



Promoting Healthy Sexual Development and Sexuality

Theme **8**

INTRODUCTION

Families have different perspectives on how sexuality should be discussed with children and adolescents (ie, who should be involved in those discussions and how much young people need to know and at what age). With respect for different individual and cultural values, health care professionals can address this important component of healthy development by integrating sexuality education into health supervision from early childhood through adolescence.¹ In the supportive environment of the medical home, health care professionals can provide personalized information, confidential screening of risk status, health promotion, and counseling for the child and adolescent. Age-appropriate, accurate resources that are related to sex education and healthy sexuality provide parents with factual information and encouragement as they educate and guide their growing child.

Health care professionals also should acknowledge and discuss the healthy sexual feelings that all children and youth have, including those with special health care needs.

Families of children with special health care needs may require additional counseling around sexual development issues to ensure a healthy understanding of their child's pubertal and sexual development.

Promoting Healthy Sexual Development and Sexuality: Infancy—Birth to 11 Months

Nurturing the development of the biological and physical foundations of healthy intimacy is an important goal that begins in infancy. These foundations require the ability to be comfortable and safe in a close physical relationship with another person. Intimacy begins in the parent's arms with good parent-child reciprocity, response to cues, management of states of arousal (eg, pain and hunger), and establishment of regular cycles of excitement and relaxation (eg, waking up and falling asleep). The infant needs to have the sense that she is valued, loved, and important for who she is.



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Establishing a sense of self early in life underlies a child's sense of being either a girl or a boy. Parents must accept their child's gender, even if they might have hoped for a child of the other gender. Parents must communicate to their children that they are intact, beautiful, and well-formed. The gender of most infants is known prenatally or immediately at birth. There are endocrinologic and genetic conditions that may result in ambiguity of the external genitalia, making gender assignment difficult initially. Gender *identity*, however, is a gradual process that is based on an internal conviction of belonging to either the male or female gender. Gender identity is distinct from gender *role*, which refers to a set of behaviors through which individuals convey to the larger society that they are male or female. Children usually develop a fixed gender identity by 2½ to 3 years of age, after which they emphatically perceive themselves as being either a girl or a boy.²

Parents often ask how to handle their infant's behavior (eg, genital touching) as the infant becomes aware of her own genitalia. This issue can be addressed as normal behavior with parents during the 6 and 9 Month Visits, perhaps when discussing bathing or diapering. Parents can be encouraged to practice proper naming of their infant's genitalia (eg, penis and vagina) during diapering and bathing. It may facilitate future discussion between parents and their children about sexuality.

Promoting Healthy Sexual Development and Sexuality: Early Childhood—1 to 4 Years

Sexual exploration is a normal, universal, and healthy part of early childhood development. At this age, children show interest in their own, as well as others', "private" areas, and they become aware of gender differences. Their curiosity can be shown in behaviors such as playing doctor with their peers, undressing during play activities, trying to

watch people when they are nude, and physically touching their parents' body parts (eg, their mother's breasts). In early childhood, children also are exposed to social norms and learn boundaries regarding sexual behaviors. Personal boundaries are the presumed interpersonal distances, both physical and emotional, that are maintained by most people. Young children first learn personal boundaries in their families. Issues related to the timing, settings (eg, public vs private), and spectrum of sexual behaviors can best be discussed in the context of trusting relationships and open communication between the parent and the child.

The most common sexuality issues for this age group are related to bathing and showering, toileting, modesty, privacy, masturbation, and sexual play. Masturbation is frequently a concern for parents. A variety of behaviors can be seen, such as posturing, tightening of thighs, sexual arousal, and handling of genitals. Parent experiences, as well as cultural, religious, and family norms, influence parents' responses to their children's sexual behavior.

Sexual play between same-age peers usually is lighthearted and voluntary in nature. This behavior diminishes when children are requested to stop. Sexual behavior in children can create uncertainty for the health care professional because of the potential relationship between child sexual abuse and sexual behavior. Consequently, it is important to understand normative sexual childhood behaviors. The less-frequent and more-concerning sexual behaviors are intrusive, such as inserting objects into the vagina or anus, or aggressive sexual behaviors. It is important that health care professionals be able to distinguish healthy and natural from concerning and distressing sexual behaviors. They should provide reassurance about normal activities, provide developmentally appropriate parameters for identifying problem behaviors, and encourage family discussions regarding sex education.

