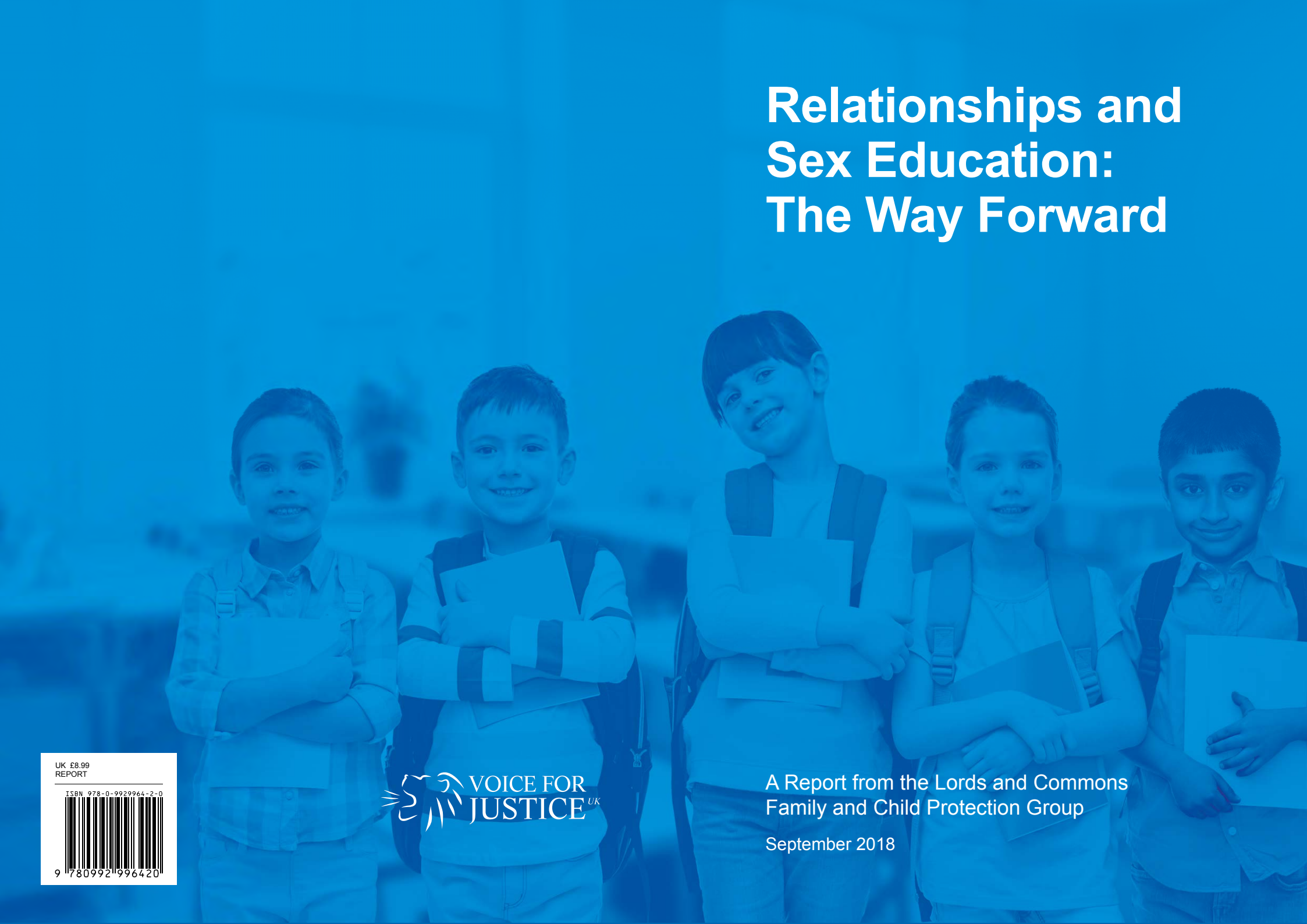
Relationships and Sex Education: The Way Forward



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A Report from the Lords and Commons Family and Child Protection Group

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A Report from the Lords and Commons Family and Child Protection Group

Co-editors

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Relationships and Sex Education: The Way Forward

Preface

by Rt Hon Sir Jeffrey Donaldson MP

Chairman of the Lords & Commons Family and Child Protection Group

As a society, we want to keep children and young people safe, but current policies have evidently failed to protect them. In recent years we have witnessed increased promiscuity, with epidemic levels of STIs among children; an alarming increase in rates of mental illness and many other signs that indicate all is far from well amongst our younger generation. This is not just the result of social change. These are the consequences of increasing ideological pressure that is destroying traditional moral values and weakening the family support mechanisms that are the natural safety net for children.

There has been a raft of policy proposals and changes that have helped to create this situation. These include the extension by the Government of the current curriculum, making relationship and sex education mandatory. This approach continues to override the rights of parents despite the fact that parents are the primary educators of children. It is clear that the basic rights of parents are constantly being challenged by the alarming growth of State control and by extension, the concept of the family is being deeply undermined.

Not content with this level of control, the Government now promotes gender choice amongst children as young as 4. This is deeply confusing for children in their formative years and may push them into making decisions they will in the future deeply regret. We contend that teaching ‘sex’ without any kind of moral frame is potentially harmful to children. It is our view that children need boundaries in order to be safe. The constant liberalisation of our laws and the removal of those boundaries leaves children and young people more vulnerable and affords them less protection.

The contributors to this report have expert knowledge of the issues covered and they use fully validated research to support their conclusions. We owe a debt of gratitude to each of them for the time they have devoted to the preparation of their respective chapters. I commend this report to the Government and to our legislators in parliament. The views expressed represent the concerns of many parents and others across our society who feel that it is time those in authority listened to them.

Introduction

by Lynda Rose and Robert S. Harris

Joint Convenors: Lords and Commons Family and Child Protection Group

Everyone agrees there is a crisis in child welfare. Despite all efforts, the UK still has the highest teen pregnancy rate in Western Europe; rates of mental illness are rapidly increasing;[1] children as young as 5 are reportedly accessing pornography; figures for child sexual abuse show that one third of attacks are committed by other children;[2] rates of STIs amongst young people are at epidemic level; and according to a report by the BMJ,[3] self-harm amongst children under the age of twelve and early mid-teen girls have more than doubled in the past six years. On top of that, the BMJ also claims that suicide rates in the United Kingdom among adolescents aged 15-19 years have increased from 3.2 to 5.4 per 100 000 between the period 2010 and 2015.[4]

The horror stories go on and on and, no matter what we do, only seem to get worse. In the increasingly sexualised, abusive, and dangerous climate that characterises modern society, everyone agrees we've got to do something to protect the nation's young. But the question is, what? The traditional answer is to give children ever more detailed sex education - so that they'll know the dangers and be able to choose for themselves. Strangely, however, this approach seems to have the opposite effect to what's intended.

The following report analyses not just why sex and relationships education policy up to now has been wrong, but how it has largely contributed to, if not caused, the problems it's designed to combat. It is argued that current Government proposals to extend and make mandatory Relationship and Sex Education (RSE) for all children, are not just flawed, but highly dangerous.

Clinical Psychologist Dr Josephine Joy Wright, Consultant Clinical Psychologist and Senior Lecturer in Child and Adolescent Mental Health, University of Worcester, begins the report by explaining that all sex and relationship education must be set within the context of normal child development. Outlining the basis for healthy development, Dr Wright shows that self-questioning - including issues of sexual attraction and gender identification - is entirely normal and commonly goes in phases, which naturally dissipate as the child matures. But messages young people receive about themselves through sex and relationships education can distort this process, she says, and have major impact on a child's sense of identity, encouraging him or her to make permanent, life-changing decisions on the basis of what is normal and usually transitory self-exploration. She warns that this is highly damaging and that we need to be careful that the values, beliefs and agendas of political groups, service mangers and care workers/therapists are not explicitly or implicitly projected onto vulnerable minds.

In the following chapter, Dr Wright then goes on to detail the alarming increase of mental illness among young people. With a quarter of young people experiencing a mental disorder in any one year, but only 23-35% receiving specialist treatment, she calls for an urgent re-evaluation of resources. In particular, she says the problem has now become so bad that mental health needs its own protected budget in schools and colleges, rooted in clear acknowledgement of normal child development stages and with agreed principles

and values to underpin all interventions. Again, she emphasises that children must not be pressurised under the banner of the 'tolerance' agenda to make lifelong decisions when they are developmentally exploring choices, whether that is in terms of options studied or identity issues.

Examining physical harms resulting from current sex education policy, Lynda Rose looks at data for the health risks to which children have become exposed by programmes which, she says, far from protecting children, have served to indoctrinate them into behaviours that pose a severe risk to health. Looking at, in turn, contraception, conception, abortion, and STIs, she says that the dominant message of sex education - that children can do whatever they want, provided only they use a condom - is misleading and highly dangerous. She argues that such teaching does not, and never can, keep children 'safe'. Conversely, withholding full information of the risks attaching to promiscuity and risky sexual behaviours amounts, she says, to ideological indoctrination aimed at embedding 'rebranded' morality, and is a systemic form of child abuse.

As background to the new regulations, Pippa Smith highlights the weaknesses of current Sex and Relationships Education (SRE) policy. Drawing on statistics, she argues that the effect of the current sex education programme has been to normalise underage sex, in the process giving inaccurate medical information that has entirely failed to warn of the risks attaching to early intercourse and promiscuity. It is time, she argues, for this to change, and for the role of parents as primary educators to be acknowledged, with all teaching to include accurate, age-appropriate information on how to avoid early sexual experimentation.

As example of an alternative approach to current methodology, Louise Kirk contributes a chapter on teaching natural fertility, which she explains helps both boys and girls understand the bonding process that is a part of sex, and to respect their bodies. She makes the point that all young people should understand how their fertility works in order to help them make informed decisions on their sexual behaviour, in full knowledge that what they do when young will profoundly affect their later life and may impact their ability to have a baby in the future. She quotes concerns at the dramatic rise in infertility and cites arguments for encouraging young people to start their families earlier. She further argues that young people need to be taught about new findings on the workings of the brain revealed by imaging technology, which clearly demonstrate the powerful physical and emotional bond formed between a couple when they have sex. By contrast, all the data shows that breaking that bond by serialised relationships or casual sex damages an individual's capacity to form and enjoy a long-term, exclusive and committed relationship. In other words, she argues that premature intercourse and/or promiscuity will radically impair a child's future capacity to have a stable and long-lasting union, and that this is information children and young people need to know.

In *Do Boys Matter?* Patricia Morgan throws the spotlight on a range of issues experienced by young males that seem to attract little attention in our society. She is a sociologist, researcher and author of numerous books who draws on the current data from peer-reviewed journals and an impressively large range of other sources.

She looks at sexual activity between young males, known increasingly in the literature as *men who have sex with men* (MSM) and cites statistics showing a starkly disproportionate weight of STIs, like syphilis and gonorrhoea, among MSM. This is greatest for MSM aged 16-19. The UK has one of the highest rates of new STI diagnosis in Western Europe, where MSM is a vulnerable group. Recent figures show that males aged 15-24 comprised 12% of all new HIV annual diagnosis. HIV preventative drugs like PreP are being peddled as one solution, but insofar that this leads to abandonment of condom use, means the proliferation of other STIs is not being properly addressed.

Drawing on NHS data, Patricia Morgan shows that, contrary to long-held stereotypes, young males are now also known to suffer increasingly from eating disorders, with treatment growing at a rate twice that of females. It is thought up to a quarter of anorexic people are male, and between 20% to 40% identify as homosexual. Longitudinal studies suggest that for MSM, there is a greater likelihood of non-consensual sex in both childhood and adulthood. Large numbers of females in intimate relationships experience sexual violence and, unfortunately, it is the frequency of sexual crimes against women that is capable of obscuring another reality: boys with same-sex partners are greatly more exposed to inter-personal violence and coercion alongside high levels of sexual risks, compared to those with exclusive heterosexual contact. The news media appears to neglect this area of crime completely, apparently avoiding this politically sensitive territory.

Patricia Morgan points out the big elephant in the room that is being obscured entirely by identity politics: an understanding of various types of relationships which "presume(s) levels of comprehension or cognitive ability which children do not have." Their lack of full autonomy reflects the fact that their brain development has yet to reach its adult maturity. She suggests an optimal public health approach is to *postpone* sexual relations, and to discourage, and not promote, high-risk behaviours.

Her chapter raises the question of how we should read the demographics more generally, especially given emerging societal ideologies attempting to shape or influence the behavioural and lifestyle norms of the younger generation. Put differently, is it right that education leaders are increasingly expected to presume what is "best" for children, even as such children undergo 'normal' experiences of self-doubt, self-harm, and sexual experimentation? Is it appropriate and in the child's "best interests" for adults to actively steer young people along a path of sexual experimentation or relationship? This happens, she insists, while their *developing* cognition renders them not able to fully process the long-term emotional, sexual and health-risk impact of underage sexual activity.

There are other compelling questions raised by Patricia Morgan's chapter. Is it within the remit of adults, in their role as educators, to decide if and when a child is to be labelled in their sexual identity? Is this adult intervention, relying as it does on ideological presumptions, helpful? Does it allow children to live out their childhood, free from subjection to categories of societal labelling, labelling that they are free to adopt as adults? Research suggests how sexual attractions and behaviours may be fluid in some people (a theme exceeding the remit of this chapter). Surely the 'answer' here is to let children simply "be children" and remove sexual identity politics from education altogether.

This is followed by Dr Rick Thomas, who charts the multi-stranded world of contraceptives and their rates of effectiveness and failure. Under 16s, he writes, cannot legally consent to sexual intercourse, yet, the sad reality is that, increasingly, adolescent girls are being provided with various forms of contraception, even in the absence of evidence of sexual activity. This state of affairs is not helped by permissive attitudes within sex education that presumptuously and wrongly anticipate adolescents are going to have sex anyway so they should be supported in doing it "safely".

According to the medical data, just how effective and safe are the range of contraceptives in common use, including those offered to adolescent girls? Dr Thomas rises to the challenge of answering this broad question and, drawing on the latest scientific data, offers a detailed account. While some of the methods in use show statistically high levels of efficacy, others may - for example, combined oral contraceptive pills - depend on user compliance, and so "success" is anything but straightforward in practice.

He also cites the latest medical evidence in support of possible side-effects when certain contraceptive methods are used. Although these medical risks of side-effects vary on a spectrum from common to rare, Dr Thomas conveys the measures of risk which are nevertheless present. It is this fact that, though the author does not say it, renders the overly simplistic and misjudged "safe sex" mantra in common use, questionable.

In fact, one of the big Trojan horses is the idea that if girls use contraceptives, they will remain "safe". But safe from what? Dr Thomas asks. They may be "protected" from unwanted pregnancies, though this is by no means always guaranteed, but contraceptive use will not provide "safety" and protection from contracting sexually transmitted infections.

