

# Sexual health – where theory meets life

Triece Turnbull and Mark Forshaw analyse the contribution of health psychology

**Health psychology has the potential to become a leading force in sex and relationship education (SRE). Government bodies, schools and parents all need the specialist knowledge of health psychologists so that a coordinated approach can be employed to give young people the information they need to make informed choices over their personal relationships and sexual behaviour. This, in time, should reduce currently high rates of teenage pregnancy, sexually transmitted infections and abortions that are well documented in the literature from the UK.**

## questions

Are young people getting the SRE they say they need and want?

The impact that health psychology can make is massive, so why hasn't the specialist knowledge of health psychologists been utilised to make a difference in SRE and the sexual health of young people?

## resources

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In 21st-century Britain the negative outcomes of sexual risk-taking behaviour in young people are well documented (Mueller et al., 2008; Sales et al., 2009). Although government strategies have previously been put in place to address the negative outcomes associated with young people's behaviour, the teenage pregnancy and sexually transmitted infection (STI) rates have continued to rise (DCSF, 2010; Rogers & Evans, 2011). This is in addition to the UK having high abortion rates, which has also raised concerns regarding Britain's sexual health strategies and the sex education that is provided (Paisley, 2009).

Taking into account the facts relating to sexual health, it is imperative that effective strategies be deployed before the negative sexual health outcomes for the UK worsen. The government is treating sexual behaviour as a public health issue, but although steps are being taken to improve the current sexual health situation it is important to address these and seek improvements for the future, drawing upon the right people and suitably qualified health professionals who can make a difference. For decades we have relied upon teachers, health promoters and health educators, but the rates of teenage pregnancy have risen. Something about the way we do things at present is not working.

Over the last decade various criticisms have been raised regarding governmental attempts to provide effective sex and relationship education (SRE). However, statutory SRE guidance (Department for Education & Employment, 2000) needs to

be adhered to, which incorporates key guidance to ensure that primary, secondary, special schools and pupil referral units in England deliver effective SRE. Regrettably, the Office for Standards in Education, Children's Services and Skills (Ofsted), who are the authority responsible for inspection and regulation of SRE provisions, suggests that some teachers do not have the confidence, knowledge and skills to deliver effective sex education. According to Ofsted (2010), this is in part due to teachers feeling embarrassed when teaching sensitive subjects, and in part because they have not been given expert training to teach SRE properly. Young people themselves say that they want properly trained teachers who are confident and competent to teach SRE as part of PSHE education (UK Youth Parliament, 2007), so it may be that more specialist teachers are needed to teach SRE.

Although it is important that schools follow the SRE guidance in relation to the quality of SRE provided, it is also vital that they follow the recommendations to include parents in the sex education that is given (DfEE, 2000). Many parents are happy for schools to undertake the role of providing SRE to their children (Sex Education Forum, 2011), but parents do recognise their responsibility to educate their children, especially since they play a central role in their development, growth and health. Some may even use computers to increase communication, allowing parents and their children to learn about SRE topics together (Turnbull et al., 2010a, 2011a).

However, research has shown that some schools do not inform parents of the SRE that is taught to their children (Turnbull, 2011a, 2011b) and parents do not see the school SRE policy, which should detail the sex education that is provided (Turnbull et al., 2011b). These factors have been found to act as a barrier to discussing sexual matters openly within families (Turnbull et al., 2008). Parents also admit to not always having the up-to-date SRE knowledge to discuss sexual matters openly with their children

(Turnbull, 2011a; Turnbull et al., 2011a, 2011b).

It is clear that many parents want to be involved in the SRE that is given to their children, and they need support in this area. This mainly needs to come from schools, but also strategies need to be developed to improve parents' knowledge so they feel equipped to talk to their children about sexual matters.

Government bodies, education authorities and parents are all striving to change the direction of the current SRE delivery that leads to sexual health problems in the UK. But barriers need to be removed and unity is needed in the approach to giving young people the SRE they need and deserve, which is an area where qualified health professionals can make a difference.

Fundamentally, SRE in the context of high quality Personal, Social and Health Education (PSHE) provision needs to be given the same precedence as other subjects within school and awarded equal importance as improving health and prevention of illness. At present emphasis is put on the physical consequences associated with pregnancy, STIs and abortions rather than on the emotional and psychological well-being that is linked with poor SRE, which in turn influences people's sexual choices and sexual behaviour. This is where we need an approach that goes beyond the training of the current providers. We need people trained in understanding human behaviour in a health context, and it is surprising to think how little,



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historically, that has been recognised. Health psychology in particular as a discipline is perfectly positioned to embrace the current needs of SRE and sexual health as it focuses not only on the biological and social but also on the psychological factors that can influence health and illness. This is especially so in providing young people with the information they need regarding relationships, emotions and self-esteem (UK Youth Parliament, 2007). In short, we've been missing a trick for a very long time.