Promoting Healthy Sexual Development and Sexuality: Middle Childhood—5 to 10 Years

Middle childhood is the time to provide accurate information to children and give them opportunities to explore, question, and assess their own and their family's attitudes toward sexuality and human relationships. At this age, the changes of puberty also can be addressed.

Health care professionals should perform a sexual maturity rating as early as ages 7 to 10 years. Health care professionals should address upcoming stages of sexual development as part of their anticipatory guidance because children and their parents can be reluctant to ask questions about normal physical development or the differences noted in their child's development compared to that of the child's peers. Normal pubertal development varies widely in the US population, and race/ethnic differences are now observed (eg, African American girls have been shown to have a higher rate of early-onset puberty than white girls).³

In middle childhood, children should appreciate wide variations in body shapes, sizes, and colors and acquire pride in their own body and gender. Children this age can, and should, understand that their bodies will change as they grow older. They should learn the differences between male and female genitalia, as well as the correct name and specific function of each body part. They also can learn that some body parts can feel good when touched, that it's normal to be curious about one's body, and that not all exploratory behaviors are appropriate in every place and time. Teaching about human immunodeficiency virus (HIV) infection and other sexually transmitted infections (STIs) can include discussion of their causes (eg, viruses and bacteria) and general modes of transmission.

Concepts of family, friendship, and other human relationships are core components of healthy sexuality at this stage. Children

should learn to express love and intimacy in appropriate ways and to avoid manipulative or exploitative relationships. Empathy and respect for another's feelings also is an essential component of a healthy relationship, facilitated through effective communication skills. Kissing, hugging, touching, and other intimate behaviors are understood within the norms of the child and family's culture. Children need to understand their rights and responsibilities for their own bodies (eg, privacy and hygiene) and the importance of communicating fears and concerns with trusted adults. Children should know that no parent or adult has the right to tell them to keep secrets from either parent, especially when someone is touching their body inappropriately. Parents should give their child permission to tell them about any uncomfortable or threatening experiences, reassuring the child that he will be believed and will not be in trouble for telling.

Children's exposure to elements of sexuality from their peers, families of their peers, and the media (eg, news stories, advertisements, television programs, and pornography on the Internet) can influence them to make choices that may not be healthy, safe, or consistent with family values. Health care professionals can encourage parents to talk with their children about these issues and suggest tools, such as books or videos, to help open these discussions and conduct them comfortably.

Promoting Healthy Sexual Development and Sexuality: Adolescence—11 to 21 Years

Experiences with romantic relationships, exploration of sexual roles, and self-awareness of sexual orientation commonly occur during adolescence. Decisions that are associated with sexual development in the adolescent years often have important implications for health and education, as well as current and future relationships.

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Key Data and Statistics

PARENTS AND ADOLESCENT SEXUAL DECISION MAKING

A National Campaign to Prevent Teen Pregnancy survey conducted in 2004 demonstrated that:

- Adolescents aged 12 to 19 years report that parents are the greatest influence regarding sexual decision making and values (37% compared to 33% for friends, 6% for siblings, and 5% for the media).⁴
- Ninety-four percent of adolescents and 91% of parents believe that adolescents should be advised that they should not have sex before completing high school.⁴
- Nearly 87% of adolescents agree that “it would be easier for adolescents to postpone sexual activity and avoid adolescent pregnancy if they were able to have more open, honest conversation about these topics with their parents.”⁴

Data from the National Longitudinal Study of Adolescent Health, sponsored by the National Institutes of Health, demonstrate that a strong parental relationship is related to an adolescent’s decision to delay sexual initiation.⁵ A report released by the National Campaign to Prevent Teen Pregnancy found that a strong parent-child relationship and parental supervision are associated with reduced risk of teen pregnancy. Adolescents who have a close relationship with their parents are more likely to be abstinent than those who do not, and, of those who are sexually active, are more likely to have fewer partners and to use contraception.⁶ Other protective factors that are related to delayed sexual initiation include strong community support, youth who are connected to their schools and faith communities, and youth who report strong personal values or religious beliefs. Adolescents report that their own morals and values are as influential as health information in their decision to delay sex.⁴

