Adolescent sexuality

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INTRODUCTION

Although medical providers often discuss adolescent sexuality in terms of "risk," sexuality, sexual behaviors, and sexual relationships are an important and necessary part of human development. Paradigms of adolescent sexuality are broadening from risk to well-being, from targeted to comprehensive efforts, and from increasing knowledge to building skills [1]. Responsible sexual behavior (eg, delaying initiation of sexual intercourse, choosing caring and respectful partners, increasing the use of condoms, and using effective contraception) is an important public health issue.

This topic will provide an overview of adolescent sexuality, including discussions of adolescent development, sexual behavior, and related health issues and outcomes. Related content is presented in more detail separately:

- (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Primary care" and "Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns".)
- (See "Gender development and clinical presentation of gender diversity in children and adolescents" and "Management of transgender and gender-diverse children and adolescents".)
- (See "Pregnancy in adolescents".)

- (See "Contraception: Issues specific to adolescents".)
- (See "Sexually transmitted infections: Issues specific to adolescents" and "The adolescent with HIV infection".)
- (See "Adolescent relationship abuse including physical and sexual teen dating violence" and "Date rape: Risk factors and prevention" and "Date rape: Identification and management".)
- (See "Confidentiality in adolescent health care" and "Consent in adolescent health care".)

DEFINITIONS

Human sexuality is a broad concept that embodies interaction among anatomy, hormones, and physiology; psychology; interpersonal relationships; and sociocultural influences (figure 1) [2]. Approaching sexuality as a paradigm of intersecting factors between gender and sex can help providers begin to appreciate the complexities of the developing adolescent sexuality. Understanding terminology and distinctions between seemingly similar constructs is helpful in providing appropriate patient care.

Assigned gender at birth (formerly biologic, anatomic, or natal sex) — Genetic, hormonal, and anatomic characteristics determine whether a person is a biologic female or male. Assigned gender or sex at birth typically is defined by medical assessment of genitalia during infancy. Children then are reared according to their anatomically assigned sex, with little additional thought given to the individual's psychologic or behavioral self-identification [3]. Anatomic sex usually is viewed as a binary concept, male or female. Rare individuals harbor both male and female gonadal tissue (intersex or differences in sex development). Patients with differences in sex development may have subtle or obvious genital abnormalities that present during the newborn period, childhood, or adolescence. Disorders of sex development are discussed separately. (See "Evaluation of the infant with atypical genital appearance (difference of sex development)" and "Management of the infant with atypical genitalia (disorder of sex development)" and "Diagnosis and treatment of disorders of the androgen receptor" and "Pathogenesis and clinical features of disorders of androgen action" and "Steroid 5-alpha-reductase 2 deficiency".)

Gender — Gender, gender identity, gender role, and gender expression are personal, psychologic, and cultural constructs referring to various aspects of maleness, femaleness, or other nonbinary designation.

- **Gender identity** is an individual's innate sense of being male, female, androgenous, or nonbinary, or if their preference is rejection of a gender designation [4].
- **Gender roles** are social constructs and embody society's expectations of attitudes, behaviors, and personality traits typically based on biologic sex. Masculinity and femininity are the main concepts conveying these cultural associations.
- **Gender expression** is how gender is presented to the outside world but does not necessarily correlate with gender identity.

An individual's gender identity is generally established at some point during early childhood but may evolve across the lifespan, although some gender-diverse individuals do not recall thinking about gender during childhood. Rather than a binary concept with fixed opposites (male/female), gender may also be viewed using different scales (eg, a continuum, a world of gender identities to explore, absolute rejection of gender as a concept that is pertinent to them) [5]. depending upon individual or social interpretation [6,7]. Current models of gender theory move beyond two dimensions and include variations of self-identification and terminology such as: gender diverse, gender queer, gender fluid, two spirit, or transgender. In general, transgender or gender diverse refers to individuals whose gender role or gender identity is not congruent with their anatomically assigned sex at birth [8,9]. (See "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Terminology'.)

Sexual orientation — Sexual orientation refers to an individual's pattern of physical, emotional, and romantic arousal (including fantasies, activities, and behaviors) and the gender(s) of persons to whom an individual is physically or sexually attracted [10]. An individual person's assessment of their sexual orientation is termed sexual identity. Sexual behavior alone is neither a sensitive nor a specific predictor of adolescent gender identification, sexual orientation, or sexual identity [11-13]. Formation of sexual identity among youth often is fluid, and experimentation with same-gender sexual contacts can be part of healthy adolescent development [14]. Heterosexual youth may experiment with same-gender sexual partners. Homosexual youth may have opposite-gender sexual partners. Either group may abstain from sexual activity altogether. (See "Lesbian, gay,

bisexual, and other sexual minoritized youth: Epidemiology and health concerns", section on 'Developmental perspective'.)

In the 1950s, Kinsey maintained that, though commonly dichotomized into heterosexual or homosexual, many individuals' sexual orientation lies somewhere in between, not absolutely one or the other [15]. Considerable debate persists about Kinsey's hypothesis with increasing sophistication about the specific elements of "nature" versus "nurture" determinants of gender identity and sexual orientation. Prenatal exposure to androgens, neurologic structures and functions, and other neurophysiologic theories have been linked to both gender development and sexual orientation, though in ways that are not entirely clear [16]. Genetics, birth order, and immunology are among other biologic factors that have been considered. A genome-wide association study on >477,500 individuals of European ancestry suggests that, similar to other behavioral traits, same-sex sexual behavior is highly complex and influenced by many genes, some of which manifest in early sexual development [17].

SEXUALITY AND SOCIETY

Understanding distinctions between gender, sexual orientation, and sexual behavior is a critical concept in adolescent health and is influenced greatly by the culture in which one lives [2,18]. An individual's impression of gender or sexuality often is conveyed first by one's parents during early childhood [19]. Parents or other immediate family members help children define what is male and female and how they express themselves as members of their gender. Some authors argue that social environments after birth may have little or no impact on gender identity or sexual orientation, with prenatal hormones having major effects on organizing developing sexuality [20]. Regardless of theoretical etiologies, increasing evidence suggests that allowing children and adolescents to explore and identify as their authentic gender and sexual selves offers immediate and long-term improved health outcomes. (See "Management of transgender and gender-diverse children and adolescents", section on 'Social affirmation and transition'.)

As children become adolescents, influences broaden with peer, media, and community norms of gender and sexuality impacting their individual value systems. Media provide information and can exert some influence on adolescents' understanding of diversity, as well as their perception of gender roles and sexual behavior [21,22]. American adolescents

are exposed to several hours of media (television, radio, internet) each day, during which they experience significant exposure to sexual content, which often contains implicit and explicit references to intercourse [23,24]. Electronic media and social networking provide adolescents with even more ways to explore their burgeoning gender identities and sexuality. Online social networking sites for adolescents frequently mention or feature sex and sexual behaviors [25,26].

Longitudinal research consistently links degree of exposure to sexuality in the media to increased sexual risk taking and adverse outcomes [21,25]. Informative and open communication and support by parents can have a positive impact on sexual attitudes and behaviors [27,28].

Adolescent sexuality occurs in the context of many other aspects of adolescent development and is more complicated for gender and sexual minoritized persons (lesbian, gay, bisexual, transgender, queer, or questioning [ie, LGBTQQ]) youth. Regardless of the acronyms and current issues in terminology, the individual youth is the person best suited to describe and define identity and behaviors. Many youth refuse categorization, preferring more diffuse terminology such as gender queer, queer, pansexual, or fluid regarding gender and sexuality. What matters for most youth is that the provider asks about their personal perspective, experience, and what terminology best suits their needs.

