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Overconfidence, sexual health awareness and sexual health risk among young female users of sexual health clinics

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ABSTRACT

This study explored the patterning of young people's sexual health competence, and how this relates to sexual health outcomes. A survey of 381 young people attending two sexual health clinics in Northern Ireland was carried out between 2009 and 2010. Latent profile analysis of self-rated decision making, self-rated sexual health knowledge, and knowledge of sexually transmitted disease questionnaire scores was used to determine typologies of sexual health competence.

Analysis revealed three categories of sexual health competence and explored their association with other behaviours and social characteristics. Young people's subjective opinion of their sexual health competency, when not matched with a corresponding knowledge of sexual health, could place people at an increased risk of poor sexual health outcomes. Greater levels of peer pressure to have sex and early sexual debut were associated with poorer sexual health knowledge. This finding warrants further investigation, as the importance of self-perceived competence for sexual health screening and education programmes are considerable.

1. Introduction

The World Health Organisation (WHO) defines sexual health as 'a state of physical, emotional, mental and social wellbeing in relation to sexuality; … not merely the absence of disease, dysfunction or infirmity' (World Health Organisation, 2006). Positive sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences, 'free of coercion, discrimination and violence' (World Health Organisation, 2006).

1.1. Young people and sexual health

Although adolescence is commonly regarded as a 'healthy' time, young people are faced with many risks as they negotiate adulthood and initiate sexual relationships (Bankole & Malarcher, 2010). The sexual behaviour of adolescents is complex,

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influenced as it is by a range of factors such as gender, the social and cultural environment, education, peer pressure, need for acceptance, education, family and personal values and beliefs, and the media.

Unplanned pregnancies, sexually transmitted infections, and unsatisfactory or coerced sexual relationships remain enduring problems for young people in both high income and low and middle income countries (Bearinger, Sieving, Ferguson, & Sharma, 2007; World Health Organisation, 2006; Singh & Darroch, 2000; Watts & Zimmerman, 2002 Across the world, the prevalence of STIs has been rising since the 1990s, with the largest proportion of sexually transmitted infections (STIs) being present in people younger than 25 years, with more than a fifth to greater than a half of some STIs occurring in young people (Bearinger et al., 2007).

Across high income countries, a considerable number of adolescents leaving compulsory education at around 16 years of age have experienced sexual intercourse, and engaged in risky sexual behaviour (Gabhainn, Baban, Boyce, & Godeau, 2009). Early initiation of sexual intercourse has implications for young people's self-perception, their social status and future health behaviour (ibid). Early initiation in sexual intercourse is also associated with an increased risk of STIs and pregnancy during adolescence (Bearinger et al., 2007; Kaestle, Halpern, Miller, & Ford, 2005), because those engaging in intercourse at an early age are more like to engage in risky sexual behaviours, for example, not using contraception.

1.2. UK context

The sexual health of young people in the UK has been described as amongst the worst in Europe (Perry & Thurston, 2008) and sexual health problems among this group have increased in recent years (Perry & Thurston, 2008). Young people are having their first sexual intercourse at an increasingly younger age with a mean at around 16 years of age for both males and females (Avery & Lazdane, 2010; Tripp, 2005), and despite widespread availability of contraceptives across the country, not all of them use contraceptives at first or consistently thereafter (Baxter, Blank, Guillaume, Squires, & Payne, 2011). In fact, in one study, half of young people under 16, and a third of those aged 16–19, said they used no contraception at first intercourse (Tripp, 2005), although in the second National Survey of Sexual Attitudes and Lifestyles of 16–44 year olds living in Britain, it was found that four in five 16–24 year-olds reported condom use at first intercourse (Wellings et al., 2001). Despite the fact that sexually active teenagers who do not use contraception have a 90% chance of becoming pregnant in one year, most adolescents do not seek prescription contraception until after 1 year of initiating sexual activity (Bradley-Stevenson & Mumford, 2007). Thus, it is not surprising that the UK, along with the USA, has the highest rate of teenage pregnancies among developing countries (Paton, Fernando, & Lamont, 2010), with the UK having the highest rate in Western Europe, only lower than Bulgaria, Russia and Ukraine in the whole of Europe (Tripp, 2005). The reduction of teenage pregnancy has been a target for Government policy in the UK in recent years, particularly with the introduction of strategies for Scotland, England, Wales and Northern Ireland, which incorporated a range of interventions designed to reduce teenage conception rates by half by 2010 (Formby, Hirst, Owen, Hayter, & Stapleton, 2010). Between 1998 and 2008, pregnancy rates in England have decreased by 13.3% in the under 18 s and by 11.7% in under 16 s. While rates of teenage pregnancy have fallen to 27.9 conceptions per thousand women aged 15–17 in England and Wales (Office for National Statistics, 2014), a range of factors such as coming from a socially disadvantaged background or having poor educational outcomes, place young women at increased risk of teenage pregnancy. In addition, young mothers and their infants are at increased risk of poor health and economic hardship (Harden, Brunton, Fletcher, & Oakley, 2009).

Apart from the risk of unplanned pregnancy, young people having their first intercourse before the age of 16 are at a higher risk of contracting STIs, particularly if they have unprotected sex (World Health Organisation, 2011; Bradley-Stevenson & Mumford, 2007). Concerns about these rising levels of STIs among young people made improving teenage sexual health also a national priority for the UK Government (Bradley-Stevenson & Mumford, 2007).

Psychosocial characteristics of young people are key to understanding the processes by which people place themselves at risk of harm, and identifying ways of preventing negative outcomes and reducing risky behaviour. Risky health behaviours, established during the teenage years, often persist into adulthood and can have serious consequences for long-term health (Viner & Barker, 2005). Research suggests that a number of factors predispose young people to risk taking behaviour. These include school connectedness; academic attainment; family support; self-esteem; peer and parent relationships and socioeconomic factors (Beyers, Toumbourou, Catalano, Arthur, & Hawkins, 2004; Thomas et al., 2008; Jackson, Haw, & Frank, 2010; Jackson, Geddes, Haw, & Frank, 2012).

Systematic reviews by House, Bates, Markham, and Lesesne (2010) and Gloppen, David-Ferdon, and Bates (2010) found that personal characteristics such as cognitive, emotional and social competence, and self-confidence are to some extent associated with sexual health behaviours (contraceptive use, sexual risk index) and outcomes (STI infection, pregnancy). These reviews did find that studies disagree about the protective effects of competence and confidence, suggesting that considerable heterogeneity may exist between populations, and that competence, confidence and sexual health outcomes may not be directly associated. A greater understanding of how these factors influence one another is required. Using latent variable modelling techniques, this paper examines the patterning of personal characteristics, how they relate to an objective measure of sexual health knowledge, and the association between these factors and sexual health outcomes.

The data for this study were collected as part of an evaluation of sexual health services for young people in Northern Ireland. Information on sexual health competence and knowledge was collected as part of the study. This paper reports an analysis of the relationship between self-perceived competence and sexual health knowledge (as measured against a knowledge test).