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Adolescent Sexuality

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Educational Gap

Adolescent sexuality has undergone many changes, with adolescents now reaching physical maturity earlier, and a number of guidelines exist to help the clinician deal with adolescent sexuality.

Objectives After completing this article, readers should be able to:

1. Understand how sexuality develops during adolescence.
2. Know the elements involved in counseling parents about their children's emerging sexuality and how to educate them.
3. Understand how clinicians can help their patients to understand and deal with their sexuality, including matters of pregnancy and sexually transmitted diseases.
4. Know that adolescents who have developmental delays or chronic medical conditions might require special approaches when the clinician deals with their sexuality.
5. Understand the elements of and approaches to emerging homosexuality, including knowledge of the implications of transient heterosexual and homosexual experimentation.

Introduction

Adolescence is a transitional stage of physical, emotional, and cognitive human development occurring before the onset of puberty and ending by adulthood. Sexuality, the expression of interest, orientation, and preference, is a normal part of adolescence. Adolescent sexuality encompasses multiple factors, such as developing intimate partnerships, gender identity, sexual orientation, religion, and culture.

Adolescent sexuality has changed over the past 50 years, with adolescents now reaching physical maturity earlier and marrying later. Puberty marks the obvious physical development in early to middle adolescence and is seen as the time for potential onset of sexual thoughts and experimentation. On average, middle adolescence is a time when teens begin to be interested in more intimate relationships and experimentation. Parental and societal concerns regarding premature sexual activity include unplanned pregnancy, sexually transmitted infections (STIs), sexual abuse, and potential emotional consequences of sexual behaviors. These concerns underscore the importance of providing adolescents with preventive health services and comprehensive sexual health education.

Adolescent Development and Sexual Behavior

Approximately 10 years ago, new guidelines published in *Pediatrics* advised that girls who start to develop breasts and pubic hair at age 6 or 7 years are not necessarily abnormal. (1) The guidelines were based on a number of studies, the most important being the trial by Herman-Giddens et al (2) of 17,000 girls between the ages of 3 and 12 years who were patients in more than 200 pediatricians' offices across the country. Published in 1997, the report was based on girls evaluated in 1992 and 1993. Previous norms for puberty

Abbreviations

ASHCN: adolescents with special health-care needs
CDC: Centers for Disease Control and Prevention
HIV: human immunodeficiency virus
HPV: human papillomavirus
STI: sexually transmitted infection

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were based on a study of fewer than 200 girls in a British orphanage in the 1960s. (3)

The obesity epidemic has been postulated as the likely cause of earlier onset of puberty. However, a recent Danish study reported that Danish girls were developing breasts at an earlier age than they were 15 years ago. (4) The study found that the onset of puberty (as measured by breast development) dropped from a mean age of 10.9 years in 1991 to 9.9 years in 2006. This change was not due to obesity, because the girls' BMI remained constant across the study periods. Other possible explanations for earlier puberty include environmental factors, socioeconomic conditions, nutrition, and access to preventive health care. Girls tend to move through adolescence earlier than boys. The stages for both sexes are the same and are divided into early, middle, and late adolescence.

Early Adolescence

Earlier onset of puberty leads us to question whether adolescence starts with puberty, because the other aspects of adolescence often are not present before the age of 10 years. In general, the early adolescent experiences physical changes, attempts to adjust to the changes, and often wonders if they are normal. Children at this stage are self-preoccupied and concerned about body image and privacy. These privacy concerns evolve into some separation from family and an increased focus on relationships with peers and group activities. Concrete thinking continues from childhood, but abstract thinking starts to develop, especially in less personal areas, such as academics. (5)

Although early adolescents may begin to experiment with their sexuality (particularly with sexual fantasy and masturbation), sexual intercourse is not common. Homosexual and heterosexual experimentation is common in early adolescence. If an adolescent has had sex with someone of the same sex, this experience does not mean that the teen is gay. It is important to note that many gay teens have never had a sexual experience with someone of the same sex, and that "teens who will eventually identify as gay, lesbian or bisexual do not always do so during adolescence." (6)

