



Case Report

Assessment of Beliefs of Older, Experienced Nurses about Legitimacy of Implementing Holistic Model of Sexual Education

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Introduction

In the society and numerous publications in our country, there have recently been significant events that have intensified the long-standing controversy over whether or not to introduce so-called sexual education in schools. The course of events caused the participants of the dispute, as it turns out, to refer to the document entitled: "Sexual education standards in Europe. Basic recommendations for decision-makers and specialists in education and health" [1]. A similar document is the International Technical Guidance on Sexuality Education [2]. Discussions of such programs can also be found in many publications [3-5].

The above-mentioned documents also present a historical outline of the implementation of so-called formal sexual education in various countries of the world. This process was started in Sweden, where from 1955 this subject became obligatory in all schools. In Germany, this subject was introduced in 1968, in Austria in 1970, and in Ireland in 2003. The authors of the document write that: "In Central and Eastern Europe, the development of sexual education began with the fall of communism. Before that time, some initiatives were taken in some countries, but looking back, it would be difficult to call them "sexual education". For the most part, these were activities in the field of "preparation for marriage and family life", which contradicted the fact that young people are gradually becoming more and more interested in partnerships, and in particular that they could be sexually active before marriage. Only some states, especially the Czech Republic and Estonia, introduced sexual education in a new style, different from "preparing for life in a family". The mentioned document, which is controversial in our country, distinguishes three types of sexual education programs:

1. Programs that are primarily or exclusively focused on promoting sexual abstinence before entering into marriage, referred to as the slogan "how to say no" or "only sexual abstinence" (type 1).
2. Programs that treat sexual abstinence as optional behavior, but also present the principles of contraception and safe sex. These programs are often referred to as "general sex education" in contrast to "only sexual abstinence" programs (type 2).

3. Programs containing elements of type 2 programs, but presenting them in a broader perspective with respect to the individual and sexual growth and development, referred to as "holistic sexual education" (type 3).

The authors of the quoted standards emphasize that "... in the USA type 1 and 2 programs are almost exclusively conducted, whereas in Western European countries, type 3 programs predominate". The authors of the standards emphasize that: "a type 3 program is based on a philosophy different from that characteristic for the type 1 and 2 models. The latter programs are more focused on measurable results [6,7]. Important questions regarding the evaluation of type 1 and 2 programs include the following: "Do the programs delay the age at which the first sexual contact occurs?", "Do they reduce the number of sexual partners?" and even "Do they reduce the frequency of sexual contact?"

The authors of the standards write that: "In Europe, sex education is primarily focused on individual development, while in the US it is mainly to solve problems or prevent them. In Western Europe, the sexuality that emerges and develops during adolescence is not treated primarily as a problem and a threat, but as an important source of personal development of a person". The experience from implementing sexual education programs in individual countries has been described by many authors [8-10]. This raises an important question about the beliefs of the citizens of our country, as well as other countries of Central and Eastern Europe about the preferred model of formal sexual education, or even about whether or not to reject such a plan altogether.

Knowledge of the beliefs on this subject is particularly important in relation to groups of people who could potentially be educators in sexual education programs. In the quoted document, we find the statement that: "It is often the solution to employ specialists from outside the school so that they can present in a broadened way issues specific to sexual education. They can be doctors, nurses, midwives, youth specialists or psychologists, and therefore people, who are specially trained in the conduct of sexual education" [1]. Having access to a special group of nurses, who are in an age predisposed to having a child, we decided to conduct

an anonymous questionnaire survey study on this issue.

The aim of the study

The purpose of the planned questionnaire survey study is to determine the average, dominating beliefs among nurses doing master’s studies and nurses undertaking studies for working people - on the legitimacy of implementing formal sexual education in schools and what type of program of such education, highlighted in WHO standards, would be preferred. The study also aims to explain whether nurses know the contents of the program of the subject called “Education for life in the family” [8], as well as the differences in the contents of this program in relation to the WHO standards discussed here.

Understanding the beliefs of this professional group, predisposed to promoting the introduction of sexual education in

schools due to their medical education, their insight into social problems and personal involvement as women having children, should allow the authors to draw conclusions about the potential disposition of the whole society to implementing a “holistic sexual education”.

Methodology

The study was conducted using our own questionnaire presented in Table 1. This questionnaire was used in two slightly different groups of nursing students. The first was a group of people who have undertaken a master’s degree in nursing. The second group of students is pursuing first-cycle studies of nursing for working people. These groups were respectively 67 and 78 people. The average age in these groups of students is as follows 33 years. In the study group, nurses had an average of one child. The data were collected in an anonymous manner.

A.

		Yes	~	No
c	Do you know the main assumptions and contents of the school subject? “Upbringing for family life.”	118	8	19
d	Did you consent (or will consent in the future) to your child’s participation in the “Family Education” subject?	126	7	12
	Read carefully and fill in Table B, afterwards answer question ‘e’ below			
e	Would you agree to your child’s participation in the ‘sexual education’ subject, if you were informed that the program contains many of the elements listed in points 15 to 28, that it has the features of so-called ‘holistic sexual education’?	125	10	10

B.

