

Promoting Healthy Sexual Development and Sexuality

Family members have different perspectives on how sexuality should be discussed with children and adolescents, such as 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 incorporating sexuality education that includes gender identity development 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. Developmentally 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 adolescents have, including children 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.²

Promoting Healthy Sexual Development and Sexuality: Infancy—Birth Through 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 such as pain and hunger, and establishment of regular cycles of excitement and relaxation (waking up and falling asleep). The infant needs to have the sense that he is valued, loved, and important for who he is.





Parents often ask how to handle their infant's sexual behavior, such as genital touching, as the infant becomes aware of his own genitalia. This issue can be addressed as typical 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 vulva) during diapering and bathing. Doing so may facilitate future discussion between parents and their children about sexuality.

Promoting Healthy Sexual Development and Sexuality: Early Childhood—1 Through 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. All people maintain personal boundaries, both physical and emotional, and young children first learn personal boundaries in their families. Issues related to the timing, settings (eg, public versus 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.³

The most common sexuality issues for this age group are related to bathing and showering, toileting, modesty, privacy, masturbation, and sexual play. Uninhibited verbal references to sexual organs and elimination are common at this age. Masturbation is frequently a concern for parents but is normal behavior unless it becomes

excessive. A variety of behaviors can be seen, such as posturing, tightening of thighs, sexual arousal, and handling of genitals. Gently setting limits on such activities when they are done in the presence of nonfamily members or in public, without harsh reaction to or shaming of the child, helps the child grasp socially acceptable behavior. 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, often serving as a source of humor for toddlers. This behavior usually diminishes when children are requested to stop and limits are set. Because of the potential relationship between child sexual abuse and sexual behavior, some sexual behaviors in children can create uncertainty for the health care professional. Consequently, it is important to understand normative sexual childhood activities. The less frequent and more concerning sexual behaviors are intrusive, such as inserting objects into the vagina or anus or aggressive sexual actions. Health care professionals should 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 sexual behavior issues.⁴ Exposure to media should be age appropriate to reduce the likelihood that undesirable sexual references and language will arise.

Children become aware of the differences in genitals as well as how boys and girls express themselves to the outside world through gender roles, hairstyles, and fashion. Fantasy play with gender expression is common at this age, and many children will explore the clothing or roles of the other gender.



Parental acceptance of their child regardless of how she identifies her gender is important for the child's mental health and adjustment (Box 1). The sex (female or male) of most newborns and infants is known prenatally or immediately at birth, but some endocrinologic and genetic conditions may result in ambiguity of the external genitalia, making sex assignment difficult initially. Gender identity, however, is a gradual process that is based on an internal conviction of belonging to a gender. Gender identity is distinct from gender role, which refers to "behaviors, attitudes, and personality traits a society designates as masculine or feminine."

Some children may identify with a different gender from their sex assigned at birth (ie, transgender). Evidence of gender nonconformity is often apparent in early childhood, as early as 2 years of age; for others, it does not occur until later in adolescence or even during adulthood.⁵ For children who establish a transgender identity, the main factor associated with persistence into adolescence and adulthood is the intensity of their gender nonconformity in childhood. For others, gender

nonconformity may change over the years or disappear altogether.⁵

Children whose developing gender identity is at odds with their assigned birth sex may show distress when identity or expression is restricted. For the health care professional, the principal task is to recognize the child's current status and to provide the parents with the best strategies to support their child. Families may benefit from supportive mental health professionals, especially those trained in gender issues, who can help guide a child's self-exploration.

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

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

Box 1

Definitions of Terms Related to Sex and Gender^{5,a}

Gender: Behavioral, cultural, and psychological characteristics associated with femaleness or maleness.

Sex: Physical attributes that characterize maleness and femaleness (eg, the genitalia).

Gender identity: Person's internal sense of being male, female, or somewhere else on the gender spectrum.

Gender role: Behaviors, attitudes, and personality traits a society designates as masculine or feminine.

Gender expression: The way a person outwardly communicates gender. A person's gender expression may or may not be consistent with internal gender identity.

Gender dysphoria: A clinical symptom characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender.

Gender nonconforming people: Persons with behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex. Gender nonconforming individuals may refer to themselves as transgender, gender queer, gender fluid, gender creative, gender independent, or non-cisgender.