Attraction occurs in late childhood/early adolescence and can precede or occur concurrently with a first romance or first sexual experience. It is not uncommon for adolescents to experience same-sex attractions; in fact, most gay youth experience opposite-sex attractions, sometimes before same-sex attractions. Previous studies report that more than 80% of same-sex-attracted girls

and 60% of the boys acknowledged opposite-sex attractions. Boys reported that the onset of heterosexual attractions happened around the same age as same-sex attractions and occurring on average 1 to 2 years earlier than girls. (7)

Middle Adolescence

This stage is marked by the full establishment of secondary sexual characteristics and growth deceleration. Feelings of omnipotence and invincibility peak (although this can also be a time of increased sense of vulnerability). These feelings favor the development of autonomy but can place the adolescent at increased risk of contracting an STI or becoming pregnant, because these individuals cannot weigh consequences appropriately. Abstract thinking and other executive functions continue to develop but still are not fully formed.

During this stage, teens are moving toward forming a sexual orientation and identity. They become increasingly concerned with whether they are attractive and place more importance on their peer group. Many adolescents in this stage may "fall in love" for the first time. Sexual experimentation is common, and many will have intercourse during middle adolescence.

Late Adolescence

It can be argued that late adolescence continues through the postsecondary education period. Brain development, particularly of the prefrontal cortex, can continue until age 22 years in female subjects and 25 years in male subjects. (8) Late adolescents tend to focus on autonomy and thinking beyond themselves. Most teens during this stage are able to think abstractly; they are future oriented and more insightful. They are secure with their body image and gender role; sexual orientation also is nearly secured. Teens in late adolescence work on transitioning to adult roles in relationships, school, and work. However, they may still act impulsively. (5) Becoming a sexually healthy adult is a developmental task of adolescence that requires integrating psychological, physical, cultural, spiritual, societal, and educational factors. It is particularly important to understand the adolescent in terms of his or her physical, emotional, and cognitive stage.

Trends in Adolescent Sexual Behavior

What Is Sex?

Traditionally, we have thought of sexuality as including sexual fantasy, masturbation, nonpenetrative sexual acts, oral sex, vaginal intercourse, and anal intercourse. In the

electronic age, other activities are included in the sexual lexicon, including phone sex, sexting, sex in chat rooms (with or without webcams), and virtual sex with the use of avatars. Most of the data available on adolescent sexual behavior are related to vaginal intercourse.

Trends in Sexual Behavior in the United States

In the United States, according to the 2009 Youth Risk Behavior Survey, students in grades 9 through 12 were less likely to report sexual intercourse with at least one person compared with students surveyed in 2003. (9) The percentage of students reporting condom use during the last sexual intercourse and use of birth control before last sexual intercourse remained unchanged. The survey indicated that 46% of students had sexual intercourse with at least one person, and 5.9% of students had sexual intercourse for the first time before age 13 years.

The National Survey for Family Growth was conducted by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics. Over the year before the survey, 13% of 15- to 17-year-old males and 11% of 15- to 17-year-old females had heterosexual oral sex but not vaginal intercourse. (10) Fourteen percent of students reported sexual intercourse with four or more persons during their lifetime.

Sixty-one percent of students reported that either they or their partner had used a condom during their last sexual encounter. The prevalence of having used a condom during last sexual intercourse was higher among male (69%) than female (54%) students. Among the 46% of sexually active students, 20% reported that either they or their partner had used birth control pills to prevent pregnancy before their last sexual encounter. (9)

Canadian Trends in Sexual Behavior

The median age of first intercourse for male and female subjects in Canada is 16.5 years according to a Canadian study that included 1,171 participants age 14 to 17 years across the country. (11) The mean age of first oral sex in this study was 15 years. Five percent of boys and 1% of girls initiated intercourse before age 12 years. Approximately 30% of boys and 20% of girls had experienced sexual intercourse at least once by age 14 years. Among the teens who become sexually active, 68% reported oral sex and 85% reported vaginal intercourse. Seventy-six percent reported condom use the last time they had intercourse. Nine percent reported the use of the withdrawal method, and 1% used emergency contraception.

In 2008, the British Columbia Adolescent Health Survey (a cluster-stratified weighted survey) obtained data from more than 280,000 students from grades 7 through

12. (12) Twenty-six percent of students reported ever having oral sex, and the percentages were similar for male and female students. The percentages increased from 3% among students 12 years or younger to 52% of students 18 years or older. The trend with condom use declined with age, and oral contraceptive pill use increased with age. Among the students who reported sexual activity, 32% reported that they drank alcohol or used drugs before their last sexual encounter.

