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Adolescent Sexual Behavior and Sexual Health

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

1. Describe the trends related to adolescent sexual and reproductive health in the United States.
2. Explain the steps of becoming a sexually healthy adult in the United States.
3. Describe the continuum of sexual risk.
4. Delineate the best method of encouraging behavior change among adolescents.
5. Characterize how the law affects adolescents' access to reproductive health care.

Introduction

Adolescent sexual behavior is influenced by a complex set of interactions of biology and genetics, individual perceptions, personality characteristics, and sociocultural norms and values. This article addresses trends related to sexual and reproductive health of adolescents as well as clinical assessment and interventions designed to reduce sexual risk and promote sexual health of the adolescents in the United States.

Patterns and Trends in Adolescent Sexual Health Sexual Behavior

Perhaps in no other single area has there been as dramatic a change in the past decade as in adolescent sexual and reproductive health. There has been a small but significant decline in the percentage of teens who report having had sexual intercourse today compared with a decade ago. Specifically, in 1988, 53% of teenage females and 60% of males reported ever having had sexual intercourse; a decade later it was 50% and 55%, respectively. However, there has been an even more dramatic trend toward early initiation of sex. In 1988, 11% of adolescent females 14 years of age and younger reported having had sexual intercourse; a decade later it was 19%.

Although we tend to think of youths who have initiated intercourse as being “sexually active,” substantial data suggest otherwise. In fact, Terry and Manlove noted that in 1997, only 37% of females and 33% of males who reported ever having had sexual intercourse said that they had sex in the past 3 months. In 1995, the majority of sexually experienced high school teens (54% of males and 70% of females) had either no partners or one partner in the previous year.

Sexual Orientation

Children engage in sexual play with same-gender friends as a normative part of development. During adolescence, engaging in sexual activity with boys and girls may be a way of testing one's own sexual feelings. Although sexual orientation is believed to be determined before adolescence, its expression may be postponed until early adulthood or indefinitely, making it difficult to estimate the prevalence of homosexuality and bisexuality among adolescents. Uncertainty about sexual orientation may diminish during the adolescent years, with corresponding increases in homosexual and heterosexual affiliation. Among adults, sexual orientation prevalence estimates vary with the operational definition of homosexuality. Using a definition that included both homosexual behaviors and attrac-

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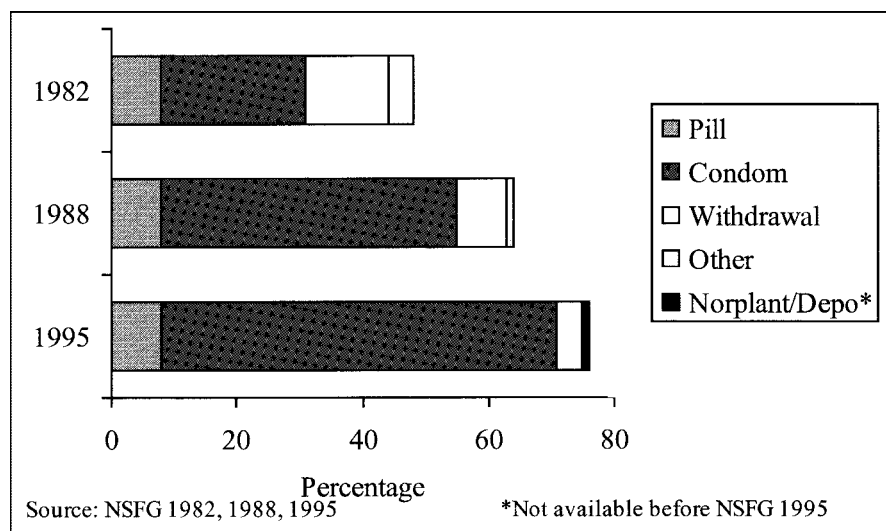


Figure 1. Trends in contraceptive use at first sex among females ages 15 to 19 years.

tions, Sell and colleagues estimated the prevalence of homosexuality nationwide to be about 20.8% among adult males and 17.8% among adult females.

In part due to the social stigma surrounding homosexuality and the lack of socially sanctioned ways to explore their sexuality, gay and lesbian adolescents typically experience a period of identity confusion in their process of sexual identity development. Some young people deal with this confusion through sexual encounters with multiple same- and opposite-gender partners or by engaging in other high-risk behaviors. For example, research suggests that adolescent girls who report being bisexual or lesbian have pregnancy rates that are as high or higher than their heterosexual female peers.

