Complete Summary

GUIDELINE TITLE

Sexuality education for children and adolescents.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatrics: Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence. Sexuality education for children and adolescents. Pediatrics 2001 Aug;108(2):498-502. [33 references]

GUIDELINE STATUS

This is the current release of the guideline.

American Academy of Pediatrics (AAP) Policies are reviewed every 3 years by the authoring body. The AAP review process involves an evaluation of new literature that has emerged since the original publication date. Following this review, a recommendation is made that the policy be retired, revised, or reaffirmed without change. Until the Board of Directors approves a revision or reaffirmation, or retires a statement, the current policy remains in effect.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Sexually transmitted diseases (STDs)
- Human immunodeficiency virus (HIV) infection
- Acquired immunodeficiency syndrome (AIDS)
- Unintended pregnancy

GUIDELINE CATEGORY

Counseling
Prevention

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To review the role of the pediatrician in providing sexuality education to children, adolescents, and their families

TARGET POPULATION

Children, adolescents, and their families

INTERVENTIONS AND PRACTICES CONSIDERED

Sexuality education and counseling and/or referral as appropriate for special needs

MAJOR OUTCOMES CONSIDERED

- Rates of sexual activity and adverse outcomes related to sexual activity (e.g., unintended pregnancy, sexually transmitted diseases [STDs], etc.)
- Sources, content, and effectiveness of sexuality education programs

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations for pediatricians are as follows:

1. Put sexuality education into a lifelong perspective. Actively encourage parents to discuss sexuality and contraception consistent with the family's attitudes, values, beliefs, and circumstances beginning early in the child's life. Do not

impose values on the family. Be aware of the diversity of family circumstances, such as families with same-sex parents. Guide these families or refer them to agencies or clinicians that can help them if they report difficulties or if you are not comfortable assisting them.

2. Encourage parents to offer sexuality education and discuss sex-related issues that are appropriate for the child's or adolescent's developmental level.
    - Use proper terms for anatomic parts.
    - Discuss masturbation and other sexual behaviors of all children, even those as young as preschool age, openly with parents.
    - Initiate discussions about sexuality with children at relevant opportunities, such as the birth of a sibling or pet. Encourage parents to answer children's questions fully and accurately. Offer parents resources to assist their communication efforts at home.
3. Provide sexuality education that respects confidentiality and acknowledges the individual patient's and family's issues and values.
    - Promote communication and safety within social relationships between partners. (Ruusuvaara, 1997) Ask about special friendships and relationships and explore their character. Complement school-based sexuality education, which typically emphasizes unintended pregnancy, sexually transmitted diseases (STDs), and other potential risks of sex. When appropriate, acknowledge that sexual activity may be pleasurable but also must be engaged in responsibly.
    - Address knowledge, questions, worries, or misunderstandings of children and adolescents regarding anatomy, masturbation, menstruation, erections, nocturnal emissions ("wet dreams"), sexual fantasies, sexual orientation, and orgasms. Information regarding availability and access to confidential reproductive health services and emergency contraception should also be discussed with early adolescents and with parents. During these discussions, also be open and nonjudgmental toward those with homosexual or bisexual experiences or orientation (see the related American Academy of Pediatrics position statement, "Homosexuality and Adolescence" [Pediatrics 1993;92:631-4]).
    - Acknowledge the influence of media imagery on sexuality as it is portrayed in music and music videos, movies, television, print, and Internet content.
    - Obtain a comprehensive sexual history from all adolescents, including knowledge about sexuality, sexual practices, partners and relationships, sexual feelings and identity, and contraceptive practices and plans.
    - In discussing reasons to delay sexual activity or use contraception, frame the suggestions in terms of the individual's development, language, motivation, and history. Be sensitive to cultural and family norms, values, beliefs, and attitudes, and integrate these factors into health promotion or behavior change counseling. Also be aware of the potential for, and ask about, abuse or coercion in relationships or sexual activity.
    - Counsel parents about sexuality. Suggest opportunities for them to provide guidance about abstinence and responsible sexual behavior to their children. Encourage reciprocal and honest dialogue between parents and children. Counsel parents and adolescents about circumstances that are associated with earlier sexual activity, including early dating, excessive unsupervised time, truancy, and alcohol use.

(Donovan, 1995; Alan Guttmacher Institute, 1994) Ensure that adolescents have opportunities to practice social skills, assertiveness, control, and rejection of unwanted sexual advances. (Frost & Forrest, 1995)

