Barriers to Addressing Patient Sexuality in Nursing Practice

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Sexuality assessment and counseling are part of the nurse’s professional role, but few nurses integrate this awareness into practice. Findings of this study suggest that educational programs are needed to help nurses develop confidence and comfort in dealing with patient sexuality.

Patient sexuality has been recognized as an important domain for nursing practice and a priority for research by many specialty organizations (American Nurses Association [ANA], 2004; Gordon, Sawin, & Basta, 1996; Kim & Moritz, 1982). Research has shown that many nurses believe sexuality assessment, evaluation, and counseling should be considered a part of their professional role (Cort, Attenborough, & Watson, 2001; Shuman & Bohachick, 1987; Wilson & Williams, 1988). Still, nurses have had difficulty integrating this awareness into their patient care (Cort et al., 2001; Krueger et al., 1979; Shuman & Bohachick, 1987; Webb, 1987). A number of barriers exist to incorporating consideration of patient sexuality into nursing practice, including personal, institutional, and patient-related factors (White, 2002). Personal factors, such as nurses’ attitudes about sexuality and sexual behavior, have been studied more extensively than the institutional and patient-related factors that may limit consideration of a patient’s sexual concerns.

Historically, the study of nurses’ attitudes toward sexuality has been both sporadic and sparse. Over the last 3 decades, research has proceeded along two distinct lines of inquiry. One has focused
on describing attitudes about specific sexual behaviors (for example, masturbation, homosexuality, premarital and extra-marital sex) (Fisher & Levin, 1983; Lewis & Bor, 1994; Payne, 1976; Shuman & Bohachick, 1987; Webb, 1988). This line of inquiry often culminates in the classification of nurses as liberal or conservative in their views about specific sex-related behaviors. A second line of inquiry has focused on identifying and describing the more general predispositions, such as comfort and confidence, that might influence the nurse’s openness to dealing with patient sexuality (Cort et al., 2001; Kautz, Dickey, & Stevens, 1990; Williams, Wilson, Hongladarom, & McDonell, 1986; Wilson & Williams, 1988). This line of inquiry has the potential for identifying concepts and relationships that describe and explain nurse-patient interactions in socially sensitive situations.

In 2003, advanced practice nurses (APNs) working at the Detroit Medical Center began raising questions about the quality of care related to patient sexuality. In general, the APNs believed that patients’ sexual concerns frequently were left unaddressed, but the reasons for this were not clear. Consequently, a descriptive correlational study was undertaken to identify potential barriers to incorporating considerations of patient sexuality into nursing practice. One purpose of the study was to identify and describe salient attitudes and beliefs about sexuality that might keep nurses from including attention to patient sexuality in their practice. The second purpose was to determine the extent to which environmental and demographic variables, such as type of patient cared for (medical, surgical, oncology), age, nurses’ years of professional experience, and attendance at sexuality workshops, influenced their attitudes and beliefs about addressing patient sexuality.

**Literature Review**

Sexuality has been recognized internationally as an important aspect of human health (World Health Organization, 1975), but one that nurses and other health care providers may ignore for a variety of reasons. Although many nurses agree that sexuality assessment and counseling are within the purview of their professional role (Shuman & Bohachick, 1987; Wilson & Williams, 1988), research suggests they may not inquire routinely about patient sexuality and provide little teaching or counseling in this area (Gamel, Davis, & Hengeveld, 1993; Katz, 2005; Krueger et al., 1979; Webb, 1987).

Nurses may be reluctant to engage patients in discussions about sexuality for any number of reasons, including embarrassment, a belief that sexuality is not an important concern given the patient’s immediate problem, concern about inadequate training, or a belief that doing so might increase patient anxiety (Guthrie, 1999; Haboubi, & Lincoln, 2003; Kautz et al., 1990; Merrill & Thorby, 1990; Wilson & Williams, 1988).

Some nurses believe that asking about sexuality invades the patient’s privacy, and they state they do not know appropriate nursing interventions for problems that patients may identify (MacElveen-Hoehn, 1985), or avoid addressing sexuality because trained professionals are not readily available for referral and follow-up consultation with patients (Tsai, 2004). Although patients have said that discussion of sexual concerns with nurses is appropriate (Waterhouse, 1996; Waterhouse & Metcalfe, 1991) and that they would prefer having nurses initiate the discussion about sexual concerns (Krueger et al., 1979), nurses are more apt to wait for patients to introduce the subject (Guthrie, 1999; Matocha & Waterhouse, 1993). As a result, the topic may never be included in nurse-patient interactions. Consequently, patients do not receive holistic care that focuses on all areas of functioning for human health. Moreover, the lack of communication increases the likelihood that patient concerns about sexuality, as well as sexual problems or dysfunction, might go unrecognized and therefore untreated.

Changing practice to include discussion of a patient’s sexual health concerns may be perceived as a barrier that is difficult to overcome; however, use of some relatively simple strategies can ensure that this is included in clinical care. The first, and perhaps most important strategy is to help nurses identify personal attitudes and beliefs that may keep them from incorporating consideration of patient sexuality in their nursing care (Katz, 2003). In addition, personal characteristics of nurses and their work environments need to be assessed because of their potential influence on nurses’ willingness to discuss patient sexuality (Payne, 1976; White, 2002).

**Methods**

A descriptive correlational design was used to elicit information about nurses’ attitudes and beliefs about patient sexuality, and to relate these data to factors such as age, work experience, and patient care area (medical, surgical, or oncology).