Contraception

Over the past 20 years, there has been a continuous rise in contraceptive use by America's teenagers. Specifically, according to data from the National Survey of Family Growth, 48% of young people ages 15 to 19 years used any contraception at first intercourse in 1982. This rose to 76% by 1995. Most of the increase reflected a nearly threefold increase in condom use during that 13-year period (Fig. 1).

Despite these positive trends, other indicators of contraceptive use among teenagers have decreased significantly. Specifically, although 43% of sexually active adolescent females said that they used oral contraceptives (OCPs) in 1988, the usage rate had decreased to 23% by 1995. Although the decline in OCP use was offset partly by increases in the use of injectable contraceptives, it was not offset by the use of other contraceptives at most

recent intercourse, which remained stable (26% in 1998 compared with 28% in 1995).

Pregnancy

Birth rates among 15- to 19-year-olds decreased dramatically during the 1990s, from a high of 62.1 per 1,000 in 1991 to 49.6 per 1,000 in 1999, which is the lowest rate since records were first collected in 1940. The 1999 rate represents a 20% decline for the decade. When the trends in pregnancy rates are analyzed by age, the greatest decline was seen among the youngest teens (<15 y), in which there was a decrease of 24% compared with declines of

17% among 15- to 17-year-olds and 12% among 18- to 19-year-olds. There was a 29% reduction in births over the same period for those younger than 15 years, 21% for 15- to 17-year-olds, and 13% for those 18 to 19 years old. Among ethnic groups, the birth rates for African-American teens dropped most dramatically (26%) compared with whites (19%), Asian/Pacific Islanders (16%), and Native Americans (15%). Concurrent with this downward trend has been a decline in abortions among adolescents, from 37.6 per 1,000 adolescent women ages 15 to 19 years in 1991 to 29.2 per 1,000 in 1996. Darroch and Singh attribute 75% of the decline in adolescent pregnancy rates to improved contraceptive use, with the remaining 25% attributable to abstinence. Although other authors have reached similar conclusions, key influences in the decline of teen pregnancy remain a hotly debated topic.

Adolescent Sexual Health: What Is It? How Do We Promote It?

A key developmental task of adolescence is to become a sexually healthy adult (Table 1). As clinicians, we can encourage development of sexual health among our adolescent patients by providing accurate information about sexuality, fostering responsible communication and decision-making skills, and offering guidance and support for young people to explore sexual attitudes and develop positive sexuality values. We also can encourage parents to communicate with their adolescent children in ways that promote sexual health and discourage risky sexual behavior. As members of individual communities and society at large, we can advocate for teenagers' access

Table 1. Adolescent Sexual Health**Includes:**

- Sexual development
- Reproductive health

As well as the following abilities:

- Appreciation of one's own body
- Development and maintenance of meaningful interpersonal relationships
- Avoidance of exploitative or manipulative relationships
- Affirmation of one's own sexual orientation and respect for the sexual orientation of others
- Interaction with both genders in respectful and appropriate ways
- Expression of affection, love, and intimacy in accord with personal values
- Expression of one's sexuality while respecting the rights of others

Adapted from Sexuality Information and Education Council of the United States, 1996; 2000.

to comprehensive sexuality education; affordable, sensitive, and confidential reproductive health-care services; and high-quality education and employment.

Adolescents should be encouraged to delay sexual activity until they are physically, cognitively, and emotionally ready for mature sexual relationships and their consequences. They should receive education about intimacy, sexual limit-setting, resistance to negative sexual pressures, benefits of abstinence, prevention of sexually transmitted infections (STIs), contraception, and delay of pregnancy. Because many adolescents are or will be sexually active, they should receive support and guidance in developing skills to evaluate their readiness for responsible sexual relationships.

Research has shown that adolescents get their sexual health information from a variety of sources. In a recent survey, 412 tenth graders were asked about their major sources of sexual information. Similar to patterns in previous research, friends were mentioned most often, with 63% of respondents noting that they obtained information related to sexual health from their friends. Siblings and cousins, the Internet, and magazines tied as the second most common source (31% of respondents); parents and clinics/health-care practitioners also were common sources of sexual information (each noted by 29% of respondents). However, when these teens were asked about their most valued sources of information on birth control and safer sex, their four top endorsements

included friends, parents, siblings and cousins, and clinics/health-care practitioners. Because teens value adults as sources of information, it is important for parents and health-care practitioners to initiate conversations and share timely, accurate information, lest adolescents obtain information only from other, perhaps less reliable, sources.

