

Words matter!

Toni Belfield

Background

What have the Royal Society of Health – 350 years old this year – the *Journal of Family Planning and Reproductive Health Care* and the Department of Health's (DH) new campaign, 'Sex. Worth Talking About', got in common? The Royal Society was set up to assist and promote the accumulation of knowledge, promote clarity of expression, and develop scientific publishing and peer review. The DH's campaign is about promoting more open and honest discussion about sex, relationships and contraception among young people. The Journal aims to improve reproductive health and sexual health nationally and internationally through published peer-reviewed research and information. What they have in common is the desire to inform through communication and this involves language. To communicate effectively we need to use understandable words and terms that enable and inform. In 2004, I wrote about the need to improve how we communicate and talk about sexual health¹ because I believed then, and still believe today, that we do this badly and we have a responsibility to do it better.

Language

There is a wealth of information about sex and sexual health, but as embarrassment, anxiety, misinformation and myth continue to surround anything to do with sex, why do we continue to use language that is archaic, unclear and confusing? More importantly, why is there seemingly no wish to understand that as sexual health issues change and evolve, how we talk about it must change too? I am not alone in this view. Grimes and Stuart² argue for improved terminology when talking about abortion, illustrating that the subject is riddled with jargon and terminology that is contradictory, obsolete, ambiguous and misleading and, that for decades, such terminology has hindered, not helped, the ongoing debate about abortion. Six years earlier, Weitz *et al.*³ raised the need to find clear, accurate and accessible language relating to abortion and address the challenge of redefining our language to serve women better when medical abortion was introduced. Berer⁴ went further in stating the need to have some consensus about terminology in recognition of international understanding and use.

John Humphrys, writing in *Beyond Words*,⁵ is passionate about language and is scathing of its poor use and ambiguity; indeed he notes how the English language "has been mangled and manipulated by those who should know better". Humphrys goes on to say that "language is more than a tool for expressing ourselves. It acts as a mirror to our world, reflecting back to us the way we live". Place a mirror on sexual health – what would we see? Humphrys addresses sex – he notes that words and phrases that have long settled into our way of speaking still bring some people out in a rash of indignation and sex "as ever – is a

problem". He says it is absurd to say that you want "to sleep with" someone when the phrase refers to the before and after and skirts around the real issue. In sexual health consultations, how many sexual health professionals ask: "Who did you last sleep with?" "Do you and your boyfriend 'sleep together?'" when actually they are asking about sexual intercourse. Humphrys goes on to say: "Why talk about 'having' sex", when it is the 'doing' it that counts! Of course that leads to the question: What do we mean by having sex? Sex is commonly equated with penetration, thus ignoring other forms of sexual expression and other definitions – much discussed and brought out into open debate inadvertently by Bill Clinton.

Having sex means different things to different people, so when talking about sexual practices we need to be clear what we are asking about and why. This will support improved discussion and understanding and help with 'safer' sex promotion. How many avoid the word sex altogether and talk about 'making love' – new lustful sex may not include 'love'! The words 'sex, sexuality and sexual orientation' are constantly muddled, yet they are inseparable. All of us are sexual beings but we may not all be sexually active or exclusively heterosexual.

Communication

How we communicate is fundamental to understanding; what we say *and* how we say it can have a profound effect: words can open doors or close them, create worry or hope, facilitate or hinder or just confuse.¹ Language and the words we use are the best communication tool we have.

There is considerable research addressing the doctor–patient partnership; how to involve patients, how to move on from the paternalistic model of clinical practice and how to improve information giving and shared decision-making to support valid consent in general medical practice.⁶ Sandberg *et al.*⁷ illustrated that patient understanding and comprehension are key dimensions in the effectiveness of doctor–patient communication. The exchange of information that takes place between them is crucial both to the doctor understanding the patient and to the patient's comprehension of his or her health status, care and maintenance. Research is clear that a critical consequence of poor communication is patient non-adherence to medical directions.

There is limited research and evidence-guided practice specifically addressing how we communicate in sexual health consultations. However, the fact that the numbers of unintended pregnancies and high rates of sexually transmitted infections (STIs) remain high must illustrate that somewhere we are not getting it right. We have a wide range of accessible sexual health services, we have trained and dedicated health professionals – so what is missing? The question is: Is the information and the way we talk about sexual health good enough? How does the use of outdated, incorrect, euphemistic and confusing language affect sexual health decisions and outcomes? Gull⁸ addresses the difficulties in communication in obstetrics and gynaecology and notes that the sexual element may lead to feelings of embarrassment or guilt, and as such the language used needs to be considered. Expressions used can be seen as patronising, aggressive or sexist by women. Words such as 'management' and 'delivery' suggest a power balance in favour of the doctor with the woman as a

