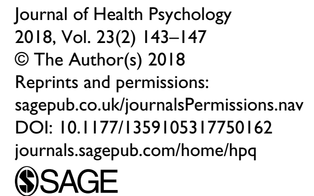
Editorial



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Towards a psychology of sexual health

Increased attention has been made in recent years to issues of sexual and reproductive health in relation to broader social and political environments and human rights issues. The World Health Organization (WHO, 2015) has indicated that we cannot consider sexual and reproductive health concerns such as HIV and other sexually transmitted diseases, sexual violence, sexual problems, unwanted pregnancies and unsafe abortions, without considering discrimination and inequality. Many individuals around the world may be actively discriminated against and even abused on the basis of their sexual and gender identity, who they choose to have sex with and their sexual practices. Within this framework, sexual health is not to be understood only in terms of the absence of sexual disease or dysfunction, but rather more holistically in terms of physical as well as psychological and social well-being. Sexual health is not just about disease, but also identity and relationships. As the WHO (2015) states, 'For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled' (p. 5). This inclusive definition of sexual health demands an imaginative sexual health psychology that theorises the individual as embedded within their psychosocial, sociocultural and geopolitical contexts. This inclusive definition also demarcates the rather impoverished attempt to develop a sexual health psychology to date. Much of the existing work on sexual health psychology has for the most part aligned with funding opportunities which address the proximal determinants of sexual ill-health. Such approaches align themselves with the medical profession and focus on behavioural determinants of unsafe sex and the transmission of sexual infections, the determinants and psychological consequences of sexual violence, and understanding the causes and psychological treatments of what are termed 'sexual dysfunctions' (e.g. Miller and Green, 2002). These are all important areas of work, but their overall focus on the proximal determinants of sexual ill-health elides other, and potentially more important determinants of sexual health. Moreover, a biomedical focus on sexual health alone and a tendency to only use the individual as a unit of analysis and theory amplifies and interpellates notions of individual responsibility and culpability. It can diminish and obscure social and other structural determinants of sex (e.g. Campbell, 2003 and Tomlinson et al., 2010 in relation to HIV) and lead to the medicalisation of sexual difficulties (Moynihan, 2003; Tiefer, 2006). Such partial understandings of sexual health can severely delimit the ways we can imagine and develop sexual health interventions (Marks et al., 2018).

It could be further argued that much of the work on sexual and reproductive health has often drawn on heteronormative assumptions about sex, behaviour and 'normality', whereas the sexual lives of marginalised others may often be conceptualised in terms of 'risk' and unconventional, or 'problem' behaviour (e.g. unprotected sex between men who have sex with men). Furthermore, other non-normative groups are typically barely considered, for example, the sexuality of people with disabilities are routinely overlooked.

We would argue that in order to develop sexual health psychology, the sexual and

reproductive health of individuals cannot be properly understood in isolation from the socio-political contexts in which people are embedded. Furthermore, so as not to perpetuate dominant models, reproduce inequalities and power relations or to reify oppressive theories (Hepworth, 2006), a pluralist approach is required. A psychology of sexual health must encourage a diversity of analytic foci and an inclusive approach to both methods and theory. In this way, a new psychology of sexual health can encompass the inclusive focus of the WHO definition.

The collection of 16 papers in this special issue presents a first step towards such a psychology of sexual health. The special issue presents a focus on many differing aspects of sexual and reproductive health from a broad range of perspectives. The papers report on research conducted in a range of national contexts not only the developed world, including Argentina, Australia, Canada, Ghana, India, Ireland, Kenya, New Zealand, South Africa, the United Kingdom, and the United States, and utilise differing quantitative and qualitative methods. The papers construct a sexual health psychology that understands multiple dimensions of sexual health and situates sexual and reproductive health within multiple wider contexts; the broader context of social and cultural normative assumptions about sexuality and gender; political discourses about rights and choices; and the role of power in shaping sexual health.

The first two papers make a critical analysis of how research knowledge on sexual health is generated and reported on both making a critique on the continuing tendency to focus on medical understandings and pathologise individual behaviours in relation to sexual health. These papers trouble the foundations on which sexual health knowledge is generated, shared and utilised. Stelzl and colleagues present a critical discursive analysis on human sexuality textbooks from the United States and Canada and point out how sexual problems were conceptualised and represented in traditional, individualised biomedical ways. Such textbooks perpetuate and delimit the ways sexual health can be understood and reify problematic assumptions that constrain change. Similarly, epidemiology, as a powerful truth system, shapes funding agendas and drives the production of knowledge about sexual health. Edelman's critique of this foundational epistemology similarly emphasises the dominant focus on the individual in epidemiology and calls for a re-envisioning of the focus of epidemiological studies to studies that focus more on sociocultural context and that counter the constructions around sexual health 'risks' that pathologize individuals and certain behaviours. Edelman outlines the need for approaches that connect epidemiology to lived experience, intersectionality and salutogenesis. New epidemiological models would generate new evidence about sexual health and in turn generate new priorities.

