

Sexual health and science

Sandy Goldbeck-Wood

Editor-in-Chief, *Journal of Family Planning and Reproductive Health Care*, Faculty of Sexual & Reproductive Healthcare, London, UK and Lecturer, Obstetrics and Gynaecology, University of Tromsø, Tromsø, Norway

Correspondence to

Dr Sandy Goldbeck-Wood,
Journal of Family Planning and Reproductive Health Care,
Faculty of Sexual & Reproductive Healthcare, 27 Sussex Place,
London NW1 4RG, UK;
goldbeckwood@doctors.org.uk

Received 13 November 2014

Accepted 13 November 2014

It is an interesting moment for sexual health research. Sexual and reproductive health has always been high on the worldwide public health agenda, with maternal and perinatal mortality, unwanted and teenage pregnancy, and sexually transmitted infections (STIs) enshrined as key international indicators of population health.¹ Whatever challenges face commissioners and providers,² as outlined by Chris Wilkinson, the FSRH President, in his commentary on page 5 of this issue,³ sexual health services are needed everywhere and sex has always been a subject that commands public interest and media attention. But right now there are also developments underway in academic medicine that play to the strengths of sexual health as a specialty, and represent an opportunity for the sexual health community to make a key contribution.

Medicine's 400-year-old system of medical knowledge is beginning to be challenged as a global model for understanding health and disease.^{4 5} Especially when it comes to complex problems such as multimorbidity and medically unexplained illness, the convenient historical fiction that body and mind are two distinct entities – each viewable as an 'object', with subjective experience screened out as a 'contaminant' – is serving us poorly.^{6–8}

Traditionally, we have amassed increasing volumes of fragmented data about individual body parts and individual manifestations of illness, while paying little attention to powerful, primary pathogenetic factors that relate not to individual diseases, but to individual people's lived experience. Treating a person who has herpes, hypertension, dyspareunia and depression as though she were suffering from separate and wholly unrelated phenomena, with multiple diagnostic labels and drug treatments offered by different specialties, can prove expensive, ineffective and frustrating. It is also unsupported by the best biological, psychological and epidemiological evidence.



When epidemiologists study multimorbidity closely, they find that illnesses tend to clump together, and the borderline between physical and psychological illness begins to break down.⁹ In terms of risk factors for disease, we are familiar with the idea that adversity can drive behavioural risk for acquiring diseases such as STIs.¹⁰ But the evidence is increasingly powerful that adverse experience leads to *biological* stress, measureable in terms of blood pressure, glucose tolerance, cortisol levels and inflammatory markers.^{11–13} And when epigeneticists look at the effect of environment on genetic expression, they find that despite genetic preprogramming of some diseases, it is often an accumulation of toxic experience – sometimes referred to as *allostatic overload* – that makes the difference between health and illness.¹⁴ In other words, empirical research is beginning to confirm what many clinicians feel they know intuitively: that physical illness does not exist in a vacuum, set apart from relationships; that biography shapes biology.

This message will not surprise clinicians in sexual health. Sexual health is an area of clinical practice where the false distinction between subjective experience and objective disease never fully caught on.



To cite: Goldbeck-Wood S.
J Fam Plann Reprod Health
Care 2015;**41**:3–4.

How could it? Sex is par excellence a biopsychosocial experience.¹⁵ So whether prescribing contraception or treating an infection, and no matter how busy the clinic, we cannot discuss sexual health without paying at least passing attention to relationships, feelings and experience. Because we cannot omit biopsychosocial complexity from our consultations, our whole field of work has a kind of inbuilt reality-checking mechanism in terms of what sort of knowledge is allowed to count. This inbuilt discipline develops in us particular skills and gives us a vantage point from which to see some of what is missing in traditional models of illness. This awareness is something we need to take beyond the consulting room and into the lecture room and the scientific paper. Alongside primary care physicians and others who have shown academic leadership in challenging medicine's incomplete, single disease-based, empirically-biased, model of knowledge,¹⁶ we have a continuing part to play in reshaping the research agenda.

