my knowledge, the relationship between general mortality awareness (willingness to think about death) and risk-taking has been investigated only once. Feifel and Nagy (1980a, 1980b) asked middle-aged subjects with varying lifestyles (e.g., alcoholics, violent-crime convicts, and government workers) to report how frequently they thought about death. Half of the sample reported either that they never or that they rarely thought about death, and their responses did not vary with apparent riskiness of lifestyle.
In the present studies, college students were asked several questions regarding their willingness to think about death, and were also asked about their readiness to engage in a variety of specific risky activities. Although the Feigel and Nagy results indicate no relationship between frequency of death-related cognitions and riskiness of lifestyle, mortality awareness possibly does play a role early in life, when risky or safe patterns of behavior are developing. Moreover, although there is little support for Elkind’s proposition that feelings of invulnerability and immortality characterize adolescence as a special developmental stage, it is possible that willingness to cognitively engage with death distinguishes youths who forgo risks from those who take them.

Study 1 consisted of three substudies, employing slightly varying questionnaires and similar subject samples. Male sample sizes for two of the substudies were small; hence, data for all three subsudies were standardized and combined for analysis. In each sub-study, two questionnaires were employed to measure, respectively, mortality awareness and risk-taking. It was tentatively hypothesized that a higher level of mortality awareness would be associated with a lower level of reported risk-taking overall.

**Study 1**

**Method**

*Subjects.* Sixty-eight male and 119 female undergraduates at the University of Washington participated in exchange for psychology course credit. Data for 2 subjects were incomplete and not included in any analyses, leaving a final sample of 187.

*Materials and Procedures.* Each subject filled out two questionnaires, counterbalanced for order. One questionnaire, the Klug Death Acceptance Scale, was designed to measure the “deliberate, intellectual acknowledgement of the prospect of one’s own inevitable death, and the positive emotional assimilation of the consequences” (Klug and Sinha, 1987–88, p. 230). The 16 Death Acceptance Scale items were invariant across the three substudies.
The other questionnaire included a number of items from the Sensation Seeking Scale (SSS) (Zuckerman, 1971) and some additional items measuring participation in risky athletic, sexual, or drug use behaviors. The modified SSS used in Substudies 1 and 3 included 57 items, and the modified SSS used in Substudy 2 included 90 items. Eleven items measuring athletic risk-taking, 4 measuring sexual risk-taking, and 2 measuring drug use were common to all three substudies, and were combined into subscales, as described below.

Both questionnaires were divided into subscales. A Mortality Awareness Subscale was developed by combining the four Death Acceptance Scale Items (4, 13, 14, and 16) that concerned willingness to think about death. Item 4, for example, read as follows: "I make a conscious effort to avoid dwelling on the thought of death." Subjects indicated agreement or disagreement with each item by circling a number from 1 to 4. This subscale had not been used by previous researchers, but a Cronbach's alpha of 0.71 indicated that its reliability was acceptable.

The modified Sensation Seeking Scale, which presented forced-choice pairs, such as "I would never have unprotected sex outside of a committed monogamous relationship," versus "I have had or would have unprotected sex outside of a committed monogamous relationship," was also subdivided on an a priori basis: an Athletic Risk Subscale was created by combining items concerning willingness to climb mountains, water-ski, bungee-jump, fly an airplane, hang-glide, parachute, swim in the ocean, dive, use a motorcycle, sail, and downhill ski; a Sexual Risk Subscale was created by combining items concerning boredom with a single sexual partner, interest in having multiple sexual partners, engagement in unsafe sex, and engagement in unplanned sex; and a Drug Risk Subscale was created by combining items concerning the use of marijuana and hallucinatory drugs. The remaining items concerned attitudes and behaviors that were related to preference for variety and interest in novel experiences, rather than to risk-taking, and were included as filler material.

