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Sexual Health is Development and Formation of Attitudes about Own Identity

Siniša Franjić
Independent Researcher

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***Corresponding author:** Siniša Franjić, Independent Researcher.

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Abstract:

Sexual health is the continuity of positive physical, mental and sociocultural experiences related to sexuality. It includes a person's ability to enjoy and express their sexuality, free from the risk of sexually transmitted diseases, unwanted pregnancies, coercion, violence and discrimination. It is closely linked to self-confidence, respect for oneself and others, finding sexual gratification in violent and non-exploitative relationships, contributing to the quality of relationships, and helping to avoid decisions that could have long-term harmful consequences.

Keywords: sex; sexuality; sexual desire; sexual health; pornography.

Introduction:

Interest in psychosexual development has tended to focus around managing problems, particularly those associated with risks and their management [1]. These areas include sexual abuse in childhood and early adolescence, unwanted pregnancy and sexually transmitted diseases (STDs) in adolescence and early adulthood and functional sexual difficulties in adults. In contrast, the interest, for example of adolescents has been shown to be more in the rite of passage and recreational aspects of sexual activity. There has also been a concentration on childhood and adolescence, with adult psychosexual development being a poor relation and any emphasis for older people being on dysfunctions and disorders rather than the expected course of development. Development through the life cycle involves important areas such as sexual identity, couple relationship issues, fertility and ageing.

At the other end of the spectrum are ideas that take a societal perspective, such as consumer culture bringing sexuality into the world of commerce. Sex is used to sell products through sexiness and physical attractiveness being closely connected with the goods we buy and are seen to own. This aspect of sex and consumerism is particularly directed towards girls and women. A further development is when sex itself is marketed as pleasure or the idea of sexual self-expression is promoted. The world is sexualized, and there is a seduction into the world of responding to sexual impulse. On the Internet in particular, representations of the body become products to buy. This becomes the world into which children and adolescents are socialized and encouraged to participate. As we grow up, sexuality becomes increasingly focussed on technique and performance with a tendency for it to come to resemble work risking the loss of much of its intimate and caring qualities.

Sexuality:

Adult sexuality is not fully biological [2]. Over an individual's lifetime, sexuality and sexual activities occur on a spectrum between normal and deviant. The meaning of "normal" may vary between traditional and contemporary social contexts. Traditional and contemporary understandings of "normal" shape the law. What was once considered to be a sex crime may later become mainstream, or lawful activities may be criminalized after some time. "Normal" may partially be defined by gender, age, culture, class, and other factors. For example, in some traditional Latin American cultures, a cotillion signifies that a woman has reached maturation at fifteen years of age, and she may marry a man of any age. However, in Protestant Anglo American culture, a sweet sixteen party holds no such contemporary parallel. Though many

sixteen year olds in the United States legally may withdraw from high school, work, and drive, most may not consent to marry or have sexual relationships with adults of any age.

Traditional members of society tend to segregate sexuality into two groups. The first group is considered to be normal. It is composed of natural, good, sanctioned, and blessed experiences. In the United States, traditional sex acts, including heterosexuality, marriage, monogamy, procreation, intragenerational relationships, noncommercial sex, and nonpornographic experiences, have nearly ubiquitously been considered to be good. The second group deviates from normal parameters. It is out of bounds, bad, unnatural, wrong, and abnormal. Homosexual, extramarital, promiscuous, lustful, commercial, masturbatory, casual, intergenerational, pornographic, public, and sadomasochistic sex acts are grouped together and considered to be bad.

Pornography is considered to be deviant, though social norms influence legal parameters for viewing, producing, and transmitting pornography. A person in the United States who is thought to be "normal" in public may privately engage in deviant pornographic practices or harbor unexpected attitudes or beliefs deviating from norms regarding pornography. Use of obscenity, by its definition, is not normative, and deviant depictions are not guaranteed protection under the law. For example, racially charged pornography has been found to be obscene, and community standards may not tolerate explicit culturally nuanced depictions. Racial and cultural themes do not automatically qualify as having redeeming political value. However, some pornography is protected, even though it is not considered to be normal. It is safe to say that protected images include traditional, inexplicit, and conservative depictions of sex.

