Sexuality in adolescence: development, experience, and proposals for intervention

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Abstract

Objective: to present a literature review of some aspects concerning the development of sexuality in the period between childhood and adolescence, and to work on some proposals for prevention and intervention.

Methods: review of literature on relevant issues related to the process of psychosocial and sexual development during childhood and adolescence, and to the importance of prevention education.

Results: differently from genitality, which is only concerned with biological aspects, sexuality encompasses emotional aspects, life history and cultural values. These factors contribute to the formation of general identity and to the components of sexual identity: gender identity, gender role, and sexual orientation. Psychosocial and sexual development, emotional balance, and social relations are based on sexual experience during childhood and adolescence. During adolescence, the relationship with family and social group go through marked changes: conflicts arise, and experimentation and risk behavior are enhanced. The family, school, and health systems represent important links of identification, support, and protection for children and adolescents before they reach maturity.

Conclusions: sexuality education, either individually or in group, allows adolescents to experience sexuality and their emotional relations in a satisfactory, creative, and risk-free manner, combined with mutual respect and absence of gender discrimination.


Introduction

Human sexuality is part of life and is connected to the global development of individuals, thus constituting an element of personality. To a certain extent, the relationships, the emotional balance, and the manifestation of feelings by an individual depend on a good development of sexuality during the stages of childhood and adolescence.

Genitality refers only to the reproductive organs, the body terminations of erotic satisfaction during adolescence and adult life; sexuality, in turn, includes affection, eroticism, love, and other aspects related to one’s life and cultural values. These aspects are at the basis of the three components of sexual identity: gender identity, gender role, and sexual orientation.1,2
Sexual identity is one of the fundamental elements of the general identity of individuals, which is modeled since the earlier moments in life and defined in adolescence. This identity is established based on interaction with the parents and on moral, cultural, social, and religious factors, among others.2-4

– **Gender identity** is the intimate conviction of each individual as to sex (male or female) independently of the body;

– **Gender role** is the manifestation of femininity or masculinity of each individual according to established social norms. The sexual or gender role is one of the social attributions that individuals internalize during the process of socialization; it refers to performing a specific behavior according to biological sex;

– **Sexual orientation** is the personal preference of each individual concerning erotic relationships; there is a wide discussion concerning the aspects of learning one’s sexual role (the innate and the acquired roles). For a long time, sexual conduct was associated with biological nature. Sexual orientation has been widely studied in the fields of genetics, endocrinology, and psychopharmacologic with the objective of understanding the mechanisms of action of genes and chromosomes in gonadal development, in conformation of internal and external genitalia, in male and female differentiation, and in sexual conduct.2-5-7

**Development of sexuality: from childhood to adolescence**2-6-8

Sexual behavior initiates during childhood and can be perceived in the attitudes and curiosities of individuals; this behavior is a result of the need to attain instinctive satisfaction that depends on erotic pleasure.

According to the stages of development, individuals associate their libidinal interest with certain areas of the body (erogenous zones). The libido, in turn, is the instinctual energy that drives the sexual conduct.

**Oral stage (zero to 18 months)**

The psyche and emotional life of individuals are related to instinctive processes. In this sense, newborn infants have basic needs that need to be met in order to attain pleasure and, consequently, establish a close relationship with the mother or person who is feeding the infant. Babies suckle in order to feed themselves and satisfy an erotic necessity, since the libido, in the first 18 months of life, is polarized in the oral and perioral zones; according to some authors, it also expands throughout the whole extension of the body. Thus suckling and skin contact bring pleasure to the baby.

Also, it is during the oral stage that the process of accepting biological sex is started, according to the reaction of the parents. The discovery of the sexual difference is the first step in growing one’s identity as a male or female.

**Anal stage (one year and a half to three years)**

After 18 months of age, the libido is polarized in the lower intestines at the perineal and anal areas. During this stage, the excretion of feces is not only a reflex; individuals start to gradually control the bowel movements and that allows them to obtain pleasure. Handling the feces and placing them in the mouth is common during this stage. Moreover, it is during the anal stage that children will start asking about sexual differences. At approximately age two years, children start establishing their sexual identity and gender role.