The modified SSS included some original SSS items, some new items, and some rewordings of original SSS items. Items concerning swimming, diving, skiing, and sexual boredom were taken verbatim from the SSS. Items concerning bungee-jumping,
TABLE 1  Zero-Order Correlations among Study 1
Standardized Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mortality awareness</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Sexual risk</td>
<td>-.16*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Drug risk</td>
<td>.07</td>
<td>.35**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Athletic risk</td>
<td>.13</td>
<td>.03</td>
<td>.21**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Subject gender</td>
<td>.07</td>
<td>-.21**</td>
<td>.04</td>
<td>.02</td>
<td></td>
</tr>
</tbody>
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*Note.* Sex is coded as a dummy variable (1 = Male; 2 = Female).
*p < .05.  **p < .01.

hang-gliding, multiple partner sex, unsafe sex, and unplanned sex were newly developed, and had not been used in previous research. The remaining items were rewordings: for example, SSS item 69A, “Sailing long distances in small sailing crafts is foolhardy,” was reworded as: “I would not like to sail a long distance in a small boat.”

Results

Descriptive Data. Data were standardized and combined across the three substudies. Zero-order correlations among mortality awareness, athletic risk, sexual risk, drug risk, and gender of subject are presented in Table 1. As Table 1 shows, there was a significant, albeit modest, negative correlation between mortality awareness and sexual risk-taking, whereas mortality awareness was not significantly correlated with either athletic risk-taking or drug use. There was also a significant correlation between gender and sexual risk-taking, indicating that males were more likely than females to report sexual risks. Drug use was positively correlated with both sexual and athletic risk-taking.

Main Analyses. The combined standardized data were subjected to a series of hierarchical regression analyses, in which the risk subscale scores were included as dependent variables, while gender and mortality awareness were treated as independent variables. The product of gender and mortality awareness was entered
TABLE 2  Predicted Values for Study 1 Standardized Sexual Risk Scores

<table>
<thead>
<tr>
<th>Mortality Awareness</th>
<th>Male (n = 68)</th>
<th>Female (n = 119)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0.50</td>
<td>-0.25</td>
</tr>
<tr>
<td>High</td>
<td>-0.14</td>
<td>-0.14</td>
</tr>
</tbody>
</table>

last so that the amount of variance determined by the interaction was assessed after main effects were controlled for.

There were significant main effects of both mortality awareness (β = −.15, p < .05) and gender (β = −.20, p < .01) on sexual risk-taking; and the interaction effect on sexual risk-taking was also significant, β = −.30, p < .01. Follow-up regression analyses indicated that for males, mortality awareness was significantly associated with sexual risk-taking (β = −.36, p < .01), whereas for females (β = .00, n.s.), the relationship between mortality awareness and sexual risk-taking was not significant. Predicted values for sexual risk-taking by high and low mortality-aware males and females were computed from the equation Y = constant + [B1 × (M1 ± SD1) + B11 × (M11 ± SD11)] + [B1×11 × (M1 ± SD1) × (M11 ± SD11)], with I equaling mortality awareness, II equaling gender, and I × II equaling the mortality awareness × gender interaction; as the values make clear (see Table 2), males were more likely than females to express willingness to take sexual risks, and sexual risk-taking in males decreased with increasing mortality awareness.

Hierarchical regression analyses revealed no main effects of mortality awareness or gender on reported drug use. However, the interaction effect on drug use was significant, β = −.25, p < .05. Follow-up analyses revealed that for males, mortality awareness was not significantly related to drug risk-taking (β = −.14, n.s.), whereas for females, there was a significant association between mortality awareness and drug use (β = .18, p < .05). Table 3 shows predicted values for drug risk-taking in high and low mortality-aware males and females. It is evident that for females, mortality awareness was positively related to use of drugs.
TABLE 3 Predicted Values for Study 1 Drug Risk Scores

<table>
<thead>
<tr>
<th>Mortality Awareness</th>
<th>Male ((n = 68))</th>
<th>Female ((n = 119))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0.03</td>
<td>-0.20</td>
</tr>
<tr>
<td>High</td>
<td>-0.12</td>
<td>0.26</td>
</tr>
</tbody>
</table>

Discussion

In summary, these results indicate that although males are more likely than females to report the taking of sexual risks, athletic risk-taking and drug use are as likely to be acknowledged by females as by males. They also show that increased mortality awareness is associated with decreased sexual risk-taking in males, but not in females; and with increased drug use in females, but not in males.