Problems may arise for adolescents who encounter conflict between their emerging sexuality and the approach to sexuality that is imposed by families, peers, culture, and society as a whole. Role modeling, sex education, and other information for developing adolescents often has a solely heterosexual focus, with homosexuality considered a social or religious taboo. Many LGBTQQ youth use internet resources as a way to combat a cis/heteronormative world and seek information, connections, and resources that are more tailored to their identities [29]. Changing social understanding regarding diversity, family connectedness, social support at school, and community support for its LGBTQQ members, as well as a strong caring adult mentor can ameliorate the effects of negative messages on sexual minoritized youth. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns", section on 'Potential psychosocial and health concerns' and "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Associated concerns'.)

ADOLESCENT DEVELOPMENT

General adolescent development is frequently divided into three stages based loosely on chronologic age and level of functioning: early, middle, and late adolescence (table 1). One of the tasks for healthy adolescent development is the acquisition of a mature and responsible sexual identity including both an expression of sexual behaviors and the capacity for meaningful intimate relationships.

Early adolescence — Early adolescence (ages 10 to 14) coincides with the onset of puberty and typically involves concrete thinking, preoccupations and insecurities surrounding the physical changes of the body, and an egocentric approach to sexuality. Sexual curiosity and exploration may lead to initiating sexual experimentation with masturbation or early sexual activity with same- or opposite-gender sexual partners.

Middle adolescence — Middle adolescents (ages 15 to 18) complete the physical changes of puberty and begin to have more romantic relationships typically characterized by serial monogamy or having several partners at once and over brief periods of time. Middle teens can begin to imagine the consequences of their actions but still may not fully understand them and, because of this, engage in risk-taking behaviors such as substance use and unprotected sexual activity.

Late adolescence — Late adolescents (ages 18 and up) have more mature social skills, empathy, and an understanding of risks and consequences that help them develop more intimate and serious relationships. They have a mature understanding and enjoyment of their physical self, gender role, sexual orientation, and sexual behaviors. They can participate in a variety of intimate and social relationships (romantic partners, friends, family, professional colleagues) with a broader sense of connection and purpose in the community.

Adolescents or young adults who are mature and healthy in their sexuality are able to [18,30]:

- Identify and live according to one's own values; take responsibility for one's own behavior
- Practice effective decision-making; develop critical-thinking skills
- Affirm that human development includes sexual development, which may or may not

include reproduction or sexual experience

- Seek further information about sexuality and reproduction as needed and make informed choices about family options and relationships
- Interact with all genders in respectful and appropriate ways
- Affirm one's own gender identity and sexual orientation and respect the gender identities and sexual orientations of others
- Appreciate one's body and enjoy one's sexuality throughout life, expressing one's sexuality in ways that are congruent with one's values
- Express love and intimacy in appropriate ways
- Develop and maintain meaningful relationships, avoiding exploitative or manipulative relationships
- Exhibit skills and communication that enhance personal relationships with family, peers, and romantic partners

ADOLESCENT SEXUAL BEHAVIOR

Among adolescents in the United States:

- Young women reach puberty and sexual maturity (eg, breast development, menarche) at earlier ages than ever before. (See "Normal puberty", section on 'Trends in pubertal timing' and "Definition, etiology, and evaluation of precocious puberty".)
- Approximately 38 percent of high school youth report having had sexual intercourse, and 27 percent report being currently sexually active [31]. Prevalence of current sexual activity increases with age, rising from 12 percent in 9th graders to 42 percent in 12th graders. In large cross-sectional surveys, 7.6 percent of male high school students and 3.6 percent of males age 15 to 24 years reported having their first sexual intercourse before age 13 years; 8.5 percent of those with sexual initiation before age 13 years described their first episode of sexual intercourse as unwanted [32]. In another national cross-sectional survey, 6.5 percent of surveyed women age 18 to 44 years reported forced sexual initiation at an average age of 15.6 years (versus 17.4

years for those with voluntary sexual initiation) [33].

- In a large national survey, more than 50 percent of adolescents and young adults (age 15 to 24 years) reported ever having engaged in oral sex with an opposite-sex partner; <10 percent reported using a condom or dental dam at the last episode of oral sex [34].

- Trends (from 1991 to 2019) in the Youth Risk Behavior Survey indicate that [31]:

  - Rates of sexual intercourse have decreased (54 to 38 percent)

  - Rates of sex with more than four persons have decreased (19 to 9 percent)

- Many adolescents have sex without using effective contraception and are at risk for unintended pregnancy. In a national survey, 11 percent of sexually active high school students reported that neither they nor their partner used any method of contraception during their last sexual encounter [35]. In a separate multicenter study, 17 percent of adolescent males and 16 percent of adolescent females who completed an electronic survey in the emergency department reported having had sex without contraceptives in the previous one year [36].

- Young women ages 15 to 24 years still rely on the least effective methods of contraception, such as condoms and short-acting methods, such as pills, patch, and depot medroxyprogesterone [37]. However, their use of more effective, long-acting reversible contraceptives, such as implants and intrauterine devices, is increasing. (See "Contraception: Issues specific to adolescents".)

- Youth 15 to 24 years of age account for a disproportionate number of new sexually transmitted infections [38]. (See "Sexually transmitted infections: Issues specific to adolescents", section on 'Epidemiology'.)

- Approximately 5 to 10 percent of teens identify as lesbian, gay, or bisexual [39,40]. Over 10 percent of females and between 2 and 6 percent of males report having participated in same-gender sexual activity [41]. Adolescents' uncertainty about their sexual orientation decreases with age, from 26 percent of 12-year-old students to 5 percent of 17 year olds [42]. Adolescents with both male and female sexual partners have higher rates of unprotected sex, teen dating violence, and forced sex [12]. Gender-diverse adolescents have similar difficulties, including higher risks of bullying,

social isolation, and suicidality. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns", section on 'Potential psychosocial and health concerns' and "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Associated concerns'.)

HEALTH ISSUES AND OUTCOMES RELATED TO SEXUALITY

Sexual behaviors in teens include a range of activities from kissing, petting, and fondling to digital, oral, anal, and vaginal sex. While vaginal-penile intercourse among cisgender persons, with its inherent risks for pregnancy and sexually transmitted infection (STI), has been the best researched, many of these other sexual behaviors may serve as a prelude to intercourse or substitute for intercourse for teens wishing to preserve their "virginity." Teens engaging in oral sex are likely to initiate vaginal sex soon after; in a prospective study, 50 percent of high school freshmen/sophomores who initiated oral sex at the end of ninth grade self-reported engaging in vaginal sex within the next two years [43].

Studies evaluating self-reported sexual behaviors are fraught with problems regarding reliability and consistency of reported behaviors, definitions and understanding of specific behaviors, difficulties in measuring activities, and the impact of these activities on their current and future lives. Many studies indicate high levels of inconsistent reporting for sensitive, sexually related behaviors including dating, abstinence, first sexual intercourse, risk for STIs, and experiences with abortion [44-48]. Statistics and trends in sexual activity, behaviors, and outcomes are helpful to clinicians and impact screening and decision making. However, it is more crucial for clinicians to understand the multifaceted nature and complexity of sexuality as teens explore their gender and sexual identity in ways that are respectful, healthy, and safe.