**Genital stage (three to five years)**

As part of the individual development, the child will continue the process of acceptance of the self. During the genital stage, the libido is polarized in the genitals. This is a stage during which significant learning and identification with the parental figures take place. Children in the genital stage are remarkable explorers of the world surrounding them. Manipulation of the genitals is frequent. They are usually exhibitionists and tend to show preference for the parent of the opposite sex, and to be hostile with that of the same sex (oedipal relationship). Children tend to ask questions in a broader sense, trying to find out where babies come from, for example. Genital-stage children also play and satisfy their curiosities with other children.

**Latent stage (six years to puberty)**

This stage coincides with the beginning of school life. It is characterized by the independence of the self and by logical and concrete thought. According to Freud, during this stage there is an instinctive truce, but others understand that there is intellectual and muscle eroticization, since these individuals find great pleasure in formal education and in physical and sports activities. There is a clear differentiation between the sexes and an increase in socialization. Boys become more intimate of friends of the same sex, and discrimination takes place (boys- or girls-only cliques). With the arrival of puberty and change in social habits, there is an approximation between the two sexes (birthday parties with dancing, and others).

At times, there can be masturbation activities. The sexual identification is already established and corroborated by the group of friends from the same sex with specific rules and characteristics differentiating boys and girls. There are opportunities for homosexual games and curiosity regarding birth, pregnancy, the role of the parents, and reproduction.

**Pre-adolescence**

During pre-adolescence, individuals have a prepubertal physical appearance characterized by increase in weight but with no other significant changes. Usually, there is little
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inquiry into sexuality; pre-adolescents obtain information and knowledge about myths from their friends, at school, and, as before, from the family.

**Early adolescence (10 to 14 years)**

This stage marks the beginning of physical and pubertal maturation; individuals are extremely curious about their own bodies and that of their peers. Sexual fantasies are frequent and can cause feelings of guilt; masturbation initiates during this stage and can also result in feelings of guilt. Early adolescents usually experience platonic love, without physical contact, such as the characteristic endless telephone conversations.

**Middle adolescence (14 to 17 years)**

In middle adolescence, the pubertal development of the individual is fully or almost complete; this is marked by menarche, in girls, and semenarche, in boys. The level of sexual energy is elevated, with emphasis on physical contact; sexual behavior is commonly inquisitive and selfish. Middle-adolescents try to take advantage of relationships with dates, caressing, and casual relationships followed by genital or extragenital relationships. During this stage, the denial of the consequences of sexual behavior represents a great risk for the adolescents.

**Late adolescence (17 to 20 years)**

The physical maturation of late adolescents is complete; these individuals tend to present a more expressive sexual behavior, rather than explorative, and the relationships tend to be more intimate and shared. There is a predominance in choosing a steady partner and establishing emotional relationships. Late adolescents usually are more aware of the risks that sexual activity entails and understand the need for safe sex.

Currently, though seemingly there are no significant differences in the behavior of either sex, the feelings and desires of boys and girls tend to present distinct characteristics.

For boys, sexual impulse is initially well separated from the concept of love. Sexual desire is clearly located on the genital organs, and presents characteristics of urgency and requiring rapid release. Aroused male adolescents prefer to have a partner, though it usually seems normal to obtain satisfaction through masturbation. Erotic fantasies are fixated on specific physical attributes, such as the breasts, legs, and genitals.

For girls, love usually has priority over genitality. Despite the fact that girls are currently more sexually aggressive and active, there are few who experiment their sexual desire in the same manner as boys. Most female adolescents tend to experience diffuse arousal, which is not differentiated from other feelings. Their desires include fantasies of romantic, giving relationships, maternal impulses, sudden mood swings, feelings of compassion or special pleasure while being combed or receiving a back rub. Orgasm is not always the main objective. In girls, specific sexual arousal requires direct body stimulation, especially of the erogenous zones.

Nevertheless, the current reality is that relationships with sexual intercourse are starting at an earlier age, on account of imitating friends, peer pressure, escape from masturbation (guilt), and actual change in behavioral characteristics. Contraceptive methods allow for a significant margin of security and more freedom for women. However, the increasing number of unplanned teenage pregnancies is alarming, and so is the increasing incidence of sexually transmitted diseases. These are a result of lack of information concerning form and function of the genital and reproductive tract, to prejudiced opinions regarding contraceptive methods, to inadequate use of these methods, and to the adolescents’ doubting and unconsciously testing their fertility.

