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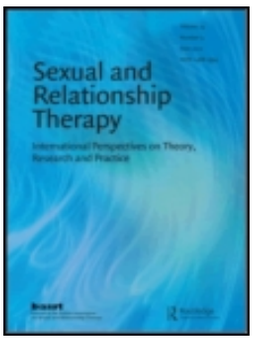

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Perceptions of sexuality and sexual health among young people in the Netherlands

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Sexual health problems are not uncommon among young people in the Netherlands and finding the proper treatment for such problems is often challenging. More insight regarding young people's perceptions of sexuality and its associated problems is needed to improve both treatment and education. This qualitative study of 22 young people (aged 13 to 25 years) explored perceptions of sexuality and sexual health. The results show that sexuality is narrowly defined by young people, with focus clearly being placed on physical aspects of sexuality, and sexual intercourse in particular. Sexual problems are usually defined as physical or medical problems. The data show that participants had limited knowledge regarding sexual problems associated with sexual functioning. Schools, parents and culture all appear to play a role in perceptions of sexuality and sexual health. In their totality, the findings suggest that knowledge about the complexity of sexuality and sexual health is lacking among young people in the Netherlands. We recommend broader sexual health education programs in schools that include the discussion of multiple aspects of sexuality, including pleasure. We also suggest that parents take a more prominent role in educating their children about sexuality.

Keywords: young people; sexuality; sexual health; education; qualitative methods

Introduction

Sexual health is described by the World Health Organization (WHO) as: ''. . . a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'' (WHO, 2002, p. 5).

Evidently, sexual health is not merely the absence of disease. Unfortunately, in most sexual health research and prevention programs focus is primarily placed on

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risk behavior, such as unplanned or unwanted pregnancy and sexually transmitted infections (STIs) (Bell, Richardson, Wall, & Goldmeier, 2006; Deligeroroglou, Christopoulos, & Creatsas, 2006; Department of Health, 2009; Harrison, Charles, & Britt, 2009; Kang, Skinner, & Foran, 2007). This is exemplified by a study that investigated the sexual health of young people in the Netherlands. De Graaf, Meijer, Poelman and Vanwesenbeeck (2005) explored sexual health among 2382 boys and 2439 girls aged 12 to 25 and concluded that Dutch young people are, generally speaking, sexually healthy. This conclusion was based on data showing, firstly, that, among youth attending school, 90–93% used contraception during their first intercourse and, secondly, non-use of condoms decreased from 27% in 1995 to 17% in 2005. The emphasis in this study was clearly on risk reduction and the presence of sexual function problems as factors contributing to sexual health was disregarded in their conclusion. However, at the same time, in the same study, data on sexual dysfunction were collected. This data showed that young people in the Netherlands experience problems with sexual desire (e.g. a lack of sexual desire or differences in sexual desire between partners) and sexual arousal (e.g. male erectile dysfunction, female lubrication disorder and low subjective sexual arousal among both men and women) as well as orgasm or pain problems (De Graaf et al., 2005; see also APA, 2000). Approximately one in every six girls reported reduced sexual desire and one in every four reported that they frequently or often do not have an orgasm during sex. Further, a significant portion of the girls (57%) reported experiencing pain during intercourse regularly or often. Boys reported fewer problems. What is most striking is that these problems were perceived as normal (De Graaf et al., 2005). One must ask if young people in the Netherlands are indeed sexually healthy when sexual health problems are so prevalent?

Experiencing a sexual function problem, even if it is regarded as normal, can significantly impact one's emotional, mental and social wellbeing. Research has shown that men who experience premature ejaculation also report lower levels of sexual satisfaction in addition to higher levels of personal distress and interpersonal difficulties (Rowland, Patrick, Rothman, & Gagnon). Men who suffer from erectile dysfunction also experience considerable psychological distress and negative social consequences (Althof, 2002) and sexual function problems in women are strongly linked to a lack of physical and emotional satisfaction and unhappiness (Laumann, Paik, & Rosen, 1999). Further, leaving sexual function problems untreated can result in secondary problems like depression and relationship problems (Grauvogl et al., 2009). Women are particularly at risk for these secondary problems. Bakker and Vanwesenbeeck (2006) reported that only a third of women who experience a sexual function problem, and are in need of help, actually receive that help. This is in contrast to men, who generally find the help they need. In men with a sexual function problem, only 4% go untreated (Akre, Michaud, & Suris, 2010).