European Trends in Sexual Behavior

Rates of condom use among teens in the United States and Europe are similar; however, teens in Europe are much more likely to use hormonal methods of contraception. (13)(14) In 2006, 61% of 15-year-old sexually active females in the Netherlands reported using the birth control pill at their last sexual encounter. In the United States among sexually active females in grades 9 through 12, 10% reported using dual methods (eg, condoms with birth control pills or medroxyprogesterone injection). Among sexually active male students, 8% used dual methods in which they used a condom and their partner used birth control pills or medroxyprogesterone.

Trends in Sexually Transmitted Infections

It is estimated that adolescents age 15 to 19 years acquire 50% of all new STIs, yet they represent only approximately 25% of the sexually active individuals in the population as a whole. Sexually active adolescents are at higher risk for acquiring STIs due to behavioral, biological, and physiologic factors. (15)

Human papillomavirus (HPV) is the most common STI acquired during adolescence. Surveillance for cervical infection with high-risk HPV types 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, or 68 was conducted in 26 STI, family planning, and primary care clinics in 6 US cities. (16) Testing was performed by using a commercially available test for high-risk HPV DNA. In all, 9,657 women ages 14 to 65 years were tested, and the prevalence of HPV was noted to be highest among women ages 14 to 19 years at 35% (confidence interval: 32–38).

Chlamydia trachomatis infection is common among adolescents. The normal cervical ectopy present in this age group puts adolescent females at increased risk. (15) The higher prevalence also reflects the multiple barriers to accessing confidential STI prevention services and resources. *Chlamydia* remains the most common reportable STI in the United States. Girls age 15 to 19 years had the highest rate of *Chlamydia* compared with any other age or sex group, with African-American, American Indian/Alaska Native, and Hispanic females

disproportionately affected. Increases in *Chlamydia* rates are likely a reflection of expansion of screening and an increase in sensitive tests.

Gonorrhea is the second most commonly reported infectious disease in the United States. (15) More than 350,000 cases were reported in 2007. The gonorrhea rate per 100,000 women age 15 to 19 years is 569, similar to the rate reported for women age 20 to 24 years. The rate is 250 per 100,000 men age 15 to 19 years, presumably because of low rates of testing.

Trichomonas infection is estimated to be the most prevalent nonviral STI in US adolescents, with an estimated incidence of approximately 5.0 to 7.4 million new cases in the United States each year. (17) The true prevalence and incidence of *Trichomonas vaginalis* infection are difficult to assess because there are no screening guidelines, testing depends on individual clinician practice, the infection is not a reportable disease, and although wet mounts are the most common test for *T vaginalis*, this method is less sensitive than culture or a nucleic acid amplification test.

Syphilis rates among women age 15 to 19 years have increased. In 2004, there were 1.5 cases per 100,000 females and in 2009 there were 3.3 cases per 100,000 females. Syphilis rates decreased to 3.0 per 100,000 females in 2010. The rate of primary and secondary syphilis in males age 15 to 19 years is 5.6 per 100,000 males in 2010. (15)

The rate of diagnosis of HIV infection among adolescents ages 13 to 19 increased 24%, from 7.1 in 2006 to 8.8 in 2009. In 2009, among adolescents African-Americans accounted for 73% of diagnosed HIV infections, and the rate of diagnosis was more than 5 times the rate for Hispanics/Latinos and nearly 23 times the rate for whites. (18)

Trends in Pregnancy

An estimated 16 million girls aged between 15 and 19 years give birth every year, with 95% of these births occurring in developing countries. Worldwide, just seven countries account for one half of all adolescent births: Bangladesh, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Nigeria, and the United States. (19) Teens across the United States and Canada have been found to have similar levels of sexual activity. However, the United States continues to have one of the highest teen pregnancy rates in the developed world (Table). (13)(20)(21) In 2009, the national US teen birth rate was 39.1 births per 1,000 females, a 37% decrease from 61.8 births per 1,000 females in 1991. Birth rates for African-American and Hispanic teens were 59.0 and 70.1 births per 1,000 females, respectively, compared

with 25.6 for white teens. In western Europe, the United Kingdom has the highest rate of teenage pregnancy at 26 per 1,000 women. (13)

Sexual Orientation

Self-definition of sexual orientation can predate sexual activity or may come after sexual debut. Sexual orientation is defined according to a person's physical and emotional arousal to people of the same or opposite sex. Particularly in adolescence, sexual and affectational preference may not be the same. Gender identity is separate from sexual orientation. The range of sexual orientation spans from heterosexual (primarily attracted to the opposite sex) to bisexual (attracted to both males and females) to gay or lesbian (primarily attracted to the same sex).