I feel fortunate to have been appointed as Editor-in-Chief of the *Journal of Family Planning and Reproductive Health Care* (JFPRHC) at this time. My clinical background is in sexual and reproductive health, obstetrics and gynaecology, psychosexual medicine and psychotherapy. I am also an international scientific editor, writer and researcher. At any point in the last 10 years you might have found me in theatre delivering a baby, inserting a 'difficult' intra-uterine device in clinic, in a mental health trust helping a patient make sense of a 'medically unexplained' symptom, supervising research, selecting papers for publication, teaching Norwegian doctors how to get published in English, leading a psychosexual medicine training group, or struggling to edit my own writing. From this vantage point between cultures, I have become concerned with communication, connections across traditional boundaries, and the need for more rigorous and integrated thinking about complexity.

JFPRHC is firmly grounded in the strong UK sexual health tradition and the BMJ Publishing Group's commitment to excellent, patient-centred evidence. Thanks to Anne Szarewski, David Horwell and a committed team of Associate Editors and international Advisory Board members, the journal now has a burgeoning impact factor and growing scientific standing. During 2015 we will be consulting widely to shape a vision for the journal that honours JFPRHC's traditional strengths and develops its potential as an international voice in sexual health. Just how that will be achieved will emerge from formal and informal conversations with many of you, within and beyond the editorial team, and I look forward to that process. But it will remain a core value to publish rigorous, accessible material that will help sexual health clinicians in

their everyday practice, and contribute to the international debate on health. We welcome all research methodologies appropriate for studying the challenges that we and our patients face. Whether quantitative or qualitative, empirical or hermeneutic, a randomised controlled trial or an ethnographic or narrative study – if a contribution is original, rigorous, and relevant to improving sexual health, we will be delighted to consider it.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

REFERENCES

- 1 United Nations. Millennium Development Goals and Beyond. 2015. <http://www.un.org/millenniumgoals/bkgd.shtml> [accessed 12 November 2014].
- 2 Public Health England. Commissioning Sexual Health, Reproductive Health and HIV Services. <https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services> [accessed 12 November 2014].
- 3 Wilkinson C. SRH commissioning in England: moving beyond transition. *J Fam Plann Reprod Health Care* 2015;41:5–7.
- 4 Insel TR, Wang PS. Rethinking mental illness. *JAMA* 2010;303:1970–1971.
- 5 Hyman SE. Can neuroscience be integrated into the DSM-V? *Nat Rev Neurosci* 2007;8:725–732.
- 6 Parekh AK, Kronick R, Tavenner M. Optimizing health for persons with multiple chronic conditions. *JAMA* 2014;312:1199–1200.
- 7 Guthrie B, Payne K, Alderson P, *et al.* Adapting clinical guidelines to take account of multimorbidity. *BMJ* 2012;345:e6341.
- 8 Eriksen TE, Kirkengen AL, Vetlesen AJ. The medically unexplained revisited. *Med Health Care Philos* 2013;16:587–600.
- 9 Barnett K, Mercer SW, Norbury M, *et al.* Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012;380:37–43.
- 10 Hillis SD, Anda RF, Felitti VJ, *et al.* Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. *Pediatrics* 2000;106:E11.
- 11 Parker VJ, Douglas AJ. Stress in early pregnancy: maternal neuro-endocrine-immune responses and effects. *J Reprod Immunol* 2010;85:86–92.
- 12 Hyman SE. How adversity gets under the skin. *Nat Neurosci* 2009;12:241–243.
- 13 McEwen BS. Understanding the potency of stressful early life experiences on brain and body function. *Metabolism* 2008; 57(Suppl. 2):S11–S15.
- 14 McEwen BS, Getz L. Lifetime experiences, the brain and personalized medicine: an integrative perspective. *Metabolism* 2013;62(Suppl. 1):S20–S26.
- 15 Goldbeck-Wood S. Female sexual dysfunction is a real but complex problem. *BMJ* 2010;341:c5336.
- 16 Heath I. *Divided We Fail. The Harveian Oration* 2011. 2011. <https://www.rcplondon.ac.uk/sites/default/files/harveian-oration-2011-web-navigable.pdf> [accessed 12 November 2014].