Pregnancy — Early and/or unplanned pregnancy, childbirth, and parenting are significant consequences of adolescent sexual activity. The majority of adolescent pregnancies are unplanned. (See "Pregnancy in adolescents", section on 'Epidemiology'.)

Consequences of early and unplanned pregnancy are several-fold. Pregnant adolescents are more likely to delay seeking prenatal care and have higher rates of unfavorable birth outcomes, such as prematurity, infant mortality, and poor health and developmental outcomes. In addition, adolescent mothers are more likely to drop out of school, face unemployment, live in poverty, and rely on public assistance than are their peers who do

not have children. (See "Pregnancy in adolescents", section on 'Outcome'.)

Almost one-half of unintended pregnancies occur among users of contraception and are due to difficulties with adherence and continuation [49]. Additionally, suboptimal contraceptive use is consistently associated with pregnancy ambivalence in both teens and adult women [50]. Providers can better assist young women to avoid unintended pregnancy by regularly assessing adherence, continuation, and perceived and real side effects. Identifying young women at risk for inconsistent contraceptive use because of disadvantage, intermittent sexual activity, or ambivalence about pregnancy intention permits more tailored counseling and contraception planning. It is important not to assume that every teenager wants to avoid pregnancy. One Key Question is a tool for youth to explore their deeper family planning goals by asking, "Would you like to become pregnant in the next year?" as a way to create open discussion and explore implicit and explicit contraception intentions [51]. Asking about immediate and long-term family planning and encouraging a teenager to openly discuss pregnancy ambivalence or intention may allow more realistic anticipatory sexual health guidance, which may include preconceptual counseling as well as contraception.

Contraception — Contraceptive counseling, including discussion of abstinence, is a critical component of any comprehensive pregnancy and STI prevention strategy. Any person may become pregnant if sperm and oocytes are involved. Given the increase in gender-diverse patients, not all penile-vaginal intercourse involves sperm and or oocytes.

Abstinence is the single most effective means to avoid pregnancy, and support is warranted for adolescents who decide to abstain from sexual activity. However, for adolescents who choose to be sexually active, this also needs to be normalized, and both genders educated regarding the many effective methods of contraception [52]. Long-acting reversible contraceptives, such as the intrauterine device and etonogestrel implant, are highly efficacious methods that have been recommended as first-line contraceptive options for teens and young adults [53-55]. (See "Contraception: Counseling and selection" and "Contraception: Issues specific to adolescents", section on 'Choosing a method'.)

Confidentiality and availability of teen-friendly family planning counseling and options are critical factors in getting adolescents to use contraception consistently and effectively. It is important to discuss contraception with both male and female adolescents, engaging

young men in family planning decision making. Additionally, many young women who have sex with women also have sex with male partners and should be offered education and methods of contraception and STI prevention. (See "Confidentiality in adolescent health care".)

STIs and HIV — Approximately 19 million STIs occur each year in the United States, of which a disproportionate number (9 million) occur in adolescents [56]. STIs and HIV in adolescents are discussed separately. (See "Sexually transmitted infections: Issues specific to adolescents" and "The adolescent with HIV infection".)

The Centers for Disease Control and Prevention considers adolescents a special population in their regular review of STI care in the United States [57]. Infections with human papillomavirus, *Chlamydia*, and gonorrhea have the highest rates in teens and young adults. Multiple aspects of adolescence contribute to this increased risk including: early sexual debut, multiple sexual partners, sequential sexual partnerships of limited duration, inconsistent condom use, increased biologic susceptibility to infection, and difficulties accessing health care [58]. Youth at highest risk for STIs include those in juvenile detention facilities, young men having sex with men, and youth using injection drugs.

In the United States, all 50 states and the District of Columbia explicitly protect minors' rights to confidential services and care for STIs. Despite these protections and the high rates of STIs in this age group, many providers fail to routinely assess STI risks, provide harm reduction counseling, and screen for asymptomatic infections [59-61]. Screening for STIs is discussed separately. (See "Screening for sexually transmitted infections".)

STI prevention counseling should be developmentally appropriate (table 2) and provide anticipatory education and guidance, balancing normalizing its developmental place in achieving mature relationships with goals of risk avoidance and harm reduction. Open-ended questions and nonjudgmental counseling is important for adolescents who may not fully report all risks and sexual behaviors. Because early age of first intercourse is a risk factor for pregnancy and STI acquisition, it is appropriate to support abstinence and delaying sexual debut. For those who choose to be sexually active, consistent and correct use of condoms is the most effective strategy to prevent STIs. When recommending condoms, it is important for providers to demonstrate appropriate techniques for condom use and to model effective communication and partner negotiation skills [62]. These goals

(abstinence or consistent use of condoms) may be difficult to achieve for adolescents who feel invulnerable and whose cognitive risk-consequence decision-making abilities may be immature.

For patients who are not able or willing to use condoms, or engage in sexual behaviors with others who are at high risk for HIV infection, discussion of HIV pre-exposure prophylaxis (PrEP) may be warranted. Patient selection for HIV PrEP, including adolescents and young adults, is discussed separately. (See "Patient evaluation and selection for HIV pre-exposure prophylaxis".)

Victimization

Teen dating violence — Teen dating violence (TDV), including psychologic, physical, and sexual aggression, is common in adolescent dating relationships. TDV is more common in sexual minoritized and gender-diverse teens and teens engaging in other risk activities (eg, drug and alcohol use). Medical providers who do not routinely discuss TDV in adolescents miss opportunities for education and intervention. (See "Adolescent relationship abuse including physical and sexual teen dating violence" and "Date rape: Identification and management" and "Date rape: Risk factors and prevention".)

Sexual minoritized youth — There is substantial research documenting increased risk behaviors, victimization, and adverse health outcomes among gender-diverse and sexual minoritized youth. Health risks and adverse outcomes include child abuse, bullying, sexual harassment, TDV, mental health problems (depression, anxiety, suicide, disordered eating and body image), substance use, and unprotected sex with risks for STIs and pregnancy. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns", section on 'Potential psychosocial and health concerns' and "Gender development and clinical presentation of gender diversity in children and adolescents", section on 'Associated concerns'.)

It is important to ask about sexual partners and behaviors in order to screen and offer anticipatory guidance. Assuming that risks and outcomes are more related to gender of partners than to social support for sexual minorities, quality of sexual experience, and self-esteem may do a significant disservice to youth. By promoting sexuality as normative, healthy, respectful, and meaningful in the global context of adolescent development, providers can encourage a positive model of empowerment, strength, and resiliency for all youth exploring their gender and sexual identities [63].

ISSUES FOR THE HEALTH CARE PROVIDER

Provision of education — As adolescents struggle to understand their emerging sexualities within their complex social environments, health care providers must provide anticipatory guidance to maintain optimal sexual health and help adolescents avoid behaviors and expressions that increase the risk of negative consequences. Understanding sexuality as a normal and necessary part of adolescent development can help providers use a strength-based approach when counseling adolescents. Using sex-positive paradigms, providers can acknowledge that sex can create positive health outcomes and embrace the diversity of sexual identities, choices, and activities based on individual consent. Sex-positive approaches along with appropriate screening, education, and support can empower and encourage teenagers to make healthy safer sexual decisions [64].