Transgender: This term can be synonymous with gender nonconforming. Some use this term to refer to individuals with gender identities that are the opposite of their assigned gender.

^aThis box is not all-inclusive of the terminology used in the medical community or gender nonconformity community.

Adapted with permission from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184-1192.



Health care professionals should perform a sexual maturity rating beginning at age 7 years because of many reports of increasingly early pubertal onset. It is appropriate to ask a child aged 7 to 8 if he has ever heard the word *puberty* and help him describe what it means: “Puberty is the time when your body grows, matures, and changes.” 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 with that of the child’s peers. Normal pubertal development varies widely in the US population, and racial and ethnic differences are now observed (eg, African American girls and Mexican American girls have been shown to have a higher rate of early-onset puberty than do white girls).⁶

Concepts of family, friendship, and other human relationships are core components of healthy sexuality. 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, and touching 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 other child 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.

In middle childhood, children should appreciate wide variations in body shapes and sizes

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 and the correct name and specific function of each body part. They also can learn that some body parts can feel good when touched, it is normal to be curious about one’s body, and not all exploratory behaviors are appropriate in every place and time. The age at which to teach about sexual intercourse and reproduction depends on the parents’ assessment of the child’s need for this information, his developmental level, and parental readiness. Over time, parents might include a discussion of human immunodeficiency virus (HIV) infection and other sexually transmitted infections (STIs), including an explanation of their causes (eg, viruses and bacteria, respectively) and general modes of transmission. For many children, this topic is more appropriate during early adolescence.

Children’s exposure to elements of sexuality from their peers, families of their peers, and the media (eg, news stories, advertisements, television programs, video games, and pornography on the Internet) can influence them to make choices that may not be healthy, safe, or consistent with family values. It is important to review Internet safety with children and parents as children’s online time and experiences increase during middle childhood. (*For more information on this topic, see the Promoting the Healthy and Safe Use of Social Media theme.*) Health care professionals can encourage parents to talk with their children about these issues and suggest resources to help open these discussions and conduct them comfortably.^{7,8}

Middle childhood also is a good age to open discussions with children about gender roles they see in the media and the world around them and to support healthy development of their own sense of self as a developing male or female, including discussion of how gender roles have changed over time and what constitutes healthy emotional



relationships for both genders. For children who have been persistently gender nonconforming, puberty can be a distressing age as their body goes through changes that may not feel right to them. Current best practice focuses on supporting the child's journey and affirming the child's gender identity. No evidence exists that professionals can change a child's internal sense of gender identity. Referral to a specialist who can further explore the gender nonconformity can be considered. Guidance from a knowledgeable mental health professional also can be considered because distress accompanying pubertal change can be associated with mental health concerns.⁹

Promoting Healthy Sexual Development and Sexuality: Adolescence—11 Through 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.

Key Data and Statistics

Several existing databases provide important and useful information related to adolescent sexual behaviors in addition to many other aspects of health.

Parent and Adolescent Sexual Decision-making

A national survey of adolescents and young adults aged 12 to 19 years conducted by the National Campaign to Prevent Teen and Unplanned Pregnancy¹⁰ showed that

- Adolescents and young adults aged 12 to 19 continue to report that parents (38%) are the greatest influence regarding sexual decision-making and values, more than peers (22%), media (9%), siblings (6%), religious

leaders (6%), teachers and educators (4%), or “someone else” (10%).

- Eighty-seven percent of adolescents and 93% of parents believe that it is important for teens to be given a strong message that they should not have sex before completing high school.
- 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.”

A separate report further outlined various factors that influence adolescents' decisions related to abstinence, safe sexual behaviors, and teen pregnancy.¹¹ Among the protective factors were living in a 2-parent household; high level of parental education; family connectedness, with active parental monitoring and supervision; and open parent-adolescent communication about sex and contraception before the initiation of sex. Other protective factors that influence delayed initiation of sex include strong community support, connectedness to schools and faith communities, high academic achievement, and strong personal values or religious beliefs.