Interviewing Adolescents: Asking the Right Questions

Individuals face many risks related to sexual and reproductive health as they venture through the developmental stages of adolescence. However, as noted in Figure 2, individual-level and environmental protective factors buffer many teens from these risks.

In the span of a brief office visit, how can health-care practitioners assess risk and protective factors in the life of a young person? The HEADSSS mnemonic (Home and family; Education and school; Activities and friends; Drugs, alcohol, and tobacco use; Sexuality and sexual activity; Safety, violence, and abuse; Suicide, depression, and emotional distress) provides an optimal strategy for clinical assessment. Assessment within these domains provides information that is pertinent to the health of adolescents.

Starting with general, open-ended questions from the HEADSSS assessment, followed by more specific sexual health questions, allows the clinician to assess risk and protective factors while gaining an adolescent patient's trust. Adolescents are most likely to respond honestly to open-ended, nonjudgmental questions. Close-ended or seemingly judgmental questions tend to elicit socially desirable (although not necessarily honest) responses. Before beginning a HEADSSS assessment, clinicians should explain briefly the routine nature of their questions and why they ask them (eg, "As I do with all the teens I see in clinic, I'm going to ask you several questions to give me a better sense of things that can affect your health."). This explanation may be especially important with new adolescent patients and with younger teens, who may be acutely aware or easily embarrassed by the physical, emotional, and social changes they are experiencing.

Although there are no "magic" questions, certain interviewing strategies result in more accurate understandings. Using HEADSSS as a guide, the clinician starts by asking questions about home, education, and activities and proceeds toward sexuality. Opening questions related to sexual health could include "With whom do you spend time?" or "Is there someone special in your life you consider to be your boyfriend or girlfriend?"