Education and interventions that promote responsible and healthy sexuality can and should be delivered in homes, schools, medical, and community settings [18]. Despite a movement to provide abstinence-only education, evidence continues to demonstrate that abstinence-only programs are not associated with decreased adolescent birth rates, that comprehensive sexuality education programs can improve knowledge and reduce risk behaviors, and that the public and parents support comprehensive programs [65-71]. Comprehensive information with motivational and skills-based content is successful in reducing penetrative sexual behaviors and improving condom negotiation and use [72-74]. There is copious evidence demonstrating that comprehensive sexual health education delays intercourse, reduces frequency of intercourse, reduces the number of sexual partners, and increases the use of condoms and other contraceptives after sexual debut [75].

School-based interventions have been the traditional source of mass sexual health education efforts. The most effective programs have common characteristics: clear health goals (sexually transmitted infection [STI]/HIV prevention or pregnancy prevention), explicit linking of behavior to goals (abstinence, condom use), and strategies to improve sexual decision making and behaviors (knowledge, attitudes, values, perception of risk, community norms, self-efficacy) [76]. Teens, however, report that their education about sexual health comes from a variety of sources. Sex education from parents, grandparents, and religious leaders has been associated with beliefs linked to delaying sex [77]. In a

meta-analysis of observational studies, parental monitoring was associated with delayed sexual intercourse, greater condom use, and increased contraceptive use [78]. Learning about sex from friends, cousins, and the media has been linked to beliefs increasing the likelihood of engaging in sex [79-82]. The focus on abstinence-only education has led to the media serving as a leading sex "educator" in the United States today [83], especially for younger sexually inexperienced teens [84].

With the importance of media and technology in youth culture, it is important for newer frameworks of health education to consider alternative electronic routes such as interactive computer modules, text messaging, and other social media networks as well as school-based lecture style interventions [85-88]. As often as STIs and early pregnancy have been studied in youth populations, there are still many opportunities to learn more about health promotion and harm reduction in some of the highest risk youth, including those who are incarcerated, have mental illness, trade sex for resources, or are HIV-positive.

Additional anticipatory guidance topics for adolescents are discussed separately. (See "Guidelines for adolescent preventive services".)

Overcoming barriers — Although sexuality is a universal component of human experience and adolescence is a time of significant exploration and decision making regarding gender roles and sexual health, many providers fail to discuss or miss opportunities to discuss these topics with adolescents [18,60,89,90].

Barriers to discussions of sexuality include [59]:

- Clinic and service accessibility (hours of operation, transportation, insurance, billing, or self-pay costs)
- Lack of or perceived lack of confidentiality
- Mandatory parental consent laws or practices related to contraception, STIs, etc (see "Confidentiality in adolescent health care")
- Lack of communication coordination among and between health programs
- Narrowed, personally biased conception of sexual health care and lack of evidence-based information negatively impacting clinician anticipatory guidance and prevention efforts

- Provider- or system-level political, religious, and ethical beliefs and biases
- Stigma and discomfort associated with various aspects of sexuality including specific sexual behaviors, gender and sexual diversity, and early sexual activity
- Practical and financial constraints of clinic time and resources

Many health care providers miss opportunities to discuss gender and sexual health issues. Abstinence, condom use, and STI prevention are routinely discussed in over one-half of anticipatory guidance visits. However, this is well below the recommendation for universal annual screening and education. Screening and counseling in regards to sexual orientation, gender identity, and a complete range of contraceptive options for adolescents is markedly below national goals and recommended standards of care [60,89]. Providers who are uncomfortable or unable to provide comprehensive adolescent sexual health care may consider referring their patients to a provider who specializes in adolescent medicine. Comprehensive sexual health education and support can be complex and time consuming, necessitating referral to additional resources.

Despite continued efforts to improve anticipatory guidance and sex education in pediatric health care settings, a 2014 study revealed continued missed opportunities for sexual health counseling in adolescents [90]. In this study, analysis of audio-recorded conversations between adolescents and their clinicians revealed that 35 percent of clinicians did not discuss sexuality with their patients, 30 percent spent <36 seconds discussing sexuality, and 35 percent spent ≥36 seconds discussing sexuality. Patient characteristics associated with longer conversations included being older, female, African American, and more participation during the visit. In another study, having private time with clinicians, completion of pre-visit screening, the perception that the visit offered benefit, and visits lasting more than 10 minutes were associated with improved recall of anticipatory guidance [91]. These factors may be used to improve promotion of healthy sexuality at adolescent visits. There are little to no data regarding pediatric providers' efforts to prepare youth for the changes of puberty or screening for gender development and gender diversity, suggesting that anticipatory discussions regarding upcoming biologic and psychosocial changes of adolescence also are neglected.

In a 2014 survey, many urban disadvantaged youth reported mistrust of physicians, fear and lack of time as barriers to accessing care, and most felt that sexual care was more difficult to access than general health care [92].

Principles of care — Health care providers play an important role for youth in discussions of adolescent health and sexuality (table 2) [10,18,93-96]. Many adolescents consider their provider to be the most valued and trusted source of advice about issues of health and sexuality. Medical providers are particularly important facilitators of sexual health discussions as many youth indicate that they "definitely would not" talk to parents, citing "embarrassment" as the main reason to avoid discussion, with least communication occurring between fathers and daughters [97].

Clinicians who provide adolescent sexual health care often use interview techniques and care paradigms that include motivational interviewing (table 3), harm reduction, and social marketing in order to create an open dialogue that invites honest answers, focuses on individual strengths and goals, builds skills, and promotes personal responsibility. Use of the following principles to guide discussions of adolescent sexuality facilitates promotion of individual strengths and responsibility while reducing potentially negative consequences:

- **Confidentiality** – Assuring confidentiality is the first step in establishing basic trust and respect between the medical provider and the adolescent patient. Most adolescents require absolute privacy to talk candidly about their sexuality. Always ask partners, friends, or parents to leave the examination room at some point during the visit and before beginning these discussions. The importance of confidentiality in caring for adolescent patients, particularly surrounding issues of sexuality, cannot be overemphasized. This is especially true for lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQQ) youth who may fear lack of sensitive or appropriate care as well as being inadvertently "outed" by their health care provider to parents or peers, an event that can have a significant effect on the sexual minoritized youth's family relationships, social status, and personal safety [97]. Concerns about confidentiality are cited frequently as a reason to avoid seeking health care. (See "Confidentiality in adolescent health care".)

  Before initiating a discussion about confidentiality, health care providers must be careful to understand both state and institutional boundaries surrounding this issue, particularly with respect to treating adolescents without parental consent. (See "Confidentiality in adolescent health care" and "Consent in adolescent health care".)

- **Normalization** – Because many adolescents do not have experience in answering

questions of a sexual nature, the role of the clinician is to normalize discussions of sex. In order to do so, clinicians must be comfortable asking questions about sexuality and sexual behavior themselves. If health care providers appear uncomfortable asking questions about condom use or sexual orientation, the adolescent patient certainly will not feel comfortable answering them. It is important for health care providers to develop a communication style that enables them to ask the questions and get the answers they need to provide patients with appropriate health care, education, support, and referral. The discussion should take place when the patient is dressed.