	Do you agree that in the course of teaching a subject, the following elements of knowledge should be provided to your child (gradually and in a manner adapted to the child’s age): <i>(Insert an X in the columns on the right)</i>	Yes	I don’t have an opinion.	No
1	Elements of body anatomy, including genital organs	141	2	1
2	Genital physiology (puberty, menopause, promenopause, ejaculation)	141	2	2
3	Elements of the physiology of procreation (fertilization, pregnancy, pregnancy complications, miscarriage, childbirth, Caesarean section)	130	7	9
4	Sex hormones and their role (estrogens, progesterone, FSH, LH, oxytocin)	133	8	5
5	Perception of sexual sensations in the nervous system, reward centre, orgasm	93	32	25
6	Circumstances of acquiring sexually transmitted diseases, known causes of cervical cancer, HPV vaccinations	142	2	2
7	Circumstances of HIV infection and AIDS disease	141	3	1
8	Arguments about the inappropriateness of early initiation of sexual activity	134	7	4
9	Arguments about the inappropriateness of premarital sex life and inappropriateness of extramarital sexual relationships	78	31	36
10	Arguments in favour of sexual abstinence	86	35	24
11	Unwanted pregnancy - how to proceed	115	16	14

12	How to protect yourself from sexual violence (harassment) in childhood and youth	139	4	2
13	How to protect yourself from sexual harassment in your adult life	139	3	3
14	How to protect yourself from addictions to various forms of sex	129	10	6
15	The importance of accepting one's own body	140	3	2
16	Not reprimanding and not embarrassing information about masturbation	82	30	33
17	Mucous membrane function, virgin membrane, methods of body modification, circumcision rituals, piercing, tattoos	99	24	22
18	About intimate relations, physical closeness, sympathy, tenderness, love, jealousy, disappointment	130	11	4
19	The ability to express emotions, communication, empathy, setting the so-called boundaries.	137	6	2
20	Standards on privacy, open and non-evaluative attitude, relation to homosexual people	113	29	3
21	Ability to deal with love, ambivalence of feelings, disappointment, anger, jealousy, betrayal, guilt, fear, uncertainty, emotional heartbreak	130	14	1
22	Methods of contraception, including the reasons for using condoms, joint responsibility of partners for contraception, so-called family planning, motherhood, fatherhood, infertility treatment also by means of "in vitro" method	136	7	2
23	Pregnancy symptoms, pregnancy tests, existing abortion methods current legislation	132	6	7
24	Different types of sexual abuse, harassment, how to avoid it, where to look for support. How to break an unfavourable, dangerous sexual relationship.	136	5	4
25	Knowledge of contemporary cultural trends, literature and films concerning sexuality. How to respond to contemporary mass media, the beauty industry, advertising, and pornography on the Internet.	117	15	13
26	Awareness of the influence of culture, religion, society, historical development on current sexual behavior.	115	19	11
27	Defining one's own values and beliefs. The ability to deal with contradictory (different) norms, attitudes, values concerning sexuality and family relationships.	123	17	5
28	The importance of knowledge about human sexuality for the formation of goals and meaning of life, for the formation of personality, existential attitude and its influence on others.	120	18	7

Table 1: Anonymous questionnaire for research survey Sex F M; age in years; ... Type of studies Semester... a. Are you a mother/father yes/no How many children you have: b. My child/children are aged

Results

The aggregated results for all the statements contained in the questionnaire are presented in Table 1. This table presents the raw numbers of the "yes", "no" and "no firm opinion". In order to emphasise the most significant results, we repeat the raw data and results in percentage for the answers to questions: c, e, 5, 9, 16, 22, 26, which give rise to controversy (Table 2).

Question No.	Bachelor of nursing students				Master of nursing students			
	78 respondents (100%)				67 respondents (100%)			
	(Yes)		(No and no opinion)		(Yes)		(No and no opinion)	
	Number of answers	%	Number of answers	%	Number of answers	%	Number of answers	%
c	64	82	14	18	54	80	13	20
e	66	84	12	16	59	88	8	12

5	54	69	29	31	39	58	28	42
9	48	61	30	39	34	51	33	49
16	72	92	6	8	64	95	3	5
22	63	80	15	20	52	77	15	23
26	64	82	14	18	54	80	13	20

Table 2: Results for selected questions of the questionnaire.

It turns out that only about 60 percent of the examined women would be willing to agree for their children to attend classes in the subject “sexual education”, if the program contained many elements of so-called “holistic sexual education”. A significant proportion of the respondents is negative about teaching the content defined by the following statements included in the formulated questionnaire:

5. Perception of sexual sensations in the nervous system, reward center, orgasm.

9. Arguments about the inappropriateness of premarital sex life and the inappropriateness of extramarital sexual relationships.

16. Not reprimanding and not embarrassing information about masturbation.

22. Methods of contraception, including the reasons for using condoms, joint responsibility of partners for contraception, so-called family planning, motherhood, fatherhood, infertility treatment also by means of the “*in vitro*” method.