Studies of adolescent sexuality often are limited by the questions asked. In addition, teens who eventually identify as gay, lesbian, or bisexual will not always do so during adolescence. Many young people who engage in some sort of same-sex experience are not gay, and many gay teens have never had sex with someone of the same sex. The 2003 British Columbia Adolescent Health Survey (representing 289,767 British Columbia students enrolled in public schools) has collected detailed data on sexual orientation. Although only 1.5% of all boys identified themselves as bisexual, mostly homosexual, or 100% homosexual, 3.5% of sexually active boys said they had experienced sex with someone of the same gender in the past year. Three percent of girls self-identified as bisexual, mostly homosexual, or 100% homosexual, yet 6.4% of sexually active girls reported having sex with someone of the same gender in the past year. (22) US data are similar, with Remafedi et al (23) reporting that 1.1% of teens identified as gay or bisexual, but 4.5% said that their main sexual attractions were same sex. A Massachusetts study (24) found that 2.5% of youth self-identified as gay, lesbian, or bisexual. A large Jamaican study showed that 3% of 10- to 15-year-old males and 22% of females in the same age bracket said that they

Table. Pregnancy Rates per 1,000 Females Age 15 to 19 Years

Country	Pregnancy Rate	Birth Rate
United States (50)	67.8	43.5 (2008)
Canada (19)	27.9	13.3 (2006)
United Kingdom (12)	26.0	26.7 (2007)
The Netherlands (12)	14.1	5.3 (2006)

had kissed or touched someone of the same gender. The numbers stayed the same for older males, whereas the number of females in the 15- to 19-year-old age range who said they had kissed a girl dropped to 4%. (25)

Young people who are in the process of “coming out” (acknowledging their homosexual orientation to themselves, family, and friends) often lack realistic models of same-sex relationships. While struggling to figure out how to meet someone who they might be interested in or how to introduce a sexual element to the relationship, these teens may turn to the Internet to meet partners, without understanding the possible risks.

A history of heterosexual activity does not rule out eventual self-identification as lesbian or gay. There are societal pressures on young people to be heterosexual, and youth who disclose homosexual feelings may be told that they cannot know that they are gay until they have had unsatisfying heterosexual sex. Heterosexual sex also may occur to camouflage a gay orientation. Several studies have shown that, while in the process of coming out, young people are as likely to have heterosexual intercourse as those who identify as heterosexual. (26)

Although homosexuality has been stigmatized in many communities, gay youth from ethnic or racial minorities in the United States report increased feelings of vulnerability and stress compared with those in nonminority populations. (27) Gay and bisexual minority youth experience unique challenges as they work through the formation of their ethnic and sexual identities, and the struggle may lead to confusion, frustration, and potentially increased rates of high-risk behaviors. (28)

Conversion or reparative “therapy,” in which attempts are made to change gay or lesbian youth into heterosexuals, is still being offered by a number of organizations. The premise is not consistent with known scientific evidence on homosexual development and should not be supported by health-care professionals, according to a report by the American Psychological Association. (29)

Adolescents With Special Health-Care Needs

Adolescents who have chronic illness or disability, collectively referred to as adolescents with special health-care needs (ASHCN), constitute between 7% and 15% of the adolescent population. The 15% estimate includes young people who have minor chronic health conditions, such as mild asthma or the need to wear corrective eyewear. (30) Unpublished data from the British Columbia Adolescent Health Survey reaffirm older data that ASHCN are at least as likely, and often more likely, to

engage in sexual behavior with others than healthy adolescents (E. Saewyc, PhD, RN, personal communication, 2010). In the British Columbia cohort, 22% of students in grades 7 through 12 without a disability, chronic condition, or mental health issue had intercourse at least once, while 30.5% of students with a physical disability, 28.1% of students with a chronic condition, and 40.3% of students with a mental or emotional condition had sexual intercourse, all significantly higher incidences than in those without special health-care needs. About 1 in 4 teens in grades 7 through 12 without a disability or chronic condition had oral sex or sexual intercourse, and almost 1 in 3 ASHCN (~10% of the overall sample) had oral sex or sexual intercourse. (31)

Despite these numbers, many people believe that individuals who have health conditions or physical disabilities are not sexual beings or that they are unable to have sex. (32) It is important, therefore, to normalize sexuality for adolescents who have chronic health conditions or physical disabilities.