- **Respect** – Health care facilities and individual providers must have respect for the diversity and differences inherent in adolescents and young adults, including gender, race/ethnicity, sexual orientation, and physical appearance [95,98]. Respect begins with front desk staff and waiting room material. It is demonstrated by:
  - Staff who are interested in seeing adolescents and skilled in the basics of providing adolescent health care
  - Brochures, posters, pamphlets, and other information that is welcoming to all youth
  - Clinic materials, administrative intake, and nursing triage that is inclusive of a wide variety of gender and sexual diversity
  - The use of open, nonjudgmental questions and avoidance of terms that could be perceived as pejorative such as "casual sex" or "multiple sexual partners"
- **Avoid assumptions** – It is important for health care providers to avoid making assumptions about the sexuality of their adolescent patients. In particular, health care providers should **not** assume:
  - That all patients are heterosexual unless told otherwise [14,99]. Gay, lesbian, and bisexual youth exist in all communities and in all pediatric practices; health care providers should ask adolescents questions that are gender and sexuality neutral. Avoid terms such as "boyfriend" or "girlfriend" but instead ask about "crushes" or "romantic or sexual partners," directly asking which gender or genders they are attracted to. Open-ended questions and gender-neutral questions allow the adolescent to reveal the gender of their partners and begin a conversation about

sexual identity and sexual behaviors.

- That adolescents who self-identify as heterosexual do not also have same-gender sexual partners [96,100]. Particularly in communities of color, young men who have sex with men may self-identify as heterosexual and are at extremely high risk of acquiring HIV [11].

- That a self-identified lesbian or transmasculine person does not require birth control [101]. Young women having sex with women may experiment with opposite-gender sexual partners and are at risk of becoming pregnant and acquiring STIs [102-105]. Transmasculine patients can and do get pregnant. (See "Lesbian, gay, bisexual, and other sexual minoritized youth: Epidemiology and health concerns", section on 'Unplanned pregnancy'.)

- That psychosocially or medically complex patients such as youth with significant neurodiversity or developmental delays, ongoing chronic illnesses, or gender dysphoria or diversity are not involved in romantic or sexual relationships. Incorporating patient specific discussions about their burgeoning sexuality is a useful part of any anticipatory guidance.

- That female adolescents do not engage in anal sex. Adolescent females may engage in anal sex as a pregnancy-prevention strategy and may not be aware of the need to use condoms for protection against HIV and STI.

- That patients have all the understanding and information they need about safer sexual practices. Providers should ask specifically what is meant by "safer sex," because their definition of this term may be different from what is thought by the adolescent.

- **Specific questioning** – It is important for health care providers to ask specific questions (table 4). Questions such as, "Are you sexually active?" are closed-ended, vague, and open to multiple interpretations with regard to both time frame and type of sexual behavior. Some adolescents who engage in oral or anal sex may not consider themselves "sexually active" and, as such, may not be aware of the health risks associated with this behavior.

  Because health consequences resulting from sexual activity have more to do with sexual behavior than sexual orientation, questions should focus on:

- **Specific sexual behaviors**, including digital, oral, vaginal, and anal intercourse (table 4). These questions should include information regarding date of last sexual activity and last sexual activity without a condom and without hormonal birth control. Detailed and specific information about behaviors and partners is important in determining risks and strengths. Sexual debut and lifetime, as well as recent numbers of partners, can be helpful components of a sexual risk assessment.

  It is important to establish the context for these questions so that the adolescent does not feel judged. The questions can be introduced with a statement like: "I am going to ask you about intimate and personal details of your sexual behaviors, partners, and other activities so I can know what to suggest for screening, testing, and healthy sex decisions." Such an introduction lets the adolescent know that all topics are open for discussion – and may open the door to other disclosures as well. Creating space for youth to disclose additional sexual desires and activities (eg, kink or bondage, dominance, sado-machoism) can facilitate a more comprehensive sexual history.

- **Condom use**, including how often and with whom. Separating condom use for STI prevention from condom use for contraception or family planning can be conceptually helpful and promotes use of dual methods for safer sex. Explicit discussions regarding the provider's "need to know" in order to make recommendations, not to make judgements, may open the door to more candid discussions about condom use.

- **Contraception**, for themselves or their partner. Questions about current use, problems with prior methods including difficulties with adherence or continuation, fears or concerns about side effects, and interest in other methods can generate useful discussion about contraceptive options. Asking directly about their immediate and long-term family planning goals, including ambivalence about pregnancy, can provide additional useful information (table 5). Including young heterosexual males in the screening and education process adds to their ability to contribute to family planning decisions [52]. (See "Contraception: Issues specific to adolescents", section on 'Choosing a method'.)

- **Victimization**, coerced sex, or "sex against your will" is common in adolescents

and may be associated with other health issues including suicidal thoughts, substance use, and concerns about personal safety. Questions that explore victimization include:

- "Have you ever had unwanted sex?"
- "Have you ever felt pressured to have sex even though you didn't want to?"
- "Have you ever been in a position where the sex went further than you wanted it to?"
- "Have you needed to trade sex for money, for food or a place to stay, or for drugs?"

Questions about exchanging sex for drugs, money, or housing may also be appropriate for homeless and disadvantaged youth.

- **Listen to responses** – All patients deserve the undivided attention of their health care providers, especially when discussing sensitive topics. Teens can be disconcerted and "turned off" to open and honest discussion of important sexual health issues if providers are perceived as either too busy, or worse, not interested. Providers who plan on providing adolescent sexual health services must plan to incorporate additional time and attention needed for sensitive and responsive screening and counseling. In addition, providers must pay attention to both verbal and nonverbal cues. Body language can be quite informative in interviews with adolescent patients, and an astute clinician might recognize opportunities for more in-depth questioning or targeted risk-prevention education.

- **Avoid medical jargon** – It is important for health care providers to speak about sexuality and sexual behavior in terms that are professional yet familiar and comfortable for the adolescent and avoid using medical jargon. As an example, questions about fellatio or cunnilingus may be replaced with more colloquial terms, such as "oral sex." For young men having sex with men, questions about anal insertive or anal receptive sex may be replaced with more familiar terms, such as "top" or "bottom," respectively. Developmentally appropriate terminology and focus is important for the early or developmentally delayed adolescent. Gender-diverse persons may be uncomfortable with terms for various gendered and sexual body parts. Providers can ask patients how they would like providers to refer to these parts or activities. Invariably, in discussions of sexuality, adolescents will use terminology or

phrases that are not understood easily by the health care provider. In these cases, one should ask for clarification by stating, "I am not familiar with that term. Can you tell me what you mean?" Adolescents usually welcome the opportunity to talk about themselves and may see this request as an expression of interest on the part of the provider.

- **Recognize the links** – When talking with young people about sexuality and safer sex, an important factor is to help patients make connections between their sexuality and other aspects of their lives. As an example, many youth engage in unsafe sexual practices while under the influence of drugs or alcohol. Helping an adolescent recognize this link is an important step in devising a comprehensive risk-reduction strategy that incorporates both substance-use services and safer sex practices. Other "links" include domestic violence, exchanging sex for money or drugs, and sexual assault. Each of these matters represents an opportunity for counseling, support, and referral.

- **Think support and prevention** – A safe and respectful conversation that enables youth to better understand sex and its role in their present and future lives may facilitate richer discussions. Providers can balance harm reduction and preventive recommendations with sex-positive messaging. Framing sexuality and sexual activity as an appropriate element of adolescent/young adult development can help to initiate conversations about what sex means to them. Asking patients to better understand their body, to have and communicate ideas about what is pleasurable to them, and to feel free to ask questions about sexual health and satisfaction is an important aspect of patient care. Incorporating sex positivity into sexual health discussions acknowledges that pleasure and prevention can go hand in hand.

  Persons who are engaged in sexual activities will hopefully be engaged in emotionally and/or physically satisfying relationships. Asking patients to better understand their body, have and communicate ideas about what is pleasurable to them, and feel free to ask questions about sexual health and satisfaction is an important aspect of patient care.

