Adolescent Sexual Development and Sexuality

Assessment and Interventions

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Chapter 7

Sexuality and Sexual Behaviors in Adolescence

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INTRODUCTION

One of the most important developmental tasks of adolescence is to become a sexually healthy adult. Sexual health includes not only the physical aspects of sexual development and reproductive health but also valuing one's own body, developing interpersonal skills of achieving a meaningful relationship, interacting with both genders in a manner that reflects respect and equality, and expressing love and intimacy (SIECUS, 2000). Adolescent sexual health is facilitated through the following:

- Access to and availability of information about sexuality;
- Building decision-making skills;
- Offering support and values clarification; and
- Modeling healthy sexual attitudes and behaviors (SIECUS, 2000).

Society can enhance adolescent sexual health by providing access to comprehensive sexuality education and affordable, sensitive, and confidential reproductive health care services.

Beginning with early adolescence there is a gradual integration of the elements essential to the development of the adolescent's healthy sexuality: physical maturation, psychosocial maturity, and the expression of intimacy through

sexual behaviors. The process begins with physical maturation. Psychosocial characteristics include an increased capacity for empathy and an increased desire for autonomy while the teen still requests parental guidance. There is also a desire for intimacy with others, identification with peers, and an increased realization of sexual orientation and preference. The sexual behaviors evident through the adolescent years include periods of abstinence/postponement, sexual experimentation, and initiation of intercourse.

ADOLESCENT SEXUAL BEHAVIORS

Age-Related Behaviors

Each of the stages of adolescent development (early, middle, late) has recognizable patterns of sexual behavior and sexuality (Haffner, 1995). In early adolescence (9–14) experimenting with non-intercourse sexual behavior is common, while vaginal, oral, and anal intercourse are usually limited. However, clinicians and school personnel have noted an increase in oral sex among this age group (Remez, 2000). Middle adolescence (13–17), brings more frequent sexual experimentation and the first intercourse (Haffner, 1995). Physical maturation is complete by late adolescence (17 and older). Sexual behavior and sexuality may become more associated with commitment and future goals (Haffner, 1995).

The legal age of consent for sexual intercourse varies throughout the United States. The legality of consensual sexual behavior depends on the statutes in each jurisdiction; age, age difference between the partners, and types of sexual behaviors are specified. However, regardless of state laws, the probability of a teen's engaging in sexual intercourse increases with age. Sexual behaviors have been the focus of numerous studies over the past two decades. From 1990 to 1995, the Centers for Disease Control reported that 53–54 percent of student in grades 9 through 12 had had sexual intercourse. In 1999, 49.9 percent of high school students indicated that they had had sexual intercourse during their lifetime (Centers for Disease Control, 2000).

Gender-Related Behaviors

In comparing rates of sexual activity for the 1990–1995 period, more male students (56.9 percent) had sexual intercourse than did female students (50.3 percent) By 1999, the percentage gap narrowed for males and females (52.2 percent of males and 47.7 percent of the females). The median age for first intercourse was 16½ years. Younger adolescents reported less sexual activity (intercourse) (38.6 percent) than did older teens (64.9 percent) of those in twelfth grade (Centers for Disease Control, 2000).

In terms of sexual partners, 23.3 percent of the boys and 13.8 percent of

the girls reported having four or more sexual partners in 1995. By 1999, the rates dropped 19.3 percent (boys) and 13.1 percent (girls) (Centers for Disease Control, 2000).

Adolescents' sexual experimentation includes identifying which activities are desirous and pleasurable for both their partners and themselves. A study conducted in 1988 and 1995 found that the range of sexual behaviors in young men is fairly wide—55 percent of the sample stated they had vaginal intercourse, 53 percent had been masturbated by a woman or girl, 49 percent received oral sex, and 39 percent had given oral sex, but only one in ten of those males who were sexually active ever engaged in anal sex (Gates & Sonenstein, 2000).