This belief in "safety" should sound alarm bells, at a time when, in popular political discourse, much is made of the problem of "alternative facts" where ideology is seen to overshadow the place of scientific evidence. The question inevitably occurs, is our society so in danger of apportioning unmerited weight to "progressive" so-called "safe sex" messages that we fail to highlight other dangers? Although not an issue specifically raised by Dr Thomas - if we select the facts that match our own ideology and biases, are we not at risk of creating our own alternative set of inaccurate 'facts'? It is hoped the evidence cited by Dr Thomas will assist policy makers to review their knowledge of this topic.

Robert S. Harris follows this by tackling the sensitive topic of abortion and its relationship to questions of mental health for those who go through a termination. Strong sentiments exist on both sides of the pro-choice/pro-life divide but the focus here is on what the studies say.

A range of questions are addressed, including: how great are the mental health risks, if any, following an abortion? What is being assessed in the realm of risk? Where risks have been identified in the studies, are certain groups of adolescents and adult women at the greater risk? What is the official medical guidance given to practitioners when they see a woman who requests an abortion? What do longitudinal and systematic review studies say, especially with regard to the scope of psychological experiences post-abortion? Where is there common ground and where does this consensus weaken? Are the post-abortion mental health features under scrutiny, depression for example, merely correlatively or causatively associated with the abortion? What makes for a robust methodology when abortion is studied in its relationship to mental health?

Current trends in female mental health render it vital that we review the professional guidelines about abortion and the risks they pose. Termination is commonly spoken of in merely one-dimensional terms as a woman's *right to choose* and has even been trivialised by being likened to removing a bunion. In so far that any free and fair discussion is ever exercised about this crucial subject, it rarely moves beyond the assertion about the right to choose. While this topic elicits strong emotions from people of all viewpoints, the focus of this chapter is on the available evidence, and the author provides a succinct and comprehensive critique of this body of findings. Readers are invited to make up their own minds based on the published findings.

Pippa Smith studies the urgent issue of pornography in the age of the internet and how children are increasingly vulnerable in the face of what is developing into a public health crisis. One strand of this is "sexting", a growing phenomenon which, according to one study, shows that boys will not go out with a girl until they first see naked photographs of her.

Should we be relaxed and liberal about adolescents who view pornography, as some public figures believe?[5] Evidence confirms common intuition: adolescents who view pornography are more likely to engage in forced sexual activity and express sexually aggressive and obscene language.

In so far that growing numbers of children are susceptible to viewing pornography, how should our education leaders respond? Is it possible to distinguish between "good" from "bad" pornography? Given its addictive nature and exploitative content, do we really want to present to adolescents the flawed idea of "good" pornography?

Pippa Smith shows how the world of pornography, driven as it is by powerful commercial interests, exploits women who are invariably presented as 'always willing and available' to agree to every kind of sexual demand made by men. Such presentations can only encourage a climate of violence and normalise abuse so are these really the kind of messages we want to 'sanitise' under the guise of 'sex education'? Anything capable of "hard-wiring" or helping to define adolescent boys' perceptions of women as no more than "meat-objects" not only shapes beliefs of male entitlement, it is at the very heart of the abuses suffered by victims of sexual harassment and can have absolutely no place in "progressive" sex education. In fact, suggesting to adolescents that there is "good porn" is a patently regressive step and ought to trigger safeguarding concerns.

For the final section Clive Ireson, who served as a school head for sixteen years, focuses on the recent proposals for changes to relationships education. It will be remembered that in December 2017, the then Education Secretary, Justine Greening, launched a *Call for Evidence* intended to update the guidance on Relationships and Sex Education "to help equip every young person for life in modern Britain."[6] This call followed legislation passed earlier in 2017 that will, from September 2019, make compulsory all relationships education in all primary schools, and relationships and sex education in all secondary schools.

Examining the proposals in detail - which he notes at first glance appear uncontroversial - Clive Ireson takes us through what children already learn about relationships in Key Stage 1 (4-7 year olds): the elements of having good friendships, which includes considering others' needs; how to deal with sadness and unkind or bullying behaviours. For Key Stage 2 (7-11 year olds), children learn the 'quality' components of friendships so they can deal with disagreements and be ready to forgive; understanding emotional needs while recognising how to maintain good mental health in oneself and supporting it in others; managing both worry and stress, and being able to avoid and diffuse conflict.

Government promises that the new compulsory relationships education will be age-appropriate is, he writes, an open admission that more sensitive and controversial matters will be included under the new regime. Parents will not be allowed to withdraw their children from such relationships education classes, although their role as primary educators is plainly enshrined in both the European Convention and UK domestic law. The European Convention makes it clear that in the "exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents" ensuring that education and teaching conforms with their "religious and philosophical convictions." The author points out, however, that the ideological promotion and normalisation of transgenderism, and same sex relationships, calls this right into question.

Children are unable to assess these issues critically and he reminds readers of what is already widely known - that not all constituencies of parents will welcome this. The government appears to assume that all parents are accepting of the new rules or, if they are not, they should then forgo their natural role as primary educators. This state of affairs raises serious questions about parental rights and the wider spectrum of freedoms being encroached upon by the state.

The Call for Evidence was also intended to hear from teachers. We are reminded how Maria Miller, who, as Equalities Minister during the passage of the Marriage (Same Sex Couples) Bill,

provided the strongest of assurances to teachers and faith schools that they would not be required to promote anything that contravened their faith and belief about marriage, a concern felt by “many” of the Minister’s constituents. She countered what she saw as “scaremongering”, by which she meant that teachers and faith schools “will continue to enjoy the same situation as they do now.” But where, Clive Ireson asks, are such assurances in the new proposals for relationships education? None have been provided.

While the DfE has offered assurances that schools will be free to teach relationships (and sex) education in accordance with the tenets of the school’s faith, the ways in which both “diversity” and the Equality Act are already being applied by Ofsted exposes an obvious conflict. It is disingenuous when faith schools are assured they can teach in accordance with the tenets of their faith, while being dictated to about affirming ideology that contradicts their ethos under the guise of “equality”.

As Clive Ireson points out, given that new “relationships education” will cover same sex relationships, it is more correct to classify it as relationships and sex education. This would allow parents to withdraw their children from such classes.

Pressure groups intent on lobbying the government with the aim of forcing their own ideology onto *all* schools are not only an attack on parental freedoms, but a major threat to cultural diversity. It is a choice between allowing parents their natural legal rights as primary educators, or, homogenising relationships education for all children, thus sabotaging the diverse ethos of society, and the many viewpoints underpinning it.

The idea of state infringement upon parental rights is best summed up by a 2016 UK Supreme Court case in which parental rights in Scotland were about to be unlawfully appropriated by the state. Five Supreme Justices agreed:

> “Individual differences are the product of the interplay between the individual person and his upbringing and environment. Different upbringings produce different people. The first thing that a totalitarian regime tries to do is to get at the children, to distance them from the subversive, varied influences of their families, and indoctrinate them in their rulers’ view of the world. Within limits, families must be left to bring up their children in their own way.”[7]

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Relationships and Sex Education: The Way Forward

Understanding the Child in Context: Healthy Child Development

by Dr Josephine-Joy Wright

Lecturer in Child and Adolescent Mental Health, University of Worcester

Background

When addressing the issue of relationship and sex education in schools and the role of PHSE in assisting children, young people and families with understanding emotions and psychosocial issues such as friendship, authority and sexual relationships, and the development of identity, including gender, it is imperative to do this in the context of understanding normal child development.

Over my thirty or more years as a clinical psychologist, I have seen the damage done by the latest fashion or political campaign for different types of parenting groups, or different policy decisions on relationship and sex education (RSE), or the various positions on gender, capacity and consent issues. We have moved from a place where children had no voice, and it was legal to operate on them or make life-changing decisions without their express agreement, to one where, through the work of organizations such as United Nations Convention on the Rights of the Child (UNHCR) and Young Minds, participation in decisions about their lives is both a right and an expectation. For example:

> *Article 12:* Children and young people have the right to say what they think should happen, when adults are making decisions that affect them, and to have their opinions taken into account.
>
> *Article 13*: Children and young people have the right to get and to share information, as long as the information is not damaging to them or others.
>
> *Article 17*: Children and young people have the right to receive, seek and give information.
>
> *Article 23*: Disabled children and young people have the right to active participation in their community.

Article 2 further requires that all of the rights in the convention on the Rights of the Child be implemented for every child, without discrimination.

Defining Normal Child Development

Over the last 80 years, key developmental theorists have sought to determine evidence-based hypotheses and models of child development. Initial theories by Freud and Klein (1932) postulated that early life experiences have a profound long-term impact on

personality development and concept of selfhood. Winnicott's (1956) research found that the key was the not the life events themselves, but the emotional life, meaning and the formative effect of early relationships known as *object relations*. He went on to stress the primary significance of the nature and quality of relationship between self and other in determining the impact of early deprivation in terms of healthy relationships, delinquency, mental health (Winnicott, 2012). Bion's (1962) theory took these ideas further, concentrating on how the maternal bonding and attachment affected the quality of this relationship and thus the child's capacity for emotional development and forming future relationships.

Peter Fonagy's research (2004) demonstrated that what was key was what he termed "Mentalization", the ability to make and use mental representations of one's own and others'. He noted that poor parenting and attachment styles meant that the developing child/young person was unable to modulate or understand others' emotions. Thus we are not defined by life events, but by the quality of care giving, which builds into capacity for managing difficult life experiences. Fonagy suggested that the developing child has an Interpersonal Interpretive Mechanism, a way of operationalising their experience of attachment, which develops the internal working model for how the child sees themselves, and how they see others and the world, in relationship to themselves. Thus there is not a simple linear relationship between poor maternal attachment and a young person's mental health. It is mediated by the way that the young person works with, and makes sense of, their experiences and thus their capacity for working with and adapting to stressors, i.e. their resilience.

A child/young person's resilience was initially seen as a trait/fixed capacity that one had or did not have. Pioneering work by Bowlby (1988; 2005) and Rutter (1985; 2015) after the World Wars, seeking to understand how some children living in severe deprivation seemed to nevertheless thrive, whilst others failed, led to the development of Bowlby's attachment theory (Bretherton, 1992). Bowlby suggested that the key to a child's healthy emotional, psychosocial and intellectual development was the presence of a "secure base" - a responsive, attuned, and emotionally available caregiver with whom the child interacted, seeking proximity when experiencing a "threat", and developing an internal working model of the world and others as safe, reliable, trustworthy, and themselves as being of worth and able to have meaningful relationships with others. Recent research has demonstrated how the presence of such a secure base impacts on a child's long term mental health, self-esteem, attainment etc., confirming Bowlby's observation:

> *...'the prolonged deprivation of a young child, of maternal care, may have grave and far reaching effects on his character and so on the whole of his future life'*
> (Bowlby p. 46, 1952).

However, bonding and attachment are not confined to the initial few months of life. Studies beginning in the 1990s started to suggest that early bonding was not an 'all or nothing' process, but that attachment continues to develop and strengthen throughout the early months of life and beyond (Goldberg et al. 2000), indicating that messages that young people receive about themselves at school through PSHE, teachers and peer relationships can have a profound impact on their sense of self and capacity for healthy relationships and their resilience (Howe, 2011).

Piaget had demonstrated that as a child develops they begin to move from a concrete view of the world to internalising abstract concepts, becoming capable of intentional thinking, and able to develop Theory of Mind and a sense of self in relationship to others, by the age of 7-8 years of age.

Erikson (1902–1994) was a stage theorist who took Freud's controversial psychosexual theory and modified it into an eight stage psychosocial theory of development (see below). During each of Erikson's eight development stages, two conflicting ideas must be resolved successfully in order for a person to become a confident, contributing member of society. Failure to master these tasks leads to feelings of inadequacy.

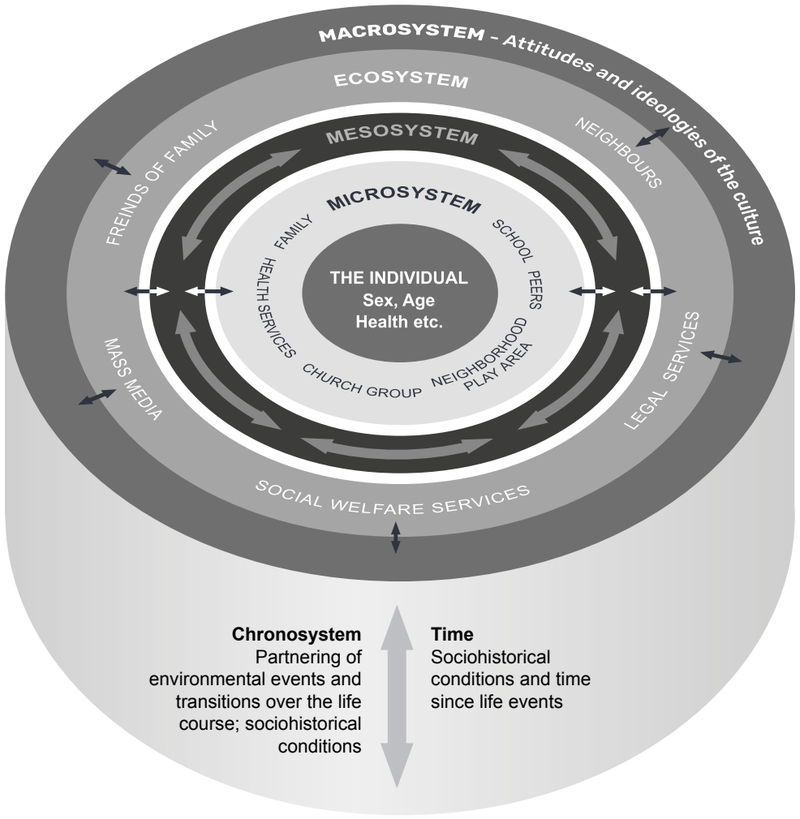
Erikson also expanded upon Freud's stages by discussing the cultural implications of development; certain cultures may need to resolve the stages in different ways based upon their cultural and survival needs.

Thus a young person at school is seeking to master issues concerning their sense of competence as a person and their social and sexual personal identity. They are naturally working through issues about fidelity and exploring who they are in terms of gender and identity. Periods of confusion are a normal part of this development, and young people will often explore and challenge expressions of gender and self in this period. They need to be able to do this safely and with support, without pressure to make life-changing decisions based on what are normal developmental phases.

