Adolescent sexual health

– selected issues

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List of issues

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Introduction

Adolescent sexual behaviour is a matter of wide public interest. It tends to be feared by adults, including parents and teachers, who are most often unable to discuss topics related to sexuality with teenagers or avoid them in conversations. Consequently, they fail to impart knowledge to the child about the physiology of puberty and emotional development, as well as neglect topics related to staying safe in relationships and online. The increase in anxiety experienced by adults is primarily related to the influence that social media content and cultural role models have on young people and the increasing number of phenomena that may pose a threat to the safe psychosexual development of adolescents, such as pornographic materials, online hate speech and other forms of peer victimisation. In addition, many adults see threats to the safety of children and young people in the ongoing and rapid social and cultural changes. Adults often do not understand them, which triggers increased scrutiny of children's behaviour.

The purpose of this chapter is to present the evolution of adolescent sexual behaviour, the opportunities and recommendations for supporting adolescents' independent and autonomous decisions concerning their sexual health and to discuss selected risky sexual behaviours. The chapter is cross-sectional and will provide information on the definition of normative adolescent sexual behaviour, legal issues related to the age of consent to sexual activity, access to gynaecological care for adolescents from the perspective of legislation and the age of consent, adolescents' knowledge on sexual health and contraception and engaging in risky sexual behaviours.

Adolescent sexual behaviour

Sexuality (from Latin term *sexus* meaning "gender") is, in other words, the fact of a person's belonging to a particular gender and experiencing all the consequences that stem from it (Beisert, 2006a). "It is an innate attribute and an innate function of the human organism, subject to complex external and internal conditions that require a broad view and interdisciplinary effort" (Izdebski, 2008). Sexuality is a component of personality and largely influences a person's life, their choices, decisions and the way they think about themselves. It manifests itself both in the way of experiencing oneself and manifesting one's needs. It is related to the identification and experiencing of one's sexual and gender identity, to sexual behaviour, as well as to the readiness and ability to satisfy needs such as the need for love, intimacy or affection (Beisert, 2006b). Sexuality is shaped from childhood: initially as a result of socialisation, which is transmitted by the child's first caregivers (usually parents), who themselves have often not received knowledge concerning sexuality. Their lack of knowledge results in limited opportunities to transmit knowledge and correct attitudes about sexuality to their

children. In many homes, parents seem uninterested in educating their children about sexuality – they avoid the subject, imagining that this problem will somehow solve itself when the child is grown enough. Other parents withdraw from talking to their children on their own, ceding the responsibility for education to the school and expecting it to impart knowledge on the subject and to educate the children in certain values and attitudes regarding relationships and sexuality. Still others expect the school to stop imparting such knowledge to children altogether, as they believe that this area entirely belongs to the sphere of convictions, for which caregivers are solely responsible. There is also a group of parents who note the necessity for the school and the family home to cooperate in the provision of sex education and who support the school in organising such classes (Beisert, 1991; Zielona-Jenek and Chodecka, 2010).

Leaving adolescents without education in this area, belittling and distorting the essence of psychosexual development results in young people not understanding the processes of their bodies, lacking knowledge on health, norms, emotionality and relationship building and – finally – not understanding their own sexuality. As a result, young people incur emotional costs: confusion, self-shaming and anxiety, other psychological costs in terms of unconsciously reinforcing harmful stereotypes and beliefs about their own and the other gender, gender roles and comparing oneself to others, as well as behavioural costs in terms of reduced ability to make responsible decisions, anticipate their consequences and plan for the future. In addition, peer pressure leads some adolescents to believe that their peers are more sexually active than they actually are, and thus engage in various forms of sexual activity without being emotionally or physically prepared for it (Izdebski, 2008).

When discussing adolescents' sexual behaviours, it is important to first define the norms concerning them: what can be considered characteristic of this age group, what is within the developmental norm or what can be described as behaviour requiring intervention. Sexual activity among children and adolescents that falls within the norm is considered to be the activity which:

- does not impede the developmental tasks envisaged for this period,
- falls within the repertoire of sexual behaviour characteristic of the age in question,
- takes place between persons of a similar age,
- is on voluntary basis
- leads to meeting sexual goals,
- does not compromise health,
- does not grossly violate the accepted social order (Beisert, 2006c).