Because sexuality is socially constructed, racial, cultural, and religious values influence norms. Traditional European-American Christian norms dictate that sexual behavior and erotic thoughts are bad or wrong unless they have been prequalified as "normal" or are procreative. People who subscribe to these beliefs are likely to be unreceptive to social cues about sexuality. They may engage in more sexual austerity and behavior that is restricted by tradition. People who tend to be receptive to social cues about sexuality are more likely to encounter erotic depictions and be exposed to sexuality in the course of nonsexual activity. They think along sexual lines that are normative to sexually active people, and they are more likely to engage in sexual behavior.

Sexual Desire:

Sexual desire during the years of sexual maturity is a physiological law [3]. The duration of the physiological processes in the sexual organs, as well as the strength of the sexual desire manifested, vary, both in individuals and in races. Race, climate, heredity and social circumstances have a very decided influence upon it. The greater sensuality of southern races as compared with the sexual needs of those in the north is well known. Sexual development in the inhabitants of tropical climes takes place much earlier than in those of more northern regions. In women of northern countries ovulation, recognizable in the development of the body and the occurrence of a periodical flow of blood from the genitals (menstruation), usually begins about the thirteenth to the fifteenth year; in men puberty, recognizable in the deepening of the voice, the appearance of hair on the face and mons veneris, and the occasional occurrence of pollutions, etc., takes place at about the fifteenth year. In the inhabitants of tropical countries, however, sexual development occurs several years earlier in women—sometimes as early as the eighth year.

The existence of the sexual instinct is continuous during the time of sexual life, but it varies in intensity. Under physiological conditions it is never periodical in the human male, as it is in animals; it manifests an organic variation of intensity in consonance with the collection and expenditure of semen. In women the degree of sexual desire coincides with the process of ovulation in such a way that sexual passion is intensified after the menstrual period.

The development of sexual life has its beginning in the organic sensations which arise from the maturing reproductive glands. These excite the attention of the individual. Reading and the experiences of every-day life (which, unfortunately, are now-a-days too early and too frequently suggestive), convert these notions into clear ideas, which are accentuated by organic sensations of a pleasurable character. With this accentuation of erotic ideas through lustful feelings, an impulse to induce them is developed (sexual desire).

Sexual Health:

Sexual health represents a growing area of interest for researchers, practitioners and policy-makers [4]. Indeed, while medicine has historically played an important role in shaping and even defining what we mean by sexuality, in recent years 'sexual health' has received increasing prominence, both as a reaction to the emergence of HIV/AIDS in the mid-1980s and also in response to a wider 'sexualization' of society whereby sexual desire and performance have come to be seen as serious public health concerns. Although the dangers of overmedicalizing sexuality at the expense of the social and interpersonal dynamics of sexual relationships have been acknowledged and, in particular, the role that economic factors play in this medicalization criticized, the focus on 'sexual health' is certainly a trend that is set to continue. It impacts upon how people perceive and manage their own sexuality, sets a norm against which people identify 'sexual problems' and defines the health professional as the most appropriate source of help if such problems are identified.

Sexual health is not simply the epidemiology of sexually acquired infections (SAIs) but wider, encompassing contraception, teenage pregnancy, HIV infection, gynaecology, menopause, sexual assault, male and female sexuality and reproduction [5]. Sexual health discourses are many and we are drawn to these by either elements of the media with messages to inform us that young people are 'out of control' in terms of their sexual activity or by the publication of rates of SAIs, abortions and conception.

These messages frequently highlight the fact that when most people talk of 'sexual health', they actually refer to it when things go wrong: to sexual problems and/or illnesses.

That said, it is a positive step to hear sexual health mentioned at all because anything to do with sexual health has often been a

taboo, silenced or invisibilised, something not to be discussed in public. More recently and for various reasons, publications in journals have been calling for nurses and other healthcare professionals to talk to their client groups about sex. Reasons for this action include the need to reduce the high rates of SAIs, HIV infections and teenage pregnancies. It is frequently argued that the rates of infection and teenage pregnancy in the United Kingdom are much higher than that of the rest of Western Europe and action is needed to address these serious but preventable conditions. Despite these calls, it is important to note that not all nurses are equipped with the language and skills to address the sexual health needs of their client groups. Many professionals have had limited or, in some cases, no input during their training in matters of sexual health and if nurses do not have the language to help them, it is no wonder the issue never gets raised. Problems around the language of sex and how it is 'medicalised' and 'pathologised' are rife within health care. The client group may use terms such as 'down there' when the professionals may use vagina and the same applies to male anatomy with the lay population talking about 'manhood' and the professionals talking about penis or reproductive organ. Others, both clients and professionals, may adopt the language of silence and not refer to anything sexual at all. The client believing that the professional will be shocked if they ask a question relating to sexual health and the professional simply burying their head in the sand and thinking this needs to be talked about 'elsewhere', both leading to much confusion all around. Nurses and others often speak of holistic care but may not see the 'personal' issue of sexual health in this way. For example, a man in the medical ward who has had a heart attack may be very concerned about when to resume sexual activity, a valid request, after recovery or a woman who has had a hysterectomy or breast removed, all linked to how they are as sexual beings and the body image.