The next three papers focus on young people's sexual health, within specific sociocultural contexts. LeGrice and colleagues challenge the predominance of a 'one size fits all' approach to sexual health education in New Zealand, which excludes Maori student's cultural understandings of sexuality. Any cultural considerations for Maori students are included as an extra 'add on'. Sexuality education in this context adopts a Western, colonising perspective. Their study shows how Maori cultural values, such as fluid understandings of gender and sexuality, should be integrated into sexual health education in a manner beneficial for all. Maori ontologies and epistemologies invite a reconsideration of sex and sexual health with particular implications for a new psychology of sexual health. In Kenya, the paper by Ssewanyana and colleagues looks at sexual risk behaviours of adolescents in Kilify County. The researchers adopt an ecological system model to explore how certain sexual risk practices, such as early sexual debut and transactional sex, are shaped by social and structural environments, particularly poverty, community insecurity and under-resourced healthcare systems. They highlight gender inequality as a key driving factor for many sexual risk behaviours,

particularly for females. Constructions around gender and sexuality are highlighted in the study by McVittie and colleagues on the understandings of sexual risk among HIV volunteer support workers in South Africa. They analyse how the HIV volunteer workers discuss and conceptualise sexual risk in largely heteronormative, gendered norms that perpetuate constructions of masculinity and femininity. Talk about men centre around their innate sexual drive and sexual power and irresponsibility. This may in turn position women as being responsible for ensuring their own sexual health and that of their male partners. The authors argue that this reliance on heteronormative and gendered constructions around sexuality may perpetuate the invisibility of other forms of HIV sexual transmission and prevent the promotion of alternative constructions of femininities and masculinities.

Gender inequality and gendered relationships and power dynamics are a key concern also explored in the next five papers that deal with women's sexual and reproductive health more specifically. The first paper by Bowling and colleagues look at the acceptability among men and women of the use of female condoms in urban India in relation to sexual pleasure. They found that women felt they could not trust their male partners with using male condoms, and so, the use of the female condom increased their sexual pleasure by giving them more sense of control and reducing anxiety about pregnancy and infections. Men indicated mixed reports about sexual pleasure and the use of the female condom, with some saying that it felt less constraining than the male condom, but others saying that the inner and outer rings of the female condom caused discomfort to their penis. Interestingly, they found that both men and women did not necessarily prioritise male sexual pleasure, although acknowledging it as a cultural norm. More important for the experience of sexual pleasure was longer duration and privacy for sex and sex which was stress free.

The paper by Moran and Lee looks at sexual health from the perspective of body image and socially constructed norms of the aesthetics of the vagina. They explore Australian women's constructions and dissatisfaction with their genital appearance. They report on how the women tended to view their genitals in terms of social constructions of the 'normal' vagina that emphasise the male gaze, against which they position themselves as inadequate. They further observe the women's difficulties in challenging these normative assumptions. The authors argue for the need to promote an awareness of natural genital diversity and challenge the messages that female genital cosmetic surgery is safe and beneficial.

The next papers point to the influence of political and social power and disenfranchisement on control over sexual and reproductive choices and its impact on identity and psychological well-being. Marston and colleagues take a dialogical approach to exploring how a sample of women in Ghana regulate their fertility and how this relates to their social identity. They report on how the women navigate the conflicting traditional versus modern social identities. On one hand, they are positioned as having obligations to bear children, on the other hand having modern educational and employment responsibilities. The women's fertility regulation practices and choice around pregnancy are shaped by sociocultural norms and are in response to men's expectations on them. The papers by Msetfi and colleagues and Sambaraju and colleagues both look at women's reproductive rights in the context of Ireland's anti-abortion policies. Msetfi and colleagues take a quantitative approach to investigating the relationship between political disenfranchisement, reproductive control and psychological well-being. They show that limiting women's access to reproductive healthcare may damage their health and well-being. They thus show how perceived socio-political disenfranchisement (rather than specific lack of access) can have important negative implications for women's sexual health. Sambaraju and colleagues present a discursive analysis on online readers' comments to news items on debates around reforming abortion laws. They show how some of the debates between readers commenting on a news

item centre around conflicts around matters of 'choice'. However, often the debates between readers centre around the legitimacy of a woman's 'choice'. Notions of legitimacy are made with reference to particular outcomes (such as medical risk) and motivations. Different orientations to legitimacy of choice are made in terms of constructing women as either independent agents or as bound up to their pregnancy. The authors make a case for such legitimisation work as socially embedded and forms a focus for a sexual health psychology that can address sexual health rights.