The observed relationships between the variables may be non-causal, but even if it is assumed that mortality awareness has effects on risk-taking, we are left with a question: Why do these effects vary with type of risk and with gender? One possible explanation is that salience of risk varies with activity and with gender. Unsafe heterosexual sex, for instance, presents only long-term risks (such as that of contracting a sexually transmitted disease) to males, but may present imminent, as well as long-term, risks to females: Herold and Mewhinney (1993) found that women at a singles bar reported considerably greater concern about the risk of physical harm from a partner than men did. Females, then, may avoid unsafe sex, no matter what their level of mortality awareness, because the potential hazard is quite salient to them; whereas males may avoid unsafe sex only if they are high in mortality awareness, because for them the risk is easily ignored.

A risky athletic activity, on the other hand, may present an immediate hazard to high and low mortality-aware individuals of both genders. Parachuting, for instance, is likely to evoke a strong visceral feeling of danger, no matter what the individual's baseline level of mortality awareness.

Drug use presents both short-term and long-term risks to both males and females, yet also, paradoxically, can create feelings of
bodily relaxation and security. Because drug-induced intoxication increases a female's vulnerability to sexual assault (Finley & Corty, 1993; Miller & Marshall, 1987; and Muehlenhard & Linton, 1987), however, drug use by females may involve a greater degree of deliberate acceptance of risk than drug use by males. In one study, female undergraduates did, in fact, report greater perceived risk associated with drug and alcohol use than male undergraduates did (Spigner, Hawkins, & Loren, 1993).

It is difficult to explain why high mortality-aware females were more likely than low mortality-aware females to report drug use, but possibly the former were deliberately courting danger when using drugs rather than simply ignoring the risks involved. Unfortunately, this argument can be neither supported nor disconfirmed by existing literature, as there has been little empirical work on the issue of gender differences in motivation for risk-taking during adolescence.

**Study 2**

Because condom use is a primary means of reducing risk during a sexual encounter, it can be argued that the level of safety of a sexual situation is more likely to be determined by the attitude of the male partner than by the attitude of the female partner. The Study 1 finding that males are more willing than females to take sexual risks is, then, particularly troubling. Study 2 was conducted in order to determine if increasing the level of death awareness in low mortality-aware males can cause them to reduce their involvement in sexual risks.

Only male subjects participated in Study 2. Mortality awareness was first measured as a personality variable, and subjects later received a manipulation designed either to increase or to leave unaffected their initial level of mortality awareness. Dependent variables were self-reported intentions of engaging in sexual, drug, and athletic risks in the near future.

It was hypothesized that low mortality-aware subjects in the control group would express greater willingness to take sexual risks than would high mortality-aware control subjects; whereas both low and high mortality-aware subjects receiving the mor-
tality awareness treatment would express low sexual risk-taking intention.

No predictions were made regarding the effect of manipulated mortality awareness on drug and athletic risk-taking.

Method

Subjects. Forty-one undergraduate males, aged 25 or younger, participated in exchange for psychology course credit. Twenty-one subjects were randomly assigned to the Control condition, and 20 subjects were randomly assigned to the Death Awareness condition. Because one subject in the Death Awareness condition failed to complete some questionnaire items, his data were omitted from some analyses.

Materials and Procedures. All subjects first completed the Klug Death Acceptance scale, so that their initial level of mortality awareness might be assessed, using the same items as made up the mortality awareness subscale in Study 1. Control subjects then completed a questionnaire that asked them to rate the extent to which they valued 10 different aspects of undergraduate life at the University of Washington (e.g., location of the campus); and how much they would miss each of 10 experiences associated with the University of Washington (e.g., participating in a fraternity) if they were to transfer to another school. Death Awareness subjects, on the other hand, completed a questionnaire that asked them to rate the extent to which they valued 10 different aspects of life (e.g., spending time with family); and how much they would regret not having the opportunity to undergo each of 10 experiences (e.g., marriage) if their lives were cut short.