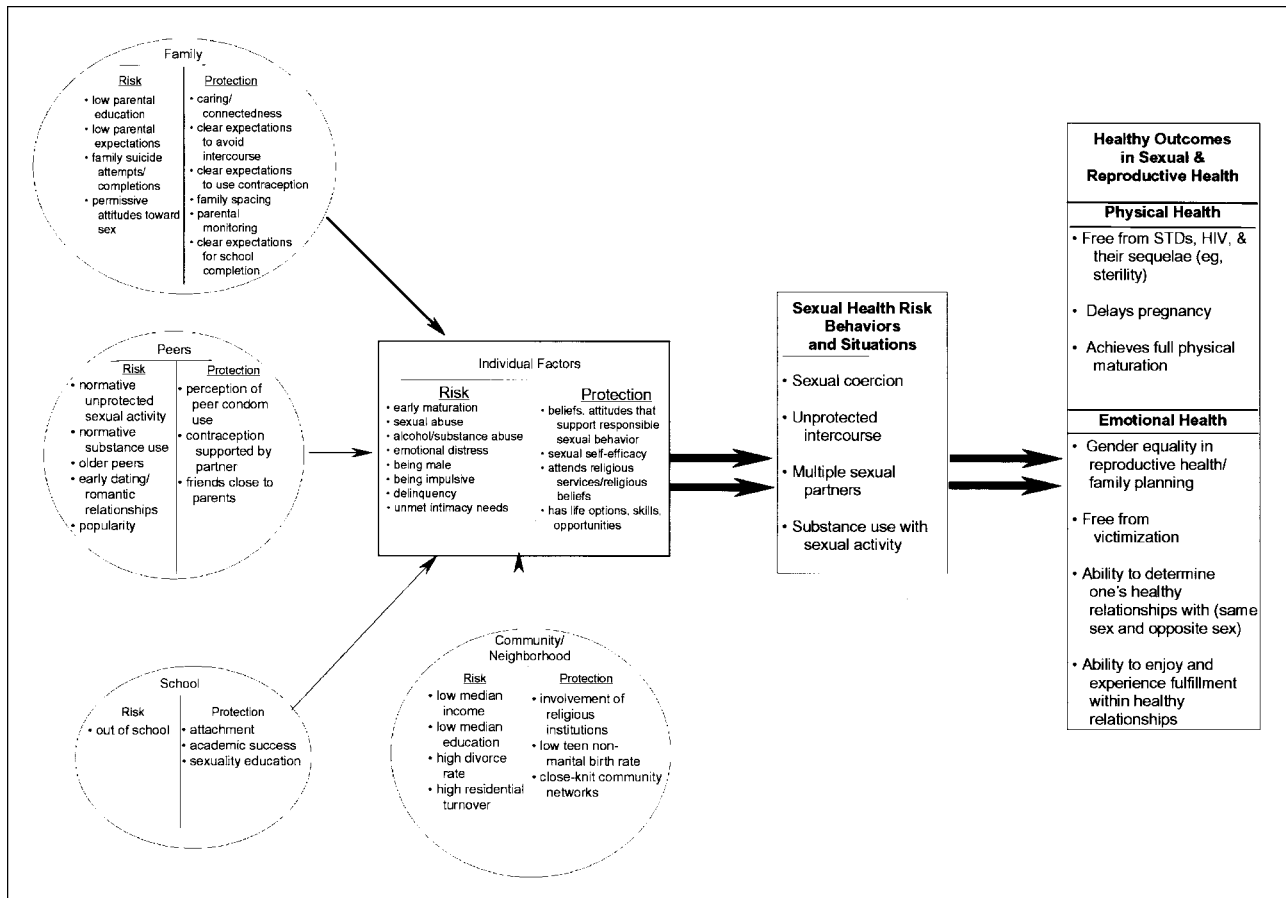


Figure 2. Predictors and protectors of sexual risk among adolescents. Adapted from a paper prepared for the World Health Organization by R. Blum, 2001.

These can be followed by more specific questions such as “What kinds of questions do you have about sex that you’ve never really had the chance to ask?” and “Is there anyone with whom you are having sex now. . .have had sex in the past. . .or are planning to have sex in the near future?” Screening questions regarding sexual attractions and behaviors should be phrased in ways that allow adolescents to discuss same- and opposite-sex attractions, behaviors, and affiliations.

Asking questions that define sexual intercourse help both the clinician and patient clarify what types of sexual risk the adolescent may be taking and allows discussion of abstinence. For example, a clinician might ask, “There are different kinds of sex—anal, oral, and vaginal sex. What kinds of sex are you having?” or “Now or in the past have you had sexual relations with males, females, or both?” Discussing types of sexual activity is important because involvement and understanding vary greatly among ad-

olescents. Giving a range of choices may be surprising to some teens, but may elicit honest responses from others.

Counseling about contraception and pregnancy prevention is especially pertinent with an adolescent. Even those currently practicing abstinence need to learn about contraception for future consideration. A question such as “What are you doing to protect yourself from pregnancy?” or “What are you doing to protect yourself from sexually transmitted infections?” works for both males and females and for abstinent patients.

Finally, closing with a question inviting additional comments shows adolescents that the clinician cares about him or her and about a specific health concern, a characteristic that adolescents consistently remark they desire in health-care practitioners. For example, a clinician might ask, “Is there anything else that I need to know or that you want to ask me so I can provide you with good health care?” This type of question encour-

Table 2. Assessing An Adolescent's Level of Sexual Risk

- Intensity of involvement in sexual risk behavior from a level of experimentation to a level of commitment
- Number of different risk behaviors in which an adolescent is involved and degree to which behaviors constitute an organized pattern or lifestyle
- Age of onset of sexual risk behavior
- Degree of simultaneous involvement in protective behaviors

Adapted from R. Jessor, 1991

ages adolescent patients to take control of their own health and provides them an opportunity to address health issues not previously discussed.

Assessing Adolescents' Level of Risk

Sexual risk behaviors, including early sexual debut, unprotected sexual intercourse, and multiple sexual partners, occur in a broader context. Table 2 provides guidelines for assessing adolescents' risk for negative outcomes associated with risky sexual behaviors. The intensity of involvement in sexual risk behavior ranges from no sexual relationship to unprotected sexual intercourse with multiple partners and prostitution. Although risky sexual behavior does not always indicate a high-risk lifestyle, sexual risk behaviors often cluster with other risk behaviors, including substance use, violence involvement, and poor school performance. Adolescents who engage in sexual intercourse at young ages are at higher risk for outcomes that can compromise their health. Finally, sexually active teens who exhibit few positive or prosocial behaviors, such as involvement in organized activities at school or in the community, are at higher risk for outcomes such as early sexual activity and pregnancy during their teenage years.