The tendency to focus primarily on the (absence of) disease is not only present in sexual health research but also in sexual health education. In fact, the focus in sexual health education programs is often limited to pregnancy and disease prevention and the placement of such programs in school curriculum reflects this. In the USA (Fagen, Stacks, Hutter, & Syster, 2010) and in Europe (Wellings & Parker, 2006) sexual health is typically taught in the biology curriculum. This incorporation of sexual health education in the biology curriculum reflects a fairly pervasive emphasis on the physical, health-related aspects of sexual health and a weaker focus on the emotional, mental and psychological aspects of sexual health (Wellings & Parker,

2006). A lack of awareness regarding emotional, mental and psychological aspects of sexual health is highly problematic. If young people are uninformed regarding the importance of these aspects and if they are uninformed about the importance of pleasure during sex and how such pleasure can be achieved and maintained, they may, as demonstrated by Bakker and Vanwesenbeeck's (2006) findings, not be alarmed or likely to seek help if sexual function problems present. In the absence of broader sexual health education, young people are likely to perceive sexual problems as normal and thereby risk potential physical and psychological side effects.

When young people who experience sexual health problems recognize and acknowledge that they have a problem, help should be sought. Unfortunately, a substantial barrier to seeking help exists. The most important reasons for not seeking help for a sexual health problem include finding it too difficult to look for help and being afraid to ask for help. Furthermore, thresholds like a lack of familiarity with, and lack of confidence in, the healthcare services available may inhibit help seeking. Also, a loss of anonymity and financial costs further reduce the likelihood that young people find suitable treatment when confronted with a sexual health problem (Akre, Michaud, & Suris, 2010; Bakker, de Graaf, De Haas, Kedde, Kruijer, & Wijsen, 2009; Bakker & Vanwesenbeeck, 2006).

In this exploratory study, we set out to identify young people's perceptions of sexual health and sexual health problems. We considered this to be imperative as greater insight regarding young people's perceptions of sexual health serves as important input for the development and implementation, or adaptation, of suitable and effective treatment for sexual health problems and appropriate sexual health education.

Methods

Study settings and design

Qualitative data were gathered in the Netherlands in May and June of 2009 at a secondary school in Hoensbroek and at the Rotterdam-Rijnmond Public Health Service (PHS). The goal of this qualitative research was to illuminate social phenomena in natural rather than experimental settings by emphasizing the meanings, experiences and views of participants. Young people's help-seeking behavior and their interactions with healthcare professionals are highly complex phenomena that, in our opinion, could benefit from an inductive approach that provides answers to complex questions being posed by healthcare professionals and policymakers (Pope & Maysa, 1995).

Our data were derived from face-to-face, semi-structured individual interviews and a focus group discussion (FGD). Both individual interviews and FGDs are widely used to explore people's perceptions, attitudes and behaviors towards health and healthcare (Boldero & Fallon, 1995; Klein, Wild, & Cave, 2005; Pope & Maysa, 1995). We opted to combine methods so as to gain insight from an individual perspective as well as insight brought forth by stimulating group dynamics and interaction.

Participants

A total of 22 heterosexual young people aged 13 to 25 residing in either Hoensbroek or Rotterdam participated in this study. This particular age group was chosen

because it covers an important developmental phase in which perceptions of sexuality and accompanying problems are formed. Furthermore, the selected age range included young people at different stages of their sexual development (e.g. with and without experience with sexual intercourse) and personal development (in school and in the transition from school to work). In sampling, we did not seek to acquire a large, representative, probability-based sample. Rather, as is the norm in exploratory studies, sampling was purposive. Participants were sampled based on specific predetermined criteria in order to cover a broad range of heterogeneous characteristics (Polit, & Beck, 2010; Pope, van Royen, & Baker, 2002;). We thus opted to sample two different areas in the Netherlands as this allowed for the representation of both young people living in a rural area with predominantly European ethnicity (Hoensbroek) and young people living in an urban center with substantial ethnic diversity (Rotterdam).