Erikson's Stage Theory in its Final Version

Age	Conflict	Resolution or "Virtue"	Culmination in old age
Infancy (0-1 year)	Basic trust vs. mistrust	Hope	Appreciation of interdependance and relatedness
Early Childhood (1-3 years)	Autonomy vs. shame	Will	Acceptance of the cycle of life, from integration to disintergration
Play age (3-6 years)	Initiative vs. guilt	Purpose	Humour; empathy; resilience
School age (6-12 years)	Industry vs. inferiority	Competence	Humility; acceptance of the course of one's life and unfulfilled hopes
Adolescence (12-19 years)	Identity vs. confusion	Fidelity	Sense of complexity of life; merging of sensory, logical and aesthetic perception
Early adulthood (20-25 years)	Intimacy vs. isolation	Love	Sense of the complexity of relationships; value of tenderness and loving freely
Adulthood (26-64 years)	Generativity vs. stagnation	Care	Caritas, caring for others, and agape, empathy and concern
Old age (65-death)	Integrity vs. despair	Wisdom	Existential identity; a sense of integrity strong enough to withstand physical disintegration

Bandura's social learning theory (1977) emphasises the importance of peer and adult relationships on the development of young people's self-efficacy, and the messages that they receive and adopt about how they are meant to behave in social contexts and personal relationships. The interplay between home and school cultures, and their strong influence on a young person's sense of self and other perceptions are detailed in Bronfenbrenner's (1979, 2006) bio-socio-ecological systems theory, which details the vital importance that school and peers have on a young person's views on gender, social roles etc. (see below). Thus messages which children and young people receive from peers, social media, school education programmes on sex education, social expectations and gender roles interact with messages from home and culture, and have a profound impact on their development.



Relevant to the development of gender within a child's cognitive and social development, Freud highlights the importance of early childhood experience in gender development, but his emphasis on psychosexual dynamics within the family has not received empirical support. A dominant debate in current research on gender development concerns the relative importance of social and cognitive factors.

Mischel's (1966) social learning approach suggested that children's gender development is a product of their social experiences. This theoretical approach focuses on reinforcement of gender-typed behaviour by parents and peers, and on children's observation of gender stereotypes in the world around them. Bandura's social-cognitive theory is a more recent

version of social learning approaches that highlights the active role of children in their observational learning.

Kohlberg's (1966) cognitive-developmental theory proposed a developmental sequence of stages in children's concept of gender. Children's appreciation of the unchanging permanence or 'constancy' of gender was thought to underlie their tendency to seek out and adhere to gender role information and mirrored the Piagetian stages of cognitive development.

Martin's and Halverson's (1981) gender schema approach suggests that children form cognitive schemas about gender as soon as they discover their own sex. These schemas drive gender development, guiding children's attention and memory in such a way that they focus on and remember gender-typed information much more than counter stereotypical information.

Therefore, from a child development perspective, SRE programmes for primary school aged children need to be extremely careful about their position on gender-typical behaviours and sexual expectations, as young children will tend to adhere to these early influences as they develop. For example, a young child may explore a wide variety of behaviours/dress codes/ relational positions within their development as male or female gender, compatible with their biological sex. A boy, for instance, may be creative, artistic, like wearing soft pastel fabrics - yet so long as we, as society, do not give him the message that these behaviours are at variance with a male gender, not see himself as gender-atypical. What is deemed acceptable gender and social behaviour is strongly culturally and socially determined at any point in time, and children's development is too precious for them to be made a political or social tennis ball.

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Mental Health Issues: The Current Agenda

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Experiencing mental health concerns is not unusual. At least one in four of the population experience problems at some point in their lives and one in 10 children and young people experience mental health issues (Children's Society, 2008; Mental Health Taskforce, 2016). Over half of mental health problems in adult life (excluding dementia) start by the age of 14, and seventy-five per cent by age 18 (Green, McGinnity, Meltzer, Ford and Goodman, 2005; Health London Partnership, 2017). A review of the magnitude of mental disorders in children and adolescents from recent community surveys across the world demonstrated that although there is substantial variation depending upon the methodological characteristics of the studies, the findings converge in demonstrating that approximately one fourth of youth experience a mental disorder during any one year, and about one third across their lifetimes (Merikangas, Nakamura and Kessler, 2009).

Anxiety disorders are the most frequent conditions in children, followed by behaviour disorders, mood disorders, and substance use disorders. Fewer than half of youth with current mental disorders receive mental health specialty treatment, and in the UK only 25-35% of children with a mental health disorder receive help each year (National CAMHS Review [Child and Adolescent Mental Health Services], 2008). Although those with the most severe disorders tend to receive mental health services assistance, in the UK, for children and young people with mental health problems, help remains significantly under-resourced.

Over the past 10-15 years several key reports have sought to address these issues by highlighting the need and presenting challenges and recommendations for future services. The National Service Framework for Children in 2004 provided a clear structure for understanding these services, from the universal services provided by schools, GPs and other primary care services, and by voluntary sector staff; to specialist CAMH outpatient and inpatient services. However, even this early report acknowledged that the gatekeeping tiered system of care often became a barrier to an effective response to children, young people and families in need.

More recently in 2015 the *Future in Mind* report sought to challenge the structure and delivery of CAMHS, and to replace the tiered model of care with an awareness that promoting the emotional well-being and resilience of children and young people is everyone's responsibility, and particularly detailed the vital role that schools have in this key aspect of children's development. They proposed locally monitored Transformation Plans to engage services working together to promote children's well-being, with clear goals for 2020. Unfortunately, as yet, services on the ground have still to see these plans underpinned by funding for training and long-term service revenue, and by sustainability across political party changes in policy, which inhibits both service development, and staff morale and engagement in the changes. Also not everyone has bought into the support role that schools appear to have assumed in the field of emotional well-being. Teachers and pastoral care staff wrestle with

Ofsted commitments and lack of supervision and training in mental health, and head teachers have to balance the gold standard of a counsellor, and pastoral and family support workers in their school against other teaching budgetary needs. In July 2015, The Association of Schools, Colleges Leaders Council Inclusion Committee agreed the following position statement on emotional health and well-being (EHWB):

> "Schools accept the need to promote EHWB, but not to treat students (this is the remit of health professionals); Those treating young people for EHWB need adequate training, qualifications and clinical supervision; This area of work needs to be adequately resourced before the needs of students become acute."

School and college leaders reported that young people today face an extraordinary range of pressures that include enormously high expectations and new technologies, which present totally new challenges, such as cyberbullying. They emphasised that there is now much more awareness of young people's mental health needs, and there has seldom been a time when specialist mental health care and early intervention is so badly needed but that they feel poorly equipped to meet these needs.

Mental health needs its own protected budget in schools and colleges if we are truly going to see schools using PSHE and other avenues effectively within an integrated plan of emotional well-being support and promotion. They also need agreed principles and values to underpin such interventions, and an acknowledgement of normal child development stages. Children must not be pressurised under the banner of the 'tolerance' agenda to make lifelong decisions when they are developmentally exploring choices, whether that is in terms of options studied or identity issues.

The Child and Adolescent Mental Health Commission's recent report (2016) argued that an important theme that stands out in previous reports is the need to consider services for children and young people with mental health problems within the wider system in and by which they are supported: families and communities, schools, health and social care, and the voluntary sector. The report highlighted the need for a consistent shared language, along with whole person, whole-system based values underpinning how services are designed and led, and how consistent outcomes measuring the effectiveness of services are agreed. Also, services varied greatly in their underpinning values, and how much they saw participation by young people and families as intrinsically core to the effective development and running of services, despite the pioneering work of Young Minds. The Commission recommended that co-production with young people and parents should be at the heart of all recovery, service redesign, commissioning and training.

The lack of financial resourcing and staff training was an on-going theme in all the recent child and adolescent mental health reports, as was the on-going issue of whose responsibility is the mental health of children and young people. Despite the Commission's recommendation that all services should adopt core values of:

1. Equal partnership (valuing children, young people and parents as partners with an equal voice);
2. Empowerment (to value empowering children and young people to understand their mental health as a critical contribution to their health and well-being);
3. Workforce (valuing the workforce who are providing the services, care and support);
4. Whole system (value working together across sectors, recognising that we all have responsibility for the mental health of children and young people – and that no one sector, or part of society, can do this alone);

5. Leadership (value leadership at all levels, especially system leadership);
6. Long-term relationships (value the power of long-term relationships as a critical factor in promoting and supporting children and young people's mental health).

Services in this area still remain very under-resourced and children and young people have to wait many months for appointments. They also have to negotiate accessing services, which are very similar in design to physical health services and thus are not child-friendly or welcoming to adolescents in distress. Thus adolescent suicide and self-harm rates are high (Young Minds, 2011) and young people and families often look to support from related charities, rather than relying on inadequate or non-existent accessible services. Young people with multiple issues who find it hard to use routine mental health services are deemed "hard to reach" (Gulliver, 2010), whereas it may be argued that such services are "hard to access" (Flanagan and Hancock, 2010).

With social media meaning there are no longer any walls, or respite for vulnerable children and young people from cyberbullying and social rejection, the potentially negative impact on such children's development of their identity, their ability to develop healthy relationships and boundaries, and their emotional health, emotional literacy and resilience is severe (Daine et all, 2013); and the demand for effective services to meet these often emotionally and socially isolated and fear-filled children is challenging (Firth, 2017).

With over 30 years in the NHS, I would argue that the first two of the Commission's core values are crucial; if young people do not understand the normality of many of their emotional struggles and attractions within a child developmental perspective, they may assume a level of dysfunctionality in themselves or others that has significant and damaging lifelong consequences (Young Minds. 2017). Most child and adolescent mental health problems find their roots in family or peer relationships, as children wrestle to understand their identity and roles in a social media dominated world with no walls (Public Health England, 2016), catalysing the development of relationship-based therapies such as Inter-personal Therapy, which seeks to enable young people to develop a new health narrative/story for their lives (Mufson et all, 2004, 2011). We need to ensure that young people are provided with the right timely care that they need in a way that enables them to access it, but also care that enables them still to be developing young people, able to explore their roles in relationships, their identity, their gender and sexual preferences as a normal part of childhood exploration, but not asked or given the responsibility and authority to make determining, life-changing decisions based on this exploration, when they are still children whose adult life choices may be very different. We need to be careful that the values, beliefs and agendas of political groups, service mangers and care workers/therapists are not explicitly or implicitly projected onto vulnerable minds. We owe the children of our future nation the right not to be social and political tennis balls in adult campaigns peddled under the guise of tolerance or sexual freedoms, but to be heard and cherished as children and young people now. Only in this way will the emotional and mental health needs of our children be truly valued and met.

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Physical Health Vulnerabilities for Children

by Lynda Rose

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The physical risks to child health arising from early (premature) sexual experimentation are clearly documented, but such experimentation is being reported at increasingly early ages, with reports of child-on-child sexual assault from as young as age 5.[1] The reality is that since the 1970s - with the freedom given by easy access to contraception and abortion, and the advent of gay rights - we have seen a seismic shift in sexual behaviour, that has been extended to children by means of the very programmes ostensibly designed to keep them safe. Sex education programmes, far from protecting children, are indoctrinating them into behaviours that pose a severe risk to health. A generation ago the problems outlined in this section, by and large, did not exist; now they are commonplace. The message given to children that they can do whatever they want – accompanied by full instruction - provided only they use a condom, is misleading and dangerous, and for some will result in life changing 'conditions' from which they may never recover.

Broadly there are four main areas of concern. First, the health risks attaching to juvenile conception, pregnancy, and abortion. Second, the largely ignored risks attaching to various forms of contraception. Third, the unprecedented and alarming rise of STIs and their long-term effects on health and longevity. And fourth, related health risks resulting from multiple sexual partners, ranging from clearly documented vulnerability to certain forms of cancer, to conditions such as anal tearing and prolapse. None of the following will address the related psychological and emotional damage associated with the health risks described, but they are significant factors in assessing childhood vulnerability.

Health Risks Attaching to Juvenile Conception, Pregnancy, and Abortion

Most teenagers are not physically developed enough to carry a child, so that, if pregnancy continues, there are risks for both the mother and her baby. Babies born to adolescents commonly tend to have a low birth weight and be predisposed to a variety of illnesses. On top of that, according to the World Health Organization (WHO), complications during pregnancy and childbirth are the second cause of death globally for 15-19 year-old girls.[2] In the UK the health risks are undeniably better managed, but, for a variety of reasons,[3] teenagers remain at risk of not getting adequate prenatal care and therefore being at risk.

Should a teenager choose to have an abortion, this too carries significant risk. Possible side-effects include: pelvic infection; incomplete removal of the baby or placenta which may result in infection and/or bleeding requiring urgent medical attention; blood clots in the uterus; scar tissue on the uterine wall. All of these conditions, if untreated, can be life threatening. All can produce enhanced risk of future miscarriage, and can also cause adult infertility. If a teenager

does not tell her parents she has had an abortion and requires emergency treatment, lack of information may result in a dangerous delay, or the wrong treatment being given.

How Safe is Contraception?

Very broadly, the most used forms of contraception for teenagers include use of a condom, the pill, intrauterine device, contraceptive injection, contraceptive patch, the morning after pill, and, increasingly, contraceptive implants. All of these methods carry health risks; some of which are relatively trivial, but some of which are severe and long-term.

Specifics: Children are commonly told that if they use a condom they will be protected against both unwanted pregnancy and infection.[4] Both statements are untrue. Condoms are claimed to give 98% protection against pregnancy, *when used by experts*. But children are very far from being 'experts', and that fact, combined with the relatively high failure rate for condoms, means pregnancy prevention is actually closer to 89%.[5]

The pill is also claimed, with more justification, to be 98% effective,[6] but there can be a variety of side effects, ranging from weight increase, to headaches, sore breasts and, more seriously, to a risk of blood clots and stroke. Teenagers also don't always remember to take them every day, so that effectiveness against pregnancy cannot be ensured. It is medically well documented that other contraceptive methods may give rise to vaginal discharge (contraceptive vaginal ring); heavy bleeding during periods, accompanied by 'spotting' in between (intrauterine device); headaches, weight gain and acne (contraceptive implant). Future fertility may also be affected, seen most commonly with Progestin injections and contraceptive implants, which release the same hormone over a period of four years.[7] Both methods operate to stop the release of eggs from a woman's ovaries, while also thickening the mucus on the cervix so that any sperm cannot swim through.

Such hormonal manipulation is still relatively new, so that long-term effects are unknown.[8] However, in 2015 the Government issued a warning after there were reports of the Nexplanon implant migrating from the arm, where it had been inserted, to the lungs via the pulmonary artery. Women receiving such implants were advised to 'locate the implant' regularly, and seek urgent medical advice if they couldn't find it.[9] There have also been reports of difficulties conceiving once the device has been removed. It has been widely reported in the national press that implants are being given to girls as young as thirteen, without parental knowledge.[10] Common side effects on top of the above include menstrual cramps, dizziness, mood swings, depression, acne, vaginal itching and discharge, weight gain, risk of osteoporosis etc. etc.[11]

The Alarming and Unprecedented Rise of STIs Amongst Teenagers

There are currently around 30 diagnosable STIs, and doctors are warning of epidemic level rates of infection amongst teenagers. STIs amongst teenagers prior to the mid seventies were so low as to be statistically insignificant.