These guidelines help to differentiate high- from lower-risk clinical situations. High-risk situations are those in which there is serious and long-term involvement in an organized pattern of risk behaviors and few protective behaviors. Clinicians need to intervene whenever an adolescent's risk-taking behavior creates the potential for outcomes that can compromise health or when the behavior threatens the achievement of normal developmental tasks. The intensity of interventions must match both the individual adolescent's level of involvement in risk behavior and his or her readiness to change behavior.

Impact of Clinician Values When Working With Youth

Values are an inherent aspect of sexuality. Patients and practitioners alike view sexuality through their own values "lenses." Sexual values are learned from home, school, religious organizations, media, and other social institutions. They are affected by exposure to life circumstances, values of one's peers, and one's own comfort with sexuality. It is important for clinicians to recognize their own values and be aware of situations in which these values have a positive or negative impact on the care being provided. Although it is not appropriate for clinicians to impose values on patients, it is appropriate to be a catalyst in helping adolescent patients explore and understand their own values. To be effective in working with adolescents, clinicians must first understand their own values.

Guidelines for Brief Office-based Interventions

Among the "best bets" in brief office-based interventions are those that: 1) focus on building protection and reducing risk, 2) help teens build motivation or skills necessary for behavior change, 3) counsel parents about adolescent sexuality in ways that protect the adolescent patients' rights to confidential services, and 4) are based on an understanding of the legal framework related to adolescents' sexuality-related health care.

A Dual Approach: Building Protection While Reducing Risk

Some behaviors, perceptions, and social forces increase adolescents' risk; other social and individual factors act as protective buffers, reducing the likelihood that young people will engage in risky sexual behaviors. Resnick and others suggest that the most effective interventions for adolescents simultaneously build protection and address risks that are amenable to change. Protective and risk factors are present within social contexts in which teens live and work as well as in the perceptions, beliefs, and behaviors of individual teens.

Behavior Change: Understanding Motivation and Skills

Adopting healthy behaviors or giving up risky behaviors can be thought of as a process involving several distinct stages (Table 3). From this perspective, change is a "spiral" process in which people typically regress and cycle back through earlier stages several times before they succeed in maintaining healthy behaviors.

Early in the process of behavior change, people often

Table 3. Stages of Behavior Change

Precontemplation

- Not intending to change behavior in the foreseeable future.

Example: The sexually active adolescent who is not using condoms and has no intention to start doing so.

Contemplation

- Thinking about a change in behavior; considering the pros and cons of change.

Example: The sexually active adolescent who is not using condoms, but is considering use because he or she is worried about sexually transmitted diseases.

Preparation

- Intending to take action in the near future.

Example: The adolescent who has decided to talk with his or her partner tomorrow about using condoms when they have sex.

Action

- Actively modifying behavior, experiences, or environment to make a change.

Example: The teen who uses a condom the first time he or she has sex with a partner.

Maintenance

- Working on continuing or reinforcing behaviors adopted during the action stage.

Example: The teen who has been using condoms every time he or she has had sex with this partner over the past 6 months.

lack the necessary motivation for change. In later stages, people tend to lack skills or confidence to bring about a behavior change. Assessing an adolescent’s level of motivation and confidence to engage in or avoid a particular behavior gives clinicians a reference for initiating brief office-based counseling (Table 4).

Depending on where an adolescent is in the process of change, different types of interviewing strategies are useful in promoting healthy decision-making and action.

“Typical Day” strategies are useful in opening discussions and assessing an adolescent’s readiness to change behavior. For example, a clinician might open a conversation about relationships, sex, and contraception in the following way: “Tell me about a typical day for you and

Table 4. Assessing Motivation and Confidence

- On a scale of 1 to 10, with 10 being really motivated, how motivated are you to _____ (eg, use birth control)?

What would it take to move you from a 3 to a 7 in terms of motivation?

- On a scale of 1 to 10, with 10 being really confident, how confident are you that you could start to _____ (eg, use birth control)?

What would it take to move your confidence from a 3 to a 7?

your boyfriend . . . What happens when you’re together, how do you feel, when and how might you decide to have sex?”