Infections:

An understanding of how SAIs are transmitted can be gained by dividing them into four main categories: bacterial, fungal, infestations and viral [6]. Bacteria and infestations are living things and, therefore, we can destroy them, mainly with the use of antibiotics. This means, after successful treatment, the symptoms will not return unless the person is reinfected. However, our bodies need a balance of good and bad bacteria to remain healthy; therefore we may not want to destroy all bacteria. Candida albicans, for example, is a yeast that lives on the skin, vagina, mouth and gut and is held at bay by the good bacteria. When there is an imbalance of the good and bad bacteria, it can cause an environment where the yeast can thrive, giving rise to irritating symptoms that may need treatment, so we need to create an environment where they fail to thrive. Viruses, however, are not living things in their own right. Viruses are genetic material covered with a protein coating (intracellular), which infect the cells of a biological organism and replicate themselves making the cell behave in a different way. They cannot reproduce on their own. The only way to deal with the virus is to destroy the host cell. Therefore, our only defence against viruses is antivirals, which limit the replication of viruses. Currently, we can treat the symptoms viruses produce, such as warts or ulcers, but once the body is infected with viruses the symptoms can reappear without reinfection. It is this phenomenon of viruses, which can cause confusion with clients who can be shocked if symptoms reappear once they have been treated for symptoms, such as warts. Some people automatically think they have come into contact with an infected partner or their previous treatment was substandard.

Pornography:

Pornography is not always portrayed as a public health crisis or emergency [7]. It has also been referred to as a "problem," "issue," and "concern." There is no hard and fast definition of what counts as a public health problem, issue, or concern—and perhaps that's for the best. Spending time and energy nailing down a definition of a public health problem seems futile, given that new concerns emerge all the time and warrant consideration. But, if there is no definition, should anything—can anything—count as a public health issue? For example, could any one of us declare that something is a public health issue (e.g., pumpkin spice lattes, TikTok dances), and voilà, make it so? We might be able to do that, but for reasons of avoiding wasted resources and watering down bona fide public health efforts, we shouldn't. And for this reason, it's a good thing that we have at least some guidance from the field about what should be counted as a public health problem, issue, concern, or priority.

Pornographic Materials:

The Internet increases the availability of sexually explicit material and, with mobile media, amplifies the domestication of pornography [8]. It enters into adolescents' everyday lives, going outside their house walls or bedroom walls, moving into adolescent discourse enriched by digital technology that can transform the narrative and the interactions within their peer group (for example, when a boy shows his friend a pornographic video through his own smartphone).

Anonymity also avoids the ritual of buying pornographic material and coping with the interaction with a seller who personifies the normative look of the adult world and the prohibitions that it carries. It is more significant for the girls who are forced to submit to a double stigma that sees it as doubly socially improper for them to gain access to pornographic material. On the one hand, they are young, a portion of the population that has to be kept away from pornography, and, on the other hand, they are women, subjects who, in the social and cultural construction, should not be interested in pornography. The Internet allows girls to have a simpler access to pornographic material because, thanks to anonymity, it allows them to avoid exposure to symbolic sanctions that otherwise could damage adolescents. Another important Internet characteristic for young people is the possibility to have free access to sexually explicit material (free in terms of both money and time). This is relevant at this moment of their lives where economically the individuals depend completely on their parents.