VALUES AND SEXUAL ACTIVITY

The transition from childhood to adulthood is a time of unparalleled influence on a young teen's life; friends, families, teachers, and personal and vicarious experiences shape the attitudes, beliefs, and values adolescents hold regarding sex, sexuality, and intimacy. The cognitive stage of formal operations begins at 11 years of age and ushers in a time when teens analyze and explore all issues in their lives from a new philosophical viewpoint. Beliefs may shift and reconfigure with new information, experimentation, and direct and indirect experiences. Whereas adolescents hold idealistic expectations, their sense of self is not well established, although they may believe that they can resolve any issue with clarity and decisiveness. Their conclusions and opinions about what is right or wrong have an ebb and flow that defies prediction and analysis. At any moment there may be simultaneous conflicting values. Opinions change on a day-to-day basis depending on input from family and friends. Ironically, their own values concerning sexual activity do not necessarily correlate with their sexual behaviors. For example, a recent study of teens ages 13 to 17 revealed that nearly 20 percent admitting to being sexually active, but almost half of that same sample stated that premarital sex is always wrong, while the other half of the sample indicated that premarital sex is sometimes permissible (Gribbin, 1999).

THE SEXUAL DEBUT

Although most adolescents engage in sexual intercourse before entering adulthood, the occasion of the sexual debut is rarely planned in advance and is usually surrounded by mixed emotions and doubts. There is tremendous uncertainty about "being ready" for intercourse. Teens undergo an intense emotional experience that ranges from romantic, intimate, and pleasurable feelings, to fear, guilt, and shame. Anticipating first intercourse with a new partner is fraught with anxiety and vacillation. Once the couple decides to engage in sexual intimacy, there is a tendency to define the relationship in those terms. The couple negotiates when, where, and how often they will have sex. If contraception is

not used or they do not practice safe sex from the outset, those issues become an ongoing source of anxiety and fear.

In one study, girls were asked to reflect back to the circumstances of their sexual debut, most felt that they were "too young" or not ready to have sex, nor had they understood the potential risks. In short they felt they had not made appropriate choices (Rosenthal, Burklow, Lewis, Succop, & Biro, 1997).

The age of first sexual intercourse among adolescents is influenced by many factors, among them physical development and maturity, social controls, interpersonal relationships, environmental factors, decision-making skills, coercion and aggression psychosexual issues, and coercion and aggression. (Planned Parenthood Federation of America, 2000).

Physical factors such as physique, attractiveness, and timing of puberty may signal readiness to the outside world when the teen may not be emotionally and cognitively ready to take the next step toward the sexual debut. Social influences such as parental supervision (Alan Guttmacher Institute, 1994; Rosenthal et al., 1997), peer pressure, and frequent dating may exert considerable influence on young teens. The intensity of interpersonal relationships, romantic attachments, wanting to show love and affection, and partner approval can also lead the teen to believe he or she is ready for sexual intimacy (Bearman & Bruckner, 1999). Environmental factors such as economic status, availability and use of drugs, and alcohol and resources can provide more opportunities for sexual intimacy activity (Alan Guttmacher Institute, 1994; Kirby, 1997; Leigh, Morrison, Trocki, & Temple, 1994; Rosenthal, 1999). Decision-making and cognitive appraisal skills that are unrealistic may contribute to a choice to become sexually active because "it is time," or everyone else is "doing it." Finally, sexual coercion and aggression, in the current relationship or in the past, may lead to an inappropriate and early sexual debut (Abma, Driscoll, & Moore, 1998; Laumann, 1996).

SEXUAL DESIRE AND SEXUAL RESPONSE

Desire in Teens

Most literature describing the sexual awakening of young women refers to the correlation between menarche and the initiation of sexual behavior (Udry, Tolbert, & Morris, 1986). There is an assumption that biological, social, and cultural factors contribute to "a sequence of events that begin with dating and the increased probability of early intercourse and childbearing" (Daniluk, 1998, p. 43). Yet, what is glaring in its absence is the concept of sexual desire and sexual responsiveness.