**Experiencing sexuality in adolescence**

During adolescence, the experiencing of sexuality is similar to walking a path in which development and maturity will determine the itinerary. The expression of sexuality takes on different forms. Firstly, there is the repression of the sexual impulse, especially if the first sexual contacts were frustrating. Another attitude of adolescents facing sexual intercourse is acceptance, even without feelings of affection; this is possibly the most frequent form of expression in early and middle adolescence. The preference for sexual relationship involving affection is a stance that shows a more integrated attitude in relation to sexuality. The choice made by adolescents is bases on the experiences, whether they are sexual or not, that each individual endured throughout their lives and that are socially labeled as mature.

**The origin of experiences**

**Sexual curiosity**

During childhood, individuals experience their first contacts while relating to their parents, caressing, playing, participating in day-to-day experiences with classmates, and experiencing pleasant and unpleasant feelings, all of which give rise to sexual curiosity, which, in turn, can give rise to doubts and conflicts. During this stage, the school is one of the main settings of interpersonal contact. Classmates can offer a minimal knowledge, allowing for sexual fantasies and erotic ideation, which can lead to masturbation or self-eroticizing with the touching of sexual organs. The repression of masturbation can lead to the beginning of restriction of sexuality.
In order to develop their sexual, or gender, role, adolescents need to be in contact with other people, playing different roles. This contact produces the need to form emotional ties that will determine new experiences. During this stage, emotional reciprocation may or may not be emphasized; in this sense, depending on the individual experiences, this reciprocity can determine difficulties in forming deeper emotional ties.

**Choosing between group of peers and the object of love**

During adolescence, the desire to establish relationships and the fear of giving oneself to another can cause several conflicts. At this time, individuals have to distance themselves from the group of peers in order to perform a new role and to start experimenting the power of seduction. Sexuality in giving relationships gives way to confiding one’s intimate secrets in the partner. A giving relationship presupposes synchrony (return) and simultaneity (time). At the moment of giving, feelings are expressed through the body and, if there is no cohesion between body and mind, there will be no communication. Contact and emotional exchange establish the desire to fulfill the act of sexual intercourse. In order to fulfill this experience, it is necessary to endure certain stages; one of which is finding the person with whom one desires to have sexual intercourse and who promotes the expansion of sexuality.

**Choosing the partner**

The desire to have sexual intercourse depends on the identification of the adolescent with another person. Interest results from attraction, curiosity, passion and it is at this point that previous experiences favor or block the desire. In situations of partial involvement, which is characteristic of the earlier stages of adolescence, individuals seek sensations. In situations of involvement, the physical contact is added to the seeking of sensations, though this may not be exactly clear for the adolescent.

**Sexual intercourse**

The experiencing of sexual intercourse reorganizes previous sexual experiences; however, the fears of adolescents may prevent them from fully experiencing the moment, and subsequently promote future insecurity. The meaning that each adolescent attributes to sexuality can change his or her expectations, creating or resolving problems. Sexual intercourse can be frustrating or a permanent source of stimulation. A satisfying sexual relationship is at the basis of the development of future sexual experiences towards sexual maturity.2,4,12

**The discovery of homosexuality**

One of the most conflicting situations for adolescents of both sexes is that of perceiving traits of latent or manifest homosexuality in him or herself. Adolescents understand that their gender role compels them to adopt specific individual and group attitudes; they also fear family and group pressure, and are distressed by trying to predict the reactions of others. Moreover, since adolescents are at a stage of great curiosity, these individuals are frequently in contact (through the media, or at school, in the community, and in support groups) with the discrimination and humiliations faced by young homosexuals, which can lead to rejection and even death.

At several stages in life, adolescents experience admiration for someone of the same sex - for example, a sports player, a musician, an actor, or someone closely related - which can be a result of various feelings such as affection and passion; of aesthetic reasons (attraction by beauty, by the distinction, by the need to look like someone); of life experiences (friendships tend to be ambiguous); or of a distorted, rejected, or narcissistic self-image.

It is important for educators and healthcare professionals to act as a safe harbor for adolescents, in order to help them improve self-esteem and self-reference. Educators and professionals should also provide the conditions for adolescents to be respected, including the providing of guidance for parents, members of the community, and other adolescents.

It is important to remember that homoerotic curiosity does not always lead to homosexual behavior; and, also, that the risk behaviors related to homosexuals are similar to those of heterosexuals. Homosexual adolescents should not be discriminated. Healthcare professionals should be prepared to respect adolescents and their reports of love, emotion, or pleasure.