Percentage of Youth Who Report Having Had Sexual Intercourse

The Youth Risk Behavior Survey (YRBS), conducted by the Centers for Disease Control and Prevention (CDC), is a national paper-based survey conducted every other year with more than 13,000 youth in grades 6 to 12.¹² Data from the 2013 survey show that

- Thirty percent reported having had sexual intercourse by the spring semester of grade 9.
- Of those surveyed, 46.8% reported ever having had sex.
- Thirty-four percent reported having had sexual intercourse during the 3 months before the survey.



In a smaller 12-site YRBS survey, which assessed the sex of sexual contacts, 2.5% (0.7%–3.9%) of youth reported sex with the same sex and 3.3% (1.9%–4.9%) reported sexual contact with both sexes.¹³

Onset of Intercourse

- According to YRBS 2013 data, the percentage of adolescents, both girls and boys, who have had sexual intercourse, including nonconsensual sex, before age 13 years has decreased from 10.2% in 1991 to 5.6% in 2013. A higher percentage of boys (8.3%) are sexually active before age 13 as compared to females (3.1%).¹²
- Among sexually experienced adolescents and young adults aged 12 to 19 years, 67% of females and 53% of males who participated in a survey by the National Campaign to Prevent Teen and Unplanned Pregnancy reported that they wished they had waited longer before initiating sexual intercourse.¹⁰

Contraception

- Data from the 2013 YRBS show that of students who were currently sexually active, 59% reported they or their partner used a condom at last intercourse and 25% reported they or their partner used other birth control methods to prevent pregnancy before last sexual intercourse. Methods included pills (19%), intrauterine device (IUD) or implant (1.6%), or an injectable, patch, or birth control ring (4.7%).¹²
- The CDC National Center of Health Statistics also conducts the National Survey of Family Growth (NSFG), which includes face-to-face interviews with adolescents and adults aged 15 to 19 years.^{14,15} Data from the 2011–2013 NSFG survey show that 79% of females and 84% of males used a contraceptive method at first sexual intercourse. This was especially true of males aged 17 to 19 years, in which contraception use was more than 90%. This survey also found that the use of emergency contraception by female teenagers and adults aged 15

to 19 who had sexual intercourse at least once has increased over the past decade, from 8% in 2002 to 22% in 2011–2013.¹⁵

Pregnancy Rates

- According to the National Vital Statistics Report, the adolescent pregnancy rate among those aged 15 to 19 years declined substantially between 1990 and 2008.¹⁶ Since 2008, the rate has dropped 15%, from 67.8 per 1,000 to 57.4.¹⁷

Sexually Transmitted Infections

- Approximately 20 million new STIs occur each year; 50% occur among adolescents and young adults aged 15 to 24 years.¹⁸ Common STIs include human papillomavirus (HPV) infection, trichomoniasis, chlamydial infection, herpes simplex virus infection, and gonorrhea.
- Young female adolescents are particularly vulnerable to acquisition of STIs and are prone to complications, such as pelvic inflammatory disease. They also have much higher rates of gonorrhea and chlamydial infection than do older women.¹⁹ The high prevalence is the result of behavioral, biological, social, and epidemiologic factors, including high-risk sexual partners, inconsistent lack of condoms, lack of immunity from previous infections, sexual violence, lack of access to confidential care, and lack of screening.
- In 2010, 26% of new HIV infections were reported to occur in those aged 13 to 24 years. Young males who have sex with males are at an increased risk of acquiring HIV infection, and approximately 72% of new HIV infections among youth occurred in that group.²⁰

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. Healthy sexuality is an important component of a healthy, happy life, and clinical encounters for



acute care, health maintenance visits, or sports physical examinations all provide opportunities to teach adolescents and their families about sexuality. Health care professionals can discuss sexual maturation, sexual attraction, 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”²¹ advises health care professionals to integrate sexuality education into the longitudinal relationship they develop through their care experiences with the preadolescent, the adolescent, and the family. Confidential, culturally sensitive, and nonjudgmental counseling and care are important to all youth. Historically, sexual and reproductive health services have been designed for female adolescents. New guidance describes how to structure services specifically for male adolescents as well.²¹ Adolescents with special health care needs and their families can benefit from knowledgeable, personalized anticipatory guidance.²² 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.^{23,24} The risk of sexual exploitation and the protection of youth are always critical.^{23,24}

Parents and health care professionals should be partners with youth in supporting healthy adolescent development and decision-making, as the reward is long-term. Although parents of most adolescents are concerned and available, health care professionals also should offer appropriate care to adolescents whose parents are absent or disengaged.