Procedure

Prior to conducting the interviews and FGD, a topic list with open-ended questions was constructed via two consensus meetings with experts in the field of adolescent development and sexual health care and the researchers. The resulting topic list, used as a guide during both the interviews and the FGD, comprised three major components: (1) perceptions of sexuality and sexual health, (2) perceptions of problems and concerns regarding sexuality and sexual health and (3) how to treat sexual health or sexual function problems. The final component was included as a means to explore possible new treatment strategies. At the same time, opportunities to discuss other relevant matters were provided. This was particularly important in the investigation of sensitive subjects like sexual health (Forman, Creswell, Damschroder, Kowalski, & Krein, 2008; Hancock, 2002; Power, 2002).

Participants were recruited through a secondary school in Hoensbroek and the local PHS in Rotterdam. The secondary school and PHS were first approached and asked if they would permit the recruitment of students (at the school) and STI clinic clients (at the PHS). Both agreed to cooperate. At the school, the parental advisory board was first consulted and, once approval was granted, an information letter was distributed to several classes. Interested participants contacted the researcher who subsequently scheduled an interview or FGD. At the PHS, the researcher approached young people waiting for an STI consultation directly and asked them if they would be willing to participate in an interview immediately after their consultation. For participants under 18, parental consent was provided. For participants over 18, informed consent was provided directly. The individual interviews took approximately 45 minutes and the FGD lasted about 90 minutes. The five FGD participants were selected from one class as it was thought that students who knew each other would be more open and trusting during the FGD. To stimulate discussion, the researcher used group process techniques such as summarizing statements, asking for examples, encouraging less dominant participants, and using generic prompts (e.g. ''tell me more'' and ''yes''). All participants received a €10 credit note for their participation.

Data analysis

Audiotape recordings were made of the individual interviews and the FGD. These recordings were subsequently transcribed verbatim and then imported into one file.

To gain an overall impression, the first author and a research assistant independently read the data repeatedly. Text representing participant's responses to the questions were then marked and a preliminary description of their individual views was noted. Relevant excerpts of text were then grouped into categories and given a suitable label (coding). This process was conducted manually and continued until saturation (e.g. until no new themes presented and redundancy was achieved) was reached (Polit, & Beck, 2010).

Results

Demographics

A total of 22 heterosexual young people participated in this study, 17 of whom were interviewed and 5 of whom participated in the FGD. Among interview participants, 11 were girls (9 from the Netherlands, 1 from Suriname and 1 from the former Netherland Antilles) and 6 were boys (5 from the Netherlands and 1 from Suriname). Ages ranged from 13 to 25 years. At the time of the interview, 5 were in a relationship. All had completed primary school, 9 were attending secondary school, 5 were enrolled in post-secondary education and 3 had completed post-secondary education and were working. The FGD comprised 3 boys (2 from the Netherlands and 1 from Suriname) and 2 girls (1 from the Netherlands and 1 from India), aged 16 to 18. One was in a relationship at the time of the study and all were attending secondary school (see Table 1).

The ratio of participants with European versus non-European ethnicity was representative of the Dutch population in 2010 (i.e., 13.7% of participants had a non-European ethnicity versus 10% in the general population) (Central Bureau for Statistics, 2010).

Table 1. Demographics.

	Age	Sexual experience	Relationship
Female	13	None	No
	14	None	No
	14	None	No
	14	None	No
	15	Intercourse, oral and manual sex	Yes
	16	Intercourse and manual sex	No
	17	Intercourse and manual sex	No
	23	Intercourse, oral and manual sex	No
	23	Intercourse, oral and manual sex	No
	24	Intercourse, oral and manual sex	Yes
	24	Intercourse, oral and manual sex	Yes
	24	Intercourse, oral and manual sex	Yes
	25	Intercourse, oral and manual sex	Yes
Male	14	None	No
	14	None	No
	14	None	No
	17	Oral and manual sex	No
	17	Intercourse, oral and manual sex	Yes
	18	Intercourse, oral and manual sex	No
	19	Oral and manual sex	No
	23	Intercourse, oral and manual sex	No
	25	Intercourse, oral and manual sex	Yes