Evidently, it is not an easy task to obtain the approval of parents or of a group of peers in relation to homosexual behavior. In the case of family, especially of a father of a male adolescent, these situations are usually accompanied by feelings of perplexity, disgust, unacceptance, and a lot of pain. Consequently, the professional should avoid confrontation with family feelings. Healthcare professionals need to be perceptive while conducting the earlier moments of discovering homosexuality until respect by others is obtained and the adolescent learns to accept him or herself.

As we mentioned before, homoerotic feelings can be transient, since in adolescence the feelings of ambiguity are not uncommon; thus, we can posit that not all homosexual relationship in adolescence means homosexuality. It is fundamental for healthcare professionals to remain impartial and not communicate their own feelings and prejudices, thus contributing to improving the individual’s self-esteem.

In relation to groups of peers and others, and often times individually, it is important to face the matter of homophobia (fear of homosexuals and homosexuality), since it is usually filled with misconceptions that can hinder even the practice of citizenship by homosexuals. It is important to remember
that there is no cure for homosexuality since it is not a disease, as established by the World Health Organization (WHO) and Human Rights associations. In homosexuality, gender identity and role are not distorted or equivocal. Homosexuality is related to sexual orientation directed towards individuals of one’s own sex (male or female). It is important not to mistake homosexuality for other conditions of sexual identity disorder, such as transexuality, and anomalies of the external genitalia, such as intersexuality. Moreover, the preference for clothing, ornaments, and hairstyles of the opposite sex does not characterize homosexuality. Adolescents are prone to follow trends, different ideas, are creative and tend to give into peer pressure.11,15-18

Sexual behavior of modern-day adolescents11

Studies have shown that female adolescents start their sexual lives between the ages of 15 and 17 years, and male adolescents between 13 and 15 years. In the wealthier social classes, the initiation tends to be at a later age.

For girls, their first sexual intercourse is, in general, with a boyfriend and, in some cases, a circumstantial partner. In turn, approximately 40 to 50% of boys initiate their sexual lives with their girlfriends or circumstantial partner and about 30% with prostitutes.

Most youths consider themselves satisfied with their sexual relationship. The majority of women consider that it is necessary to have some sort of emotional involvement in relationships, which is not the case of men. However, it seems that there has some change in this sense, considering that 60% of male individuals report that affection is an important element in experiencing sexuality.

Most adolescents, despite having knowledge of contraceptive methods, initiate their sexual lives without using protection. In continuing their sexual activity, approximately 30% of adolescents still practice unsafe sex both in terms of contraception and STDS/AIDS. The most widely used settings for sexual intercourse are the home or the house of friends.1,13,18,19

Problems related to sexuality

Due to the changes in sexual behavior, healthcare professionals, parents, teachers, and the society at large have faced several problems and conflicts that require policies for the psychosocial and health care of adolescents. There are several problems and symptoms that present difficulties when dealing with adolescents, including:

- premature pregnancy due to early sexual initiation and practice of unsafe sex;
- sexually transmitted diseases and AIDS in adolescents;
- impotence, premature ejaculation, and others that most often are etiologically psychosomatic;
- anorgasmia, which is more common in the female sex; it is usually related to anxiety, lack of information on sexual physiology, absence of dialog with the partner who, often times, is also inexperienced and young.10,20,21

Intervention

Intervention can be carried out with individual or group sexual education by means of engaging activities, group discussions, and individual or group counseling or treatment. The interventions can follow specific techniques of conventional psychotherapy carried out at healthcare services, at schools, at the doctor’s office, or at outpatient clinics.

Emotional and sexual education

In order to promote adequate sexual education, educators need, in addition to empathy and handling the matter naturally, a good level of knowledge on certain concepts and characteristics of human sexuality, which are essential for the discussion of related matters.

Sexual education is a continuous process associated with the development of children and adolescents. This process offers both scientific information and answers that help understand and develop sexuality in a complete and healthy manner, and at different stages in life.