It is worth remembering that sexual contacts undertaken by adolescents have a specific developmental significance – they both serve as preparation for taking up specific roles in the future (of a partner) and form the basis for shaping relational and interpersonal attitudes as well as emotional and social development of young people. Adolescent sexual activity usually follows a similar, characteristic pattern, i.e. from less to increasingly mature forms. It usually begins with masturbation, through kissing and non-penetrative sexual contacts (e.g. petting) up to sexual initiation, which is usually understood as genital penetrative contact (Beisert, 1991, 2006b; Lew-Starowicz, 2000). However, it should be borne in mind that this understanding is exclusionary for people in heterosexual relationships with experiences of oral or anal contact and for people in homosexual relationships. Furthermore, increasingly sexual initiation is also conceptualised as any form of advanced whole-body caressing of a non-penetrative nature. It is worth bearing in mind at this point that the whole process is characterised by a high degree of differentiation and can proceed without intermediate phases.

Sexual initiation – legal and medical procedures

In Poland, as in most countries in the world, the age of sexual initiation is steadily decreasing. It currently falls between 15 and 18 years of age. (Beisert, 1991; Jarząbek-Bielecka et al., 2012; Wojtasiński, 2021; Woynarowska, 2014). From the analysis of research reports, it is possible to conclude

that sexual activity before the age of 18 affects approximately 80% of adolescents, making it common among this age group (Woynarowska et al., 2004). This age is relevant from the medico-legal perspective for a minor engaging in sexual activity and expecting the advice of a gynaecologist, an examination or the prescription of hormonal contraceptives. The legal and medical principles are in contrast to each other – the fixed age of consent in Poland (15 years of age) and the decision to undertake sexual activity by adolescents is at odds with their functioning in the area of guardianship, which until the age of 18 is usually exercised by parents, and the requirement of the guardian's consent to certain health services. The situation is similar in the case of health care – a minor acquires full rights as a patient at the age of 16. In Poland, there is no common position of the legal and medical communities on this issue (Jarząbek-Bielecka et al., 2012). According to the Act on Health Care Institutions, every patient has the right to self-determination, respect for physical and mental integrity and respect for privacy. According to these rules, the participation of the legal guardian of a patient who is 16 years of age or older represents the co-determination of the performance of a health service. The results of a minor's subjective and physical examinations theoretically do not have to be communicated to his or her legal guardian if he or she requests confidentiality and when confidentiality does not affect his or her health and possibly planned medical procedures. According to these rules, minors have the right to health care and protection to the extent necessary for their well-being and in an appropriate manner that takes into account their age and maturity. In addition, young persons should be able to express their views freely and their opinions should be taken into account in matters concerning them (Act of 5 December 1996 on the Professions of Physician and Dentist [Dz.U. 1997 No. 28 item 152]; Act of 25 February 1964 – Family and Guardianship Code [Dz.U. 1964 Nr 9 item 59]; Convention on the Rights of the Child adopted by the United Nations General Assembly on 20 November 1989 [Dz.U. 1991 No. 120 item 526]).

While in Poland only the legal guardian gives consent for a minor (under 18 years of age) to be admitted to hospital and examined, the situation may be different in an outpatient setting. In some family outpatient clinics, when a minor patient presents for an appointment, the doctor usually assumes the presumed consent of the guardian and examines the patient. However, when the patient contacts a gynaecologist, the procedure is not so clearly defined. The possibility of counselling on sexual activity, prescribing contraceptives or performing a gynaecological examination is debated (Jarząbek-Bielecka et al., 2011; Jarząbek-Bielecka et al., 2012; Sowińska-Przepiera et al., 2008;). This is related to the fact that, in the case of adolescents, the possibility of prescribing and using contraception has been the subject of much debate in Poland for years, with medical, ethical, moral and religious arguments being invoked. Diverse, often personal beliefs, and therefore ambiguous positions, make it difficult to establish clear procedures and adequately assist the underage patient. It is necessary to look at the phenomenon and the possibility of accessing medical help bearing in mind that a girl most often should become a patient of a gynaecological clinic after her first menstrual period (i.e. around the age of 13) (Jarząbek-Bielecka et al., 2012). Informed consent to sexual activity and the possibility of accessing medical care are considered independently of each other, and the concept of a child's maturity – depending on the category – is vague and marked by subjective judgement (Kędziora, 2003; Kmieciak, 2017). In order to assess this discrepancy and to indicate the potential health care options for minors, according to experts, the age limits relating to

> *Lately I've been depressed, very stressed and sleeping badly. I am bullied because I belong to the LGBT+ community. My family is homophobic. I can hardly imagine disclosing who I am in front of them. How can I tell my mom about it?*
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> *14-year-old girl*
> *A quote from phone calls and emails to 116 111 Helpline for Children and Young People*

the legal acts of minors appear to be worth highlighting (Sowińska-Przepiera et al., 2013):

- at 13 years of age – the child acquires some capacity for acts in law, however limited;
- at 15 years of age – sexual intercourse with the minor is no longer criminalised;
- at 16 years of age – the minors attain limited patient rights.