  Young people have a lot of questions about their bodies and sexuality and have few safe, confidential spaces in which to ask about them. Whether it is a visit for a sore throat, abdominal pain, or yearly anticipatory guidance, each interaction can be seen

by the health care provider as an opportunity for discussing health promotion and disease prevention. Just as providers discuss the importance of exercise or seat belts, or the health benefits of quitting smoking, they should provide sexuality education at every opportunity. It is important that disease prevention and contraception, including both condoms and hormonal methods, be readily available. No evidence suggests that the availability of contraception makes adolescents sexually active at younger ages than they would have been otherwise. Introducing sexuality in developmentally appropriate ways and while it is still relatively hypothetical is often welcomed by parents. Providers can model how to open discussions regarding sensitive topics as well as how to engage and counsel regarding safer sexual decision making.

As an example: "Well Sam, I am glad you and your dad are here together. During these adolescent health visits, we typically do some education about sexual health. Have you and your dad had any talks about puberty, dating, or sex? What have you and your dad talked about? It can be really hard for parents to think about their child having sex; just like it can be hard for teenagers to talk to their parents specifically about sex. It can be more comfortable to talk about sexuality and sexual health before there are any significant concerns. It is also really important to talk about sexual health and safety to prevent problems, diseases, unintended pregnancy, and unhealthy relationships.

"Let's talk about some common questions or concerns that people your age and a little older might have about sexual health. What is important for you (directed to the parent) to communicate about sex with your teen? From my perspective, it is important to discuss ways to enter into relationships safely and when you (directed to the teen) are ready for this. Picking a respectful and loving partner who listens to you and respects your limits is also important. We also want to make sure you/your teenager knows about how to avoid or prevent sexually transmitted infections. We want both boy and girl patients to consider ways to plan and prevent unintended pregnancy until they are ready to parent and raise a family."

- **Know community resources** – Adolescents may require or desire educational resources or other youth services that are beyond the scope of the individual practice setting. This need is particularly true for gay, lesbian, bisexual, and gender-diverse youth. (See ["Lesbian, gay, bisexual, and other sexual minoritized youth: Primary care"]

and "Management of transgender and gender-diverse children and adolescents".)

It is important to know what resources exist for youth in your community and/or state. In addition, a variety of internet websites are available to provide relevant information and education on adolescent sexuality issues. They include:

- American Academy of Pediatrics
- American Social Health Association
- National Youth Advocacy Coalition
- Sex Information and Education Council of the United States
- Nemours Foundation

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Adolescent sexual health and pregnancy".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or email these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword[s] of interest.)

- Basics topics (see "Patient education: Teen sexuality (The Basics)" and "Patient education: Normal puberty (The Basics)")

- Beyond the Basics topics (see "Patient education: Adolescent sexuality (Beyond the Basics)")

SUMMARY

Human sexuality is a broad concept that embodies interaction among anatomy, biology, psychology, interpersonal relationships, and sociocultural influences. Sexuality, sexual behaviors, and sexual relationships are an important and necessary part of human development. "Responsible sexual behavior" (eg, delaying initiation of sexual intercourse, choosing caring and respectful partners, increasing the use of condoms, and using effective contraception) is an important public health issue. (See 'Introduction' above and 'Definitions' above.)

- Adolescent development is frequently divided into three stages based loosely on chronologic age and level of functioning: early, middle, and late adolescence (table 1). One of the tasks for healthy adolescent development is the acquisition of a mature and responsible sexuality including both an expression of sexual behaviors and the capacity for meaningful intimate relationships. (See 'Adolescent development' above.)

- Health care providers are a valued and trusted source of information and advice about adolescent health and sexuality. It is important for them to take advantage of opportunities to discuss sexual behavior, particularly as it pertains to the prevention of pregnancy and sexually transmitted infections (table 2). (See 'Issues for the health care provider' above and 'Health issues and outcomes related to sexuality' above.)

- When discussing sexuality and sexual behavior with adolescents, it is important to create an open dialogue that invites honest answers, focuses on individual strengths and goals, builds skills, and promotes personal responsibility, while reducing the risk of potentially negative consequences (table 4 and table 5). (See 'Principles of care' above.)

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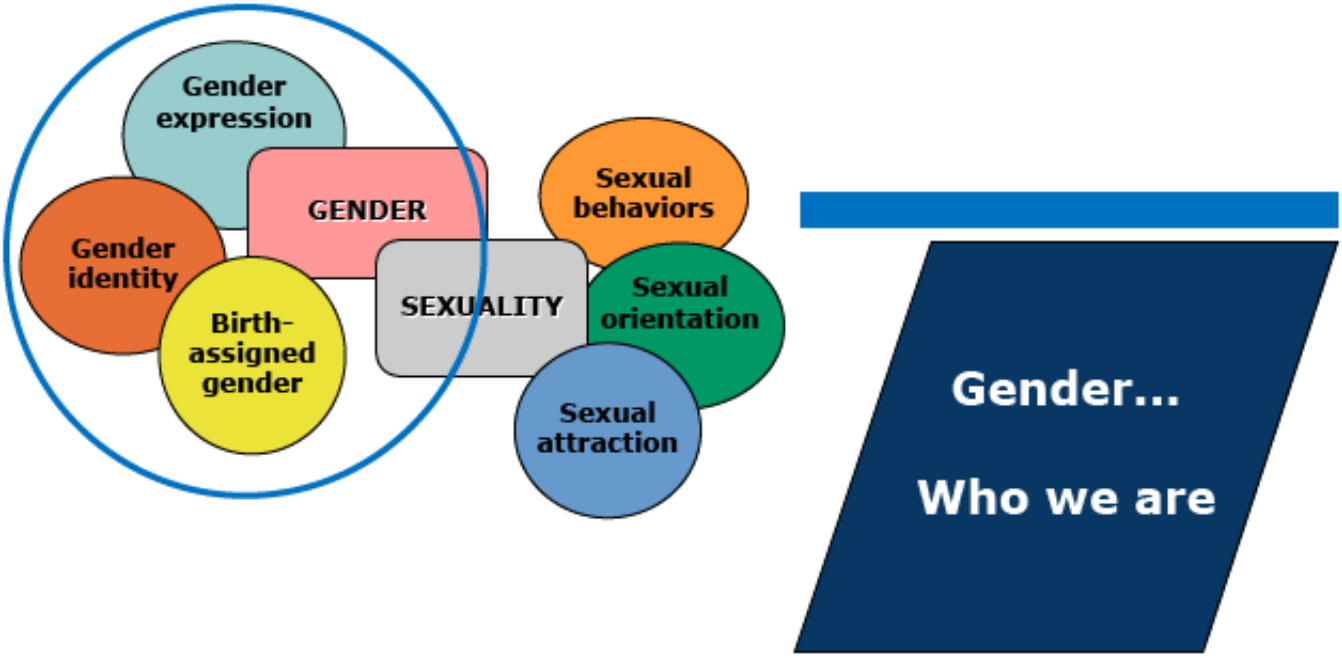
GRAPHICS