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PERCENTAGE OF YOUTH WHO REPORT HAVING HAD SEXUAL INTERCOURSE

The 2002 National Survey of Family Growth (NSFG) released by the Centers for Disease Control and Prevention in 2004, contains the following data about adolescent sexual activity⁷:

- Forty-six percent of never-married male and female adolescents aged 15 to 19 years reported that they have had sexual intercourse. This represents a significant decline in sexual involvement for male individuals from 55% reported in 1995.
- Approximately 30% of female and male adolescents aged 15 to 17 years reported having intercourse in 2002, compared to 38% for female and 43% for male adolescents in 1995.
- African American males aged 15 to 17 years reported the most remarkable decline in sexual intercourse. Their rate of sexual initiation changed from nearly 76% in 1995 to 53% in 2002.
- Older female adolescents (aged 18 to 19 years) reported stable rates of sexual intercourse at approximately 69% in 1995 and 2002, while male adolescents declined significantly from 75% (1995) to 64% (2002).



- Young adolescents (younger than 15 years) also are delaying sexual intercourse. Between 1995 and 2002, the percentage of young adolescents who reported sexual intercourse dropped from 21% to 15% among males and from 19% to 13% among females.

ONSET OF INTERCOURSE

- In 2005, according to the Youth Risk Behavior Surveillance System, the percentage of students who had sexual intercourse for the first time before the age of 13 years was 6.2% (8.8% for boys and 3.7% for girls)⁸ compared to 1995, in which it was 9.0% (12.7% for boys and 4.9% for girls).⁹
- Early age of onset of sexual intercourse is associated with an increased number of partners during adolescence.¹⁰ Young women who first had sex before age 14 years were about twice as likely to have had multiple partners than those who first had intercourse at age 16 years or later.¹¹

Two thirds (66%) of the sexually experienced adolescents (aged 12 to 19 years) who participated in the 2004 National Campaign to Prevent Teen Pregnancy survey said they wished they had waited longer before having sexual intercourse.⁴

CONTRACEPTION

Data from the NSFG⁷ show that education about contraceptive use may be reaching the adolescent population. Its studies report the following:

- Along with an overall decline in the percentage of sexually active adolescents, contraceptive use at first intercourse for women is much higher for those who had first intercourse between 1999 and 2002 (79%) compared to those who initiated sexual activity before 1980 (43%).
- Although the birth control pill and condoms are the most frequently used

methods of contraception, use of injectable contraception and other methods is increasing.

- Between 1995 and 2002, reported condom use increased for 15- to 19-year-old sexually active, never-married males (from 64% to 71%) and females (from 38% to 54%).

PREGNANCY RATES

- The adolescent pregnancy rate in 2000 was the lowest since 1976; it declined by 27% among female adolescents aged 15 to 19 years since 1990. In 2000, the rate of pregnancy among female adolescents aged 15 to 17 years was 54 per 1,000, compared to 67 per 1,000 in 1996.¹²
- Santelli et al¹³ analyzed the decline in adolescent pregnancy. Approximately 53% of the decline can be attributed to decreased sexual experience, and 47% can be attributed to greater contraceptive use.

SEXUALLY TRANSMITTED INFECTIONS

- An estimated 9 million young people (aged 15 to 24 years) develop infections that are spread primarily by sexual contact.¹⁴ Common STIs for people in this age group are human papillomavirus (HPV), trichomoniasis, Chlamydia, herpes simplex virus, and gonorrhea.^{14,15} Each type of infection has the potential for both short- and long-term consequences.
- Female adolescents are more likely than older women to become infected when exposed to STIs because their vaginal and cervical tissues are not completely mature.¹⁶
- An estimated 1,991 15- to 24-year-olds were newly diagnosed with acquired immunodeficiency syndrome (AIDS) in 2003, bringing the cumulative number of 15- to 24-year-olds with AIDS to 37,599 in the United States that year.¹⁷

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Role of the Health Care Professional

Clinical care for adolescents and young adults is commonly related to concerns about sexual development, contraception, STIs, and pregnancy. Clinical encounters for acute care, health maintenance visits, or sports physicals all provide opportunities to teach adolescents and their families about healthy sexuality. Health care professionals can discuss sexual maturation, family or cultural values, communication, monitoring and guidance patterns for the family, personal goals, informed sexual decision making, and safety.