“Good and Less Good Things” strategies are useful for exploring positive and negative perceptions teens may hold about an existing or new behavior. These strategies are useful with teens in early stages of behavior change. The goal is to help a teen identify and consider reasons that he or she might have for changing behavior. The following example illustrates a “good/less good” strategy: “For you, what are some of the good things about using a condom? And what are some of the less good things about using condoms?”

“So What?” strategies are useful in helping teens express concern about an issue. These strategies are useful with teens who are contemplating behavior change. The goal of these strategies is to have a teen voice a reason or reasons for change. The clinician might follow a discussion of good/less good things about an existing situation with a question such as: “What concerns you most about the way things are?”

“Now What?” skill-oriented strategies are most appropriate for teens in the preparation, action, and maintenance stages of behavior change. With these strategies, the goal is to help the teen plan and practice skills that allow him or her to take action in the direction of healthy behavior change.

Table 5 provides an additional set of guidelines to help adolescents develop and exercise decision-making skills. Rollnick and colleagues expand on office-based strategies that support healthy behavior change (see Suggested Reading).

Table 5. Help with Making Decisions

- Don't rush the teen into making a decision
- Present options for the future rather than a single course of action
- Describe what other teens have done when faced with similar situations
- Emphasize that "You are the best judge of what's best for you"
- Provide information in a neutral, nonpersonal manner
- Remember that failure to reach a decision is *not* a failed counseling session
- Resolutions to change often break down; make sure the adolescent understands this and doesn't avoid future contact with you if things change
- Acknowledge that commitment to change is likely to fluctuate; empathize with the teen

Counseling Parents

Research clearly documents that parents have an influence on their adolescent children's sexual behaviors. Although parents cannot determine whether their children have sex, use contraception, or become pregnant, their values, parenting practices, and quality of their relationships with their children can make a difference.

Ideally, practitioners should set aside time during routine health supervision visits to talk privately with parents about issues related to parenting adolescents. Grounded in research on parental influence, the National Campaign to Prevent Teen Pregnancy articulated "Ten Tips" along with a list of resources for parents and other adults who work with young people for talking about love, sex, and relationships. These tips provide a useful guide for talking with parents around promoting sexual health and reducing sexual risk of their adolescent children.

Be clear about your own sexual values and attitudes. Before communicating with teens about sex, love, and relationships, it is important to clarify your own values and attitudes around these topics as they relate to adolescence.

Talk early and often with your children about sex. Kids have lots of questions about sex, and they often say that they'd like to go to their parents for answers. Initiate an honest and respectful conversation, remembering that two-way conversations are often more effective than one-way lectures. Ask teens what *they* think and what they want to discuss so you can start at their point of interest. Research clearly shows that talking with children

about sex does *not* encourage them to become sexually active.

Help your teenagers find options for their future that are more attractive than early pregnancy and parenthood. The chances that your children will delay sex and pregnancy are increased substantially if their futures appear bright. As parents, you can help your children reach toward the future by helping them set meaningful goals, talking to them about what it takes to make the future plans come true, and helping them reach their goals. In particular, by becoming involved in community service, adolescents learn job skills and come into contact with a group of committed and caring adults.

Let your teens know that you value education. Encourage your children to take school seriously and set high expectations for their school performance. Be attentive to your children's progress in school; intervene early if they are not doing well. Get to know your children's teachers, principals, coaches, and guidance counselors. Volunteer at school if possible.

Know what your kids are watching and reading and to what they are listening. The media is full of material sending the wrong messages: Sex rarely has meaning, unplanned pregnancy seldom happens, and few people having sex appear to be especially committed to each other. Is this consistent with your values? If not, it's important to talk with your children about what the media portray and what you think about it. Encourage your children to think critically, asking them what they think about the programs they watch and the music to which they listen.

Supervise and monitor your children. Establish rules, curfews, and standards for behavior, preferably through a process of respectful family communication.

Know your children's friends and their families. Friends have substantial influence on each other, so help your children to become friends with kids whose families share your values. Welcome your children's friends into your home and talk to them openly. Consider talking with parents of your children's friends to establish common rules and expectations.

Discourage early, frequent, and steady dating. Group activities among teenagers are important and fun, but allowing teens to begin steady, one-on-one dating much before age 16 years can lead to trouble. Let your children know your expectations about dating throughout childhood or they may think that you just don't like a particular person or invitation.