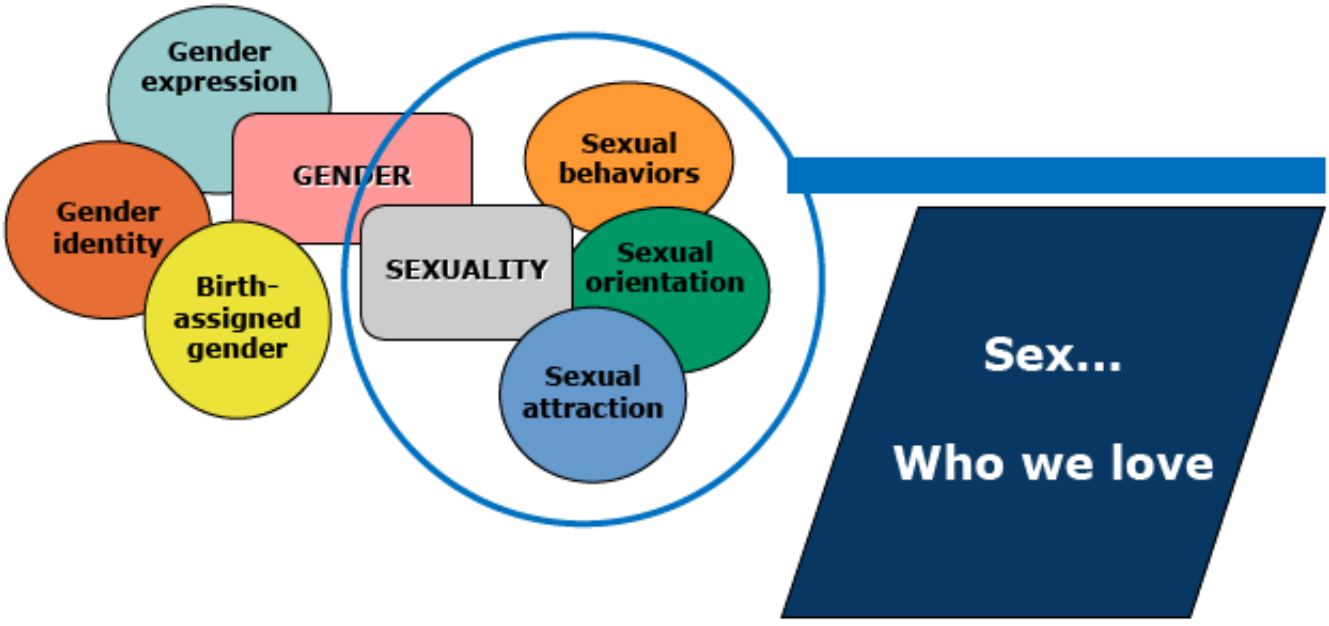
Paradigm of sexuality



Birth-assigned gender - Brain, hormones, body parts assigning male/female gender, usually at birth

Gender identity - Person's basic sense of being male, female, both, neither, or something else entirely – especially as experienced in self-awareness and behavior

Gender expression - Ways in which person acts, presents self, and communicates gender within a given culture



LGBTQQI - Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex

YMSM - Young Men who have Sex with Men

YWSW - Young Women who have Sex with Women

Bisexual, pansexual, asexual, queer

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

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Adolescent development

Tasks	Early, 10 to 14 years	Middle, 15 to 17 years	Late, 18 and older
Physical	Initiation of puberty; preoccupation with appearance; potential to reproduce	Completing puberty	Physical reproductive maturity
Cognitive	Concrete thinking	Increasing ability for abstract reasoning; risk-consequence deficits	Abstract reasoning; understands risk-consequence
Emotional	Egocentric	Developing sense of identity; risk-taking and experimentation	Intimacy as basis for sexual relationships; empathy and connectedness with others
Social	Reliance on family/parents; same-sex peer relationships and few romantic relationships	Peer influence, sexual exploration; differentiating from family	Exploring new mature role in family, romantic relationships, social networks, and workplace
Sexual	"Crushes"; beginning sexual experimentation	Exploration and experimentation; intense romantic relationships; serial monogamy	Mature acceptance and enjoyment of sexual self; good communication and decision-making skills regarding sex

Courtesy of Robert Garofalo, MD, MPH, and Michelle Forcier, MD, MPH.

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Suggested examples of developmentally appropriate ways to discuss adolescent sexuality and screen, counsel, and prevent sexually transmitted infections*

	Developmental stage		
Issue	**Early adolescence** **10 to 14 years old**	**Middle adolescence** **15 to 17 years old**	**Late adolescence** **≥18 years old**
Puberty	"Has your mom/dad talked to you about puberty and the way your body changes as you become a teenager?" "Do you have odor from your armpits and/or use deodorant now?" "Do you notice that your breasts/penis/testicles or balls are getting bigger?" "Have you experienced something coming out of your penis during the night? We call these nocturnal emissions and they are very normal." "Most girls will get some discharge or fluid and mucous that comes out of the vagina, which is normal and related to hormones." "Do you have any concerns about the changes your body is starting to go through?"	"It looks as if your body is finishing/finished puberty, but that does not mean you have finished all the other tasks and growing of puberty." "Do you have any concerns about your body?" "Do you like your body or do you have strong feelings about any particular body parts?"	"You have completed puberty but still have additional brain, social, and emotional growth ahead." "How do you feel about where you are in your development?" "Do you feel confident and competent to make health decisions?" "Do you have questions about the social and emotional development that occurs as you leave for school or a job?" "As you get older we will start doing regular breast or chest examinations and/or cervical pap screenings to check for or prevent cancer."
Gender	"Most of us learn about being a girl or boy from early on. When you think about your brain and body, do you consider yourself a girl, a boy, somewhere in between? Are you happy and comfortable being a boy or girl, or do you have questions about your gender?"	"I ask all my patients when they come in for check-ups: 'Do you consider yourself a girl, boy, or somewhere in between? How do you describe your gender?'" "There are lots of ways that people experience or express gender. I am open to discussing this or any questions about gender with you."	"How do you identify, regarding gender? That is, do you feel or regard yourself as a woman, man, or something in between, or some other way?" "Do you have any questions or concerns about your gender?"
Sexuality	"Have you and your parent(s) talked about sex and how to make decisions about getting involved in a romantic or sexual relationship?" "What have you and your	"Are you attracted to girls, boys, or both?" "Who have you been romantically and sexually involved with in the past?" "Have you ever had sex?"	"Are you attracted to women, men, or both?" "Who have you been romantically or sexually involved with in the past?" "How many sexual partners

	parent(s) talked about so far?" "If you were to have a crush or romantic feelings toward someone, would that someone be a girl, boy, both, or neither?" "Do you have someone that you like or that you would like to talk to or date?" "Do you have any questions about your sexuality?"	(See specific questions related to types of sex below.) "Do you feel safe with your partner(s)?" "What do you do for sexually transmitted infection protection?" "What do you use for pregnancy prevention?" "What do you know or what would you like to know about birth control options?"	have you ever had? What types of sexual behaviors have you tried or are currently having?" "Does sex feel good and satisfying for you and your partner? Do you have any concerns about orgasm, ejaculation, or your sexual function?"
Sexual behaviors	"Do you have any questions about a common way some young people your age are sexually active, such as masturbation or touching yourself?" "What sorts of things have you been taught or heard about sex?"	"What kinds of sex have you had? ▪ Kissing ▪ Petting or touching breasts ▪ Touching a penis to masturbate and make it cum ▪ Fingering or putting fingers in vagina or anus ▪ Putting your mouth on a penis or vagina ▪ Having someone put their mouth on your penis or vagina ▪ Putting your penis in a vagina or penis in an anus ▪ Having someone else put their penis in your anus?"	"What kinds of sex and partners do you have?" "Some people feel uncomfortable talking about sex. I hope this can be a safe and comfortable place for you to talk about sex." "There is a variety of ways to be sexually active. Do you have any questions about different ways to be sexual or have sex?"
STI prevention	"Do you have any questions about how to be safe in a sexual relationship?" "What have you heard about ways to protect yourself if you do have sex?" "Do you know about condoms? How we use them? How they can help prevent pregnancy and sexually transmitted infections?" "What do you know about sexually transmitted infections?"	"What do you know about sexually transmitted infections?" "What do you know about how to protect yourself or a partner from sexually transmitted infections?" "Have you ever had: chlamydia, gonorrhea, genital warts, or herpes?" "Have you ever been tested for syphilis or HIV?" "What have your used or tried in order to prevent sexually transmitted infections?"	"Are you currently having sex and/or in a relationship?" "Who do you have sex with?" "Have you and your partner discussed whether your relationship is monogamous or whether you both will also be having other sex partners?" "Are you feeling valued and respected in your relationship? Do you feel safe in your relationship?" "What would or could make

		"What has worked for you? What has not worked so well for you in the past?" "Would you like testing for sexually transmitted infections today?"	your relationship better?" "Until age 26, we recommend at least annual sexually transmitted infection testing; can we do this today?"