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passive recipient, and pregnant women are generally considered and treated as 'ill' rather than a well person having a baby. People attending for sexual health are called patients rather than clients, yet they are mostly well people. Grimes and Stuart² agree, showing that suboptimal terminology is widespread in obstetrics. Many traditional terms are inaccurate, insensitive or stigmatising; terms such as 'fetal wastage', 'incompetent cervix', 'blighted ovum', 'pregnancy failure'. They state the need for clearer, more accurate terminology: 'induced abortion' not 'elective' or 'therapeutic', 'abortion' not 'termination of pregnancy' (they make the point that all pregnancies terminate, but not all abort), 'late abortion' not 'late-term abortion'.

Who chooses the words we use when talking about sex and sexual health? Is there a common understanding of the terms we use? Are terms clear and descriptive? Do we 'censor' information or 'dumb down' language in the belief this makes it easier or, in the case of sex, 'nicer' for some to understand?

Language develops from the moment we learn to talk. Goldman and Goldman⁹ state that it is not always realised that children are sexual from birth, and an awareness of this is important if children are to be helped to a healthy natural view of sexuality. They discuss the four types of sexual languages that children and adults speak: clinical sexual language, sexual language of common usage, family sexual language and erotic language. Whilst overlap occurs between the four, the authors recommend that correct vocabulary should be used from the beginning with explanations of meanings. This helps improved understanding of the 'processes' (i.e. pregnancy) earlier and, importantly, correct usage can minimise the aura of taboo and 'dirty talk' associations. Goldman and Goldman state: "children need sexually honest adults. Coy, evasive or deceitful language makes children aware of taboo, avoidance and embarrassment" and "to suggest that correct words are rude is absurd and a distorted outcome of years of adult prevarication and inhibition".

Good sex and relationships education follow these principles, recognising the need to both inform and enable young people to understand sexual and reproductive health issues. Research¹⁰ looking at the language teenagers use on the website, *Teenage Health Freak* (www.teenagehealthfreak.org), when asking about sexual health, shows that young people know and use correct terminology, they do not use vague or slang terms or euphemisms about their bodies or issues to do with sex. This may reflect the fact that the site provides frank, clear and detailed information but also there is anonymity when obtaining information. In addition, there is not the reticence seen in 'face to face' consultations where embarrassment by both client and professional can sometimes occur and 'get in the way'.

Educational ability is important and Rutherford *et al.*¹¹ show that low literacy impacts on sexual health knowledge and behaviour and relates to poorer sexual health outcomes. Protheroe *et al.*¹² state there has been little research into health literacy in the UK and more is needed to improve patient participation and develop improved interventions. Quilliam¹³ talks about "emotionally induced illiteracy", whereby a person may be perfectly capable of understanding medical material in their everyday life but finds their comprehension dropping in situations where they are distressed, anxious or embarrassed. Quilliam indicates the need for those working in sexual health to take account of this fact. People have a wide range of different abilities and skills; those attending sexual health services should receive appropriately 'tailored' information

to suit individual need, this includes being sensitive, acknowledging and understanding the different terms and words people use, but should provide an opportunity to use correct vocabulary and discuss precise words and terms.

Terminology

Addressing the terms and words currently used in sexual health – how are these terms used? Who makes the decision about what terms to use? Does everybody understand them or like them?

Sexual health

Sexual health is now on everyone's agenda but do we share a common understanding of what it really means? All four UK countries have sexual health strategies, yet the term continues to be misused. Sexual health is about promoting positive sexual well-being. It embraces contraception, planning pregnancy and choices: abortion, STIs and sexual problems. Yet many people using the term 'sexual health' use it to mean STIs; health professionals talk about contraception and sexual health; community clinics are often referred to as contraception and sexual health (CASH) clinics. This continues to undermine a holistic understanding and delivery of all aspects of sexual health.

Family planning or contraception

In 2004¹ I asked the questions: Do we talk about contraception, family planning or birth control? Are the terms interchangeable? Do they mean the same thing? The last few years have shown a positive shift from the term 'family planning' to 'contraception'; most find this clearer and more understandable. Young people certainly do not equate with the term 'family planning' – after all, they are not 'planning' families. Research continues to confirm that fewer young men than young women use contraception services. Brook, in their review of boys, young men and sexual health services,¹⁴ addressed how young men become service users; what motivates them and what helps or hinders them in this process. 'Family planning clinics' are perceived as women-orientated by focusing on female contraceptive methods and conception. In addition, young men see 'family planning' as a tag for couples. The Men's Health Forum has for many years stressed the need for clinics to become more male friendly. Improving service terminology provides an opportunity to not just be clear about what is being offered but also to be more inclusive. However, Shawe and colleagues¹⁵ argue that reorganisation of community 'family planning' services to 'contraception and sexual health' (CASH) clinics may reduce proactive discussion of 'planning' with regard to pregnancy and preconception care – not so, if we truly understand, use and promote what we mean by sexual health.