In the Polish legal system, causing a person under 15 years of age to engage in a sexual intercourse, to submit to another sexual activity or to perform such an activity is an offence (Kunicka-Michalska and Wojciechowska, 2001). According to the law, anyone who engages in sexual activities with a minor under 15 years of age violates the minor's sexual freedom, as the victim of such an act is not able to express a legally valid decision on consenting to these activities. This issue is similarly regulated in other countries in Europe, where a 15-year age limit prevails, which is in line with the standards of the Council of Europe. This age limit is based on two facts – according to scientific reports it is adequate as regards the age at which most adolescents decide for sexual initiation and it is accepted by legal experts (Filar, 2004). At the same time, under Polish legislation, a child under the age of 18 cannot exercise their rights as a patient on their own and without control, as the participation of their legal guardian is required in the decision on diagnosis and treatment. Thus, a child over the age of 16 and under the age of 18 may exercise patient rights under the control of a legal guardian, whose consent is necessary to carry out certain procedures with respect to the child. From the age of 16, the child acquires the right to participate directly in decisions relating to medical procedures and health services concerning the child (Dercz and Rek, 2003). Considering the age of sexual initiation and the age of informed consent to sexual activity, the legal regulations concerning the granting of consent for medical procedures and restrictions in this regard seem illogical. The gynaecological community has called for changes in the rules for the treatment of underage patients of outpatient gynaecology clinics. Of those proposed, the following seem relevant to this chapter:

- Above 15 and under 16 years of age:
  - visit to the doctor should take place with the participation of the legal guardian;
  - gynaecological examination requires the consent of the legal guardian;
  - knowledge of intercourse should not be concealed from the legal guardian;
  - prescribing contraceptive pills, if there are no medical contraindications, requires the consent of the legal guardian and of the patient if she has initiated or intends to initiate sexual intercourse soon
- Above 16 and under 18 years of age:
  - patient should confirm that her legal guardian consents to her visit to the doctor. If the patient presents herself on her own for a gynaecological examination, written consent is not necessary;
  - gynaecological examination should be carried out with the patient's consent, without the need for the consent of her legal guardian;
  - knowledge of sexual intercourse does not have to be communicated to the legal guardian if the patient objects to it and if it does not affect further medical procedures;
  - prescribing contraceptives: refusal if there are absolute medical contraindications, requirement of the legal guardian's consent in case of relative contraindications. Contraceptives can be prescribed without the consent of the legal guardian if the patient is healthy (as confirmed by an examination), refuses to inform the guardian of her wish to take contraceptives, engages in sexual intercourse and there is an established emotional bond with her partner. In such a situation, it is advocated that the prescription of hormonal contraception is noted in the medical history with an annotation that the minor is not willing to inform the legal guardian (Jarząbek-Bielecka et al., 2012; Sowińska-Przepiera et al., 2013).

At this point, it should be emphasised that the common belief that the child is the property of the parents is not only incorrect, but also harmful to the child's psyche.

According to the Family and Guardianship Code, it is the duty and right of the parents towards the child – until the child acquires full rights – to ensure that the child is properly cared for and that his or her interests are safeguarded. Decisions made by parents concerning the child should take into account the child's autonomy to decide about themselves, including their age, maturity and beliefs (Andrzejewski, 2014; Szok and Terlecki, 2016). Family law adopts the principle of the best interests of the child, which legal guardians should be guided by and which means that the interests of the child should determine how parents perform their tasks in relation to the child (Pawlak, 2015).