Health education should allow for the understanding of the relationship between lifestyles and protective or risk behaviors, and it should be based on the existing perception of adolescents.11,22,23

Objectives

1. Develop critical thinking that will foster positive attitudes towards sexuality, which is an inherent element of the human being.
2. Favor a continuous process of recognizing, identifying, and accepting oneself as a sexual and sexualized individual free from fears, distress, or guilt.
3. Allow for the development of sexual roles based on human rights, respect, and equality, thus overcoming the barriers of gender discrimination.
4. Emphasize the importance of affection for the life of the individual and for relationships.
5. Favor the understanding of the body towards the practice of caring for one’s own health.
6. Stimulate safe and responsible sexual conduct in relation to oneself and the others.
7. Foster communication and dialog with the family to promote egalitarian relationships with emphasis on respect and consideration.
8. Promote equality and shared responsibility in relation to the sexual partner in both situations of having children and use of contraceptive methods.

Educators and human sexuality

Sex education should start as soon as possible. It should follow a conscientious and responsible decision made by the parents to carry out this education. According to the objectives, this educational process should allow individuals to learn and introject basic elements of their sexual identity, in a process that is closely related to the socialization and to the construction of their total identity.24-26

Formal education

The system of formal education is an important determinant factor in the socialization and social representation of the male and female sexes. Formal education operates through didactic material (textbooks, texts, articles) or by the direct effect of educators - based on their own social representation and values - on pupils, which can leave lifelong scars. Education professionals have a direct interference on the early development of the personality of the student based on the exchange of values, on their own rules, and on their level of instruction. Education, in this sense, is carried out in an organized manner according to school curricula and is a result of the action of teachers trained for this function. Educators play an important role in relation to socialization.

During the past few years, there have been different experiences in trying to improve this pedagogical setting for the development of students; there are, however, a lot of difficulties. Dealing with the matter of sexuality in formal education is a conceptual and methodological challenge. This challenge has to be faced due to the repercussions it presents for the teachers’ and the adolescents’ and their families’ lives. Likewise, the curricula of several technical and professional courses should include the matter of sexuality, especially in the case of professionals related to everyday work with adolescents. Currently, matters related to sexuality are, to a certain extent, being discussed with some frequency between teachers and parents.22,24,25

Informal education

Informal education takes place through spontaneous mechanisms of socialization. The repercussions of informal education are significant for the conduct of children and adolescents. This type of education is continuous and occurs in several different levels: family, groups of friends, community, media, and is at the basis of the relationships and ties between people in everyday life.

In general, the importance of this educational mechanism is not recognized. It is explicitly based on what is said or what information is provided for children and adolescents. Daily experiences at different moments and situations of one’s life are important for the generation of role models, through which adults decisively influence the behavior of youths.22

The role of healthcare professionals

Healthcare professionals responsible for the care of adolescents play a key role in sexual education, either explicitly, in carrying out healthcare education activities, or participating in courses at education centers, in communities, and in other settings.

Overall, the work of healthcare professionals is carried out within a framework of primary prevention, which is primarily aimed at the prevention of premature pregnancy, of sexually transmitted diseases, of HIV/AIDS infections, of the use of psychoactive substances, and at emphasizing the importance of one’s lifestyle for the preservation and protection of health.

It is widely understood that sexual education is of the sole responsibility of the family and the school, and not of the healthcare professionals and services. At times, there are professionals who would like to help adolescents, but they lack specific training for this area and end up by passing on personal values and experiences. Providing adolescents with open dialog and a space for communicating, and for developing health-related activities, can foster a favorable environment of trust and respect in order to deal with matters related to sexuality.2,22

Participation of youths

Results from health education processes that rely on the active participation of adolescents. Every process aimed at the formation of conscientious actions and adoption of protective conducts should allow for self-management and consider people as active subjects.

Considerations on emotional and sexual education for adolescents

1. Educators should be trained to deal with the biopsychosocial and pedagogical process involving adolescents. It is important that prejudice, taboos, and myths in relation to sexuality be introjected together with scientific knowledge.
2. Parents should be aware of, and integrated into, the process of emotional and sexual education in order to overcome all barriers blocking the development of the adolescent’s sexual identity.
3. The lectures, the group dynamics techniques, and the stance and attitudes of educators have to be in agreement with what they practice. Adolescents apprehend and learn, are critical and insubordinate and if they perceive
5. Educators should allow for cross-sectional and interdisciplinary relations, which can allow for the emotional and sexual education to positively penetrate other disciplines in the curriculum; this interdisciplinary work requires educators to operate collectively and cooperatively between themselves and with adolescents.22,23,25,26

**Sexuality at the doctor’s office and at outpatient settings**

Dealing with sexuality at the doctor’s office or at outpatient clinics can be carried out individually or in groups, and by employing objective techniques. In group activities, the participants learn from one another; some participants verbalize their opinions more easily, but in the end everyone can take advantage of the activity. The feeling of universality of problems or, in other words, the perception that problems are common to almost everyone, is probably the best advantage of group activities. Good results can be achieved in eight to 10 sessions. After group counseling, some young patients will request individual care.