Young people prefer to consume pornography via mobile media to avoid parental control connected to the possibility of leaving digital footprints in the case of the use of a shared computer. In relation to pornography mobile media are used (mainly by boys) also in-group interaction to define and redefine gender roles. If viewed with a classmate or friend a porn video is used to perform masculinity (with other men), it sometimes happens that they play with gender definition also by showing the video to girls who,

usually, have a disappointed reaction. When boys introduce girls to pornography this practice confirms that boys are viewed as symbolic gatekeepers of sexual knowledge. There is also a homosocial reinforcement of masculinity. This relates to the management of who is a member of a group and who is an outsider. To show a video, to reject the viewing of it, to mock, etc., is the miseen-scène of a symbolic and ritual conflict that contributes to maintaining the boundaries between girls and boys and increasing internal cohesion.

Effects:

Pornography's positive effects may also include general sexual education for some young adults and for those who might not have access to relevant sexual health information, primarily among sexual minorities [9]. In addition, pornography may constitute a sphere in which individuals can achieve a sense of identity and membership. For example, viewing online pornography may allow socially or sexually anxious or marginalized individuals to find and form virtual communities in which they can communicate or practice some sexual behaviors in a relatively safe environment. There is also some qualitative evidence to suggest that pornography can function to expand users' sexual horizons, which may provide a source of personal empowerment.

Violence:

Regarding the potential infl uence of pornography, whether nonviolent or violent, on sexual assaults and violence against women there are three basic possibilities, all of which have their advocates [10]:

1. Pornography increases the rate of sexualized violence
2. Pornography has no effect on sexualized violence
3. Pornography decreases the rate of sexualized violence

As some scholars have noted, the evidence from research is inconsistent at best. It is worth nothing that, although the catharsis hypothesis has struggled for acceptance in other areas of media violence studies, it has gained at least equal footing with the other alternatives in debates about the effects of pornography on sexualized violence. The argument for this view suggests that individuals who are predisposed to engaging in sex crimes such as rape may use pornography and subsequent orgasm through masturbation to vent their sexual drives and, at least temporarily, reduce the urge to engage in sex crimes. The opposing standard social science model view suggests the opposite, namely, that viewing pornography, particularly violent pornography, may desensitize viewers to sexualized violence increasing risk. Although there may be some disagreement on this point, both models would likely agree that individuals who are already predisposed to sexualized violence are most likely to be infl uenced by porn, either for good or for bad. Individuals who are not predisposed to sexualized violent activity would experience fewer effects from viewing porn at least in this regard.

Health Problem:

A typical public health strategy is to observe that there is an outcome we wish to change and then to consider the full spectrum of risk and protective factors that may influence it [7]. For example, if the problem is diabetes, we may work on solutions that have to do with diet, exercise, access to care, and racism. One of the problems with declaring pornography a public health problem is that pornography is an exposure—not a disease, condition, or behavior. Sometimes an exposure is solidly linked to numerous health outcomes, in which case we consider the exposure itself a public health problem. Racism and lead, for example, are exposures that are considered public health problems. But pornography is not yet clearly established as a risk factor for multiple health outcomes. Evidence suggests that certain types of pornography may cause aggression and compulsive use in some people and negatively influence youth sexual behavior, and it is implicated in some cases of human trafficking. But there are also drawbacks to, and even possible harms from, eradicating pornography—including harms to those who create it consensually and earn an income from it, harms associated with limiting the availability of information about sex generally, harm related to stigmatizing nondominant sexualities or sexual behaviors, harm in denying that eroticism is important for human health, and harms associated with controlling what adults say, do, or can see, which influence whether they can live safe, fulfilling, and free lives.

For these reasons, it is problematic when advocacy groups appropriate public health language to try to advance their cause without engaging in an authentic public health agenda-building process. However, it would be a mistake to discount what may also be real threats to health posed by pornography just because advocacy groups have framed their message in ways that do not resonate with the standard public health approach. As a field, public health has much to offer if our task is to contemplate whether pornography has relevance for individuals' health and well-being, and excellent tools that we can use if we decide there is some aspect of pornography production, dissemination, or use that we wish to address.

Conclusion:

Sexual health is affected by a number of different factors, from sexual behavior, attitudes and influences present in society, to various biological influences. Sexual health is also influenced by a person's general mental health, physical health and experiences of violence. Being sexually healthy means taking care of your physical and emotional health by practicing safe sex and satisfaction with your body, sexuality and relationships. Sex education is a lifelong process, which includes the acquisition and collection of information, the development and formation of attitudes and values about one's own identity, relationships with other people, intimacy, love, sexuality. It includes information on sexual development, reproductive health, relationships with others, intimacy, self-image, gender roles and relationships.

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