Subjects in both conditions then completed a 55-item modified Sensation Seeking Scale, which asked them to indicate their willingness in the near future to engage in various activities. The Sexual Risk Subscale of the modified Sensation Seeking Scale comprised four newly developed items concerning willingness to participate in sex with a stranger; interest in having more than one sexual partner at a time, willingness to have unsafe sex, and willingness to have unplanned sex. The Drug Risk Subscale included four modified SSS or newly developed items concerning
interest in use of cigarettes, marijuana, hallucinatory drugs, and alcohol. And the Athletic Risk Subscale included 10 modified SSS or newly developed items concerning interest in mountain climbing, water-skiing, bungee-jumping, flying a plane, hang-gliding, parachuting, swimming in the ocean, motorcycle riding, sailing, and downhill skiing.

Results

Preliminary Analyses. Scores on the Control and Death Awareness questionnaires had possible ranges of 20 to 100. Three subjects in the Control condition and two in the Death Awareness condition failed to complete the questionnaires. A t-test revealed that the Death Awareness questionnaire mean score of 75.76 (SD = 9.32, n = 17) was significantly higher than the Control questionnaire mean of 66.33 (SD = 10.11, n = 18), indicating that general life experiences were valued significantly more than University of Washington experiences (t = 2.86, p < .01). Death Awareness and Control questionnaire scores were correlated significantly with initial mortality awareness scores (rs = −.34, and −.42, respectively, ps < .05), indicating that low mortality-aware subjects valued life experiences and University of Washington experiences more than did high mortality-aware subjects.

Descriptive Data. Possible ranges for sexual, drug, and athletic risk subscales were 0 to 4, 0 to 5, and 0 to 10, respectively. Mean sexual, drug, and athletic risk scores were similar for the two conditions: Control group means were 0.93 (SD = 1.10), 0.76 (SD = 0.77), and 5.95 (SD = 2.67), respectively, all ns = 21; whereas Death Awareness group means were 1.00 (SD = 1.37, n = 19), 0.80 (SD = 1.15, n = 20), and 5.95 (SD = 3.24, n = 19), respectively. The mortality awareness subscale had a possible range of 4 to 16, with the Control group mean equaling 8.07 (SD = 2.25, n = 21) and the Death Awareness group mean equaling 8.95 (SD = 2.48, n = 20).

Correlations among mortality awareness, sexual risk, drug risk, and athletic risk were computed separately for the two conditions. For the Control condition (n = 21) there was a significant positive correlation of sexual risk score with drug risk score (r =
.69, p = .001). No other correlation was significant, although, in accordance with Study 1 results, for both the Control and the Death Awareness conditions the correlations between mortality awareness and sexual risk-taking were negative ($r = -.32, n = 21$; and $r = -.34, n = 19$, respectively).

**Main Analyses.** Study 2 data were subjected to a series of hierarchical regression analyses, in which the risk subscales were included as dependent variables, while mortality awareness score (as measured by the Klug scale) and manipulated death awareness were treated as independent variables. The product of initial and manipulated mortality awareness was entered as an interaction factor during the second step of each analysis.

The hypothesized interaction effect of initial and manipulated mortality awareness on sexual risk-taking was not found. However, there was a significant main effect of initial mortality awareness on reported sexual risk-taking, such that higher mortality awareness scores were associated with a lower reported intention of engaging in risky sexual behaviors, $\beta = -.33, p < .05, n = 40$. There was no main effect of manipulated mortality awareness on sexual risk-taking, and there were no main or interaction effects on reported drug use or athletic risk-taking.

**Discussion**

Study 2 results indicate that low mortality-aware males are more likely than males high in mortality awareness to intend future sexual risk-taking. The death awareness manipulation failed to moderate the relationship between initial mortality awareness and intended sexual risk-taking, however: Low mortality-aware subjects in the Death Awareness group were as likely as those in the Control group to score high on the sexual risk subscale. Unfortunately, as a manipulation check was not performed, it is not clear whether the manipulation failed to increase death awareness, or whether mortality awareness has no causal relationship with intended sexual risk-taking.
General Discussion

Study 1 examined the correlations between mortality awareness and three types of risk-taking (sexual, drug, and athletic) by male and female college students. Main findings were as follows: (a) Males reported higher sexual risk-taking than females did, (b) mortality awareness in males, but not in females, was negatively associated with sexual risk-taking, and (c) mortality awareness in females, but not in males, was positively associated with drug risk-taking. These results led to the hypothesis that high mortality awareness is associated with reduced participation in behaviors that have easily ignored adverse consequences.