Sexual health knowledge and sex education

The topic of access to gynaecologists and ability to talk freely about sexual health issues is linked to adolescents' knowledge when it comes to contraception and sexual health. The World Health Organisation (WHO) postulates that teaching about different methods of contraception should be a collaborative effort of parents, teachers and all other adults around the child who influence their education, as well as gynaecologists and paediatricians (WHO, Federalne Biuro ds. Edukacji Zdrowotnej w Kolonii, 2012). Based on data from the literature and experts' own opinions, the American College of Obstetricians and Gynecologists (ACOG) emphasises that an essential factor in conducting sex education is to provide adolescents with an atmosphere of privacy and safety where they can ask questions and talk about their concerns (ACOG, 2016). Research in recent years indicates that teenagers have a very low level of knowledge about contraception. Adolescents make the decision to start sexual intercourse quite early, they want to appear mature, and they often succumb to peer pressure or pressure from the partner. Literature data indicate a tendency for young people to initiate sexual intercourse earlier and earlier. The average age of sexual initiation for women in 1997 was 19.34 years, in 2001 – 19.2 years, and in 2005 – 18.83 years. For men the figures are similar, in 1997 it was 18.43 years, in 2001 – 18.32 years, and in 2005 – 18.06 years (Jankowiak and Gulczynska, 2014). The reasons for the decision to initiate intercourse are varied. The majority of girls (70.7%) indicate love, while boys declare sexual excitement and curiosity (64.3% and 60.6%, respectively; Pastwa-Wojciechowska and Izdebski, 2014). Lack of sex education contributes to early initiation of sexual activity, thereby increasing the number of pregnancies in young girls, as well as the incidence of sexually transmitted infections. Estimates indicate that approximately 40% of pregnancies worldwide are unintended. This is usually due to not using contraception, failure of a contraceptive method or its ineffectiveness (Wendot et al., 2018). In the Polish socio-political environment, there has been a conflict for years about the legitimacy of introducing reliable, worldview-neutral sex education in primary and secondary schools (Dec-Piotrowska and Walendzik-Ostrowska, 2020; Jeznach, 2021; Rzecznik Praw Obywatelskich, 2022). Political opponents of its introduction justify their position by the alleged sexualisation of children and adolescents by those conducting such classes, the promotion of wrong and inappropriate attitudes, and the encouragement of children by educators to engage in sexual activity. It therefore seems important to pay attention to both social attitudes towards sexual education and the experts' opinions. Many experts are of the opinion that Polish society is not mature enough to discuss contraception. At the same time, research as early as in 2007 indicated both a significant approval of Polish society for sexual education classes (84%) and a large percentage of the population supporting the use of various forms of pregnancy prevention (Centrum Badania Opinii Społecznej [CBOS], 2007). Research conducted by CBOS in 2019, showed that the majority of respondents (74%) disagree with the opinion about the demoralising effect of sex education on children. In addition, 70% of Polish adults do not see the link between sex education and an early sexual initiation or arousing children's interest in sex. Respondents believed that knowledge about human sexuality should be obtained by children from their parents (87%), followed by teachers, school psychologists or educators (75%). Respondents also pointed to specialists outside the school, such as a sexologist (51%). Although the respondents assign the responsibility for sex education mainly to the parents,

they also indicate the need for support from the school and from persons professionally trained to deliver sex education (CBOS, 2019). A 2015 report by the Educational Research Institute (IBE) shows a similar trend. The majority of both 18-year-olds (87%) and parents of school-aged children surveyed (88%) pointed to the need for sex education classes at school. More than half of the adolescents (54%) felt that the classes should be conducted by a professional not connected with the school: a psychologist, physician or sex educator. The necessity of sex education is advocated by a large part of society, its introduction is supported by expert consensus and NGOs, but despite a clearly defined position it is still difficult to find agreement between its supporters and opponents, with the latter usually disseminating incomplete, untrue or manipulative content. Some of the teaching is also done by people who often have neither the knowledge nor the preparation for it (IBE, 2015).

> *People around me do not accept me because I am a lesbian. It terribly hurts me that my friends rejected me when they found out about my orientation. I realised that they never were my friends after all.*
>
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Despite years of tireless and consistent work by many communities for reliable knowledge, adolescents still do not know how to build romantic and sexual relationships. They often focus not on what intercourse might look like, but on getting into it as quickly as possible. They are also often aggrieved by peer victimisation or exposed to content that is inappropriate for their age and treated without due criticism. There is no doubt, therefore, that the introduction of reliable sex education programmes could significantly influence decisions to engage in sexual activity and use contraception, thus reducing the number of unwanted pregnancies and sexually transmitted infections, as well as support young people in building relationships and teach caution in the use of the internet and social media. Physicians of all specialities and other health care professionals should be knowledgeable about adolescent sexuality and their needs. Providing adolescents with knowledge about contraception, including its benefits and the consequences of not using it, is the most important factor in protecting young people from unwanted and premature pregnancy. Bearing in mind that sex education is one of the basic elements of health education, it would be advisable to develop specific health care regulations concerning adolescents and a core curriculum for sex education classes, which could improve the formation of proper habits and behaviour in adolescents.