Facts: in 2015, 15 to 24-year-olds accounted for 62% of those diagnosed with chlamydia, 52% with gonorrhoea, 51% with genital warts, and 41% with genital herpes.[12] At the same time, figures produced by Public Health England for the period 2012-2015 suggested a 76% increase in syphilis.[13] The Terence Higgins Trust further reported that the UK has one of the highest rates of HIV diagnosis in Western Europe, with 10% of all new diagnoses affecting young people between the ages of 15-24.[14]

These figures are a major cause for concern. Young women's bodies are biologically more susceptible to STIs. If they indulge in risky behaviours, however, both boys and girls are at risk of contracting all these infections, many of which remain untreatable, while some, such as gonorrhoea, are becoming increasingly antibiotic resistant. All of which means there is every danger that a young person contracting one or more of these infections will have them for life.

Current SRE programmes tell children that if they use a condom they'll be safe. This is misleading and dangerous. Condoms, even if correctly used, never provide complete protection and, contrary to what is said, some STIs are transmitted not by the exchange of bodily fluids, but by skin-to-skin contact, in which case condoms are useless. For example, HPV, genital herpes, syphilis, pubic lice, and molluscum contagium. STIs are also a major cause of adult infertility.

Related Health Risks

In 2013, the film star Michael Douglas created a sensation after revealing that his stage 4 throat cancer was the result of an HPV infection that he had contracted from oral sex. In recent years the number of people suffering this form of cancer has increased dramatically and, though there are several possible causes, it is estimated that up to 70% of all such cancers are related to HPV, transmitted during sex. The virus is also known to cause anal cancer, for which Cancer Research reports a 56% increase since the 1990s,[15] with a further projected rise of 43% between 2014- 2035.[16] All girls are now being offered HPV vaccination to guard against cervical cancer, but the danger for boys of contracting anal and oral cancer is now seen as so great that they too are being recommended to receive vaccination. The danger would not exist, or would at least be considerably reduced, if children were taught to moderate their behaviour, rather than encouraged into promiscuity.

Related risks attaching to anal sex include anal tearing and prolapse. Risks from encouragement to using urine and faeces in sex perhaps speak for themselves, as also risks arising from the practice of 'cutting'. All these practices, once regarded as 'unusual', are described in detail in current sex education materials being provided to schools, as seen for example in the Warwickshire schools' resource, *Respect Yourself.*[17]

Conclusion

Despite all the calls for increased and more detailed delivery of sex education, the policy is demonstrably not working. The normalization and promotion of what was once regarded as deviant behaviour, described in graphic detail in education materials being offered to schools[18] is serving rather to indoctrinate children into behaviours that carry significant and severe risks to health. Withholding full information as to these risks is ideological indoctrination aimed at embedding 'rebranded' morality, and is a systemic form of child abuse.

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1. A BBC report of 9th October 2017 revealed that sexual offences by under 18s against other under 18s had risen 71% during the period 2013-2017. Reports of sexual offences on school premises, including rape, rose from 386 in 2013-2014 to 922 in 2016-2017, including primary schools. The figures were obtained from a FOI request to police forces in England and

Wales. 38 out of 43 forces responded. Simon Bailey, the national police chief lead for child protection, said that the number of sexual assaults was rising and that these figured were only 'the tip of the iceberg'. (http://www.bbc.co.uk/news/uk-41504571 (Accessed 16-10-17).

2. http://www.who.int/mediacentre/factsheets/fs364/en/ (Accessed 10-02-18).
3. Sometimes, as result of an erratic menstrual cycle, teenagers don't realize they are pregnant until relatively late in pregnancy. Equally, some teenagers try and conceal their pregnancy from parents and other adults – while still others simply refuse prenatal care.
4. See below.
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The Flaws in Some Current Practice of SRE

by Pippa Smith

Co-founder, Safermedia

Who decides what is good and bad? How is it defined?

Over half of parents 'want sex education to promote the value of abstinence alongside contraception; to be taught in its "moral context" with an emphasis on marriage; and the importance of the legal age of consent'[1]

A. SRE Guidance, DfEE 0116/2000

The following points state:

"5. Pupils need also to be given accurate information… and,

6. SRE should contribute to promoting the spiritual, moral, cultural, mental and physical development of pupils at school and of society and preparing pupils for the opportunities, responsibilities, experiences of adult life.

7. Effective SRE does not encourage early sexual experimentation…and understand the reasons for delaying sexual activity."

However, despite some areas of excellence and over 30 years of sex education, Britain has the highest rate of teen pregnancy in Europe; UK rates of sexually transmitted infections (STIs) also remain relatively high, with 16-year-olds to 24-year-olds accounting for most new UK diagnoses despite comprising only 12% of the population."[2]

Unfortunately, inaccurate and sometimes misleading advice from the agencies who advise Government policy is failing pupils in these areas and actually encouraging early sexual activity. Parents' wishes are now largely absent from guidance produced by the Sex Education Forum, Brook,[3] FPA[4] and others. This is despite the fact that the State must, according to both domestic law and the European Convention on Human Rights, respect parental philosophical or religious convictions.[5]

B. Agencies involved in advising Government:

Sex and Relationships Education (SRE) for the 21st Century - Supplementary Advice to the SRE DfEE 0116/200 (Brook, PSHE Association, Sex Education Forum)

- The Sex Education Forum, which has produced a resources list including some of the explicit publications listed below, "believes that all children and young people have a right" to sex and relationships education. The head of the Sex Education Forum, Lucy Emmerson, has called for the Government to take "bold action to implement statutory SRE and PSHE in all primary and secondary schools".[6]

It is these bodies, above, not parents who have a legal responsibility for their children, who are calling for mandatory RE and RSE lessons.

Teaching materials have become more explicit. For example, in 2010 the Channel 4 DVD, Living and Growing, an explicit animation showing sexual intercourse, caused an outcry and was heavily criticised by MPs who called for action to ban it because of the distress and concern of parents. However it was not banned and an updated version is in schools.

C. Some Sex Education Forum recommended resources:

- *Sexpression* is a sex education website by students (It is sponsored by Durex, who are major condom manufacturers, their slogan, 'love sex').[7]
- *Brook Sexual Behaviours Traffic Light (safeguarding) Tool.* This treats sexual activity below the age of consent as a 'positive choice' and an opportunity to give 'positive feedback'. It gives the green light to 'consenting oral and/or penetrative sex with others of the same or opposite gender who are of a similar age and developmental ability', and regards 'sexually explicit conversation with peers' and 'interest in erotic/pornography' in a positive light.
- *Living & Growing* Channel 4 (see above)
- *Mummy Laid an Egg!* Babette Cole (Recommended age 5+). Sexual positions are shown using childish cartoon characters: "Here are some ways…mummies and daddies fit together". One drawing uses a 'space hopper'.

Examples of other explicit resources:

- *Where did I Come From?* Peter Mayle[9] (age 7+). Cartoon drawings of adult male and female nudity and a description of their bodies, also a description of how sex feels, 'a gentle tingly sort of tickle'.
- *Primary School SRE Pack* (age 7+) includes descriptions on anal sex, 'when a man puts his penis in another person's anus'; masturbation; oral sex; clitoris, which is described as producing feelings of pleasure and excitement when rubbed.
- BBC Active '*Focus*: *Growing Up*' (age 7+) includes computer generated image of erect penis; computer generated image of penis penetrating vagina'; real teen nudity, male and female.

Because SRE is not compulsory in primary schools, many exercise their own better judgement and do not take up the more explicit resources.

D. Ineffectiveness of SRE

(a) In the Cochrane review published in 2016, doubt was cast on the effectiveness of sex education.[10] The first line reads:
"A global review of school-based interventions for preventing HIV, sexually transmitted infections (STIs), and pregnancy in adolescents shows sex education programmes have no impact in lowering numbers of young people affected..."

(b) The reasons and evidence are clearly set out in an important new report, *'Unprotected: How the normalisation of underage sex is exposing children and young people to the risk of sexual exploitation.'* [11]

(c) Children, parents and carers are not receiving accurate medical information about the risks of early intercourse. Dr Karen Rogstad, consultant physician in genitourinary medicine in Sheffield, said: "The increase in chlamydia among teenagers is very worrying because teenage girls are more likely to get damage due to chlamydia than older women…"[12]

The limitations of contraception and the influence of the internet are discussed in separate chapters.

E. Recommendation

Good RSE and RE in schools should involve parents as the primary educators and include life skills and wider opportunities, as well as accurate and age-appropriate information on how to avoid early sexual experimentation.

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Relationships and Sex Education: The Way Forward

Teaching Fertility

by Louise Kirk

UK co-ordinator for Alive to the World

Understanding of human fertility has greatly outstripped popular knowledge in recent decades. Young people have a right to this knowledge, which helps them make informed decisions on their sexual behaviour, knowing that, as with every aspect of health, what they do when they are young will have an impact on their later life.

A key to fertility rarely taught adequately at school is the female mucus cycle. Young women are emerging from school with no knowledge of it: when they observe mucus, it disconcerts them and causes them to worry rather than appreciate the sign of healthy fertility. Once it is explained, they are not only reassured but become educated in their own bodily patterns. Learning to chart helps them anticipate their periods and their mood swings,[1] and gives girls a ready health check. The female cycle is tightly controlled by the interaction between the brain, ovaries and uterus so that medication and health problems, physical or mental, which disrupt this communication, tend to show up in the menstrual pattern. Teaching mucus has immediate application to all women of reproductive age.

Learning that the menstrual cycle is integral to the whole person and is affected by age teaches both boys and girls to respect fertility and realize that it cannot be taken for granted. Women are at their most fertile aged 19 or 20; by the mid-30s fertility falls off rapidly, disappointing many couples who have waited to establish their careers before trying for children. Twenty per cent of UK women will now never have a child, up from 10% a generation ago, according to Professor Adam Balen, chairman of the British Fertility Society.[2] He warns that women “do not have the control over their fertility that access to contraception might make them believe” and urges that young people be taught at school that the best time to think of starting a family is in the 20’s or early 30’s. This demands a societal change in the way people think but he considers the facts too urgent to ignore.[3]

Dr Erik Odeblad’s work explains an important factor which contributes to infertility.[4] A woman’s cervix ages over time, producing annually less of the fertile mucus which is abundant in healthy 20-year-olds. However, the birth of children refreshes the cervical crypts which produce fertile mucus. Hence older mothers find it easier to conceive than like-aged childless women. The Pill, by contrast, ages the cervix prematurely[5] and the damage can be long-lasting even after a woman leaves hormonal contraception.

By teaching young people the full menstrual cycle over the span of reproductive life, how sperm are created and how the seminal fluid interacts with the mucus in sexual intercourse, the scientific principles behind modern methods of natural family planning are also described. Students’ perspectives change when they learn the delicate beauty of human sexuality, and that it can be regulated without recourse to drugs or devices. Fertility control is thus brought into line with other aspects of health and environmental education, which point to the dangers of unnecessary chemical intervention. Teachers of the TeenSTAR fertility awareness programme have found that just educating students teaches them greater respect for themselves and each other.[6]

Modern methods of natural family planning, including the Ovulation and Sympto-thermal methods, have been found to be as effective as the Pill for avoiding pregnancy. Recent research shows that, well taught, it is not only their Method Effectiveness rates but also their User Effectiveness rates which measure up.[7] There are now apps which can help with charting. These facts are rarely taught to school children. Instead, they are regularly given data on natural family planning which applies to outdated calendar methods.[8] They are also given unrealistic figures for the effectiveness of the Pill and other contraceptives, especially when used by unmarried young people, giving them a distorted sense of security in chemical intervention and a bias against trusting in their bodies' natural working.

Young people have a right to know that sex bonds a couple physically as well as emotionally and to be introduced to the results from brain scan technology.[10] If the sexual bond between two people is broken, the capacity to make a future long-term exclusive bond is diminished. In practice, the younger a person starts to have sex, the more sexual partners he or she is likely to have. Early sexual experimentation has sometimes been encouraged on the basis that it helps young people to make good long-term choices, but in practice it does the opposite, setting them up to fail at founding the lasting families on which individual happiness and the health of society depend.[11]

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10. See *Hooked: New science on how casual sex is affecting our children*, by Joe McIlhaney and Freda McKissic (Northfield Publishing, 2008), for a useful overview of recent research.
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Relationships and Sex Education: The Way Forward

Do Boys Matter?

by Patricia Morgan

Author and Sociologist

The House of Commons Life Education Committee's report on Life lessons: *PSHE and SRE in schools* insists that problems confronting the young be addressed (from Sept 2019) by statutory PSHE (from infancy) and SRE (for senior pupils) with centrally prescribed curricula and teacher training.[1] Claims are that PSHE (Personal, Social, Health and Economic education) requires improvement in 40% of schools and pupils "consistently report that the sex and relationships education (SRE) they receive is inadequate". (Whether youngsters can or should decide is questionable.)

The PSHE Association describes a programme "through which children and young people acquire the knowledge, understanding and skills they need to manage their lives".[2] Ofsted emphasises: "health and safety education, including substance misuse, sex and relationships education, careers education, economic education and financial capability".[3] Public Health England says that PSHE "adds to pupils' knowledge and resilience, and will help them achieve at school".[4]

The Sex Education Forum as a leading power behind this move sees SRE as "learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health… [that] should equip children and young people with the information, skills and positive values to have safe, fulfilling relationships, to enjoy their sexuality and to take responsibility for their sexual health and well-being".

This covers just about all aspects of learning, socialisation or human development – available for the state to commandeer. There is no independent, impartial body (should that be possible) identifying specific areas for intervention, with clearly defined ends and strong evidence for effective means. Various interests simply advance their agendas through interpretations of 'health' and 'safety'. Pressure for compulsion last arose over New Labour's teenage pregnancy strategy, as sex education and contraception lobbies insisted that their remedies were insufficiently applied.

Ambitions are now wider and more radical, as identity groups have acquired significant power and influence over educational policies. The Sex Education Forum lists as its three primacy core advocates: the National AIDS TRUST, The International Planned Parenthood Federation or "leading advocate of sexual and reproductive health rights for all" and Stonewall, LGBT campaigner. SRE is described as particularly important for the "most vulnerable" or "looked after [in care] LGBT children and those with special educational needs".[5] As the then Education Secretary Justine Greening - government champion of the LGBT agenda - allocated another £3million for LGBT initiatives in schools in addition to other millions and ostensibly to combat the bullying of pupils considered to be homosexual. Greening has emphasised how schools must "teach 21st century relationships".

Boys are now increasingly targets of intervention when (apart from being recipients of condoms), it has been girls who have received more guidance given concerns over early

pregnancy. Any policy - present or proposed – should be assessed for its impacts on boys' as well as girls' well-being.