26. Awareness of the influence of culture, religion, society, historical development on current sexual behavior.

Discussion

Careful study of the program of the subject of “Upbringing for family life”, taught in many schools, leads to the conclusion that it contains many elements of the so-called “holistic sexual education model” promoted in the “WHO standards” discussed here [1,2 8]. The differences only concern issues that correspond to the content raised in questions No. 5, 9, 16, 22, 26 of the proposed questionnaire. We try through questions 1 to 5 of our questionnaire to find out if the respondents (in this case, nurses) accept that their children are familiarized with the basic elements of the anatomy and physiology of reproductive organs and the process of reproduction. The teaching content resulting from questions No. 1-4 regarding anatomy and physiology is accepted. This consent very often does not apply to the seemingly integral part of these processes, defined by the phrase: “perception of sexual sensations in the nervous system, the center of reward, orgasm”. Those people who do not accept presenting in the course of sexual education the content mentioned in question No. 5, generally do not accept either the content specified in question No.

16, namely: Not reprimanding and not embarrassing information about masturbation”. Surprisingly, these people often do not accept presenting their children the content specified in the above questions No. 22 and 26.

At the moment, it is difficult for us to convincingly explain why the majority of respondents do not accept the presentation of “arguments about the inappropriateness of premarital sex life and the inappropriateness of extramarital sexual relationships” (question No. 9). This statement is inherent in sexual education type 1. There is therefore a contradiction in points of view. One can only assume that such answers could be a manifestation of hypocrisy. This should be clarified in further studies. The obtained results make us aware of the significant difference in attitudes among the selected group of citizens of our country who were the subject of our survey. The so-called “holistic model of sexual education”, discussed in the above-mentioned “WHO standards” is derived from modern definitions of sexuality and so-called “sexual health”. This model is derived from: (1) psychologists’ knowledge of the average course of sexual development in children (the study of this subject was initiated by Sigmund Freud, distinguishing the oral, anal and phallic phases of development); (2) the thesis that sexuality is a positive value.

Perceiving sexuality as a positive value results from the belief that it is one of the most basic human anthropological features. Sexual attitudes and experiences organize or, at least, have an overwhelming influence on the biographical path of each of us. Increasing knowledge about sexuality is an important part of the education and development of every human being. Sexuality even gives an existential sense to most of us. This is confirmed in thousands of published novels, produced films and other cultural creations. However, a significant proportion of the respondents, who are students of nursing or nurses realizing their master’s studies, do not share such an understanding of human sexuality.

Perhaps one of the important differences in the manner of implementing these two discussed programs is also the postulate included in the WHO standards, expressed in the following formulation: “An important prerequisite is that teachers are ready to present their own attitude towards sexuality, as well as to social values and norms, because they will be a role model for their students.” Many authors write about the possible participation

of nurses in implementing sexual education and other activities related to the so-called reproductive health of women [11-13]. It just so happens that in our previous publications, we presented the results of our research determining the average skills, competences and predispositions of nurses to carry out such authorised sexual education [14-17]. Our own research shows that only a part of nurses have personal predispositions and manifest an attitude of readiness to express their personal views on issues related to sexuality. A quarter of the nurses openly admit that “they are unable to talk to patients about sexuality” and that “they are uncomfortable talking to other people about sexuality”.

We postulated that knowing the beliefs of this professional group, predisposed to promoting the introduction of sexual education in schools, due to their medical education, insight into social problems and personal involvement as women with children, should shed light on the potential disposition of the whole society to implementing “holistic sexual education”. Therefore, it should be assumed that this attitude towards “holistic sexual education” in the general population of our country is not greater than in the surveyed professional group. The presented detailed results regarding the proportions of answers to questions No. 5, 9, 16, 22, 26, the content of which is worth recalling at this point, explains why such a large proportion of citizens of our country is disinclined to “holistic sexual education”.

Conclusions

1. Analysis of the documents regarding the WHO standards on so-called “holistic sexual education” and the curriculum of the subject “Education for life in the family” enabled the development of a questionnaire, useful for conducting an anonymous survey about the beliefs and attitudes of representatives of a selected professional group on plans to provide this education in schools.
2. The results of such a survey conducted among older, experienced nurses, most of whom have children, show that a significant proportion of respondents (around 15%) are against the intentions to implement “holistic sexual education”.
3. Among the people who approve of implementing “holistic sexual education” in its general framework, there is a much larger proportion of people who do not approve of selected, detailed elements of such education.
4. The content of the questionnaire which was not approved by some of the respondents, explains what the psychological and world outlooks are of the disinclination towards the entire program of “holistic sexual education” or its individual elements.
5. The persons who do not approve of some fragments of “holistic sexual education” or as a whole, are disinclined

to the presentation of information on such topics as: orgasm, masturbation, family planning, infertility treatment using the “in vitro” method, or the influence of culture and religion on current sexual behavior.

6. An interesting cognitive challenge, which has not been taken up to now, would be an attempt to determine how this attitude will evolve and what factors determine the opinions towards “holistic sexual education” in the societies of Central and East European countries.

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