Results

Perceptions of sexuality and sexual health

When asked what sexuality and sexual health means to them, most participants emphasized sexuality as actual sexual intercourse. In the words of one girl (aged 15), sexuality is ''physical contact with someone else''. Another participant stated that sexuality is ''simply having sex with your partner'' (14-year-old girl). In most responses, participants conveyed what sexual intercourse means to them. They frequently indicated that sex is about pleasure: ''It's not about procreation but more for pleasure'' (17-year-old boy). According to one young woman, ''it's relaxing'' (24-year-old girl). At the same time, many participants conveyed that sexual intercourse is about more than merely physically connecting and experiencing pleasure. Most stated that sex is something you do when you love someone and some said that sex creates an emotional bond: ''It's about expressing your love for your boyfriend. It's attraction – something that makes you feel good. It strengthens your connection'' (24-year-old girl). In the words of one young man, aged 25, sex is, ''a way of expressing love with both your body and your spirit. It's not just about needs but about sharing how you feel about one another''. Not unsurprisingly, sexual intercourse was considered by many participants to be integral: ''Sex is very important in my life. I don't think I could do without if I had to'' (23-year-old girl). Occasionally, participants indicated that they have sex in the context of one-night stands: ''Most of my sex is with different partners. I do know them and I have sex with them'' (24-year-old girl).

In addition to connecting sexuality with sexual intercourse, participants, especially the younger participants, connected sexuality and sexual health with pregnancy and STI prevention: ''At school, we were told about STIs'' (14-year-old boy), ''We also received sex education about contraception'' (14-year-old girl). Occasionally, participants mentioned sexual preference as an aspect of sexuality: ''It's, in any event, about what your orientation is'' (19-year-old boy).

What is noteworthy regarding participants' responses to questions about the meaning of sexuality is the fact that the focus was clearly physical. In all responses, sexuality was either about sexual intercourse, STIs, pregnancy prevention or sexual orientation. Emotional aspects, albeit mentioned, played a subordinate role. It is possible that the young age of some of the participants, possibly combined with a lack of experience, contributed to the subordinate role of emotional aspects of sexual health. Furthermore, we found no differences between boys and girls. Additionally, the mental and social function of sexuality and the existence of sexual function problems were not mentioned at all.

Discussing sexual preferences

In order to gain additional insight in participant's conceptions of sexuality, we asked about communication with partners. Most reported intentions to talk to their partner about their sexual desires but that this is not always easy. Some reported feeling ashamed or uncomfortable but that this dissipates in time. The longer you are together with someone, the easier it is to discuss sexual preferences. One girl, aged 16, stated: ''If you've been in a relationship for a while, then you can do it [talk about sexual preferences] but if you do it early on, it's embarrassing. You haven't been with that person for very long and you like them. With every thing you do and say, you

think, 'I hope I'm not doing something wrong'. And once you've been together for a while, then you trust each other more''. Another participant said, ''I think if you do that [talk about sexual preferences] early on, that the whole thing will flop. It's a total letdown'' (17-year-old boy). Lastly, one young woman, aged 23, said that she talks about, ''what I like and what he likes. I'm open about that – less so in the beginning. You have to get to know each other.'' These statements suggest that being in a long-term relationship improves one's willingness and capacity to communicate with one's partner about sexuality and sexual health. Thus a long-term relationship may act as a protective factor against sexual health problems.

Influences on perceptions of sexuality and sexual health

Participants were also asked about the role their parents have played in their perceptions of sexuality. Some indicated that their parents were particularly open about sex. One participant said, ''My mom and I are close. We've always been able to talk about things'' (15-year-old girl). Another stated, ''We could talk about everything at home. I was brought up pretty liberally. I appreciated that. We still talk about things – not in detail – but if there's something I need to talk about'' (25-year-old girl). Other participants indicated that sexuality is not something they can discuss with their parents. One girl, aged 17, conveyed that, ''In my home, we don't talk about it. If you say sex, they totally shut down''. Another participant said, ''My parents are pretty conservative and there's not a lot of talk. I'm the oldest and I was also the quietest. They never worried about me but the first time I went on vacation, there was this five minute talk with, 'Take condoms along, etc.'" (23-year-old boy).