Selected risky sexual behaviours among adolescents

The tendency to engage in risky activities among young people is considered a normative feature of adolescence (Arnett, 2007; Jankowiak and Wojtynkiewicz, 2018). As a rule, it is related to testing the limits of one's independence, the tendency to experiment and to seek a variety of experiences that influence the understanding and formation of one's own identity. In other words, in addition to the real hazard, risky behaviour carries and can have a developmental value by contributing to gaining independence and self-reliance, achieving new goals. Adolescents perceive risk differently, tend to underestimate it. Adolescence is a process stretched into a "rite of passage" between childhood and adulthood (Pringle et al., 2017), when young people tend to close down in their own world and withdraw from relationships with previous authority figures (both in the family and at school). This is accompanied by ambivalence and emotional and behavioural lability – contradictory behaviours, explosive and violent emotional reactions, as well as anxiety about their own sexuality. This often results in helplessness, powerlessness in the face of bodily changes and, as a result, attempts to cope with these changes in ways with varying degrees of adaptability (Jankowiak and Wojtynkiewicz, 2018; Smith et al., 2013; Valle et al., 2009). The strong experience of anxiety, tension and resentment towards the difficulties experienced can be alleviated by frequent use of the internet. From the point of view of

the developmental stage of adolescence, when belonging to a peer group is a way of defining one's identity and separating oneself from the adult world, the internet makes it possible to express feelings and opinions and to belong to the community. For some young people, it also acts as an external container for the difficulties they experience, where they can vent their fears, frustrations, difficulties in building peer relationships, learning problems or anxieties about their own sexuality. The answer to these anxieties can be found in social media, where young people try to build relationships, but also draw inspiration for their image and attractiveness, due to the multitude of content available there focusing primarily on these aspects. This results in a need for self-expression, a desire to fit in with current role models and therefore frequently sharing of bold sexually explicit images and creation of such content. The internet and social media provide an opportunity to easily communicate with others. However, online forums, social networking sites and their advantages in terms of anonymity and ease of communication provide an opportunity for adults seeking to contact and establish relationships with minors for sexual purposes.

Risky behaviour is a term that is usually used to describe behaviours that are potentially harmful to health (as opposed to health-promoting behaviours). These can include, but are not limited to, premature or risky sexual behaviour, substance use, eating disorders and suicide-related behaviour. The literature suggests that adolescents' risky behaviours are correlated, meaning that engaging in one type of behaviour may indicate an increased likelihood of engaging in other types or patterns of behaviour (Nadworna-Cieślak and Ogińska-Bulik, 2011; Romer et al., 2017; Tinner et al., 2021). Reports from research among children and adolescents indicate that the most common behaviours of this type include smoking, drinking alcohol, using other psychoactive substances, premature sexual initiation, peer violence and bullying (including cyberbullying). Engaging in these behaviours is associated with increased symptoms of stress and depressive states, problems at school, difficulties in relationships with peers and parents, and an increased risk of persistence of dangerous behaviour in the future (Topping, 2012). The most important and prevalent risky sexual behaviours among young people include engaging in sexual activity too early and without adequate protection (discussed earlier in the chapter), as well as *sexting* (sending erotic content over the phone or internet) and *grooming* (seducing minors online).