Pubertal development can be affected by a medical condition or disability in either direction: young people who have cystic fibrosis have a higher rate of delayed puberty than healthy youth, while menarche often is early in young women who have spina bifida. (32) Urogenital malformations can have an impact on sexual functioning, and mobility disabilities can make unassisted sexual activity difficult. The fatigue that is a part of many conditions may interfere with sexual desire and activity. Anything that makes an adolescent look different from his or her peers (including skin diseases, short stature, and facial differences) can interfere with finding a partner.

Even with a totally invisible condition, however, adolescents often worry that there is something unusual or deficient in their sexual functioning but are reluctant to ask a health-care provider about this concern. Sexual functioning and behavior should be addressed with these young people, not just to prevent pregnancy and STIs but to reassure them that they can have sex (even if it might take extra planning or not fit societal definitions of “real” sex). (33) Discussions with ASHCN of both genders should also include accurate information about fertility, the heritability of their condition, added concerns regarding STIs, contraceptive options (reviewed by Nelson and Neinstein [34]), and the impact of a pregnancy. (35)

Adolescents With Cognitive Delay

It is normal for all adolescents to have questions about relationships, sexuality, and reproduction in addition to

sexual feelings and behavior. It is equally normal for caregivers and health-care providers to struggle to find ways to present complex information in a way that is understandable to young people who have cognitive delays; it is also normal for these caregivers and providers to have concerns about sexual exploitation and pregnancy in this population. (36)

Unfortunately, young people who have delays often are described as functioning at the level of a younger age or at a certain grade level. This viewpoint can be helpful when dealing with a specific type of functioning but is almost never applicable to all of the realms of function in a young person's life. If "functioning at the first grade level" means that the young person recognizes a few words and can count but not add or subtract, it may be a useful descriptor. But that designation does not necessarily mean that the young person is emotionally or sexually at a first grade level. (37)

Sexuality education in the office should concentrate on what is essential first. This counseling should be done in small, understandable pieces. Explaining the anatomy of what is visible is much more important than focusing on the invisible. Early in puberty, young people should be told that, for girls, menstruation and breast development are expected and, for boys, that erections and ejaculation similarly are normal. It can be hard to convey that it is acceptable to talk about sexuality with some people but not others, but this concept and discussions of "public versus private," the importance of being able to say "no," and appropriate greeting behavior (who you hug, who you do not) should be addressed before puberty.

Using concrete examples, pictures, or models can be very helpful in these early conversations and when discussing more complex topics, such as figuring out who to trust, how to flirt, and how to develop a relationship. A strong desire to have an infant is often encountered. The clinician can let the young person know that there are a number of skills she needs to master to prepare for parenthood. With the young person, break down these skills into a list of tasks that can be tackled one at a time.

Sexual Health Education

All sectors, including parents, schools, community agencies, religious institutions, media, business, health-care providers, and policy makers, have a responsibility to promote healthy sexuality. Strong evidence suggests that comprehensive approaches to sex education help adolescents withstand the pressures to have sex too soon. This approach encompasses education about all aspects of

sexuality, dating and relationships, decision-making, communication, birth control methods, STIs, and pregnancy prevention. Comprehensive sexual education also encourages adolescents to cultivate healthy, responsible, and mutually protective relationships whenever they decide to become sexually active. (38)

In Schools

Recent US data revealed that 46% of male subjects and 33% of female subjects did not receive formal education about contraception before their sexual debuts. (38) Among teens aged 18 to 19 years, 41% reported that they knew little or nothing about condoms and 75% reported that they knew little or nothing about the contraceptive pill. The appropriate type of formal school-based sexual education has continued to be an ongoing topic for discussion.