As in Study 1, in Study 2, mortality awareness and various types of risk-taking were measured. But in Study 2, half of the exclusively male subjects also received a manipulation designed to increase death awareness. The results of Study 2, like those of Study 1, indicate that high mortality-aware males are less likely than low mortality-aware males to take sexual risks. However, contrary to prediction, the death awareness manipulation used in Study 2 had no effect on sexual risk score.

The absence of a manipulation check in Study 2 is a major limitation of the current work, and one that future researchers should avoid. Although the observed relationship between mortality awareness and sexual risk-taking in males may be noncausal, it is also possible that reminding young males that premature death obviates future life experiences is not a sufficiently strong manipulation of death awareness.

A second major limitation of the current studies is the self-reported nature of the data. Some risky activities (such as unsafe sex and drug use) are difficult to measure objectively: nonetheless, a useful goal of future research would be to determine if mortality awareness is associated with actual as well as with merely reported risk-taking.

Despite its limitations, this work raises some questions that future researchers might wish to address:

1. Although previous investigators found no relationship between death anxiety and risk-taking, the present findings indicate that willingness to think about death may be re-
lated to risk-taking. What is the association between mortality awareness and other death attitudes? For example, does low mortality awareness indicate genuine indifferences to the thought of death, repressed death fear, or some other affective state?

2. Although there is little empirical support for Elkind’s thesis that adolescent risk-taking results from feelings of immortality which characterize adolescence as a developmental stage, the present results indicate that unwillingness to think about death may characterize some young people who take certain kinds of risks. Does mortality awareness increase with age? And how does mortality awareness relate to risk-taking by mature adults?

3. The current results show a moderating effect of gender on the relationship between mortality awareness and sexual risk-taking. It is argued that low mortality awareness is associated with reduced participation in activities that have potential long-term but not short-term hazards; and that sexual activity presents both long- and short-term hazards to females, but only long-term hazards to males. Are there, in fact, gender differences in the perception of various risky activities during late adolescence? Is low mortality awareness associated with nonsexual activities, such as cigarette smoking and consumption of fatty foods, that also can be categorized as representing long-term hazards?

This work also may have some practical implications. If a causal relationship between mortality awareness and youthful risk-taking is ultimately established, it might be exploited as part of an intervention program to reduce problem behaviors. For example, lack of mortality awareness may indicate a general unwillingness to consider possible negative consequences. Many negative outcomes, such as an unwanted pregnancy, an arrest for drunk driving, or the contraction of a sexually transmitted disease other than AIDS, can be survived; hence, even direct experience with an unfortunate consequence of a risky decision may not serve to increase an adolescent’s future caution. However, if a trouble-prone young person were counseled to practice envisioning his or her future life in its entirety, including its eventual
termination, he or she might develop the habit of anticipating the potential costs of risky activities, rather than focusing exclusively on their perceived present benefits.

Van der Pligt and Richard actually used a similar treatment in their 1994 study of adolescent condom use. Control subjects were asked to describe their feelings about unprotected sex, whereas treatment subjects were induced to describe the regret they would experience after having engaged in unprotected sex. Follow-up data indicated that males in the anticipated regret condition reported significantly higher rates of condom use than did males in the control group, although reporting rates for the two female groups did not differ.

The low mortality-aware adolescent knows that death will eventually happen to him or her, as well as to others, but may simply not anticipate its occurring as a result of a risky action. Accentuating positive potentialities may well be an adaptive strategy for young people, who must embrace change and uncertainty if they are to take the steps necessary for achieving adult status. But failing to foresee negative outcomes may tragically halt or abort their march to maturity.

References