Contraceptive methods

There are few studies that explore women's views or perceptions about contraception and there are many things that influence what method is chosen and how it is used.¹⁶ A vital factor contributing to good uptake and use of contraception is the information that women receive from their health providers; poor communication between providers and contraceptive clients results in incomplete knowledge.¹⁷ Research continues to confirm that women and men do not know about all contraceptive choices. While most are familiar with oral contraception – 'the pill' (a misnomer when we have so many types) and condoms – most are poorly informed about new methods and long-acting reversible contraception (LARC). Incorrect beliefs, a lack of understanding of how methods work and how

they should be taken, poor knowledge of risk and benefit, all contribute to negative attitudes about contraception.

An additional contributor to this must relate to how we discuss contraception. Professionals talk about short-acting methods, long-acting methods, fit-and-forget methods, forgettable contraception, high-dose pills, low-dose pills, mini-pills, and so on, but are these terms understandable? Long-acting methods are now widely promoted using the easy acronym, LARC, but research by Glasier *et al.*¹⁸ showed that women did not like the term 'long-acting'. Whilst 'long-acting' implies positive attributes to providers, the term had negative connotations to women, who were concerned that these methods may jeopardise their future fertility. The term 'lasting' was considered more positive, implying reliability and quality. Having listened to women, the authors state: "arguably it should become the norm in describing these methods".

Professionals and manufacturers use the terms 'fit-and-forget' or 'forgettable' contraception as a method that can be started and forgotten. However, not only is the term not understood by women, it is not true. Sterilisation, the only permanent and non-reversible contraceptive method, is forgettable; reversible methods still need to be considered and renewed within different time frames. Do we know the difference between long-acting and forgettable? Grimes¹⁹ discusses forgettable contraception and defines it as "a method that requires user attention no more often than every 3 years". The National Institute for Health and Clinical Excellence (NICE) LARC guideline²⁰ defines long-acting as "a method that requires administering less than once per cycle or month". If these terms are used interchangeably, how will this help?

When terms are decided upon, wouldn't it be helpful to ask consumers whether they mean anything or are understandable before they become fixed in stone? What about our inflexibility in changing our language? How does using outdated terminology influence use and uptake of methods? Why are intrauterine contraceptive devices (IUDs) called 'coils' and, worse still, the levonorgestrel-releasing intrauterine system (LNG-IUS) called a 'hormonal coil' or Mirena® 'coil'? Why is there such reluctance to use the term IUD? (Should we in fact call it the IUCD? Indeed, this might be more correct and will stop the ongoing confusion with intrauterine death.). Research shows that IUD use is low compared to other methods; this relates to women's doubts and worries about effectiveness, side effects such as pain, menstrual disturbance, infection, infertility and the unnaturalness of the device. The term 'coil' relates to the Safe-T-Coil®, an IUD introduced in the 1960s, some 50 years ago! Modern IUDs bear no comparison with early first-generation plastic-only IUDs, and to refer to them as 'coils' continues to misinform women about a very effective and safe method of contraception. Clinicians say "this is what women call it" – of course they do, because they will use the same terms their doctor or nurse use. Other comments include "women will not understand the term IUD" – this is just not correct, women can and do when correct explanations are given.

Acronyms are common today – CD, DVD, iPod™, hi-fi, to mention a few. Mullin and Kirkman²¹ showed that whilst women preferred familiar terms, precise terminology should be used to make informed, appropriate choices. I will provide some other examples. The 'mini pill' – what does this mean? Women do not know; they think it is a smaller version of the combined (Do those new to contraception understand the term 'combined'?) pill. Emergency contraception (EC) is still wrongly referred to and promoted as 'the morning-after pill' – this terminology compounds confusion about timing of use and negates the

use of the copper IUD, a more effective choice. With the introduction and use of ulipristal acetate up to 5 days after unprotected intercourse or contraceptive failure, the term 'morning-after pill' becomes even more misleading and inappropriate. Trussell and Guthrie²² discuss the need for improved information about EC and to "talk straight about emergency contraception" to improve uptake; this must surely include the need to talk about EC correctly, so women know what EC is and when it can be used. Poor contraceptive terminology can reflect an individual's subjectivity – the negative and outdated term 'rhythm method' tends to be used by those who do not like, discuss or promote natural family planning, thus removing a possible choice for some couples. The term 'cap' may not allow for discussion of the range of different barrier methods. Other terms such as 'safe' and 'effective' are often muddled when women want to know how good the chosen method is in preventing pregnancy.