The UK has one of the highest rates of new STI diagnosis in Western Europe, due to ongoing transmission and, it is suggested, high testing levels. In 2016, there were 417,584 new STI diagnoses in England.[6] Young people (aged 15 to 24 years) have the highest diagnosis rates (including 50% of gonorrhoea), with young women, black minorities and men who have sex with men (MSM) most affected. The most common were chlamydia (202,546), first episode genital warts (62,721) and gonorrhoea (36,244). A 4% overall decline since 2015 is due to the fall in genital warts with female vaccination. Otherwise, there were 5,920 diagnoses of syphilis, a 14% increase on the previous year and highest since 1949. From 2012, syphilis diagnoses rose by 97%, and overwhelmingly for MSM, who account for 86% - along with 65% of gonorrhoea. This is greatest for those aged 16-19[7] and occurs predominantly in the gay centres of Brighton, London and Manchester. In 2015, over half of London's MSM syphilis diagnoses were in individuals co-infected with HIV (51%), and 53% of MSM diagnosed with syphilis were diagnosed with another new STI during the same episode or within the previous year.[8] Around a half of diagnoses for HIV in the UK are aged under 35. In 2015, those from 15 to 24 made up 12% of diagnoses.[9]

For many infected as teens, this is often by older HIV positive men.[10] HIV diagnoses among (principally African) heterosexuals have fallen steeply to about half those ten years ago, while levels for MSM have been consistently high up until 2016. The very recent fall in diagnoses is likely due to repeat testing, anti-retroviral therapy (ART) and access to pre-exposure prophylaxis (PrEP). Anal cancers, strongly related to penetrative anal sex, are rising sharply.[11]

The number of young males receiving treatment for eating disorders has been growing twice as fast as the rate for females. Up to 25% of those affected by anorexia may be male and 20% to 40% identify as homosexual[12] - or even four-fifths for bulimia nervosa.[13] Bigorexia - a form of body image distortion among young males - is also increasingly common, not least given hyper-sexualised imagery and pornographic standards. Conflict involving physical ideals is predictive of depression as well as peer bullying, eating and shape concerns and far more common among sexual minority males.[14]

Along with a general increase in rapes and indecent assaults, those recorded for young men have risen considerably in England and Wales, although these hardly approach female levels.[15] Disclosing male non-consensual sexual experiences might have become more acceptable or commonplace, particularly if more at younger ages have sex. Studies back to the 1990s and including recent well-controlled longitudinal ones suggest a much greater likelihood of non-consensual sex for MSM, in childhood, teens and later.[16] A large number of assaults occur where victims and (often older) assailants are sexually 'active'.[17]

For long it has been apparent how exploitative, abusive or upsetting sexual experiences create confusion, distress and disease. A large proportion of young girls within intimate relationships experience sexual violence.[18] Similarly, boys with same-sex and both sex partners are far more exposed to inter-personal violence, coercion and high levels of sexual and other risks, compared to those with exclusive heterosexual contact.[19] This is even after other leading risk factors are taken into account,[20] although these add to the likelihood of physical and sexual abuse.[21] Girls and boys in care or dysfunctional families are far more likely to be victimised.

Early sexual debut is likely to exacerbate pre-existing problems and distress and has its own negative outcomes.[22] There is low relationship control along with risks involving drugs

and alcohol, infection, abuse, coercion and more long-term negative health outcomes, physical and mental.[23] This includes young suicidality (ideas, plans and attempts) for both sexes irrespective of family background.[24] Early sex is often casual sex, which is particularly associated with greater levels of unprotected sex, psychological distress and lower levels of well-being. The more 'partners', the higher the chances of multiple sexual infection acquisition/ transmission.[25] The youngsters who are 'safest' are those who are not sexually involved.

Pubertal physical maturation is not matched by brain development, which does not attain adult capability until the early 20s. Youth is a very fluid and confused period, marked by labile moods, with increased responsiveness to incentives and emotional cues, while the capacity for cognitive and emotion regulation is immature.[26] Adolescents are unprepared for the nature and implications of sexual involvement; including the consequences of risky behaviours. Although condoms are distributed even to pre-teens, these are likely to be poor and inconsistent users.[27]

Attractions and behaviours vary much over time and none need indicate a fixed 'orientation' - which educators are expected to affirm and applaud. The evidence is for considerable variation and instability in sexual feelings, behaviour and relations across adolescence and early adulthood. Instances cannot be read as indicative of an underlying nature, dedicated 'choice' or a lifelong 'orientation'.[28] This makes it inappropriate to superimpose adult beliefs onto the young by referring, for example, to "LGBT children". If youngsters 'come out', are labelled, or expected to have a sexual 'identity' or enter an 'orientation' there is, at the very least, a serious risk of erroneously 'affirming' experimenters or the temporarily confused.

Along with the media, sex education has for long now been imparting details of a cornucopia of sexual practices and possibilities. There is the popular NHS endorsed sexual health site 'Respect Yourself' with its felching, fisting, scat, rimming and so forth. The report from Public Health England in 2016[29] insists that "Statutory, high-quality relationship and sex education in secondary schools will equip young people with the skills to improve their sexual health and overall wellbeing". What is "high quality relationship and sex education" other than a wishful boast? In report after report this boils down to promoting condoms and "positive sexual relationships".

There is failure to notice how, after decades of profligate condom promotions and distribution, suggestions are that popular 'bareback' sex among MSM has, if anything, increased.[30] It is also being suggested that condom advocacy is useless and expensive, so preventative drugs like PreP must instead be more widely provided (at an estimated cost to the NHS of £4,800 per MSM).[31] There are pressure groups like *I Want PReP Now!* for condom free sex. Michael Weinstein (president of the AIDS Healthcare Foundation in the US) sees unintended consequences or "the potential for overall spread of the virus as well as other sexually transmitted diseases for which PReP offers no protection" and a "public health catastrophe" as this encourages more people to dispense with condoms and engage in practices from which they might otherwise desist.[32]

The second HIV wave followed the availability of anti-viral drugs, relaxation of the law on consent and greater support for homosexuality. Due to herd immunity conferred by female immunisation, heterosexual infection levels of the papillomavirus (HPV) are falling. As HPV's genital warts are a major risk factor for anal cancer it is now proposed that boys be vaccinated.[33]

A lesson comes from the well conducted RIPPLE and SHARE studies in UK schools. The researchers attributed differences in sexual risk and unwanted early sex by partner type to

a lack of sexual health knowledge and skills – stemming from limitations in sex education programs and less “gay-sensitive sex education”.[34] They then found that teenagers with same-sex partners were *more knowledgeable* about sexual health.

Moves to make youngsters ‘safe’ or able to “enjoy their sexuality” or ‘explore’ sexual possibilities and consolidate an ‘identity’ can - given the often unpredictable and variable nature of human behaviour - pose as many or more risks than these profess to avoid; resulting in a proliferation of ills affecting more people and demanding ever more complex and expensive solutions.[35]

Understanding various ‘relationships’ presumes levels of comprehension or cognitive ability which children do not have.[36] Children cannot “manage their lives” or “take responsibility for their sexual health and well-being” as fully autonomous beings; this is the responsibility of adults. Recent significant advances in the knowledge of human development have had no discernible influence on policy. Political correctness and ideological interests need to be usurped by sound science and replaced by credible, evidence-based public health policy.[37]

The healthiest, safest youngsters are not sexually involved - whatever lifestyle they later adopt, when hopefully, they are better able to cope. An optimal public health approach would aim to postpone sexual relations and discourage high-risk behaviours – not promote these . As delineated by the American College of Pediatricians, education should concentrate on avoiding exposure to potentially harmful risks, including drugs, alcohol and adolescent sexual activities, and focus later on the development of skills for avoiding risky behaviours, along with preparation for mature relationships, marriages and parenthood. Information should be developmentally appropriate. All should be careful not to alienate children from parents. Children are nowhere without parents. Identity groups should not be making government policy and their agendas need to be kept out of schools.

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Relationships and Sex Education: The Way Forward

Contraception for Adolescents: Failure Rates and Health Implications

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Introduction

The best contraception for adolescents is abstinence. It is 100% effective, and risk-free. Abstinent adolescents will not contract sexually-transmitted diseases (STDs), and they will not suffer the emotional distress and the disillusionment associated with the (almost) inevitable breakup of those relationships. They are neither mature enough nor free enough to make long-term commitments. The best choice they can make is to 'say no' and it is surely the role of education to empower young people to make best choices.

If we assume that adolescents will 'do it anyway', and give tacit approval by providing ever more sources of free contraception, they will conclude that such behaviour is both expected and acceptable, and so prove our assumption right. For years the policy of enabling so-called 'safe sex' has led to premature sexualisation, increasing rates of STDs, stubbornly high levels of teenage pregnancy and an endless stream of young people visiting abortion clinics. When will we have the courage and integrity to question the policy? Our young people are paying a huge price for our reluctance to 'tell a better story' about sex and relationships, one that resonates with their own instinctive convictions.

Parliament has an opportunity to change the message our young people hear, through the new programme of sex and relationships education. It could dress up the same old message in new clothes, but then should not expect different outcomes from those we have grown accustomed to. Or it could take courage and call for change – to relationships of mutual respect and self-restraint, to abstinence before the long-term commitment of marriage and to sexual faithfulness within it.

The message young people have heard is that the only important thing about sex is that it should be 'safe'. They need a better message – that sex is special, an expression of mutual commitment that is worth waiting for, and a better story as the context for sex – that love in relationships is best measured by what we are prepared to sacrifice for the one we love.

What follows is a factual summary of those methods of contraception that are considered by doctors to be the most suitable for adolescents, discussed in their order of effectiveness. In light of the above, the reader will appreciate that it should not be taken to imply approval of their use.

Failure rates

No contraception works perfectly. Sometimes they fail to prevent pregnancy and the frequency with which this happens can be expressed as a percentage — the percentage of

couples using that method who will become pregnant in the first year of use.

Of course, 'user error' will account for a proportion of the 'failures' and so the failure rate can be expressed in two ways:

- theoretical failure rate, or *'correct use'* percentage
- realistic failure rate, or *'typical use'* percentage

The typical-use efficacy rates reflect how well a contraceptive method works with an average user, factoring in mistakes, such as missed pills, forgotten condoms, or patches that are left on too long. To illustrate, the correct use failure rate of 0.3%[1] for the combined oral contraceptive pill may rise as high as 9.0%[2] with typical use and would be expressed as a failure rate of 0.3% — 9.0%.

Hormonal Contraception

All hormonal contraceptives have more than one method of action. Whilst their primary effect may be to inhibit ovulation or thicken the cervical mucus plug, they can also act post-fertilisation by inhibiting implantation in the womb. The likelihood that this last method of action is enlisted in practice varies from one form of hormonal contraception to another and thus constitutes a variable risk for a user who would wish to protect the life of an early human embryo from the point of fertilisation.

Sexually-Transmitted Diseases

The greatest physical health risk to sexually active adolescents is from STDs, particularly chlamydia. This can be present without causing noticeable symptoms and, left untreated, can cause infertility. The use of a condom can reduce the transmission risk of chlamydia but much less effectively guards against transmission of some other STDs such as genital warts and genital herpes. Clinicians recommend that patients use condoms in conjunction with all hormonal methods of contraception, and with the use of intrauterine devices. Whilst this will reduce the risk of contracting STDs, it will not remove it entirely.

It would be a dereliction of the doctor's duty if a child known to be sexually active were not warned of the high risk of contracting an STD. It should be noted that children, below the age of consent, cannot be presumed to give consent to sexual activity.

The most effective contraceptive methods for adolescents are those that rely the least on individual adherence. Contraceptive methods most commonly used by adolescents are listed below, ordered from most to least effective, starting with long-acting reversible contraception (LARC): implants and IUDs.

Long-acting reversible contraception (LARC)
Progestogen Implants

This device consists of a small plastic rod or capsule, inserted under the skin that releases a progestogen (etonogestrel) at a controlled and slow rate. It is one of the most effective forms of contraception, with a typical use failure rate of only 0.05%.

Unacceptable, frequent or prolonged bleeding affects around a fifth of implant users at one year and is the most common reason given for premature removal. Other adverse effects are

not common, but may include emotional instability, weight gain, headache, and acne.[3] There are concerns about a possible effect on bone mineral density (BMD),[4] but data are limited.

Intrauterine Contraception

Intrauterine devices (IUDs) are small, plastic, usually T-shaped devices that often include banded copper around the stem. Intrauterine systems (IUSs) look similar but carry levonorgestrel, a synthetic progesterone, in place of copper.

They are generally effective methods of contraception (failure rates of less than 1%[5]) and can be left in place for a number of years before replacement. However, where an IUD fails, the risk of the resulting pregnancy being ectopic is very high, with some studies showing half of them being ectopic.[6]

There is a small risk of perforation of the womb during insertion. IUDs can be expelled spontaneously (in 2%-10% of women in the first year), sometimes without the woman being aware of the loss.[7] Mechanisms of action of both IUDs and IUSs may not always be to prevent fertilisation; they will sometimes have their effect by preventing implantation of the early embryo.

Unacceptable levels of pain, particularly in women who have never had children, and irregular bleeding are the main reasons given for requesting early removal.

The insertion of a foreign body into the womb carries the risk of introducing infection that can lead to pelvic inflammation and the possibility of tubal obstruction, with implications for subsequent levels of fertility.

Progestogen Injections

These injections are given every 13 weeks into a muscle or just under the skin and contain a high dose of progestogen. The active hormone is in an oil suspension that results in a gradual release of the medication over time. They act in the same way as implants and reliably suppress ovulation as long as the injections are given on time. Having periodic injections avoids having to remember daily pills but it is important not to extend the period between injections. Their failure rate is 0.2% – 6.0%.[8 9]

There could be a delay of up to one year in the return of fertility after stopping the use of injectable contraceptives but long-term fertility is not adversely affected. Some hardening or discolouration of the skin around injection sites is common, especially if given subcutaneously, but the primary user complaints are of menstrual cycle irregularities and weight gain – a mean of around 3kg in two years in one review, but considerably more when BMI[10] prior to use was over 30.[11] Other adverse effects include headache, breast pain, hair loss, and change in libido. Although rare, severe allergic reactions to such injections DMPA have been described.[12]

Combined Oral Contraceptive Pills (COCs)

For adolescents, COCs remain a popular contraception option. They are the prototype for other combined methods of birth control, including the vaginal ring and transdermal patch (discussed later), which have similar effectiveness, medical benefits, situations in which their use would be inadvisable and side-effect profiles.

Low-dose oestrogen (20mcg) combined preparations are first-line options for adolescents. What can be said with confidence is that the primary actions of COCs are to inhibit ovulation and thicken cervical mucus and that reliably taken they will prevent fertilisation in the vast majority of cycles.[13] However, it is not possible completely to rule out the possibility that they may have a post-fertilisation effect.

The failure rate for COCs is 0.3% - 9.0%, and may be higher in adolescents.[14 15 16] The wide range suggests that compliance is a key issue and this is likely to be especially so among adolescents. Strategies to promote adherence, such as mobile phone notifications, are being trialled.

Common transient adverse effects include irregular bleeding, headache, and nausea. More seriously, there is fourfold increase in risk of clots forming in blood vessels in healthy non-pregnant adolescents who use the most commonly prescribed COCs.[17] These clots can break loose and be carried in the bloodstream to plug another vessel (thromboembolism). Were this to block the circulation to part of a lung or brain, the result may represent a medical emergency. The absolute risk of this is mercifully low, but is greater in smokers and those whose body mass index exceeds 30.