Health care professionals can acknowledge the appeal of sex and the normalcy of sexual interest with their adolescent patients and also share the

advantages of delaying sexual involvement, suggest skills for refusing sexual advances, provide information about drug and alcohol risks, and express encouragement for healthy decisions. The risks of date rape should be emphasized. In addition, the health care professional can discuss poor decision-making under the influence of alcohol or cognition-altering drugs. Adolescents with and without sexual experience may welcome support for avoiding sex until later in their lives. Information about contraception, emergency contraception, and STI prevention should be offered to all sexually active adolescents and those who plan to become sexually active.^{25,26} Each contraceptive method has instructions for correct use, effectiveness for preventing pregnancy, potential adverse effects, and long-term consequences. Inconsistent or incorrect use of contraceptives contribute to the incidence of unintended pregnancy. Long-acting reversible contraception (LARC), delivered through IUDs and subdermal implants, are safe for adolescents^{25,27-29} and are the most effective reversible contraceptive methods. Health care professionals are encouraged to counsel adolescents on contraception, discussing the most effective contraceptive methods (ie, LARC methods) first. Adolescents also may be counseled on emergency contraception to prevent pregnancy after intercourse.³⁰ Many teens who self-identify as gay, lesbian, or bisexual may have sexual encounters that may not be predicted by their orientation, and conversation about birth control is important.^{14,31,32} It is important to screen youth for risks related to the sexual activities in which they participate and the body parts they possess (ie, ensuring pregnancy protection for a transgender boy who has a uterus). It is important to remain nonjudgmental and allow autonomy for adolescents when they are making decisions about their preferred method of birth control.

Adolescents should be reminded that hormonal contraception and IUDs do not protect against



STIs, and they should be encouraged to use dual protection. The latex condom is the only method available to prevent the spread of HIV and can reduce the risks of other STIs, including chlamydial infection, gonorrhea, and trichomoniasis.³³ Condoms also can reduce the risk of genital herpes, syphilis, and HPV infection when the infected areas are covered or protected by the condom.

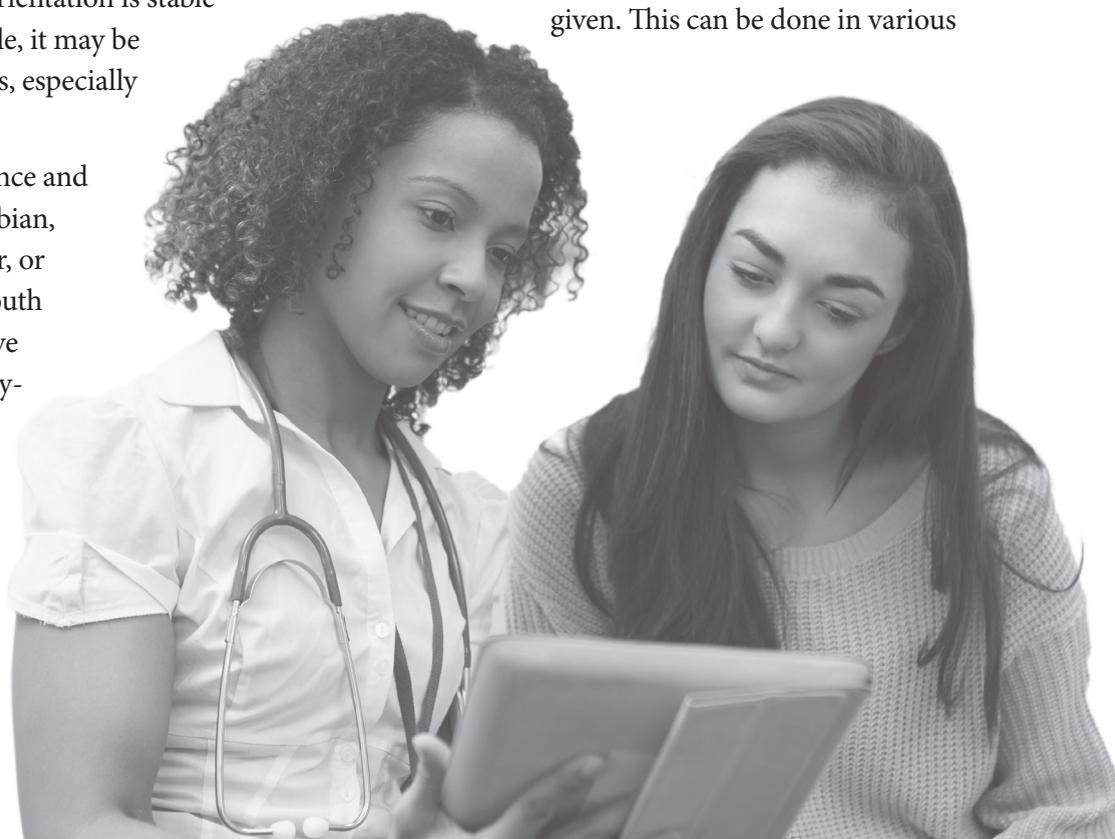
Caring for Youth Who Are Lesbian, Gay, Bisexual, Transgender, Questioning, or Gender Nonconforming