STI: sexually transmitted infection; HIV: human immunodeficiency virus.
* This is not meant to be a comprehensive list, but to provide examples of the developmental differences among early, middle, and late adolescents. Questions related to dating violence are discussed in the topics on date rape.

Courtesy of Michelle Forcier, MD, MPH, and Johanna Olson, MD.

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Overview of motivational interviewing

Key clinician behaviors:
▪ Collaborative and supportive approach:
• Communicate respect for and acceptance of the patient and his/her feelings.
• Establish a nonjudgmental, collaborative relationship.
• Express empathy through reflective listening.
• Listen rather than tell.
• Compliment rather than denigrate.
• Support self-efficacy and optimism – Focus on patient strengths to foster hope that is needed for change.
• Provide support throughout the process of recovery.
• Discuss behavior change, but affirm that change is up to the patient.
▪ Promote behavior change:
• Note discrepancy between the patient's goals or values and current behavior, helping them recognize the discrepancies between where they are and where they hope to be.
• Avoid argument and direct confrontation – These are core characteristics of power struggles.
• Roll with resistance – Adjust to, rather than oppose, patient resistance.
Key strategies:
▪ **Ask open-ended questions.** They allow for more expansive responses. For example, ask "What do you like about smoking?" instead of "Do you like smoking?"
▪ **Listen reflectively.** This involves demonstrating that you have heard what the patient has said by periodically repeating or paraphrasing what he or she has said.
▪ **Summarize.** Periodically summarize what has transpired in a particular visit, including discrepancies that are presented.
▪ **Affirm.** Support and comment on the patient's strengths, motivations, intentions, and progress. For example, "It seems as if you would really like to quit smoking, but see that it might be difficult."
▪ **Elicit self-motivational statements.** Have the patient voice personal concerns and intentions, rather than try to persuade him/her.
▪ **Assist with planning.** Ask questions to help the patient make a behavior change plan (identifying the change that he/she wants to make, reasons for doing so, first steps, obstacles, and solutions).

Motivational interviewing is a specific technique in which the clinician elicits and reflects back the patient's thoughts so that he/she can identify intrinsic motivations, work through ambivalence, and develop strategies for behavior change. This table summarizes the author's approach to applying the principles of motivational interviewing to counseling about tobacco or other substances in adolescents.

Courtesy of Marianna Sockrider, MD, DrPH.

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Strategies for interviewing middle and late adolescents about sexual attraction, identity, and behaviors

Sample questions regarding sexuality	Developmental goals
For middle adolescents (age 15 to 17 years)	
▪ Do you have any romantic interests in your life? ▪ Are you dating anyone? ▪ Is there anyone with whom you have a sexual relationship, including kissing, touching, or other stuff? Tell me about your partner. ▪ Are you sexually active or have you ever had sex*? ▪ What do you mean by "sex"? ▪ What sorts of sex have you had? ▪ What parts went where when you were having sex? ▪ Has sex been something you have wanted or something you felt emotionally or physically forced into doing? ▪ Have you ever paid for sex or been paid for sex? ▪ Who have you talked with about sex? ▪ What do your parents have to say about sex? ▪ What do your parents, family, and friends say about same-sex or gay people? ▪ Do you have any gay or bisexual people in your life that you can talk with? ▪ How do you feel about homosexuality or same-sex relationships?	▪ Safer exploration, experimentation ▪ Risk reduction and prevention of: sexually transmitted infections, unintended pregnancy, dating violence, bullying, substance use, mental health concerns, and suicidality ▪ Acknowledging and modeling support for diversity
For late adolescents (age 18 and older)	
▪ Are you sexually active or have you ever had sex*? ▪ Why or why not? ▪ What benefits or risks does being sexually active bring to a relationship? ▪ What sorts of things do you and your partner(s) do when you are sexually active? ▪ Do you kiss, touch each other's genitals, put your fingers in your partner's vagina or butt, put your penis in your partner's vagina or butt, receive a penis in your vagina or butt, give or receive oral sex? ▪ Has sex been something you have wanted or something you felt emotionally or physically forced into doing? ▪ Have you ever paid for sex or been paid for sex? ▪ Is sex pleasurable for you? ▪ Do you have any concerns about sex, orgasm? ▪ Any concerns about premature ejaculation or having a hard time getting aroused, wet, or hard? ▪ Do you do anything else that gives you and/or your partner sexual pleasure? Masturbation? Pornography? Drugs or alcohol with sex? Sex games or fantasy? Sadism or masochism? Fetishes or unusual ways to pleasure yourself or partner?	▪ Risk and harm reduction ▪ Explore sex for pleasure and pleasurable sex ▪ Explore sex's role in intimacy and mature relationship building ▪ Prepare for intimate partners, family planning

▪ (Remember to **leave long and open pauses** for patients to fill in the blanks or report other activities or interests)	

* For those who are sexually active, it is also important to ask about the number of partners, use of condoms or dental dams, and contraception.

Courtesy of Michelle Forcier, MD, MPH and Johanna Olson-Kennedy, MD.

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Specific tips for counseling adolescents about contraception

Counseling	Specific examples	Tips
Assessing pregnancy intention or ambivalence	▪ "What are your thoughts on pregnancy or delaying pregnancy?" ▪ "At present, in the next couple years, and long-term?" ▪ "If you were to be pregnant, would that be a good thing or a problem for you?" ▪ "Are you interested starting or continuing birth control?"	▪ Avoid assuming all adolescents want to contracept ▪ Adherence failures may indicate ambivalence or an unstated desire to become pregnant
Assessing birth control methods and options	▪ "What birth control do you use now?" ▪ "What kind of birth control does your partner use?" ▪ "What birth control have you tried or used in the past?" ▪ "What did you like or not like about that birth control method(s)?" ▪ "Was your method(s) easy to do or take?"	▪ Don't forget to include boys and men in discussions about pregnancy planning and contraception ▪ Women who decline birth control or who are condom-only users should be offered Plan B and prenatal multivitamins (this includes young women who have sex with women) ▪ Consider long-acting reversible contraceptives (intrauterine devices and progestin implants) for superior effectiveness and ease of use
Assessing side effects, concerns, and next steps	▪ "Did you have any problems keeping up with your method?" ▪ "Did you have any side effects that made you concerned?" ▪ "If you want to try method X, we can always reassess how this is working for you in Y weeks or months."	▪ Thorough counseling and education about normal and abnormal side-effects up front may help patients continue on their method ▪ Encourage patients to call or return to clinic with questions or concerns, rather than just discontinuing a method

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