Sexting, i.e. sending photos or short videos with erotic content to another person, is usually done using a mobile phone (Fundacja Dajemy Dzieciom Siłę, 2020). This behaviour often refers to people who are trying to overcome their shyness in interpersonal relationships, who want to attract attention of someone of the same or opposite sex, who are afraid of rejection or who lack the ability to establish a relationship through traditional contact. This usually involves expressing trust in the partner or feeling a bond with him or her. According to research by the Internet Watch Foundation, an English NGO, almost 90% of images of this type taken by teenagers are stolen and then posted on pornographic sites (UK Safer Internet Centre, 2017). Making such an image public often involves blackmailing or excluding the teenager from their peer group. Other UK research shows that among 14–16 year olds, 40% know someone who sends nude pictures and 27% know people who do it regularly. In addition, 20% of young people see nothing wrong with distributing pictures showing full nudity and 40% think that sending topless pictures is perfectly acceptable (Kamieniecki et al., 2017). As far as Poland is concerned, data from a study conducted by the NASK research institute *Teenagers 3.0* in 2021 shows that 8.3% of young people aged 15–18 have ever received a nude photo or video and 2.2% have sent a nude photo or video of themselves to another person, which is a decrease of at least several per cent compared to data from previous years (Pyżalski et al., 2019). On the other hand, the *EU Kids Online* survey conducted in Poland in 2018 shows that in a year 3.8% of respondents had been exposed to sexting, and one in four teenagers in this group sends their intimate material to others at least once a month (Pyżalski et al., 2019). It is also increasingly common to encounter the phenomenon of minors producing and publishing sexual content online. The data of the Dyżurnet team indicate that in 2019, out of 2,157 reports of content showing child sexual abuse material (CSAM), 9% were self-generated

by minors. In 2020, the percentage was 14% with 2,517 CSAMs reported, and in 2021 8% with 2,069 CSAMs reported (NASK, 2021).

For a teenager, contact with sexually explicit content is embarrassing and causes fear, powerlessness and helplessness. Figures for the European Union as a whole show that, among online dangers, sexting is one of the experiences providing children with the most intense emotions they cannot cope with. It is worth remembering that the child is completely vulnerable to abuse and does not know how to deal with exposure to this type of content – 45 to 60% of children do not take any countermeasures (Kamieniecki et al., 2017). Particularly difficult for them emotionally is to be confronted with unfamiliar and incomprehensible content. Also, those sending sexually suggestive content put themselves at risk – they may face blackmail to extort benefits in exchange for keeping secret the received photos/videos discrediting the sender.

According to the *Teenagers 3.0* survey report, a large group of teenagers communicate online with people they have never met before. When asked about communicating with "online acquaintances you haven't met in the real world", the answer *never* was selected by less than half of the respondents (48%). The next most common responses were *several times a day* (14.6%), *several times a year* (13.5%), *several times a month* (8.9%), *several times a week* (8.6%) and *once a day* (6.4%). When asked "Do you think it can be dangerous to meet adults you know from the internet?" 8.4% of the children surveyed answered *no*, while as many as 19.1% answered that it was *hard to say* (NASK, 2016). Thus, the results indicate a rather high percentage of children who do not see the danger in communicating with people they meet online, while these people, using numerous manipulative techniques, can influence the child to create a relationship that suits them. A vulnerable and trusting child is under the impression that such an interlocutor is a friendly person, and may be willing to confide secrets and problems, give their home address or agree to a meeting. The results should be thought-provoking regardless of the number of children who are aware of the potential threat. It is the task of parents and schools to educate children about the need to exercise due caution and the risks of meeting in the real world, as according to the data, the number of such encounters is increasing significantly (in 2016 it was 12.6%, in 2018 already 23.1%). According to official data from the Polish police, in 2020, 584 proceedings were initiated in connection with grooming, of which 456 cases were actually classified as an offence and in 316 cases the perpetrator was successfully detected (Informacyjny Serwis Policyjny, 2021; Policja, 2021).

Norm, caution and prevention

The shaping of health-promoting behaviour is important already during childhood and early adolescence. This is when patterns of behaviour are established that directly influence behaviour later in life. With this in mind, adult actions should be primarily directed towards education, expanding opportunities to reflect one's experiences and building a stable, attentive relationship with the parent and caregiver. Affectionate, warm and loving parenting, understood as a stable bond with the parent based on trust, as well as the promotion of social relationships and pro-social attitudes by school institutions, are beneficial for the child's development. It is practices in the form of discipline and coercion, as well as a lack of consistency on the part of the parent, that can contribute to reinforcing aggressiveness and oppositional behaviour among children. On the side of risk factors, one can also mention rejecting the child, punishing for interest in sexuality, incoherency in parenting, low levels of protection and interest in the child, and lack of warmth and positive reinforcement (Beisert, 1991, 2001; Berger and Font, 2015; Bojarska, 2005; Grossman et al., 2018; Halim et al., 2017; Juul, 2007; Rasmussen et al., 2015).

Preventing the various problems associated with a child's potentially risky sexual activity and being cautious with the use of the internet should start at an early age. This is when the child begins to ask questions and forms the foundations of the relationship-building they observe in their immediate environment. Education should be in place from the beginning of a child's contact with the web, but it is important to remember that any time is the right time to join in and take an interest in the child's world.