The development of a sexual identity is important in adolescence. Health care professionals should be sensitive to the full spectrum of sexual behaviors and gender identities. Youth express a variety of sexual orientation or gender identity differences. According to the AAP clinical report “Sexual Orientation and Adolescents,” “sexual orientation refers to an individual’s pattern of physical and emotional arousal toward other persons.”³⁴ Some youth may be aware of this attraction to people of the same sex before or early in adolescence, but other youth may not recognize same-sex attractions until later in adolescence or adulthood. Although sexual orientation is stable over time for many people, it may be fluid for some individuals, especially during adolescence.^{35,36}

Studies document resilience and positive outcomes for lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth associated with supportive families, teachers, and gay-straight alliances at school.^{37,38} It has been demonstrated that family acceptance has the strongest overall influence on positive health outcomes for youth

who are LGBTQ.³⁹ Absent family acceptance or lacking community supports, LGBTQ youth are at risk of isolation, abuse or bullying, depression, and suicide.³² Care needs to be confidential, but with the youth’s permission, health care professionals can explore the family’s values and attitudes so they can address the youth’s sexual orientation or questioning status in ways that respect the family’s values and meet the adolescent’s need for support, acceptance, and competent health care. Health care professionals can provide accurate information and answer parent and youth questions about what supports healthy development for youth who are LGBTQ and what does not.^{10,31} They also can identify experienced and knowledgeable mental health professionals for youth with mental health concerns and provide referrals for specialty consultation about puberty blockers and hormone therapy when requested or indicated. Some adolescents may feel alone, especially if their family is not supportive or if they live in a community that does not have an active support system for LGBTQ youth.

Health care professionals should be prepared to support the LGBTQ youth and the family when immediate parental acceptance is not given. This can be done in various





ways. For example, the health care professional can encourage parents to seek support and encourage them to have an open and nonjudgmental dialogue with their adolescent. The health care professional's goals for these youth are the same as for all adolescents—to assess for risks behaviors and to promote healthy development, social and emotional well-being, and optimal physical health. Supportive, quality health care for adolescents means that adolescents are welcomed as individuals, regardless of social status, gender identity or expression, disability, religion, sexual orientation, ethnic background, or country of origin. The health care professional must be prepared to discuss sensitive personal issues, including sexual orientation and gender identity.^{31,40}

Clinic personnel and practice materials can convey a nonjudgmental and safe environment for care and confidentiality for adolescents who self-identify as LGBTQ.⁴¹ However, self-identified youth are only a small percentage of LGBTQ youth. Health care professionals who provide care to adolescents are caring for some who have not disclosed their gender identity or sexual orientation. Professional development, course work, or other modalities may be necessary to ensure that health care professionals can provide comprehensive health care

and quality care to all adolescents. Health care professionals should learn about local LGBTQ centers and programs in their communities and should be able to provide online national resources.⁴² If the health care professional cannot ensure a supportive environment for these adolescents because of personal feelings or other barriers, the adolescent should be referred to another practice or clinic with appropriate services.³¹

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. (*See also the Introduction to the Bright Futures Health Supervision Visits section.*) In situations of serious concern, the health care professional should help the adolescent discuss the issue with 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. 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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