Conclusion

How do we facilitate choice and understanding when we limit our vocabulary in sexual health? If our language is unclear, how does this support valid consent? Grimes and Stuart² are clear that medically accurate, dispassionate terminology is important and words should convey meaning and preclude possible misinterpretation. They conclude with the need for doctors and other health care providers to take the lead in using and promoting proper medical terms. My conclusion is that this is not just relevant for abortion; this is mandatory for all areas of sexual health.

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CONFERENCE REPORT

“Sexual Pleasures”: an evening seminar organised by the RSM Sexuality and Sexual Health Section, London, UK, 26 February 2010

Susan Quilliam

Background

Given that we work in a largely problem-led area, it is perhaps surprising to find a Royal Society of Medicine (RSM) seminar entitled “Sexual Pleasures”. The session (the third of its kind), which aims to bridge the divide between medicine and gynaecology, is declared suitable for professionals from both arenas; the actual delegate listing for this one also included microbiologists, therapists, midwives, endocrinologists and sexologists, as well as a smattering of medical journalists from publications as diverse as *Prima Baby Magazine* and *New Scientist*.

Female sexuality

Following a welcome and brief introduction by the seminar's organiser, Dr Kevan Wylie (Clinical Lead, Porterbrook Clinic, Sheffield, UK), it wasn't long before attendees were shocked by Professor John Studd (Consultant Gynaecologist, Chelsea and Westminster Hospital, London, UK), whose presentation on ‘Attitudes to Female Sexuality’ centred on the disturbing revelation that in the 19th century so-called ‘hysterical’ symptoms as diverse as premenstrual syndrome, female masturbation and a desire for divorce were at one time treated by ovariectomy and clitoridectomy. Drawing on sources as diverse as medical history – Isaac Baker Brown and Marie Stopes – through to literature – H G Wells and Oscar Wilde – the presentation left the whole audience gasping at the brutality of such treatments, and the female portion of the audience incredibly grateful that they were born in the 20th century.

Sex during pregnancy

Next came Rachel Foux (Psychosexual Therapist and Director of Household Companion Ltd, UK), who highlighted the issue of sexual pleasure in pregnancy. Citing the worrying statistic that 70% of client sexual dysfunction in her practice seemed to begin after pregnancy and childbirth – but that most couples then waited 5 years before seeking help – Rachel went on to explore possible therapeutic and educational solutions. In particular she highlighted – and then debunked – several common myths that pregnant couples hold and that might prevent them from continuing their sexual relationship during (a healthy)

pregnancy, such as that orgasm harms the fetus (truth: orgasm releases beneficial hormones) and that semen can induce premature labour (truth: only when the pregnancy is nearing term).

STIs in MSM

Dr Michael Waugh (Regional Sub-Dean for the Royal Society of Medicine - Northern and Yorkshire, Retired Consultant Genitourinary Physician, Leeds General Infirmary, Leeds, UK) then gave us a comprehensive introduction to the topic of sexually transmitted infections in men who have sex with men (MSM). From identifying several factors that, in today's sexualised society, make the whole issue even more worrying than before, he moved on to a definition of a ‘good clinician’ in this context. He then doubtless shocked a number of non-sexual health delegates with his coverage of the current fashion for barebacking (anal sex without a condom), and certainly turned a few non-medical stomachs with his graphically detailed slides of sexually transmitted symptoms.

Benefits of sexual intercourse

Finally, Professor Stuart Brody (Professor of Psychology, University of the West of Scotland, Paisley, UK) summarised for us his controversial research that links penile/vaginal intercourse with emotional maturity and physical health, but suggests that masturbation and mutual masturbation don't convey the same benefits. He acknowledged early in his presentation – and with a wry smile – that his views might not receive instant acceptance given current beliefs about the importance of the clitoris. Yet in fact his case was carefully argued and, when in the question and answer session following the presentations he was challenged by delegates, he seemed consistently able to defend his conclusions. Shere Hite and her fans may well have to rethink.

Concluding remarks

As promised, the seminar was well balanced, useful in content and more than competent in presentation style. All in all, an informative, entertaining and inspirational event.

Should readers need any further encouragement to attend next year's “Sexual Pleasures” seminar, let me add two more practical motivators. First, the seminar is free to RSM Fellows, Associates and Student members and costs only between £10 and £35 for non-RSM members. [NB. You don't have to be an RSM member to attend their seminars or indeed to be on their e-mail list: <http://www.rsm.ac.uk>]. Plus, the seminar carries two CPD credits. What's not to like?

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