Protecting children from risky sexual behaviour should focus on countering sexual abuse (including online) and supporting them to build relationships with peers and others. It is the parent's task to teach children as early as possible what the boundaries (including bodily boundaries) of the child and their peers are, how they should be respected and why this is important. This involves teaching children about body structure, indicating which parts of the body are "private" and should not be touched by anyone else, what pressure or coercion is and what to do when someone tries to behave in this way. During adolescence, transmitting knowledge about building close relationships, changes in one's own body and the diversity of experiencing one's sexuality helps to create a safe, welcoming environment, supports the creation of responsible relationships and responding properly when pressure arises to engage in sexual activity too early, and counteracts other risky behaviours such as sending sexually explicit photos (Penfoldi et al., 2009; Pilarczyk, 2021; Seidman, 2012; WHO, 2019).

Risky behaviour resulting from the experience of minority stress

A topic not directly related to the discussion of risky sexual behaviour, but necessary to address in the context of identity development, is the behaviour undertaken by non-heterosexual, transgender or non-binary young people (referred to by the acronym LGBT which stands for lesbian, gay, bisexual, transgender) as a result of experiencing discrimination and rejection. As mentioned earlier, the term risky behaviour refers to a range of potentially harmful behaviours, the spectrum of which includes sexual behaviour as well as those relating to self-harm or suicide. A group particularly prone to risky behaviour in the form of self-harm or suicide attempts are adolescents with a non-heterosexual orientation and who, to varying degrees, do not identify with the sex assigned to them at birth. Although for many years the scientific community has emphasised that belonging to a sexual minority is not a cause of mental dysfunction (Iniewicz et al., 2012), attention is also drawn to the specific social situation of non-heterosexual and transgender people and it is this situation that is seen as a significant factor in the emergence and persistence of mental disorders, leading, among other things, to risky behaviour (Testa et al., 2015).

The socio-cultural context, including homophobia and transphobia, is an important risk factor affecting the psychological well-being of LGBT persons. In other words, a specific factor in the emergence and persistence of psychological problems among people from sexual minorities is oppression, triggered and sustained by elements belonging to and resulting from the experience of the so-called minority stress (Iniewicz et al., 2012; Meyer, 2003). This term, derived from the fields of psychology and sociology, denotes the impact of the social, legal, environmental norms prevailing in a given society on the psychological functioning of those affected. Minority stress, therefore, refers to prolonged, exceptional psychological tension resulting from experiences of prejudice and discrimination and their projection on the basis of sexual orientation or gender identity. Heteronormativity and cisgenderism are perceived as appropriate and desirable in society, and the effects of not identifying with them are invalidated or downplayed. However, the impact of minority stress on mental health cannot be overlooked, with stressors including distal (external) and proximal (internalised) stressors. Distal stressors include, but are not limited to, psychological and physical violence (from family, strangers, peers), lack of acceptance from staff in various organisations (including school, university, companies, institutions) and lack of or limitations on rights. These stressors influence the internalisation of experiences and the formation of negative self-perceptions, self-hatred and self-loathing, questioning of one's own identity and – as a result – the emergence of psychological disorders (Lefevor et al., 2019; Talan et al., 2017).

A special situation applies to children and adolescents who, as mentioned earlier, in the face of many social, legal and, above all, parental circumstances, are defenceless and dependent on their caregiver. As there is no reliable sex education in Polish schools, the topic of sexual minorities is usually neglected or misinformation is spread when discussing it. Moreover, it is sometimes discussed in relation

to faith, and non-normative sexual orientation and gender identity are presented as something that goes against the "natural" order of human development and functioning. Similarly, many parents do not accept information about their child's non-heterosexual orientation or non-cisgender identity. While young people, including LGBT youth, need emotional support and a sense of security from their caregivers, belonging to a sexual minority is associated with the risk of exclusion from the group, name-calling and physical violence. In Poland, there is still a lack of places, including schools and educational institutions, where reliable and basic knowledge on sexuality can be acquired. Research shows that knowledge about minority groups reduces stereotypical attitudes and counteracts social exclusion. Young people themselves often emphasise the need for teachers to support them in the process of self-acceptance of their sexual orientation and in combating expressions of aggression and violent behaviour taking place at school. Similarly, a large proportion of LGBT youth do not tell their parents about their identity, because of the parent's negative opinion and fear of rejection or abuse. Most often sexual orientation or gender identity is first communicated to close friends (Antonio and Moleiro, 2015; Kampania Przeciw Homofobii [KPH], 2017; Marshall et al., 2015; Ryan et al., 2010; Schoeps et al., 2020).