Culture was also suggested as a relevant influence on participants' perceptions of sexuality and sexual health. Western cultures were perceived to foster a more open and permissive perception of sexuality and sex than Islamic cultures, where, according to participants, the normative view of sexuality is considered more restrictive. In the words of one participant, ''I had a Muslim girlfriend. She was open with me but really careful with her previous boyfriend. She was scared that her family would find out and they are really strict. Muslims do it secretly. Even though we had a steady relationship, it had to be a secret'' (25-year-old boy).

Clearly, school, parents, and culture were considered by participants to play a substantial role in the development of young people's concept of sexuality and sexual health. It seems that when sexual health education at school focuses on mere disease prevention, when parents fail to discuss sexuality with their children and when cultural taboos on talking about sexuality pervade, perceptions of what sexuality and sexual health entail are limited and quite narrow in focus.

Problems with, or concerns about, sexuality and sexual health

When asked if they had problems, concerns or questions about sexuality and sexual health, most participants indicated no problems or concerns. Exceptions were some younger participants who had little or no experience with partnered sexual contact. These participants reported curiosity about sex and wondering what they would need to do if they had sex. For example, one boy, aged 15, said he had concerns, ''a while ago, about how things work with sex and what you do. Now I know through my brother and stuff.'' Another participant said she went to youth information services to ask about sex and safe sex (14-year-old girl).

Participants were subsequently asked to imagine possible problems related to sexuality and sexual health. Their answers were consistently limited to problems relating to STIs and pregnancy: ''A condom could break and the girl could get pregnant, or you could get a STI'' (17-year-old boy). No other potential problems were mentioned.

Evidently, participants' perception of sexual health problems were, like their perceptions of sexual health, limited to the physical aspects of sexuality. This is perhaps because young people are less capable of imagining themselves experiencing a sexual health problem (e.g. erectile dysfunction, early ejaculation, etcetera) or, alternatively, because their knowledge regarding sexual health problems is lacking. This is important as a lack of awareness could inhibit the recognition and acknowledgement of sexual health problems if present. It is possible that younger young people without experience struggle to discuss these problems. If so, it is important parents and schools provide a secure and trusting environment in which young people feel safe to discuss sexual health problems.

Care needs

Participants clearly struggled to communicate care needs (i.e., the help they would like to receive when experiencing sexual health problems) regarding sexuality and sexual health, probably because of their lack of knowledge regarding sexual health problems. They were unable to convey the form or content professional care should take, although many indicated that their general practitioner would, in their opinion, be an adequate starting point for seeking care for sexual health problems. Further, they reported that what is most important is that the care provided is effective: ''I don't care what needs to be done as long as it works'' (19-year-old boy); ''It doesn't matter [content and form] as long as it gets better'' (14-year-old boy).

What participants were able to do was indicate the people outside of the healthcare sector with whom they would discuss a sexual health problem if they experienced one. Most said that they would likely discuss this first with their friends. One participant said she would talk to friends as ''they are usually helpful'' (23-year-old girl). Another stated, ''I have a good friend, a kind of mentor and I can go to him whenever I have questions'' (25-year-old boy). Female, but not male, participants said they could also voice their concerns with a relative like a mother or sister if need be: ''My mom provides good advice. She knows more than my boyfriend'' (15-year-old girl). Additionally, the Internet was reported to be a useful source of information: ''I'd type the problem into Google. And sometimes you know where you need to look like at the Public Health Services [site]'' (23-year-old girl).

As with sexual health problems, young people with mental health problems often rely first on friends or try to cope alone and, subsequently, turn to an adult or professional help (Barker, 2007). This suggests that young people's help-seeking behavior for sexual problems is probably not very different than their help-seeking behavior for other problems. Further, because help-seeking behavior tends to focus on the Internet, professionals should make an effort to be accessible and present on the Internet.

Discussion

This study set out to document young people's perceptions of sexuality and sexual health (problems). The findings suggest that perceptions of sexuality and sexual

health problems are greatly influenced by the information or, rather, the lack thereof, young people receive from their parents and at school.