In individual treatments, there are more specific objectives aimed at the particular matters at hand. In order to help patients contain their anxieties, the professional, in addition to explanations on sexuality, can help patients perceive and verbalize difficulties and thus help them to cope with difficulties. In this sense, adolescents may be able to better understand their conflicts, define their identities, and, consequently, their sexual conduct.

The most commonly reported problems are lack of experience and absence of dialog with partners. These problems result in lack of adjustment; absence of orgasm; impotence; unprotected sex; inadequate use of contraceptive methods due to lack of information; sexual intercourse at improper places, resulting in inhibition; feelings of guilt in relation to the parents; premature sexual initiation in order to imitate peers and without the necessary psychological maturity; lack of emotional involvement in relationships; need to use drugs in order to have sex; and others.

Sexuality cannot be dealt with separately, but rather as a part of the whole context of the adolescent’s life, including relationship with partners, family life, and work and school activities. There may be cases of middle adolescents who seek specific healthcare advice in relation to their sexual initiation. These patients may seek advice regarding how to prepare themselves, how to behave in their first sexual experience, or regarding some difficulty encountered in a previous experience. Most of the times, however, the problem is not reported explicitly and clearly. Adolescents often report somatic manifestations, hiding frustrations or conflicts based on sexual difficulties. It is the professional’s task to diagnose these conflicts through the information provided and attitude of the patient, and to decide on how to better deal with the matter.

It is not uncommon to make use of several appointments to deal with matters related to other activities of the patient. These other matters can be important for a later approach of the problem of sexuality, or for allowing patients to reveal their sexual concerns or difficulties themselves. In cases of patients who provide clear information, it is important to obtain as much information as possible. In turn, in cases of extremely reserved patients, it is important to ask them to answer questions whenever possible.

The work of healthcare professionals is aimed at identifying whether the doubts or difficulties are real or fictitious, whether they are part of conflicts acquired during development or just questions characteristic of adolescents and, thus, easier to be solved. Answers should be provided based on facts related to the patient or based on scientific data. Inadequate information received from friends/partners, educators, or parents themselves need to be corrected with expertise.

Usually, experience shows that most cases are of adolescents with characteristic difficulties, resulting from lack of information, family education, or prejudiced environment; these difficulties can thus be solved by the professionals who work with adolescents and are trained to deal with the biological and psychosocial aspects related to their everyday life, their relationship with the family, school, and social group.

During treatment, doctors should be able to perceive whether the adolescent feels more at ease and whether the adolescent is better reporting doubts or performance difficulties; it is also important to verify whether the patient requires being indicated to a mental healthcare professional.1,11,27,28

**Final considerations**

Sexuality and emotional and sexual education are fundamental matters that need to be faced by the society at large. It is necessary to keep in mind that the media trivializes matters of sexuality, without any contribution in the sense of making adolescents think or establish cause-and-effect criteria for dealing with, and the practicing of, sexuality. Another aspect that needs to be considered is providing human resources aimed at developing sexual education, which, very often, is carried out spontaneously and according to the educators’ own perceptions on the matter and on dealing with day-to-day situations.
Consequently, due to the lack of proper technical and methodological training, misconceptions and misrepresentations may be transmitted to adolescents, without considering scientific and ethical criteria that are fundamental for the development of young individuals.

In the family environment, most conversations about sexuality are related to warning against STDs and AIDS and to hygiene during the menstrual period. Most parents do not recognize that their children need objective and clear orientation in order to establish cause-and-effect criteria in relation to their actions.

Misled adolescents learn and disseminate erroneous information and prejudice that, in addition to the characteristic self-confident behavior of adolescents, contribute to increasing the risks related to sexual experience.

It is fundamental to understand that the family, the school, and the healthcare professional can all contribute towards allowing adolescents to experience their sexuality and affections in a pleasant manner and with less risks, always observing mutual respect and unprejudiced behavior.

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