> *I am pregnant with my boyfriend's baby. My mother constantly criticises and blames me because of this. Also, she insists that we get married as soon as possible. I trust my boyfriend and I know I can count on him, but we don't want to get married yet. I don't know what to do.*
>
> *18-year-old girl*
> *A quote from phone calls and emails to 116 111 Helpline for Children and Young People*

An analysis of the literature indicates that difficulties such as negative self-image, low self-esteem, adaptive and depressive disorders and a tendency to self-destructive behaviour, including self-harm, are more common in non-heterosexual persons and those whose gender identity is inconsistent with the sex assigned at birth than in heterosexual persons and those whose gender is consistent with the assigned sex (cisgender). In 2017, a report on the situation of LGBT people in Poland was published by the KPH, the Lambda Foundation and the Trans-Fuzja Foundation, in which 69.4% of LGBT persons under the age of 18 admitted to having suicidal thoughts and almost 12% said it happens often. The study also analysed the prevalence of depression among LGBT youth. It found that severe symptoms of it were found in 49.4% (KPH, 2017). In the corresponding study for 2019–2020, the statistics on youth functioning are much more worrying, with 74.29% of LGBT adolescents feeling lonely and 75% reporting having suicidal thoughts. The report also shows that only a few per cent of them received institutional support (KPH, 2021). As with other risky behaviours, it is the adult who is responsible for the child's safety; young people may not be aware of the existence of relevant organisations, or may not have access to them. Similar data on suicidal thoughts among young people is presented in the UNSECO paper entitled *Out in the open*. The statistics presented there show that LGBT youth from Poland (but also Belgium, the United States and the Netherlands) have suicidal thoughts two to more than five times more often than their heterosexual or cisgender peers (UNESCO, 2016). Adolescents who have little parental support have been shown to experience more severe anxiety. According to other studies, adolescents who do not receive parental support are 8.4 times more likely to report attempting suicide compared to peers who have received support from their parents (Bergeron et al., 2015; Katz-Wise et al., 2016). A study conducted in the United States found that 15% of LGBT youth had attempted suicide in the 12 months preceding the survey and 40% had seriously considered it. Adolescents aged 13–17 are the most vulnerable group. The data shows that 39% of LGBT teens considered attempting suicide, of which 44% attempted suicide while aged 13–17 and 29% attempted suicide while aged 18–24. In addition, 48% of LGBT adolescents also stated that they had self-harmed in the past year before the survey. This problem mainly affected transgender and non-binary youth (over 60%). As the data shows, non-heterosexual

and transgender youth are almost five times more likely to attempt suicide compared to heterosexual and cisgender youth (The Trevor Project, 2020).

Basing on the research, it can be concluded that parents and teachers who are accepting and supportive of non-heterosexual and transgendered adolescents provide an effective buffer against the development of depression and anxiety in these young people, which consequently reduces the incidence of risky behaviour. Specific caring behaviours, such as helping a child when he or she is experiencing mistreatment or supporting the adolescent's gender expression, are associated with a lower risk of depressive and anxiety disorders, substance abuse and suicidal thoughts and attempts. Among the supportive behaviours mentioned are expressing warm feelings when the child discloses or the caregiver learns about the child's orientation or gender identity, expecting and demanding respect for the child from other family members, inviting and welcoming the child's loved ones into the home, and emphasising support for the child's identity (Birkett et al., 2015; Clark et al., 2020; Puckett et al., 2015).

Summary

Young people engage into romantic relationships and become sexually active. Their psychosexual development primarily involves learning about and experiencing themselves in terms of sexual orientation and gender identity. The internet is part of reality. Adolescents often lack the capacity to reflect on the relationships they form and are unable to predict the consequences of their behaviour, assess the risks associated with content found on the internet or understand the intentions of new people they meet. Parents and teachers often avoid discussing the topic of psychosexual development and online safety with the children for lack of adequate knowledge and skills. Above all, education should be guided by a genuine, sincere relationship based on trust, time spent with the child and interest and attention to the child's needs. These are conducive to a lower risk of engaging in risky sexual behaviour, as well as reduce the risk of negative consequences of situations which the child may encounter.

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