Currently, 20 states and the District of Columbia mandate sex and HIV education; an additional 12 states mandate only HIV education. Thirty-six states require abstinence education, with 27 requiring that abstinence be emphasized, and 9 require that abstinence be included as a part of the instruction. Eighteen states and the District of Columbia require that sex education programs include information on contraception; however, no state requires that contraception be emphasized. (38) School boards should be aware of local mandates for sexual health education which can be found in the *State Policies in Brief* document published by the Guttmacher Institute.

Forty-eight comprehensive programs were studied, and the two thirds that supported both abstinence and safer sex for sexually active teens had positive behavioral effects. (39) Many adolescents either delayed or reduced sexual activity, reduced the number of sexual partners, or increased condom or other contraceptive use. To date, there is no evidence to support the belief that abstinence-only-until-marriage education delays sexual debut. More importantly, studies have shown that abstinence-only strategies may deter contraceptive use among sexually active teens, consequently increasing their risk of unintended pregnancy and STIs. (38)

In March 2010, Congress created a 5-year Personal Responsibility Education Program, a federally funded program instituted to replace the Title V abstinence-only program. Its purpose is to "educate adolescents on both abstinence and contraception and to prepare them for adulthood by teaching such subjects as healthy relationships, financial literacy, parent-child communication and decision-making." (38) This intervention replaces the Community-Based Abstinence Education Program and supports evidence-based interventions.

Parents

In a Canadian study of high school youth, those who had sexual intercourse before age 14 years reported lower connectedness to their mother and father figures than youth who did not have these experiences. (40) Frappier et al (41) found that adolescents ranked parent, peers, and the media as important sources of information. Although the majority of teens claimed to be knowledgeable about sexuality and sexual health, they lacked knowledge about STIs and their consequences. Most reported a very good relationship with their mothers, whereas fewer reported a very good relationship with their fathers; 45% of the boys and girls regarded their parents as their role models regarding sexuality and sexual health.

Many adults acknowledge the challenges inherent in engaging in discussions about adolescent sexuality and sexual health. Many adults will deny or express disapproval of adolescent sexuality. Adolescents are aware of this disapproval and may be willing to risk STIs and pregnancy rather than talk with a parent or other adult about their sexual behavior.

Sexual health education can be provided by parents primarily through discussion and by modeling an approach to discussions of sexuality. Open communication in the home typically creates an environment in which teens may behave more responsibly, learn from their mistakes, and accept their feelings around sexuality. Open communication is a strong predictor of young people's likelihood of turning to parents in times of trouble. Parents of adolescents who are sexually healthy tend to value, respect, and accept their children, model sexually healthy attitudes in their own relationships, maintain a nonpunitive approach toward sexuality, discuss sexuality, and provide information about contraception, STIs, and relationships. (5) Parents should be encouraged to share their values, work on gaining trust, and provide information and resources about sexual health. Parents also should be encouraged to look for "teachable moments" and use gentle humor as a means of acknowledging awkwardness around this particular topic.

Media

Youth now get much of their information and exposure to sexual content on the Internet, which is even less regulated than television. It is estimated that up to 90% of Americans use the Internet. (42) A recent report reveals that 61% of US teens have a desktop or laptop computer, and 84% report that they have home Internet access. Sixty-four percent of online teens age 12 to 17 years have

created and posted a wide range of content on the web. They also engage in online activities, such as games that include text and voice interaction with other players.

Social networking is the most popular online activity. A 2010 Pew Research Center report indicates that 73% of US teens with Internet access now use social networking websites, a significant increase over previous estimates by the center. In 2006, researchers found that 55% of teens used social networking sites and 65% did so in 2008. (42) (43)

The Internet affords adolescents free and easy access to anonymous sexual information, and smart phones give youth ongoing access to social networking, instant messaging, and other media. This availability may result in more exposure to sexual content at more times of the day and in more contexts than with traditional media. A number of studies describe the sexual content found in newer forms of media, but very few studies of new media effects have been conducted. The effects of new media may differ from those of traditional media, although empirical evidence on this topic is lacking. (42)

Clinician's Approach to the Adolescent Patient

Schools and community organizations are responding to the need for primary and secondary health prevention. The Guidelines for Adolescent Preventative Services, published by the American Medical Association, (44) and Bright Futures, published by the American Academy of Pediatrics, (45) can be used to help health-care clinicians deliver adolescent-friendly services appropriately. Both supply a comprehensive set of recommendations, thus providing a framework for the organization and content of adolescent preventive services. According to these recommendations, all adolescents and young adults age 11 to 21 years should have an annual preventive service visit. These visits should address biomedical and psychosocial aspects of health.