Build close, caring relationships with your children early in childhood. The previous tips work best when they occur in the context of caring, connected parent-child

relationships. Strive for relationships that are warm, firm in discipline, rich in communication, and that emphasize mutual trust and respect.

For more information as well as resources for parents to talk with teens, visit the Campaign's website at <http://www.teenpregnancy.org>.

Legal Considerations

The legal precedent that many minors have the capacity and, indeed, the right to make important decisions about health care has been established in federal and state policy. At a minimum, the law must offer two different kinds of protection: 1) federal and state laws must allow an adolescent who is a minor to give his or her own

consent for care, and 2) laws must ensure that information about care will not be disclosed without the young person's agreement, except in uncommon circumstances. To ensure these protections, experts recommend that the source of health-care funding accommodate provision of independent and confidential services to minors.

The necessity for the law to provide for and protect confidential access to reproductive and sexuality-related care is not inconsistent with the idea that parents play an important role in the care of their adolescent children's health-care needs. Practitioners, parents, and adolescents interact to different degrees around decisions related to health care, depending on the nature of medical issues, family dynamics, and the developmental maturity and legal status of the minor. Many adolescents voluntarily involve their parents in health-care decisions, and many parents are aware of health-care services that adolescents receive. However, some adolescents cannot or will not involve their parents when seeking care. For these young people, legal protection of the ability to give consent and to receive confidential services is necessary.

Many states specifically authorize minors to consent to contraceptive services, testing and treatment for human immunodeficiency virus infection and other STIs, prenatal care and delivery services, treatment for alcohol and other drug abuse, and outpatient mental health care.

English and colleagues provide a state-by-state review of minor consent statutes (see Suggested Reading).

Conclusion

Office-based interventions are most likely to contribute to a reduction of risks and promotion of sexual health among young people if they occur in concert with other efforts in schools, communities, and families. Kirby describes key characteristics of successful multilevel efforts to prevent pregnancy and promote sexual health of adolescents. Building skills in effective office-based interventions is worth the effort because although adolescents frequently appear to dismiss our guidance, they listen actively to what clinicians have to say. Whether such

interactions facilitate an adolescent's process of making behavior change depends on the accuracy of information provided and the clinician's skills in connecting with and understanding a particular young person's perspectives and readiness for change. Finally, because clinicians may be one of very few adult resources in the

lives of some teens, they must be mindful of keeping "an open door" for ongoing conversation and support.

Suggested Reading

- Abma J, Chandra A, Mosher W, Peterson L, Piccinino L. Fertility, family planning and women's health: new data from the 1995 National Survey of Family Growth. National Center for Health Statistics. *Vital Health Stat.* 1997;23(19)
- Borzekowski D, Rickert V. Adolescent cybersurfing for health information. *Arch Pediatr Adolescent Med.* 2001;155:813–817
- Darroch J, Singh S. *Why Is Teen Pregnancy Declining? The Roles of Abstinence, Sexual Activity and Contraceptive Use.* New York, NY: The Alan Guttmacher Institute; 1999
- DiCenso A, Borthwick V, Busca C, et al. Completing the picture: adolescents talk about what's missing in sexual health services. *Can J Pub Health.* 2001;92:35–38
- Dittus P, Jaccard J. Adolescents' perceptions of maternal disapproval of sex: relationship to sexual outcomes. *J Adolesc Health.* 2000;26:268–278
- Emmons K, Rollnick S. Motivational interviewing in health care settings: opportunities and limitations. *Am J Prev Med.* 2001; 20:68–74
- English A, Simmons P. Legal issues in reproductive health care for adolescents. *Adolescent Medicine: State of the Art Reviews.* 1999; 10:181–194
- English A, et al. *State Minor Consent Statutes: A Summary.* 2nd ed. Chapel Hill, NC: Center for Adolescent Health & the Law; 2001
- Goldenring J, Cohen E. Getting into adolescent heads. *Contemp Pediatr.* 1988;5:75–90

Research clearly documents that parents have an influence on their adolescent children's sexual behaviors.