Thereafter, two papers focus on people with disabilities, a group generally excluded in the sexuality literature. Both papers aim to challenge the assumptions that may be held about the sexuality of people with disabilities. Ilyes presents an impassioned analysis and challenge to how sexual consent is understood, conceptualised and policed for people with learning disabilities, calling for a more emancipatory and inclusive way of working with matters of consent and sexuality. Hunt and colleagues report on a photovoice study on the sexuality experiences of people with physical disabilities in South Africa, revealing how normative assumptions about sexuality, masculinity and femininity shape much of the participants' experiences and have to be renegotiated and challenged. Exploration of sexuality in the context of disability provides a dynamic opportunity to interrogate concepts such as embodiment, pleasure, intimacy, mutuality and what it means to be sexual.

There are two papers looking at sexual health matters within samples from sexual and gender minorities. Aristegui and colleagues explore the resources used by a sample of gay men and transgender women in Argentina to cope with their HIV-positive status and marginalised identity. They report on how participants not only draw on individual and interpersonal resources for coping with stigma but also how broader contextual and institutional processes had a positive impact on coping with stigma. These include political changes around laws and human rights. Grant and Nash's paper focus on a sample of lesbian, bisexual and queer Australian women. The authors observe how public health messages of safe sex and risk tend to focus on heteronormative practices, against which women identifying as lesbian are constructed as 'low risk'. They take a sociological framework to explore how participants' understanding and meaning about safe sex and risk are shaped by gendered heteronormative sexual scripts. Safe sex and risk are understood primarily in terms of sex with men, rather than sex with women. The authors point to the absence of sexual scripts and sexual health literacy that are meaningful for lesbian, bisexual and queer identities.

The final two papers of this special issue focus specifically on matters of men's sexual health. The paper by Own and Campbell presents a discursive analysis of how masculinity and the penis are constructed in a sample of popular men's magazines in the United Kingdom. Their analysis demonstrates how constructions of the penis create a sense of anxiety and fear about the reader's manhood. They identify two main discourses: the 'Laddish' discourse which focuses primarily on size, dominance and superiority and the 'Medicalized' discourse which focuses on functionality and aesthetics. They argue how both discourses create anxiety and fear around a masculine ideal that is unachievable and runs the risk of trauma and damage when penis surgery goes wrong. This may leave male readers wrestling with a fragile sense of manhood. Finally, the paper by Tutino and colleagues focus at the level of the individual, but point out how research on men's sexual health has typically focused on sexual functioning with much less attention given to broader dimensions of men's sexual health. They examine the relationship between psychological variables and sexual health outcomes of a sample of undergraduate male students in Canada. Using a quantitative approach, they found that difficulties with emotional regulation, greater anxiety sensitivity and increased psychological distress predicted poorer sexual health outcomes, particularly sexual functioning and sexual quality of life. The authors argue for a need to take a broader, psychosocial perspective

in men's sexual health and clinical psychology practice.

This special edition provides an initial step towards imagining a new psychology of sexual health. At its heart is an inclusive understanding of what sexual health *can be* and an invitation to psychologists to respond to this dynamic opportunity. Critically, sexual health psychology should encompass far more than attempts to reduce the onwards transmission of sexually transmitted diseases alone. Of course, such disease prevention work is vital, yet we believe it is short sighted to address such issues in isolation. Deracinating people and pathogens from the contexts in which they are embedded will not improve sexual health. Sexual health psychology must assist in troubling systems of truth and knowledge. Sexual health psychology must question the social organisation of sex, bodies and gender. Sexual health psychology must articulate how the scope of individual agency is globally patterned by diverse social structures. Sexual health psychology must connect the complexities of the discursive realm to everyday lived experience. We believe that it is only through such holistic and multifaceted understandings that we can imagine and deliver pluralistic sexual health interventions to genuinely improve sexual health.

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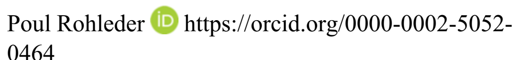
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