Other situations in which COCs should not be used include severe and uncontrolled high blood pressure, liver disease, complicated disease of heart valves, migraines with aura or focal neurological symptoms and in diabetes associated with kidney, eye, neurological or vascular complications.

COCs are associated with an increased odds ratio of ectopic pregnancy, increasing from 0.14 to 4.16 (when compared to pregnancy controls).[18] They are also associated with an increased risk of gall-bladder disease.[19]

Recent work[20 21] has suggested that there may be an increased risk of breast cancer in women who take long-term COCs that contain higher doses of oestrogen but more research in this area is needed to quantify the risk. As the risk is cumulative, it is of particular relevance when COC usage is begun in adolescence. Ten years after discontinuing the COC, this risk is thought to have fallen back to normal levels.[22]

A recent study[23] has found a positive association between the use of oral contraceptives and suicide attempts and suicide. Adolescent women experienced the highest relative risk.

Combined Hormone Vaginal Ring

Using this device the combined hormones are delivered by a small, flexible ring, inserted (after counselling) by the user vaginally once a month. It is removed after 21 days, allowing a withdrawal bleed, and another ring inserted after seven days. It is appreciated by adolescents because of its monthly use, meaning a good daily memory is not essential.[24]

Expulsion due to coughing or straining is a small risk.[25] Users can wash and reinsert the ring and if this is done within three hours, hormone levels are unaffected. Longer than this and condom use is advised over the next seven days.

A recent study among users (not specifically adolescents) of vaginal rings found a 6.5 times increased risk of venous thrombosis compared with non-users, or 1.9 times the risk associated with COCs.[26] Failure rates are the same as for COCs.

Combined Hormone Patch

This is a small adhesive patch, applied to the skin that releases both oestrogen and a progestogen into the bloodstream. A fresh patch is applied every week, for three weeks, and then no patch is used for the fourth week during which a withdrawal bleed will usually occur.

The need to remember a daily pill is thus avoided, though a good weekly memory is essential. Where adolescent girls are using this method, official reminders are sometimes sent through text messaging or social media to improve compliance.

As with COCs, the failure rate varies between 0.3% and 9.0%. The effectiveness of ovulatory suppression can be improved by using consecutive patches for two or three months, omitting a patch-free week, and/or by shortening the patch-free interval by one to three days.[27]

The risk and side-effect profiles for the combined hormone patch and ring are the same as for COCs.

Progestogen-only Contraceptive pills (POPs)

The primary mechanism of action for progestogen-only pills appears to be thickening of the cervical mucus to prevent sperm penetration. This action depends on the ability of the mini-pill to change the acidity of the mucus, an effect that takes some hours after the dose to develop fully and that wanes again rapidly, such that it is completely effective for only a relatively short window of time each day. With the first generation of POPs, containing the hormone levonorgestrel, this meant giving an almost obsessional attention to timing.

An increased odds ratio of ectopic pregnancy has been noted in association with progestogen-only pill use,[28 29] corresponding to an absolute risk of four to 79 ectopic pregnancies per 1,000 woman-years – higher than with COCs.[30]

Newer POPs, containing the hormone desogestrel are much more effective than earlier POPs in suppressing ovulation (97% effective),[31] have a ‘missed-pill’ window of about twelve hours that compares favourably with COCs, and a significantly reduced risk of ectopic pregnancy associated with their use.

However, in the early months using desogestrel-based POPs, unacceptable irregular bleeding may occur. This will usually (though not always) improve over time.

Barrier Methods

The most accessible and widely-used form of contraception among adolescents is also one of the least effective. Failure rate with the male condom is 2% – 18%.[34] Failure is usually the result of inexperience or of damage to the condom, sometimes from associated use of oil-based lubricants that disrupt latex varieties.

With the female condom (Femidom), the failure rate is 5% – 21%,[35] and again is higher among younger, less experienced users.

The diaphragm, cap and sponge are variations on a common theme, barriers made from latex, soft rubber or polyurethane that are inserted into the vagina before sex to cover the cervix. They are pre-fitted for size and used together with a spermicidal jelly, cream or foam to increase effectiveness. Nonetheless, failure rates are high, even in experienced hands,

as the devices can be dislodged during sex. They are awkward to use and avoided by adolescents.

Potential side effects include allergy to latex, urinary tract infections, and a rare but occasionally fatal illness known as Toxic Shock Syndrome (TSS) where overwhelming infection with staphylococcal or streptococcal bacteria appears to complicate the use of the sponge. Traumatic manipulation of the sponge, use during menstruation or the puerperium, and prolonged retention of the sponge may additionally increase TSS risk.[36]

Withdrawal

In this method the male partner attempts to withdraw just before ejaculation. It has a very high failure rate (22%[37]) but is commonly used.[38] It also offers no protection against STDs.

Emergency Contraception

Emergency contraception (EC) is taken after a couple has had unprotected sex, or condom malfunction, and wish to avoid an unwanted pregnancy. It has been promoted as a kind of retro-active contraception – the 'morning-after pill'. The epithet is misleading in that it can be used as long as 120 hours after unprotected sex. Depending on the phase of the woman's cycle, EC might not act by preventing conception but by preventing implantation of the embryo in the womb.

Today, in the UK, three forms of EC are in use:

- insertion of the copper IUD
- oral progestogen-only pills
- selective progesteronereceptor blocker (Ulipristal).

When inserted into the womb following unprotected sex and within the first five days following ovulation, the copper IUD will prevent implantation but not fertilisation. If it is inserted before ovulation, it will work as it does in long-term use (see above), sometimes through a post-fertilisation effect.

The progestogen-only pills are used up to 72 hours following unprotected sex. If taken well before ovulation, they will reliably prevent pregnancy, but if given in the 48 hours prior to ovulation they may work via their abortifacient effect. Taken after ovulation, they will have no effect.

Ulipristal, taken any time before ovulation, is thought to prevent or delay ovulation effectively.[39] Taken at or after ovulation it will still reliably prevent pregnancy and must at these times be acting post-fertilisation to induce, in effect, an early abortion.

Conclusion

Our young people deserve a better vision of sex and relationships. Whilst educators and legislators wring their hands, culture and media combine to steal their innocence and idealism while commercial interests pick up the profits.

Society has divorced sex from commitment. Websites encourage sex-without strings - casual and recreational. Television, film and magazines dress it up in glamour and glitz

and teenagers are provoked to post soft porn images of themselves on social media. They desperately need to hear a better story.

Adolescent sex can never be truly 'safe' unless by 'safety' we simply imply avoiding (or terminating) pregnancy. Such thinking ignores the cost of premature sex in terms of the epidemic of STDs it has given rise to, the emotional pain and distress that result from the breakup of immature but intimate relationships and the strain on family relationships. Not to mention the agonising choice between even more costly options, to be faced when pregnancy results.

Young people are idealistic. If they catch a vision they will sacrifice in pursuit of it. It is the role of educators to envision young people, to develop and affirm their aspirations and equip them to realise them. This is a plea that, alongside accurate and unbiased information about contraception and its associated risks and side-effects, the new sex and relationships curriculum give equal emphasis to the advantages of abstinence as a viable choice - a way of 'making love last'.

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Abortion and Mental Health Outcomes: What do the Studies Say?

by Robert S. Harris

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Introduction

It has been thought that as contraceptives, including emergency contraception, became more widely available and used, abortion rates would inevitably fall.[1] While some contraception advocates still see a solution to reducing abortion rates[2] this is not supported by research in the case of emergency contraception.[3] It is perhaps no surprise then that some of the previously held optimism now appears to be in recess. Anne Furedi, Chief Executive of the British Pregnancy Advisory Service revealed the weaknesses of contraceptive use when admitting: “Our data shows women cannot control their fertility through contraception alone, even when they are using some of the most effective methods. Family planning is contraception and abortion. Abortion is birth control that women need when their regular method lets them down.”[4] (emphasis original)

The wider implications of all this now merits a fresh examination, especially in the context of sex education messages. What are the risks, if any, to the subsequent mental health of teenagers (including adult women) undergoing abortion?

The medical profession’s safety claims about abortion are meant to primarily explain away fears that the procedure may leave health complications on the body, yet possible physical risks are recognised but considered statistically low enough to evoke little concern.[5] Another inevitable aspect of what constitutes “safety” is that of risk of adverse impact on psychological health. In which ways, has the impact of this risk been observed in cohorts of women? In theory, pre-abortion counselling may be offered though the subjectivity underlying decisions as to who receives it[6] renders such service provision unfit for purpose.

While numerous studies have identified adverse mental health outcomes for women who undergo abortion, many others appear to establish the reverse, while still others show more nuanced results with a variety of caveats commonly ignored by a media more hungry for dramatic, binary headlines.

The challenge posed by assessing post-abortion risk to mental health is that there is great diversity in the scope of psychological responses to abortion.[7] Until now, official policy, while recognising post-abortion mental health risks, also appears to marginalise or diminish[8] the implications from findings linking abortion decisions to subsequent adverse mental health. Higher mental health problems among female teenagers and younger women (cited below) over that of their male counterparts, alongside elevated risks of post-abortion mental health problems for those with a prior history of poor mental health, suggests current advice based on the research findings needs an urgent review.

It appears that for some to recognise the overall risks too publicly will strengthen fears of restrictions being placed on abortion provision. This politicising of public policy holds public health implications for women. If women are not provided with comprehensive information about the risks to their future mental health, their best interests are failed.

Methodology and Research Design

The extent to which study results are scientifically rigorous is determined by a wealth of factors, including the sample size used; for how long was there follow-up with the study participants; whether the risk of research bias is accounted for; how validated and robust are the diagnostic tools used to measure psychological health; to what extent, if at all, are confounding factors accounted for, i.e. other potential factors accounting for the observed correlations but which may not in themselves be causal. Many of the studies cited below have accounted for such variables by different means. A significant and highly controversial part[9] of the research design is the comparison control group chosen, against those women whose mental health is being studied post-abortion. Control groups may constitute women who give birth, experience miscarriage, those who have not had children, including regard for whether the pregnancy was wanted or not.

Expert opinion as to whether observed associations between abortion and subsequent mental health problems are causal or correlative is divided. They range between: evidence for a small causal effect though other explanations are thought possible,[10] emerging indirect evidence for causation,[11] strong longitudinal evidence for causation,[12] while others either reject causal associations[13] or believe it is not subject to scientific testing, ethically or practically.[14]

The not untypical problem of drop-out rates attracts understated attention from researchers in terms of the impact it may be having on overall results,[15] where some women discontinue contact with the researchers at any stage during the lifespan of the research. The American Psychological Association (APA) Task Force has said: “In the case of abortion… underestimation of the prevalence of distress in the final sample would occur if women who were most upset by the abortion were more likely to be lost to a follow-up than those who were retained in the sample.”[16] Likewise, the National Collaborating Centre for Mental Health developed a systematic review for the Academy of Medical Royal Colleges, in which it said: “it is possible that those who were most distressed” by their abortion “withdrew from the study, leaving only those with good responses to be compared against a control group.[17] It would be surprising if at least some of these women who withdrew did not feel distress and regret having to revisit their abortion experience. If this hypothesis is correct, study results will be skewed and thus subsequently inflate the numbers of women who, post-abortion, report good psychological health.

The best collation and assessment of findings ought to draw on results from broadly similar cultures, where abortion[18] is legal and treated as voluntary.[19] It should be noted that while abortion is common to most liberal democracies, the widespread myth of abortion as a human right in the UK continues to be propagated.”[20]

Studies of Post-Abortion Mental Health Outcomes

In a longitudinal study[21] women who had a first-trimester abortion for an unintended pregnancy were tracked for up to two years. Seventy-two percent of women felt satisfied with their decision, 69% would have their abortion again, 80% did not feel depressed and 72% reported there being more benefit than harm. Existence of depression prior to a pregnancy

was cited as a risk factor for depression and other negative outcomes. The study showed that while most women in this cohort did not suffer adverse post-abortion psychological outcomes (including regret) some did and these tended to be women with a history of prior depression.

In another longitudinal study,[22] at an average of eight years following an abortion, women aborting their first pregnancy had a “significantly higher likelihood [at 65%] of being at risk for clinical depression than childbearing women who do not report a history of abortion.”

Elevated rates of subsequent mental health problems including anxiety, suicidal behaviours, depression and substance use disorders were found in a 25 year New Zealand longitudinal study[23] of women aged 15 - 25 who had abortions. An association between abortion and adverse mental health continued even after adjusting for confounding factors.

Twenty-two studies were examined in one review covering the period 1995-2009, the combined sample being 877,000 women of whom 163,000 experienced abortion. It was found that women who had undergone an abortion experienced an 81% increased risk in problems of mental health. Nearly 10% of the incidence of mental health problems was found to be directly attributable to abortion.”[24] This review has attracted strong criticisms.[25]

A Review[26] commissioned by the Academy of Medical Royal Colleges found that the most reliable predictor of mental health problems following an abortion was where there was a previous history of poor mental health, “a finding that emerged regardless of the…method of reporting used.”[27] This predictor of post-abortion mental health problems confirmed earlier studies by the APA Task Force, and separately, a critique of the evidence published by the Harvard Review of Psychiatry.[28] One of the conclusions of the Review was that in the case of a woman having an unwanted pregnancy, rates of adverse mental health will be “largely unaffected” whether she gives birth or has an abortion.[29]

According to the authors, the evidence suggested that women who hold negative attitudes to abortion may see a negative impact on their mental health. This is unsurprising and invites two questions: Does this imply that women should, if they want to protect their mental health, nurture positive attitudes about abortion and is this implication not evidence suggesting researcher bias?[30] In so far that abortion is viewed either positively or negatively, can researchers ever claim to be free of bias? It is suggested that while researchers rightly aspire to objectivity, risk of bias cannot be entirely eradicated, given the strength of sentiment felt by advocates on both sides of the abortion argument. “Pro-choice” advocates believe that one way in exercising autonomy is to choose whether a pregnancy should come to term. “Pro-life” advocates also exercise choice in choosing to affirm both the right to life for the developing child and the sanctity of human life. Both viewpoints are not value-free and therefore are biased.

An APA task force examined 50 studies addressing the mental health factors associated with abortion, confined to studies published between 1990 and 2007.[31] The report, not constituting official APA policy, concluded that the best scientific evidence shows that for adult women having an unplanned pregnancy, the relative risk of mental health problems is no greater if they had a single first-trimester abortion than if they carried that pregnancy to term. However, evidence for the relative mental health risks in cases of multiple abortions was found to be more “equivocal”. Drawing on international studies but limited to those published in English, the Report authors recognised its results should not be taken as globally representative of abortion and mental health because not only are they a “small set of international contexts” but “laws, customs, and contexts vary widely.”[32]

In the few cited studies examining abortion done for reasons of foetal abnormality, it was suggested that aborting a wanted pregnancy of late gestation, appeared to be associated with negative psychological reactions, comparable to experiences of miscarrying a wanted pregnancy, stillbirth or death of a newborn. The report also concluded that "it is clear that some women do experience sadness, grief and feelings of loss following termination of a pregnancy, and some experience clinically significant disorders, including depression and anxiety."[33]

Due to the large number of papers published, the Task Force authors considered it "inappropriate" to count those studies showing an effect in one particular direction. This report thus arguably falls short in one key regard: it declines to present a concluding numerical breakdown of studies pointing to specific psychological outcomes. This could have been attempted with relevant commentary to avoid risk of over-simplification.