When asked what sexuality and sexual health means to them, most participants emphasized the physical aspects of sexuality, namely actual sexual intercourse. Participants reported a willingness to talk about sexuality and sexual health with their partner but only when sufficient trust has been established. Otherwise, shame or discomfort would arise. Also, for many participants, sexuality and sexual health was not something they could easily discuss with their parents. Perhaps parents feel uncomfortable talking about sexuality with their children and thus leave this role, intentionally or unconsciously, to schools, who focus primarily on physical aspects of sexual health. As a logical consequence, young people's perceptions of sexuality and sexual health are also limited to physical aspects of sexuality. Emotions and other aspects play a minor role. Participants were, generally speaking, completely unaware of the complexity sexuality and sexual health entail. The findings further show that most participants had no problems or concerns regarding sexuality and sexual health. When asked to imagine possible problems, they consistently reported problems relating to STIs and pregnancy. Clearly, when it comes to sexual health problems, the young people in our study again focused on only the physical. The possibility of experiencing, for example, a sexual function problem was relatively unfathomable, perhaps because young people are less capable of imagining themselves experiencing these problems or, alternatively, because their knowledge regarding sexual health problems is lacking. This is consistent with De Graaf et al. (2005) who, despite paying little attention to this, found in their study that young people perceive sexual functioning problems to be normal.

We contend that a lack of knowledge regarding sexual health and sexual health problems made it difficult for participants to convey care needs regarding sexuality and sexual health. They simply could not imagine having such a problem. Nonetheless, they could report how they would seek information (via the Internet) and what they find important in the treatment of sexual health problems (effectiveness). Previous research has shown that young people do struggle to seek help for sexual health problems (Akre, Michaud, & Suris, 2010; Bakker et al., 2009; Bakker & Vanwesenbeeck, 2006) and that the resulting biological, psychological and social consequences can be extensive (Althof, 2002; Grauvogl et al., 2009; Laumann et al., 1999; Rowland et al., 2007). Bakker and Vanwesenbeeck (2006) have shown that a mere third of women with sexual health problems seek treatment.

As suggested above, the lack of knowledge the study participants had regarding the complexity of sexuality and sexual health problems may be rooted in the sexual health education young people receive. As previously outlined by Fagen et al. (2010) and by Wellings and Parker (2006), sexual health education in the USA and in Europe is usually incorporated in the biology curriculum and tends to focuses on physical, health-related aspects of sexuality. Little attention is paid to emotional, mental and psychological aspects of sexual health (Fagen et al., 2010; Wellings & Parker, 2006). Sexual health education rarely discusses the meaning of a (sexual) relationship, the pleasurable aspects of sex and how to recognize sexual function problems that can lead to less pleasurable sexual experiences. If young people were to be made more aware of such aspects, acknowledging and seeking help for sexual health problems would be more acceptable. This, in turn, could reduce secondary problems like depression. It is therefore necessary that sexual health education programs in schools be developed or revised such that a broader concept of sexual

health is taught. Additionally, parents can be encouraged to play a more prominent role in educating their children about sexuality and sexual health problems.

The present study has a number of strengths but also some limitations. Strengths include the heterogeneity and diversity of our study population in terms of age and location. We also accessed young people directly and gained their trust, such that they were willing to discuss a sensitive and difficult topic. Also, our sample size yielded saturation. A final strength was our use of a voice recorder and verbatim transcriptions, which increased the rigor and trustworthiness of our data. Given the qualitative nature of the data, however, we suggest that caution be applied in generalizing the results of this study to other populations. A limitation of our study is that it included young people who had little or no sexual experience. It might be more suitable to include sexual experience as a selection criterion in future research.

Conclusion

In conclusion, our findings point to the need to increase young people's knowledge and awareness of the complexity of sexuality and sexual health. Sexual health education in schools and at home are important tools by which knowledge and awareness can be created and through which perception of sex and sexuality can develop such that it encompasses more than the physical aspects of sex and sexuality. Furthermore, by providing more accessible information, problems could possibly be alleviated quicker and more directly. The current study can be considered an entry point for further research on how to best provide young people with high quality sexual health education and youth-friendly sexual health services.

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