4. Provide specific, confidential, culturally sensitive, and nonjudgmental counseling about key issues of sexuality.
    - ***General counseling***. Counsel children and parents about normal sexual development before the onset of sexual activity, and encourage parent-child communication about sexuality. Parents should be encouraged to discuss explicit expectations for abstinence, for delaying sexual activity, and for responsible expression of one's sexuality. Advise children and adolescents to discontinue high-risk sexual behavior and avoid or discontinue coercive relationships. (Peckham, 1993) Discourage alcohol and other drug use and abuse not only for the direct benefits to the adolescent's health but also to prevent unwanted sexual activity or adverse consequences of sexual activity. Some pediatricians may want to consider the use of established curricula to ensure that all major points are covered. (Card et al., 1996) Additionally, handouts to reinforce safe sex practices and responsible decision-making should be available in the office or clinic. Pediatricians may directly provide this counseling, and other members of the office staff, such as nurses, social workers, or health educators, may also provide counseling and health education.
    - ***Preventing unintended pregnancy***. Discuss methods of birth control with male and female adolescents ideally before the onset of sexual intercourse (see the related American Academy of Pediatrics position statement, "Contraception and Adolescents" [Pediatrics 1999;104:1161-6]). Barrier methods should always be used during intercourse in combination with spermicide or with hormonal contraceptives. Providing access to contraception for adolescents who are sexually active is an important method of reducing pregnancy rates. (Peckham, 1993)
    - ***Strategies to avoid STDs, including HIV infection and AIDS***. Abstinence should be promoted as the most effective strategy for preventing human immunodeficiency virus (HIV) infection and other STDs as well as for prevention of pregnancy. Adolescents who become sexually active need additional advice and health care services. Adolescents should be counseled regarding the importance of consistent use of safer sex precautions. Pediatricians should assist adolescents in practicing communication and negotiation skills regarding use of condoms in every sexual encounter (Darrow, 1989) and should consider providing adolescents with information and demonstrations about how condoms should be used. Comprehensive recommendations for HIV counseling, testing, and partner notification are addressed in detail in the American Academy of Pediatrics position statement "Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention" (Pediatrics 2001;107:188-90).
5. Provide appropriate counseling or referrals for children and adolescents with special issues and concerns.
    - ***Gay, lesbian, and bisexual youth***. Maintain nonjudgmental attitudes and avoid a heterosexual bias in history taking to encourage adolescents to be open about their behaviors and feelings. (Harrison,

1996; Ryan & Futterman, 2000) (See also the related American Academy of Pediatrics position statement, "Homosexuality and Adolescence" [Pediatrics 1993;92:631-4]).

- If adolescents are certain of homosexual or bisexual orientation, discuss advantages and potential risks of disclosure to family and peers, and support families in accepting children who identify themselves as gay, lesbian, or bisexual. Adolescents who are homosexual should be screened carefully for depression, risk of suicide, and adjustment-related mental health problems. Similar issues are important to children unsure of their sexual orientation.
- ***Children and adolescents with disabilities***. Rates of sexual activity for adolescents with disabilities are the same as those for adolescents without disabilities. (Suris et al., 1996) However, children in special education may not receive sexuality education in school. Children and youth with disabilities should be provided developmentally appropriate sexuality education. Parents may need reassurance and support in getting sexuality education for children and adolescents with disabilities. Discussions should be initiated with parents or guardians of children with disabilities at a young age to encourage self-protection and acceptable forms of sexual behavior. Community resources and support groups may also be of assistance.
- ***Other children at risk***. Identify children at risk for early or coercive and unintended sexual behaviors at an early age. Children who have been victims of physical or sexual abuse or have witnessed sexual violence or physical abuse; children with precocious puberty; and children with social risk factors, such as learning problems, drug or alcohol use, and antisocial behavior, may be at increased risk. Provide or arrange for counseling about sexuality for these children or adolescents. Refer to mental health services if appropriate.

6. Routine gynecologic services should be provided to female adolescents who have become sexually active. Screening for cervical cancer and STDs should be performed for sexually active females, and screening for STDs should be performed for sexually active males, as recommended elsewhere by the American Academy of Pediatrics (American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. Guidelines for Health Supervision III. Elk Grove Village [IL]: American Academy of Pediatrics; 1997)
7. Become knowledgeable about sexuality education offered in schools, religious institutions, and other community agencies. Encourage schools to begin sexuality education in the fifth or sixth grade as a component of comprehensive school health education and to use curricula that provide effective and balanced approaches to puberty, abstinence, decision-making, contraception, and STD and HIV prevention strategies and information about access to services. Because nearly one third of school districts do not provide any information about contraception regardless of whether students are sexually active or at risk, (Landry, Kaeser, & Richards, 1999) pediatricians should consider presenting material at the school. The American College of Obstetricians and Gynecologists publishes a resource, the "Adolescent Sexuality Kit: Guides for Professional Involvement" (Washington [DC]: American College of Obstetricians and Gynecologists; 1992). This series addresses acquired immunodeficiency syndrome (AIDS), date rape, contraceptive options, and other topics that may be useful to pediatricians who plan to provide sexuality education. Participate in community activities to

monitor the effectiveness of prevention strategies and revise approaches to decrease the rate of untoward outcomes. Consider serving as a referral source for students who need comprehensive reproductive health services.
8. Work with local public planners to develop a comprehensive strategy to decrease the rates of unsafe adolescent sexual behavior and adverse outcomes.

Summary of Recommendations

1. Every pediatrician should integrate sexuality education into clinical practice with children from early childhood through adolescence. This education should respect the family's individual and cultural values.
2. Educational materials, such as handouts, pamphlets, or videos, should be available to reinforce office-based educational efforts.
3. Pediatricians should be knowledgeable about community services that provide appropriate high-quality sexuality education and additional services that children, adolescents, or families need.
4. Pediatricians should consider participating in the development and implementation of sexuality education curricula for schools or in public efforts to decrease the rates of unsafe adolescent sexual behavior and adverse outcomes.
5. Linguistically appropriate materials could be provided in the office or the pediatrician should have a way of helping children, adolescents, and their families get information in their language of choice.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Sexuality education for children and adolescents by pediatricians allows for longitudinal sexuality education as part of preventive health care, and complements school or community-based programs. Sexuality education may help decrease the risk of early, exploitive, or risky sexual activity which may lead to health and social problems, such as unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus infection (HIV) and acquired immunodeficiency syndrome (AIDS).

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Aug (reaffirmed 2004)

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics (AAP)

GUIDELINE COMMITTEE

Committee on Psychosocial Aspects of Child and Family Health

Committee on Adolescence

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatrics (AAP) Policy Web site.

Print copies: Available from AAP, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on May 7, 2002. The information was verified by the guideline developer on June 11, 2002.

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