There is a somewhat negative undertone to the idea of adolescents, especially girls, engaging in sexual behavior. Early traditions and guides for young women suggested that sexual behavior should be resisted at the risk of ruined reputation. Although one of the most critical developmental tasks of adoles-

cence is the integration of sexuality and the expression of intimacy (Erikson, 1968; Miller & Simon, 1980), actual discussion of how those tasks can be accomplished is not offered or superficially acknowledged to teens.

Only a few studies address sexual desire either as a meaningful factor in adolescent decision making or as a predictor of sexual intercourse (Tolman, 1990). It is astounding that sexual desire in adolescence is omitted from nearly every study addressing intercourse, contraception choices, and sexual decision making. If scientists studied diet and nutrition without ever exploring appetite as a key factor, they would be ridiculed. Yet "sexual appetite" is often the underlying "evil" that gets teen boys into trouble. Tolman (2000) believes, "if sexual desire is a part of the human condition, then being able to know and feel one's sexual desire is an important component of one's lived experience. Sexual desire provides us with potent information, an embodied compass, about ourselves and our relationships" (p. 70).

Boys and young men learn about sexual arousal and responsiveness at a young age. They can visually recognize sexual arousal. They are aware of the feelings in their bodies and how they can increase pleasurable sensations. With maturity, boys gain an even better understanding of how their body works, but there are some misconceptions as well. Historically, men and women have been told that when it comes to sex men are more "physical" in nature, whereas women are more interested in the emotional or relational aspect of the sexual encounter. Whether this is true or not or to what degree it is true is unknown as the data on the crucial topic are missing.

Tolman was among the first to listen to adolescent girls talk about desire. She identified three voices: an erotic voice, a voice of the body, and a response voice (Tolman, 1994). The erotic voice is the subjective experience of wanting. Lorde (1984) refers to it as the "yes within ourselves." It is the adolescent's awareness and consciousness of sexual feelings. This does not mean that the adolescent girl acts on those feelings, but she will be able to recognize them in herself (Tolman, 2000). It is also significant to note that this erotic voice is not just a sexual voice but an affective one as well. The voice of the body is to the girl's "indication and description of her own bodily feelings and responses" (Tolman, 1994). The voice of response focuses on how the adolescent girl can react to her desire and the feelings within her body. Tolman (2000) emphasizes:

> When educating girls about sexual health, not only are we obliged to teach them about the physical and emotional risks of sexuality, but also the ways in which our sexuality can make us more resilient and more alive about our entitlement to an erotic voice . . . we will not turn girls into sex fiends . . . but they will no longer be "dependable for bearing the responsibility to control boy's "raging hormones." (p. 79)

For both male and female adolescents the awareness of sexual desire and the resulting physiological responses can be frightening. In the clinical setting helping the teen boy or girl understand the anatomy and physiology of sexual response will allow them to know their bodies better. In addition, it can also bring some measure of comfort to know that a physiological response in the genital area does not equate with desire even if the adolescent experiences an orgasm. In other words, there can be a physiological response without desire. This knowledge can allay anxiety and confusion in cases of coerced or forced sexual activity where there may be such a physical response.

Sexual Response vs. Desire

Before discussing the physiology of the human sexual response it is important to understand the terminology related to this very complex human experience. The term "sexual response" generally indicates a comprehensive set of physiological changes and psychological experiences that surround sexual intimacy. A *sexual stimulus* is an environmental cue that is received by the individual through one of the five senses (sight, sound, taste, touch, smell), or an internal physical sensation or a mental stimulus such as a sexual thought or fantasy. The *genital or physiological response*, a result of vasocongestion, refers only to the physical changes in the genitalia caused by the extra blood accumulating in the pelvic region. *Subjective sexual arousal* is the psychological experience of sexual excitement and other emotions and thoughts that accompany the physical experience. These thoughts and feelings can be enhanced by awareness of genital changes. *Desire* is the wish or intent to engage in intimate sexual behavior