Adolescents should be provided with guidance on sexuality and sexual decision-making. If sexual health education has been a regular part of visits in early years (with discussions of pubertal changes or sexual content viewed on television and the Internet), it may be more comfortable to embark on more detailed discussions with a young person.

Adolescents should be engaged in a nonjudgmental, nongendered, and confidential discussion regarding sexual health concerns within the context of a comprehensive clinical encounter. (44) It is unlikely that the young person will be willing to discuss his or her sexuality if

confidentiality is not addressed. Standards of practice should be reviewed, and the development of clear and concise office protocols for confidentiality should be developed for staff, patients, and parents. These policies should include guidelines for when confidentiality must be breached, as well as policies for medical record access and information disclosure.

Office staff must be sensitive to the importance of delivering confidential health services. (46) Laws regarding confidentiality vary among jurisdictions, and clinicians must be aware of, and inform their patients about, any limitations to a confidential relationship. Family involvement should be encouraged; however, this involvement should be discussed with the adolescent.

Setting expectations at the beginning of the discussion is a key component in obtaining an adolescent's psychosocial history. Respectfully disengaging the parent so that the adolescent can be interviewed alone is crucial. Clinicians should reinforce confidentiality, because this approach will likely help the adolescent to disclose sensitive information. In addition, one should obtain direct contact information for patients, acquiring consent to share information with other clinicians involved in the patient's care. (46)

With the onset of puberty, adolescents may be aware of and embarrassed by the physical and emotional changes that they are experiencing. Throughout the clinical encounter, it is important to avoid assumptions, such as what sexual behaviors have or have not taken place or the sexual orientation of the adolescent. Adolescents tend to respond honestly to open-ended questions; this approach allows the clinician to obtain a thorough sexual history and to establish a rapport with the patient.

The patient's history should include information regarding attitudes and knowledge about sexual behavior and the degree of involvement in sexual activity. The interview can be guided by questions from the HEADSSS mnemonic (Home, Education, Activities, Drugs, Sexuality and sexual activity, Safety, and Suicide) and the CDC's five "P" approach to obtaining a sexual health history. The five Ps include: Partners, sexual Practices, Past history, Pregnancy, and Protection. (47)

When approaching the subject of Partners, the clinician can ask:

- When you think about who you are attracted to, do you think about boys, girls, or both?
- Are you currently spending time with someone special? Do you consider this individual your boyfriend or girlfriend? How old is he or she?

When inquiring about Practices and Past history, the clinician can ask:

- There are different ways people have sex. Have you ever had oral sex or vaginal or anal intercourse?
- Are you now or have you ever had sex with males, females, or both?
- When was the last time you had sex?
- How many sexual partners have you had?
- How old were you when you first had sex?
- There are various forms of contraception; did you use a condom and/or birth control with your last sexual encounter?

The clinician should address Pregnancy and Protection:

- Have you ever been worried that you were (got someone) pregnant?
- Have you ever been (got someone) pregnant? Have you ever had a termination?
- Have you ever had an STI?
- Have you ever been tested for an STI and HIV?

The clinician should always address safety:

- Have you ever traded money or drugs for sex?
- Has anyone ever touched you in a way you did not want to be touched?
- Has anyone forced you to do something you did not want to do sexually?

It is important to address these issues in a manner that does not stigmatize lesbian, gay, bisexual, and transgendered youth. The clinical encounter should be used as an opportunity to provide resources with accurate information. Ending the encounter with questions leaves room for the adolescent to open up regarding a possible concern that may not have been addressed. The clinician can ask, "Is there anything else that you would like to share or are there any other topics you would like to discuss today?" Providing information at every opportunity is important for adolescents who may be misinformed about various issues of sexuality and sexual health.