Thirty studies published between 1995 and 2011 were reviewed in an Italian study.[34] When abortion was compared to childbirth, of 13 studies, a risk of mental disorder was present in groups of women who had an abortion; a further five studies failed to show risk in the abortion group compared to the childbirth groups. When abortion was compared to unplanned pregnancy that resulted in childbirth, four studies identified a higher risk in loss of self-esteem, including anxiety disorders, depression, suicidal thoughts and substance abuse problems, while in two studies, no difference was found.

In cases when abortion groups were compared to cases of miscarriage, the researchers found three studies in which there was a "greater risk of subsequent loss of self-esteem, substance abuse or depression, anxiety disorder, suicide ideation and – above all – substance abuse disorder after an abortion…". In three further papers, no differences were found. Of the research literature studied, the study authors concluded that "abortion is a risk factor for subsequent mental illness when compared with childbirth." Compared to miscarriage or birth of an unplanned baby, risk of post-abortion mental illness was found to be "greater or similar". The authors go on to explain that while the birth of an unplanned pregnancy is often traumatic, "abortion seems to be even more traumatic".

A Swedish study concluded that while post-traumatic stress disorder (PTSD) was rare among women who requested abortion (7%), a "relatively high proportion" of 23% suffered from post-traumatic stress symptoms (PTSS).[35] In contrast, another Swedish study[36] showed that only a fraction of those who had an abortion developed PTSD or PTSS. Of the women who developed PTSD or PTSS within six months of the abortion, the majority did so for reasons of trauma experiences said to be unconnected to the abortion.

In a study[37] looking at university students who had an abortion under the age of 25, more than 50% of students studied preferred to have follow-up psychological treatment services in order to address their post-abortion distress. The authors stated that the 50% incidence of post-abortion persistent distress was significantly higher than the 30%-40% incidence previously thought. They found that all those who had abortions, both the students who preferred post-abortion follow-up and those who did not, reported persistent symptoms of PTSD. The authors suggest this finding shows that the "abortion experience may independently contribute to distress…".

A Dutch study[38] found women who had abortions were twice as likely to report a history of drug or alcohol abuse and four to five times more likely to report a history of drug or alcohol dependence. It concluded that a lifetime prevalence of all categories of disorders was higher for women who had abortions. The authors clarify that the results did not imply that most women having abortions have mental health problems.

There was a consistent association of moderate increase in risk found between abortion and mental health disorders during late adolescence and early childhood, in a thirteen year longitudinal US study that attempted to replicate two earlier longitudinal studies.[39]

Not uncommonly, it is thought that any post-abortion mental health problems are to be expected, for example, in conservative cultures where abortion is treated unfavourably. Yet the above cited evidence from liberal societies like the Netherlands and Sweden suggests this view may be overly rash and simplistic.

Mental Health Gender Gulf and its Implications on Post-Abortion Mental Health

According to the last survey on mental health in England done every seven years, one adult in every six had a common mental disorder (CMD)[40] This finding aligns with World Health Organisation figures for European countries, based on a systematic review of data and statistics.[41] Twenty-seven percent of adults aged 18-65 were found to have experienced at least one of a number of mental disorders, with overall rates dramatically higher for women at 33.2%, compared with 21.7% for men.[42]

In the same survey on mental health in England, women aged 16-64 were estimated to be more likely than men to have CMDs, with nearly 1 in 5 reporting such symptoms, compared with 1 in 8 for men. Women aged 16-24 came out as a high-risk group for a range of CMDs such as PTSD (12.6% compared with 3.6% of men of the same age). One in four 16-24 year old women (25.7%) reported self-harm, which is more than twice that of men in the same age group (9.7%). Most notably, CMD symptoms increased markedly between 1993 and 2014.

The data clearly shows a general prevalence of mental illness in the population, with a clear gender gulf warranting an urgent need to newly assess the mental health risks posed by women of all ages considering abortion, and especially older teenagers and those in their early twenties. Given how the research shows that women with a prior history of mental illness are more risk-averse in their post-abortion mental health, such recognition must be read alongside the data on women's mental health in the general population. When this is done, there are implications which suggest the need for a review of public health messages. Put simply, can abortion continue being framed as risk-free for most women, either in sex education or pre-abortion counselling?

Discussion and Conclusions

In a subject mired in much heated politics, it is little surprise that consensus is so sharply divided. There is however a growing body of credible and compelling evidence highlighting the links between abortion and subsequent mental health problems. Whatever is to be made of the differing opinions about these links being causal or correlative, it is difficult to deny that some women do indeed suffer psychologically because of their abortion. As it stands, the overall evidence should be translated into honest public healthcare messages for women feeling unsettled by their pregnancy, designed to convey comprehensive advice about the potential risks of the post-abortion mental health impact.

On the one hand, it is clear that not all women report psychological problems post-abortion. At the same time, a large body of findings strongly presents the impact of abortion not to be risk-free, and reasonably merits the case for abortion decisions to be treated as a public

health issue in both education and pre-abortion counselling. Certainly, ongoing research is needed to review this field and if we are to address sufficiently the possibility of skewed results, where women drop-out from research samples, greater attention must be given to this methodological problem and its impact on data.

It is less controversial, if not an established consensus that women with a history of mental health problems who undergo abortion place their mental health at greater risk. Sharp differences in the mental health problems experienced by young women compared to young men should speak for themselves. If a prior history of adverse mental health renders a woman having an abortion at higher risk, this leaves the question: in sex education messages, how can abortion continue being presented risk-free for most women, on the back of relatively higher estimates of poorer female mental health?

If teenage girls at school, as well as women of all ages, are kept safe from risk of all harm, then educational and counselling messages can no longer be overshadowed by political sensitivities seeking to marginalise post-abortion mental health risks.

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6. In its official guidance designed for all relevant health practitioners, the Royal College of Obstetricians and Gynaecologists (RCOG) states conditionally: "Women should have access to objective information and, if required, counselling and decision-making support about their pregnancy options." See: *The Care of Women Requesting Induced Abortion: Summary. Evidence-based Clinical Guideline Number 7*, November 2011 (4.14). The RCOG further recommends that the provision of counselling to pregnant women should not be given to all: "Women who are certain of their decision to have an abortion should not be subjected to compulsory counselling." (6.3). This recommendation raises a number of serious questions. By what objective criteria is it judged when a woman is "certain" of her decision? This fails to count as conclusive unless she knows about the long-term potential impact of her choice. The RCOG claims spuriously that all its recommendations were "derived from available research evidence using consensus methods" (p. 4) but when a practitioner is faced with a woman who appears certain about having an abortion, this belief is a judgment call that is subjective, and less suggestive of anything "objective".
7. In the Report of the American Psychological Association Task Force (*Report of the APA Task Force on Mental Health and Abortion*, Brenda Major, et al, 2008), it was recognised that "abortion encompasses a diversity of experiences", may be done for a range of reasons, including among other factors, within different cultural contexts, and therefore women may experience "variability" in their post-abortion "psychological reactions." p.3.
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14. *Report of the APA Task Force on Mental Health and Abortion*, Brenda Major, et al, 2008, p. 87.

15. Ibid., p. 18.
16. Ibid.
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Pornography and Sexting: A Public Health Crisis

by Pippa Smith

Co-Founder, Safermedia

> “Porn is not real sex, real sex is about love not lust”
> Matt Fradd

Easy internet access to hardcore pornography, violence, social media and chat rooms is having a significant harmful impact on the physical and emotional health and development of children and young people. The messages they receive promote an unhealthy interest in early sexual experimentation,[1] violence and bullying.

Collaboration between DfE, DofH, DCMS, parents, schools, health carers, churches, charities and police is vital. There needs to be agreement and transparency on the best approach to this aspect of RSE and PSHE.

Pornography

We should do everything possible to ensure children and young people are not exposed to its harmful effects. Several states in the USA declared pornography a public health crisis in 2017.[2]

There is a belief that “we can no longer protect [young girls] from the darker side of modern tech”[3] and, “you cannot get rid of it”,[4] but we cannot allow our children to be such easy targets of an industry bent on capturing them as future consumers. Despite the value of good sex education, it will not deter children from stumbling accidentally on pornography or seeking it out. The industry has already put in place some controls (ISP level filters and age verification) but these have their limitations. Given the enormous damage being done to so many children, greater efforts to prevent access to such content should be an urgent priority for the Government’s Internet Safety Strategy; technical solutions are possible.

Sexting

“The transmission of self-image nudity via mediums such as ‘Snapchat’ on smartphones (‘sexting’) by people under 18 years old is illegal. However, the prevalence of ‘sexting’ suggests many young people view it as a normal part of growing up or no more than ‘flirting’.

Four out of five respondents claimed to have engaged in sexting, 51% of them when they were under the age of 18 years.[5] Sex education should emphasise trusting/long-term relationships and directly challenge the images associated with ‘internet porn’ that supports and possibly encourages coercive sexual bullying and forced sex (experienced by at least 7% of English female pupils from their peers at school and in the community).”[6]

In one study, it was said: “The increased disinhibition provided by online spaces allows teens to be more forward or assertive with sexually explicit content than non-digital spaces.”[7]

Teen boys often won’t go out with a girl without seeing pictures of her naked first,[8] and their idea of how girls should look and behave comes from pornography. ‘Adolescents who used pornography are “more likely ... to frequently con/manipulate others ... to engage in coerced vaginal penetration and forced sexual acts such as oral or digital penetration, [and] to express sexually aggressive remarks (obscenities).’[9]

Consensual but Unwanted Sexual Encounters

Girls may be unsure but go along with it to show affection or prevent a conflict. Boys’ tactics called ‘working a yes out’ involve repeated pressure. Girls feel they have to go along with it. Fifty-five percent of young women undergraduates in one study engaged in unwanted but consensual photographic and textual sexting.[10]

Consensual sex is a key part of current SRE teaching and online advice (even under age). But it is a grey area which can lead to exploitation. Given the fundamental flaws inherent in such a concept, as illustrated above, its promotion as a protection to cognitively immature children should be abandoned. Instead clear boundaries need to be taught.

In one study, *Sexting and porn part of everyday life for teenagers*, ‘some (young people) spoke of feeling “pressured” into sex by teachers through rushed and awkward sex education lessons promoting the message that it is “normal” to have sex before the age of consent as long as contraception is used.’[11]

Parents

In this fast moving technological age parents are left in the slow lane, often unaware of what their children are doing online. Children have a whole range of codes to signal each other what they want sexually and to hide their actions from parents. They are living in an adult free universe, where no rules apply, leaving them vulnerable to cyber bullying, sexual exploitation, grooming, rape and trafficking and occasionally murder.

Ultimately parents are the number one line of defence but urgently need to understand the problems and how to talk to their children. It is vital that children feel able to talk to their parents if they see or experience something unpleasant online.

Some excellent conversation starters and resources:

Dr Caroline Leaf, cognitive neuroscientist, has stated: ‘The emotional/chemical bonding that a relationship produces in our brains is certainly wonderful, but it can be challenging for teenagers who are casually dating, especially when it comes to sexual intimacy.’[12] Other organisations offering excellent advice to parents include *Enough Is Enough*[13] and The National Centre on Sexual Exploitation.[14]

Parents listen to the advice of the ‘experts’ rather than their own instincts because they trust the school provider, the NHS etc. Too often, standing at the school gates, parents’ conversations on this topic show surprise at what their children are being taught and some feel their children are too young to be exposed to such materials.

Consequently, the content of Relationships Education in primary schools should be approved

by parents. A poll shows the public wants parents informed of the curriculum content ahead of time and awareness of who is delivering classes for Relationships Education.[15]

It is surprising and regrettable that parents of primary aged children are being denied the right to withdraw their children given the new regime that is to be implemented.

Schools and Teachers

There are some good quality and appropriate programmes being taught already.

However, many teachers do not feel informed or that they have sufficient training or time and some feel uncomfortable.[16] Greater investment is necessary.

Teaching on these sensitive topics should encompass moral values of right and wrong, self-restraint, respect, modesty, basic legal issues and the importance of marriage and family. Individual needs should be taken into account.

Culture Reframed says children need “Critical Porn Analysis’ which teaches online protective behaviours; the impact of porn on the brain…(its) addictive nature; high rates of erectile dysfunction…”[17]

In the 2014 edition of the Sex Education Forum’s e-magazine on pornography, it includes in the Sex Education Supplement a ‘Teachers’ wishlist’ which states: *“We want teachers to know… That pornography is hugely diverse – it’s not necessarily ‘all bad’.”* (emphasis added) This advice is perverse. Children should not be deciding between good or bad porn. *All* porn is bad; it is degrading, violent, abusive and exploitative. Such discussion presupposes that all children in a class have viewed pornography and it could arouse interest where it was not before. Children should be made aware of the dangers online, the need to run from porn and how to seek help. For example, the Reward Foundation provides such support.[18]

With good training, teachers and head teachers should be able to work with parents and carers to help keep the lines of communication open and put proper boundaries in place.

Charities and Websites

Several charities and websites which advise on SRE do not talk about love or long-term relationships, and much of their advice uses permissive language. These are unsuitable for under age children. Examples include:

- *Brook Traffic Lights Tool* for teachers.[19] The resource is flawed. It states that ‘sex between 13-17 year olds should be viewed in a favourable light, provided it is consensual and ‘between children or young people of similar age or developmental ability.’ Consent is dealt with earlier in this chapter.[20]
- *BISHUK ‘Planet Porn’* (produced by BISH Training). The pack includes a game comprised of 36 cards, each bearing a different statement. Pupils take turns to decide whether the statement belongs on ‘Planet Earth’ or ‘Planet Porn’ (porn sex). It is assumed that pupils watch pornography. Pupils are told: “You can learn some helpful positions from some films.”[21]

Websites on sexual health should undergo independent scrutiny to ensure they follow the same advice given in RSE and, crucially, that they meet with parents’ approval. They should be age appropriate and have age verification.

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Relationships and Sex Education: The Way Forward

Relationships Education in Primary Education for 4-11 year olds

by Clive Ireson

Director, Association of Christian Teachers

It is the intention of government to introduce Relationships Education as a new compulsory subject into all primary schools from September 2019. There will be no right of parents to withdraw their children from this subject. They state:

> "The government is proposing the introduction of the new subject of 'relationships education' in primary school and renaming the secondary school subject 'relationships and sex education', to emphasize the central importance of healthy relationships. The focus in primary school will be on building healthy relationships and staying safe. As children get older, it is important that they start to develop their understanding of healthy adult relationships in more depth, with sex education delivered in that context." [1]

The introduction of compulsory Relationships Education to the primary curriculum at first glance seems uncontroversial. Indeed, it may be doubted that there is any primary school in the land that doesn't in their already crowded curriculum teach about relationships from an early age. So it is important that we dig deeper to see what the intention of government is.