The Science of Sexual Psychophophysiology

The science of sexual psychophysiology has grown tremendously since the work of Masters and Johnson in 1966. Research and clinical efforts from the fields of neurobiology, sexology, endocrinology, and psychology have contributed in a major way to this body of knowledge. The four-stage model of Masters and Johnson (1966) depicts a desire for sex initiating a linear sequence of events: Excitement, Plateau, Orgasm, and Resolution. However, there are concerns with this model today: (1) it does not accurately reflect sexual arousal in both men and women, (2) it was built on a heterosexual, phallocentric view of sexual behavior, (3) the stages of human sexual response are presented in a linear, prescriptive manner, and (4) there is an overemphasis of physiological genital responsivity. Moreover, orgasm is depicted as the culmination of the sexual response. Although this is often true for men, women may not need to reach orgasm on every or even any occasion in order to achieve satisfaction (Basson, 2000, 2001; Tiefer, 1991).

However, for women desire does not occur spontaneously. For a young

woman, it is the desire for intimacy and not physical release (as is the case in men) that often underlies her willingness to find or be responsive to sexual stimuli, which can initiate her sexual response cycle (Basson, 2000, 2001). Physical arousal and desire may be interchangeable for women, one reinforcing the other. Once sexual desire is accessed, there is an increase in receptivity to sexual stimuli, which then progresses to a more intense physical experience.

Vaginal lubrication, a result of vasocongestion (from the increased blood flow to the pelvic region during sexual arousal), may not be a reliable indicator of sexual excitement in women (Basson, 2000; Leiblum, 2001). Unlike young men, who are acutely aware of their erections (also from vasocongestion), young women may be unaware of their increased lubrication in response to sexual stimulation. Laan, Everaerd, van der Velde, and Geer (1995) found that a woman's subjective sexual arousal is more likely due to external or environmental information rather than perceptions of her own physiological changes. In fact, their partners may be the first to tell them they are feeling "wet down there."

There are four characteristics of a woman's sexuality that support the need for a different model of sexual response:

> 1) women have a lower biological urge to be sexual for release of sexual tension (ejaculation and orgasm), 2) a woman's motivation or willingness to have a sexual experience stems from a number of "rewards" or "gains" that are not strictly sexual, which are often more relevant than biological neediness or urges; 3) a woman's sexual arousal is a subjective mental excitement that may or may not be accompanied by awareness of vasocongestive changes in her genitalia and 4) orgasmic release of sexual tension may or may not occur, but if it does, it will take place in any one of a variety of ways. (Basson, 2000, p. 53).

The female sexual response is not a linear process, as Masters and Johnson outlined, but a circular feedback model with a number of factors that can enhance arousal and desire at any point in the process as mentioned earlier (Basson, 2000, 2001). The "power" behind the cycle is often the emotional intimacy with the partner, but this can be a vulnerable entity, liable to be damaged or disrupted by nonsexual interpersonal factors. Negative emotional states, such as previous abuse and current aggression or fear, can negate the effectiveness of sexual stimuli.

Counseling Adolescents

The sexual response is a highly complex phenomenon that seems to be instantaneous in the young and can become increasingly dysfunctional with

aging. It is influenced by dozens of factors, psychological, physical, and environmental. Young people need to understand this aspect of their sexual physiology; it will demystify the process and allow for more open communication with health care providers and ultimately their partners.

Clinicians working with adolescents should integrate questions and counseling related to sexual response in their visits. This is critical when working with victims of nonconsensual sex or early sexual abuse. Physiological response often accompanies genital stimulation in both men and women. It is possible to experience arousal (Groth & Burgess, 1980). Victims can become frightened and confused, thinking that this feeling means they "desired" the sexual abuse or assault. Explaining that the body's response is reflexive and not intentional will help them begin to heal from their trauma and not feel guilty or responsible.

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