For decades, several approaches in health psychology have proved useful at understanding sexual behaviour and the social cognitions relating to attitudes and sexual experiences. For example, from as early as the 1940s sex surveys have been employed to investigate people's sexual habits from a behavioural perspective (e.g. Johnson et al., 1994; Kinsey et al., 1948). In the 1960s greater attention was given to the physiology of human sexual behaviour (Masters & Johnson, 1966), and more recently health psychology has turned its attention to using health psychology models to focus upon measuring the beliefs, attitudes and perceptions of people and their sexual behaviour, including studying safer sex practices, such as condom use (Abraham & Sheeran, 1994; Bayley et al., 2009). Although these approaches are beneficial in explaining, understanding and predicting sexual behaviours and sexual attitudes, qualified health psychologists are able to provide sexual health information and have a profound effect on the delivery of SRE if only they get chance to do so.

Examples of the beneficial areas where health psychologists have contributed

towards facilitating learning in relation to SRE and sexual health include:

- | teens' sexual experience and preferences for school-based sex education (see Newby et al., 2012);
- | interventions to change individuals' behaviour in relation to safer sex (see Hancock & Brown, 2011);
- | effectiveness of school-based sex education (see Wight, 2011);
- | SRE in the family context using interactive technologies (see Turnbull et al., 2010b);
- | risk of chlamydia infection among young people attending a genito-urinary medicine clinic (see Newby et al., 2012);
- | school-based condom promotion leaflets (see Hill & Abraham, 2008).

However, how do health psychologists work in practice compared to other health specialists regarding sexual health? If we were to use chlamydia in young people as an example, health specialists would take the stance of emphasising the use of a condom to prevent infection and reduce national statistics. They would also point out the risks associated with acquiring chlamydia and the problems this can have on reproductive health (i.e. risk of fertility if not treated). Although this information is important, health psychologists would be looking at advancing upon these determinants of preventing chlamydia by accessing young people's knowledge, risk perceptions and self-efficacy to use condoms. They would identify the reasons for young people not using a condom to prevent chlamydia and put interventions in place that are purposeful to the individual to meet their specific aims of preventing infection. A good example of how this has been achieved in practice is by Joshi et al. (2012), who looked at using intervention mapping to develop a computer-based sex education lesson on chlamydia for secondary school pupils. Their initial aims were to conduct a needs assessment, followed by intervention objectives and practical strategies. From this they were

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able to develop an intervention plan that allowed for delivery and evaluation to demonstrate that their approach had been effective in preventing chlamydia. Various strategies have been employed by sexual health specialists that have not demonstrated overall effectiveness (Kirby, 2007), which is why it is imperative that health psychologists are involved in the design and delivery of such programmes associated with the promotion of sexual health.

Perhaps there is a misconception that qualified health psychologists focus upon how people cope with and manage illness? In fact they are well trained to promote health and change risky behaviours by working with the government and the National Health Service, if only they themselves, and others around them, will see it. Properly qualified health psychologists have a vital role to play in relation to research and teaching and as independent SRE sexual health consultants. Therefore, utilising their skills and knowledge they can have a massive impact in the future on providing SRE and promoting positive sexual health.

It's time for a coordinated approach to sexual health issues. In essence, a comprehensive sex education programme needs to be developed, in collaboration with relevant bodies such as the British Psychological Society and its Division of Health Psychology, that follows the legislation and SRE guidance given by the DfEE (2000). Although SRE facts would be the main element regarding content, the programme also needs to challenge people's beliefs, attitudes and perceptions relating to sexual health and sexual behaviour. We would advocate an e-learning programme that would

- l allow a uniformed approach for teaching SRE to all children and young people;
- l give teachers and parents the knowledge to teach SRE and work together when educating children and young people of sexual matters;



- l mirror the content detailed in the SRE guidance by the government; and
- l provide a system where sex education can be measured on its effectiveness and altered if needed to meet changing demands of SRE guidance and policy.

As well as delivering these benefits, the e-learning programme will allow teachers and parents to learn about sexual matters from specialists who have the knowledge and skills to train them and increase their confidence so they too can feel comfortable and competent in the delivery of SRE topics. Over time the training will allow for others to learn from this system, which can be modified to keep abreast of any Department for Children, Families and Schools SRE guidance changes resulting from a current review, being part of a wider review for PSHE. Furthermore, a 'champions' system could be employed once there are sufficient numbers of trained teachers to train other SRE teachers in order to improve and sustain a holistic approach to teaching SRE. This would provide an overarching approach to teaching SRE whereby the advantages – for children, teachers, parents, and even the health and economy of the nation, could be immense.

Several SRE packages, such as 'Share',

'Ripple' and 'Healthy Respect' (see Wight, 2011) exist to teach about sexual matters, but there is no single e-learning programme, based on health psychology principles, that can be measured on effectiveness when educating teachers, parents and their children. Therefore a structured SRE programme needs to challenge this as it might have massive gains, not just through the dissemination of SRE knowledge, but acting directly upon it. This could then help to reduce teenage/unwanted pregnancies and STIs, and save the National Health Service and sexual health services in particular millions of pounds a year. Utilising the approach discussed is a perfect step forward in SRE and an achievable strategy to tackle the current SRE problems that are leading to the sexual health challenge in the UK. Promoting and encouraging an open culture in SRE and sexual health provides better health and well-being for all and would allow the UK to share its successful SRE strategy with other countries by transferring knowledge to promote positive sexual health at a global level. Let us start thinking in joined-up ways, and let health psychologists be the glue between the policy makers and the service users.



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