In the 'best' primary schools, relationships education will focus around key issues, for example:

Key Stage 1: 4-7 year olds

1. *How to make and keep a friend* – at this early age children need to learn about the importance of friendship and begin to understand how to consider other peoples' needs as well as their own in this context.
2. *Strategies for dealing with sadness* – at this young age some children are sad because they are worried about things, sometimes at home, sometimes in school. It is important that they are taught who they can trust and who they can go to for support and to talk things through.
3. *Unkind behaviour and bullying* – it is important that children learn the difference between an upset as a one off, and bullying – also that they know the different strategies to use if they find themselves in either situation, and who to go to for help and support.

Key Stage 2: 7-11 year olds

1. *How to build 'quality 'into friendships* – how to be a good, reliable friend. How being a friend that lasts means that there will sometimes be disagreements, followed by a need for forgiveness.

2. *Emotional needs, my own and others* – recognising and being taught ways of keeping good mental health, both personally and how to support it in friends. Exploring worry and stress and what causes that, and which relationships I have that will help me when worried or stressed.

3. *How to manage conflict* – learn how to avoid causing, and how to diffuse, conflict.

Primary schools, increasingly in their coverage of relationships education, are tackling the issues surrounding mental health and well-being – but currently lack sufficient resources to help those children they uncover with needs.

Most primary schools are covering these areas well as part of their core curriculum, without government prescription. So the question arises, what does the government want primary schools to do that they aren't doing currently?

Relationship Education we are told will be "age appropriate" and, as already said, there will be no right for parents to withdraw their child from class. If, of course, the curriculum for Relationships Education is as outlined above, then parents would not be worried. The range of constituencies in the country includes parents who are concerned, because they believe the government is trying to introduce into the Relationships Education curriculum, at an inappropriate age, issues such as homosexuality, family diversity, and transgenderism. Children introduced at a young age to these issues are unable to assess them critically.

It is important that parents and guardians retain the fundamental freedom to bring up their children in accordance with their own beliefs and values. This parental right to choose the education that aligns with their philosophical or religious beliefs is embedded in the European Convention on Human Rights and enshrined in the Human Rights Act 1998. If the state is not to exceed its powers, the nurture of children must remain strictly secondary to that of the parents or guardians. The Government's decision to impose Relationships Education on every child in England from the age of five could undermine that freedom. It also heightens the likelihood of more children becoming home educated, which will feed into concerns that more children will be susceptible to radicalisation, thus sabotaging the reputation of home schooling.

But it isn't only parents who are worried - teachers too are very concerned about the introduction of compulsory Relationships Education. Their concerns centre around them being required to promote relationships that may be contrary to their own beliefs, what they believe is in the best interest of children, and indeed may contravene the philosophical and religious ethos of the school.

During the passage of the Marriage (Same Sex Couples) Bill, teachers were reassured they would not be required to teach anything that went against their faith. In response to a question in the House of Commons by Julian Brazier MP, asking whether teachers who espoused a Christian view of marriage would be safe from prosecution or civil action, the then Equalities Minister, Maria Miller, stated:

> "My Hon. Friend is right to raise this issue, which has been a concern for many of our constituents. I can confirm that nothing will change what children are taught. Teachers will be able to describe their belief that marriage is between a man and a woman, while acknowledging that same-sex marriage will be available. It is important to reassure people. There is a great deal of what perhaps one could call scaremongering. It is important that teachers and faith schools are aware that they will continue to enjoy the same situation as they do now."[2]

No such reassurances have been given under the proposed new legislation.

If Relationships Education does start to cover issues such as same sex relationships etc., then it *must* be classified as Relationships and Sex Education – as there is no way of explaining the different types of relationships without going into sex education. This distinction is very important, because while there is no right of withdrawal from Relationships Education, there is from Sex Education, meaning that parents would retain some control over what their children are taught.

The Government's Call for Evidence on Relationships Education and Relationships and Sex Education, that closed on February 12th, was non-controversial. It is now essential that when government brings out guidelines, as an outcome of the Call for Evidence, that time for consultation - as promised- is once again given. Only if this is done will parents and education staff feel they are joint stakeholders with a sense of ownership involved in the shaping of final guidelines.

It is clear that there are many pressure groups pushing for children to be taught issues in the Relationships Education curriculum that are not age appropriate. Following the close of the Call for Evidence, Humanists UK made the following statement:

> The Department for Education's (DfE) consultation on Relationships Education (RelEd) in primaries and RSE in secondaries closed on Monday. Whilst the consultation invited views on what content should be included in the two subjects, some religious groups – including Christian, Jewish, and Muslim organisations – used it as an opportunity to encourage supporters to respond by attacking the Government for its insistence that both RelEd and RSE be inclusive of same-sex relationships and LGBT people. Exposing the deeply homophobic, sexist, and pseudoscientific claims made by various religious organisations in their guidance for responding to the consultation, Humanists UK has urged the Government to be resilient to intolerance and defend the 'equality and dignity of all people'.
>
> Humanists UK Education Campaigns Manager Jay Harman commented: 'It is time for the Government to make a decision. Will it continue to allow state-funded schools to teach that homosexuality is a sin and to condemn, stigmatise, or just entirely ignore the existence of LGBT people? Or will it move to end the state's endorsement of such teaching and prohibit it as an anachronistic, discriminatory, and unconscionable affront to the equality and dignity of all people?[3]

There is a fear among some that the introduction of Relationships Education may lead to the promotion of same-sex relationships, and further leading to the sidelining of heterosexual relationships and lowering the status of marriage.

It is helpful that it is the DfE's intention that all faith schools should be free to teach Relationships Education and Relationships and Sex Education 'according to the tenets of their faith.'[4] It is likely though that this may well come into conflict with the DfE and Ofsted requirement for schools to have good practice in considering all types of diversity. Crucially, if all types of diversity as a principle are to remain credible and free of the charge of ideological bias, there must be a willingness to unreservedly accommodate ideas that include the traditional model of male-female marriage. If this model is excluded in RSE in deference to certain political sensitivities, then the professed diversity required to be taught becomes self-serving and is narrowly attuned to particular ideas, thus no longer being diverse. If diversity is not a broad church, then it becomes a sectarian ideology that is incompatible with freedom, democracy and authentic diversity.

Whilst we live in a country where there is freedom of speech, freedom of religion and freedom of sexuality, it is of paramount importance that we protect our children from confusion or indoctrination from the age of 4-11 years. Let Relationships Education be what it should be in Primary Schools and be centred around friendships. Let anything else be labelled correctly Relationships and Sex Education in Primary Schools, so that parents have a right to see all materials used and the right to withdraw their child from the lessons. The 'best' schools currently achieve this well, taking the parents along with them successfully. Let us learn from that and do nothing that will become divisive. Let us allow our children to remain children and retain their innocence for as long as possible, while not ignoring that we need to keep them safe too.

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Conclusion: Proposals for RSE Reform – Mandatory Health Warnings

by Lynda Rose and Robert S. Harris

Joint Convenors: Lords and Commons Family and Child Protection Group

All of us want to protect the nation's young and keep them safe, but sex education policy over the last couple of decades, far from achieving this end, has achieved the opposite and been a spectacular failure. As contributors to this report have shown, rates of STIs amongst teenagers have now reached epidemic levels, with young people having easily the highest number of new infections, including HIV and gonorrhoea, as well as what may be seen as more minor infections such as herpes and chlamydia. We also still have the highest teenage pregnancy rate in Western Europe, although most teenage girls are (intermittently) using some form of contraception, including, but not limited to, the morning after pill.

To put it bluntly, sex education policy has been a fiasco, and it isn't just that current strategies are failing to meet the challenge; they are in large part causing it. Not only that, current policy, in large part focusing on condom use as giving overall protection, entirely fails to warn young people of the wider spectrum of dangers. We are therefore proposing a completely different approach that will both acknowledge the problem and seek to combat it at source.

Relationships Education

Under the new RSE proposals, relationships education will be mandatory for all children, starting in Primary and continuing through to Secondary school. As currently framed, the emphasis would appear to be on teaching the equality of diverse relationships.

We applaud the primary importance given to relationships, but argue that the current emphasis is wrong. Any education on relationships must start with teaching children they are unique and of infinite value; that they are precious. But they need to understand that precious things can easily be damaged or broken – indeed, that the most precious things are especially vulnerable to damage. As first principle, therefore, children must be taught to guard themselves against abusers, of whatever age. They must be taught to say 'No' – because they matter.

Respect for oneself and others

It is only when a child fully understands his or her own value that they can begin to understand the equal value of others. It is here, therefore, that the idea of respect for all begins.

Bullying

There has rightly been major emphasis on bullying in recent years. Bullying of those

perceived as weak, and therefore an easy target of the ill-intentioned and vicious, has always been a problem. It is, however, arguable that the concept has now become used almost as an ideological weapon to normalise and reinforce the position of interest groups striving for recognition. For example, the widely used anti-bullying resources supplied by Stonewall place a disproportionate emphasis on homophobic bullying. This is not to deny homophobic bullying occurs, but Stonewall's resources largely ignore other causes, such as physical appearance, disability, family set-up and ethnic origins etc. There are two unfortunate results that flow this. First, some major causes of bullying falling outside the approach of these materials are being neglected, or even overlooked, by schools; and second, behaviours not intended as 'bullying' are wrongly being branded as such. For instance, children will commonly brand behaviours 'gay' without intending any kind of labelling, malice, or judgement.

Children need to be taught exactly what constitutes bullying in all its forms, how to identify it, and what to do. As a part of the general respect for others that flows from the teaching of individual worth, they need to learn that all forms of intimidatory behaviour are wrong. They need to be taught proportionate response. Most importantly, they must not be 'intimidated' into acceptance of rebranded and potentially dangerous sexual behaviours by the very teaching purportedly designed for their protection.

Personal safety

Children need to be taught how to recognise potentially risky situations and how to protect themselves, first by not putting themselves in a hazardous position, and second, how to access help, should the need arise.

Sex Education

The value of commitment

Current sex education starts from the position that children will become sexually active as soon as they 'feel ready' after the onset of puberty. Because they are taught this, this is what they tend to do. As a matter of priority, therefore, children need to be taught that sex is a powerful biological tool for bonding a couple together, with well documented effects on the brain that strengthen a couple's ability to form a strong and healthy relationship.

Children need also to understand that if an individual has multiple partners, this capacity becomes irreversibly damaged, severely impairing their future ability to form a strong and committed relationship. Children need to be taught, therefore, that avoidance of multiple sexual partners will greatly enhance their future prospects of enjoying a stable and happy family relationship.

The dangers of promiscuity - mandatory health warnings

It has been justly said that children are a lot more responsible than we give them credit for. If we are honest with them about the dangers, they will be far more likely to behave sensibly.

The message commonly given to young people is that if they choose to have sex they must be 'responsible' and take precautions, so as to avoid unwanted pregnancy and the risk of infection. The misleading message is given that to avoid problems they need only use a condom. This is inaccurate. Children must be taught both the probability rates of contracting the various sexual infections, and the difficulties in treating them. They must be taught that some infections cannot be cured, and that some are life shortening, if not life threatening. They must also be taught other associated health risks attaching to

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promiscuity or certain sexual behaviours, especially those attaching to anal and oral sex, and ranging from infertility, to prolapse, to cancer.

Sex education materials currently being given out in schools explaining different and often 'unusual' sexual practices in lurid detail (such as, for example, fisting and felching) should be prohibited. Such information is excessive as well as medically hazardous, and can only operate to encourage experimentation of such practices, which normally would almost certainly not occur, even to a precocious adolescent.

Factored into any policy must also be recognition of the scientific knowledge that brain development does not reach maturity until the mid-twenties. Given, therefore, that the long-term consequences of early sexual experimentation by adolescents cannot be easily recognised, much less understood, it is imperative that they receive guidance and protection, and not encouragement to make damaging decisions.

Online safety

It is agreed that children need to be taught how to protect themselves online, but this will be helped in part at least if young people are first taught to respect both themselves and others, and that certain behaviours, whether coercive or consensual, are unacceptable. The benefits of placing sex education within a moral frame, as suggested, would have two benefits. First, it would help desexualise the climate, and second it would help protect children from abuse by both their peers and adult predators.

Pornography

There is an acknowledged danger of children being exposed to, and accessing, pornography online. It is argued that teaching children to differentiate between 'good' and 'bad' pornography in class, far from safeguarding them, can only unacceptably normalise the concept of pornography (eg, giving the message of 'naughty but nice'), and encourage them to delve more deeply for themselves. The damaging effects of pornography are well established, and the current approach is rather like offering beer and whisky to an eight year old, so that they can see which is stronger – despite the fact underage alcohol consumption is treated as harmful by the Chief Medical Officer for England.

As a basic principle, sex education should simply condemn anything that affirms in any way the sexual exploitation of another human being, whether male, female, or a child. It should not give the message by inference that 'some' exploitation is fine.

Conclusion

Children, by definition, cannot by themselves determine the boundaries of acceptable and safe behaviour. They are reliant for such teaching on, first, their parents and, second, school. It is the moral responsibility of schools and those engaged in teaching to civilise and not sexualise those in their charge.

Contributors

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Clive Ireson trained at Culham College before a career in primary schools, including sixteen years as head of a large urban Northampton primary with pupils from a wide variety of backgrounds. He is now Director of the Association of Christian Teachers (ACT) and is also media spokesperson for ACT, often speaking on radio and putting the Christian perspective on education issues of the day. He also represents ACT in national forums and partner organisations. Clive is also a governor of a large primary school.

Louise Kirk has been UK co-ordinator for the Alive to the World values education programme since 2007. The programme gives children aspiration to marriage and productive citizenship. She wrote *Sexuality Explained: a guide for parents and children* to complement it, encouraging parents to teach their own children through the use of stories and the latest science. Her book is being translated into Spanish, Polish, Romanian and French and is designed to be promoted by schools and parishes. Louise speaks throughout the UK and abroad on topics related to the family and the reform of sex education. She sits on the Shrewsbury Diocese's Commission for Marriage & Family Life and is currently part of a team in Cardiff Diocese creating a resource for relationships and sex education.

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Lynda Rose was called to the Bar in 1987, and subsequently became one of the first women to be both deaconed and then priested in the Anglican Church. She is now CEO of Voice for Justice UK, the campaigning group founded to uphold freedom of religion and belief, and to defend the disadvantaged, marginalised, exploited, and abused. She serves as Joint Convenor of the Lords and Commons Family and Child Protection Group, and also writes, regularly contributing articles to a variety of publications. She has written a number of books, both Christian, and fiction. Her current primary interests include education and child protection, and human rights.

Pippa Smith has always been concerned about the effects of the media on children. Pippa was formerly co-founder of the charity Safermedia, and now co-chairs the Working Party on the Family, Lords & Commons Family & Child Protection Group. Their focus currently is online

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