The Guidelines for Adolescent Preventative Services recommends that "all adolescents should receive health guidance annually regarding responsible sexual behaviors including abstinence. Latex condoms to prevent STIs, including HIV infection, and appropriate methods of birth control should be made available, as should

instructions on how to use them effectively.”(40) Counseling should include discussion about the prevention of STIs, as well as education on effective contraceptive methods. For sexually active adolescents who are using contraception, the role of the clinician is to support adherence, manage adverse effects, change the method of contraception as circumstances require, and provide referrals and frequent follow-up with periodic screening for STIs. (44)

The promotion of healthy and responsible sexual decision-making is one of the goals of counseling adolescents about contraception. Pediatricians can help adolescents identify their own goals for safe and responsible sexual behavior. Issues of health concerns and individual risk assessments may lead to appropriate discussions between the adolescent and clinician. The teaching of responsible sexual decision-making requires skilled history taking, careful listening, and repeated simple messages that contain essential information.

Note: To view the references for this article, visit the January online issue at <http://pedsinreview.aappublications.org> and click on the "Adolescent Sexuality" article.

Summary

- Providing information and fostering motivation for behavioral modification has been supported empirically as a framework for sexual health and risk reduction. (48)
- School-based abstinence plus contraceptive interventions have been shown to be more effective than interventions that promote abstinence only, with a demonstrated effect on knowledge and use of contraceptives. (49)
- Strong evidence demonstrates that sexual health promotion interventions have a positive effect on improving condom use and reducing the frequency of sex and number of sexual partners in adolescents. (49)
- Despite ongoing efforts, adolescents continue to face numerous barriers to acquiring comprehensive and accurate sexual health information. There is a growing need to pursue a variety of individual-, clinician-, and system-level policies and strategies to ensure confidential, preventive, and accessible sexual health care and education for adolescents.

PIR Quiz

This quiz is available online at <http://www.pedsinreview.aapublications.org>. Note: Learners can take *Pediatrics in Review* quizzes and claim credit online *only*. No paper answer form will be printed in the journal.

New Minimum Performance Level Requirements

Per the 2010 revision of the American Medical Association (AMA) Physician's Recognition Award (PRA) and credit system, a minimum performance level must be established on enduring material and journal-based CME activities that are certified for *AMA PRA Category 1 Credit™*. To successfully complete 2013 *Pediatrics in Review* articles for *AMA PRA Category 1 Credit™*, learners must demonstrate a minimum performance level of 60% or higher on this assessment, which measures achievement of the educational purpose and/or objectives of this activity.

In *Pediatrics in Review*, *AMA PRA Category 1 Credit™* may be claimed only if 60% or more of the questions are answered correctly. If you score less than 60% on the assessment, you will be given additional opportunities to answer questions until an overall 60% or greater score is achieved.

1. You supervise a school-based health center at your local high school. You ask the school board to consider installing condom dispensers in the boys' and girls' bathrooms. As justification, you tell them that among 14- to 19-year-old girls, the rate of human papillomavirus infection, which is associated with cervical cancer, is:
 - A. 10%.
 - B. 15%.
 - C. 20%.
 - D. 25%.
 - E. 35%.
2. You also inform the school board that of all sexually transmitted diseases diagnosed annually, infection among 15- to 19-year-olds account for:
 - A. 10%.
 - B. 25%.
 - C. 33%.
 - D. 50%.
 - E. 66%.
3. A 14-year-old boy confides to you that he had sex with another boy last summer. This was the first such experience he has had. You recall that the rate of sexual experimentation among boys with boys is approximately:
 - A. <1%.
 - B. 1%.
 - C. 3%.
 - D. 5%.
 - E. 7%.
4. The mother of an 18-year-old girl who has Down syndrome is concerned about sexual exploitation of her daughter. You tell her that young people who have cognitive delay:
 - A. Are more likely to understand when concrete examples, pictures, or models are used.
 - B. Do not have the same desire to have an infant as other adolescents do.
 - C. Do not require sexuality counseling because their understanding is limited.
 - D. Function sexually at the level of their academic competence.
 - E. Should receive sexuality counseling in school, not in the pediatric office.
5. Among the following, the group of teenagers most likely to engage in sexual intercourse during junior and senior high school are those who have:
 - A. A chronic condition.
 - B. A mental health condition.
 - C. A physical disability.
 - D. An invisible health condition.
 - E. No disability.

Adolescent Sexuality
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