The American Academy of Pediatrics (AAP) policy statement, *Sexuality Education for Children and Adolescents*,¹ advises health care professionals to integrate sexuality education into the longitudinal relationship they develop through their care experiences with the preadolescent child, the adolescent, and the family. Confidential, culturally sensitive, and nonjudgmental counseling and care are important to all youth, including youth with special health care needs and nonheterosexual youth. The American College of Obstetricians and Gynecologists has a similar statement that supports the same approach.¹⁸

To address this issue in ways that respect values and meet the adolescent's needs, health care professionals must learn about the family's values and attitudes. Parents and health care professionals should be partners with youth in supporting healthy adolescent development and decision making. The rewards are long-term. Health care professionals, however, cannot assume that the family's values are the adolescents' values. In addition, although parents of most adolescents are concerned and available, health care professionals also must offer the best care possible to adolescents whose parents are absent or disengaged.

Counseling adolescents should include stating the advantages of delaying sexual involvement, suggesting skills for refusing sexual advances, providing information about

drug and alcohol risks, and expressing encouragement for healthy decisions. Adolescents with and without sexual experience may welcome support for avoiding sex until later in their lives. Health care professionals also should support adolescents in how to have healthy relationships. In addition, health care professionals should screen for, as well as counsel against, coercive and abusive relationships for adolescents who are involved with intimate partners.¹⁹

Information about contraception, including emergency contraception and STIs, should be offered to all sexually active adolescents and those who plan to become sexually active. Each contraceptive method has instructions for correct use, effectiveness for preventing pregnancy, potential side effects, and long-term consequences (eg, potential bone density concerns with depot medroxyprogesterone acetate). Hormonal contraception does not protect against STIs. Emergency contraception is available to prevent pregnancy after intercourse.²⁰ The latex condom is the only method available to prevent the spread of HIV and can reduce the risks of some other STIs, including Chlamydia, gonorrhea, and trichomoniasis.²¹ Condoms also can reduce the risk of genital herpes, syphilis, and HPV infection when the infected areas are covered or protected by the condom.

Health care professionals who care for adolescents may encounter some adolescents who are gay, lesbian, bisexual, transgendered, unsure, or uncomfortable with their sexual orientation or gender identity. Many of these youth remain unidentified and secretive because they are not comfortable enough to identify themselves and their sexual concerns. They may fear rejection or stigmatization from disclosure of their sexual orientation or gender identity issues to health care professionals. The goals for these youth are the same as for all adolescents—to promote healthy development, social and emotional well-being, and optimal physical health.^{22,23}

Supportive, quality health care for adolescents means that adolescents must feel welcomed as individuals, regardless of social status, gender, disability, religion, sexual orientation, ethnic background, or country of origin. The health care professional must create a clinical environment in which the adolescent believes that sensitive personal issues, including sexual orientation and expression, can be discussed.¹ According to an AAP clinical report on sexual orientation and adolescents, “Sexual orientation refers to an individual’s pattern of physical and emotional arousal toward other persons.”²² The health care professional must help the adolescent understand that same-sex interest and behaviors can occur at this age and that they do not define sexual orientation.²² Clinic and practice materials, as well as personnel, can convey a nonjudgmental and safe environment for care and confidentiality for adolescents who may be experiencing same-sex attractions.^{1,22,23} Nonheterosexual adolescents are sensitive to jokes, attitudes, and comments regarding their sexual orientation, and they may not feel comfortable discussing significant health history or concerns. If the health care professional cannot ensure a safe environment for these adolescents because of personal feelings or other barriers, the

adolescent should be referred to another practice or clinic with appropriate services.

As with all other patients, the adolescent should be assured that confidentiality will be protected and also should be told of the conditions under which it can be broken. In those situations of serious concern, the health care professional should help the adolescent discuss the issue with her parents or family and, if necessary, obtain additional services with mental health professionals or other health care professionals. The health care professional also should offer advice to guide these adolescents in avoiding sexual and other health risk behaviors.

Adolescents with special health care needs and their families can benefit from knowledgeable, personalized anticipatory guidance.²⁴ Education about normal puberty and sexuality can be augmented with information that is germane to adolescents with physical differences, especially those that directly affect sexual functioning, as well as youth with cognitive delays. The risk of sexual exploitation and the protection of youth are always critical. A focus on youth access to accurate and complete information and support for healthy decision making is key for all youth who are transitioning to adulthood.

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