- Jessor R. Risk behavior in adolescence: a psychosocial framework for understanding and action. *J Adolesc Health*. 1991;12:597–605
- Kirby D. *Emerging Answers*. Washington DC: National Campaign to Prevent Teen Pregnancy; 2001
- Kirby D. *No Easy Answers*. Washington DC: National Campaign to Prevent Teen Pregnancy; 1997
- Meininger E, Cohen E, Neinstein L, Remafedi G. Gay, lesbian and bisexual adolescents. In: Neinstein L, ed. *Adolescent Health Care: A Practical Guide*. 4th ed. Baltimore, Md: Williams & Wilkins; 2002
- Miller B. *Families Matter: A Research Synthesis of Family Influences on Adolescent Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy; 1998
- National Campaign to Prevent Teen Pregnancy. *Ten Tips For Parents To Help Their Children Avoid Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy; 1998
- Paroski P. Health care delivery and the concerns of gay and lesbian adolescents. *J Adolesc Health Care*. 1987;8:188
- Philliber S. In search of peer power: a review of research on peer-based interventions for teens. *Peer Potential: Making the Most of How Teens Influence Each Other*. Washington, DC: National Campaign to Prevent Teen Pregnancy; 1999
- Remafedi G. Adolescent homosexuality: psychosocial and medical implications. *Pediatrics*. 1987;79:331
- Remafedi G, Resnick M, Blum R, et al. Demography of sexual orientation in adolescents. *Pediatrics*. 1992;89:714–721
- Resnick M. Protective factors, resiliency, and healthy youth development. *Adolescent Medicine: State of the Art Reviews*. 2000;11:157–164
- Rollnick S, Mason P, Butler C. *Health Behavior Change: A Guide For Practitioners*. New York, NY: Churchill Livingstone; 1999
- Saewyc E, Bearinger L, Blum R, et al. Sexual intercourse, abuse and pregnancy among adolescent women: does sexual orientation make a difference? *Fam Plan Perspect*. 1999;31:127
- Sell R, Wells J, Wypij D. The prevalence of homosexual behavior and attraction in the United States, the United Kingdom and France: results of national population-based samples. *Arch Sexual Behav*. 1995;24:235–248
- Sexuality Information and Education Council of the United States. *Annotated Bibliography: Adolescent Sexuality*. Available at: www.siecus.org/pubs/biblio/bibs0001.htm. Accessed April 2001.
- Sexuality Information and Education Council of the United States. *Guidelines for Comprehensive Sexuality Education: Kindergarten–12th Grade*. 2nd ed. Washington, DC: Sexuality Information and Education Council of the United States; 1996
- Sieving R, Sucoff C, Blum R. Maternal expectations, mother-child connectedness, and adolescent sexual debut. *Arch Pediatr Adolesc Med*. 2000;154:809–816
- Terry E, Manlove J. Trends in sexual activity in contraceptive use among teenagers. *Pregnancy Prevention for Youth (PPFY) Newsletter*. 2000:5
- Troiden R. Homosexual identity development. *J Adolesc Health Care*. 1988;9:105

PIR Quiz

Quiz also available online at www.pedsinreview.org.

1. The *most* common source of sexual information among teenagers is:
 - A. Friends.
 - B. Health clinics.
 - C. Parents.
 - D. Siblings.
 - E. The Internet.
2. The prevalence of sexual intercourse among teenagers during the late 1990s, as compared with a decade earlier, is *best* characterized as:
 - A. Decreased among both boys and girls.
 - B. Decreased among boys, but increased among girls.
 - C. Decreased among girls, but increased among boys.
 - D. Increased among both boys and girls.
 - E. Stable among both boys and girls.
3. A 14-year-old girl who has been sexually active for several months comes to your office requesting a prescription for an oral contraceptive. The law:
 - A. Allows you to provide information and perform a health assessment, but prohibits you from prescribing a contraceptive without parental consent.
 - B. Allows you to provide information, perform a health assessment, and prescribe a contraceptive without parental consent.
 - C. Prohibits you from providing information, performing a health assessment, or prescribing a contraceptive without parental consent.
 - D. Is moot on the issue of parental consent, leaving the decision about provision of services and parental notification to your discretion.
 - E. Varies by state regarding the issue of parental consent and the services you can provide without parental notification.
4. A 17-year-old boy who has been sexually active for 3 months almost purchased a package of condoms yesterday, but put them back when he saw a neighbor at the checkout line. He has decided to talk with his girlfriend this weekend about using them. This behavior *best* exemplifies which of the following stages of change?
 - A. Precontemplation.
 - B. Contemplation.
 - C. Preparation.
 - D. Action.
 - E. Maintenance.

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