**Sample and setting**. A convenience sample of 148 nurses working in selected inpatient units and outpatient clinics of a
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A large metropolitan medical center was surveyed regarding personal attitudes and beliefs about incorporating patient sexuality assessment and counseling into nursing practice. All nurses approached agreed to participate. Mean age of nurses in this sample was 41 years (range 24 to 60 years, SD=9.98). Nursing experience ranged from less than 1 year to as much as 43 years (M=13.26 years, SD=10.75). Most survey participants (65.3%) reported receiving some type of education on human sexuality while completing their nursing programs, but few (20.8%) reported ever attending a sexuality workshop or seminar. Additional characteristics of the sample are reported in Table 1.

**Data collection procedure.** This study was approved by the institutional review board of Wayne State University. Data collection occurred predominantly on 1 day. A second day was added to accommodate the work schedule of one data collector who surveyed an outpatient clinic. Nurses were surveyed while at work. On designated days, data collectors visited individual nursing care units and outpatient clinics to recruit potential subjects, distribute questionnaires, and collect completed instruments. To minimize the possibility of coercion, nurse managers assented to having nurses participate in the study during work time but did not participate in any aspect of recruitment or data collection. Data collectors read a recruitment script to potential subjects, and they ensured that all subjects received an information sheet describing the study and their rights as research subjects. Anonymity was assured by having data collectors reinforce with subjects the importance of not writing any identifying information on the questionnaires and by having subjects return all questionnaires, whether completed or not, in sealed unmarked envelopes. Consent to participate was assumed if the participant returned a completed survey. Data collectors maintained a count of surveys distributed and returned, but no special steps were taken to ensure that participating nurses completed only one survey.

**Data analysis.** Data were analyzed using SPSS 11.0 software (2001). Both descriptive and inferential statistics were used to analyze the data. Inferential statistics included use of correlational tests, t-tests, and analysis of variance (ANOVA). Assuming a medium effect size, an ANOVA power analysis with alpha set at 0.05 and power set at 0.80 indicated that a sample size of 132 subjects would be needed to determine whether attitudes about sexuality differed for nurses working with medical, surgical, or oncology patients. Similarly, a sample size of 132 would be sufficient to detect statistically significant small correlations (r=0.25).

### Table 1. Characteristics of the Sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>135 (92.1%)</td>
</tr>
<tr>
<td>Male</td>
<td>9 (6.1%)</td>
</tr>
<tr>
<td>Not reported</td>
<td>4 (2.7%)</td>
</tr>
<tr>
<td><strong>Nursing Education</strong></td>
<td></td>
</tr>
<tr>
<td>Associate degree</td>
<td>87 (58.8%)</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>35 (23.6%)</td>
</tr>
<tr>
<td>Master's degree</td>
<td>15 (10.1%)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (5.5%)</td>
</tr>
<tr>
<td>Not reported</td>
<td>3 (2%)</td>
</tr>
<tr>
<td><strong>Shift Worked Most Often</strong></td>
<td></td>
</tr>
<tr>
<td>Days (0700-1500)</td>
<td>99 (66.9%)</td>
</tr>
<tr>
<td>Afternoons (1500-2300)</td>
<td>23 (15.5%)</td>
</tr>
<tr>
<td>Midnights (2300-0700)</td>
<td>25 (16.9%)</td>
</tr>
<tr>
<td>Not reported</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td><strong>Area Worked</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>108 (73%)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>29 (19.6%)</td>
</tr>
<tr>
<td>Both in/outpatient</td>
<td>9 (6.1%)</td>
</tr>
<tr>
<td>Not reported</td>
<td>2 (1.4%)</td>
</tr>
<tr>
<td><strong>Types of Patients Seen</strong></td>
<td></td>
</tr>
<tr>
<td>Oncology</td>
<td>59 (39.9%)</td>
</tr>
<tr>
<td>Medical</td>
<td>57 (38.5%)</td>
</tr>
<tr>
<td>Surgical</td>
<td>32 (21.6%)</td>
</tr>
</tbody>
</table>
with power of 0.80 and alpha set at 0.05.

**Instrumentation.** Nurses’ attitudes and beliefs about patient sexuality in nursing practice were assessed using the *Sexual Attitudes and Beliefs Survey* (SABS) (Reynolds & Magnan, 2005). This brief inventory was developed specifically for the purpose of assessing nurses’ attitudes and beliefs about human sexuality in relation to nursing practice. The SABS uses a 6-point Likert response format (1 = strongly disagree; 6 = strongly agree) to obtain self-reports across 12 items, some of which are reverse coded. The theoretical range of the scale is 12 to 72, with higher scores indicating more attitudinal barriers to addressing sexuality in nursing practice.

Results of a pilot study involving registered nurses suggest that the SABS provides an internally consistent measure of barriers to incorporating human sexuality assessment/counseling into nursing practice with Cronbach’s alphas of 0.75 to 0.82 and with good test-retest reliability, \( r = 0.85; \) \( p = 0.001, \) over a 7 to 10 day interval (Reynolds & Magnan, 2005). Significant correlations in the expected direction, \( r = -0.37, \) \( p < 0.05, \) between the SABS and the attitudes section of the *Sexual Knowledge and Attitudes Test* (SKAT) (Miller & Lief, 1979) support the construct validity of the SABS. Further support for the construct validity of the SABS was demonstrated by its significant correlation, \( r = 0.43; \) \( p = 0.01, \) with the *sexual myths* subscale of the SKAT attitudes scale. Finally, the nonsignificant correlation, \( r = 0.28; \) \( p = 0.10, \) between SABS scores and scores from a shortened, 10-item version of the Marlowe-Crowne Social Desirability Scale (M - C 2(10)) (Strahan & Gerbasi, 1972) suggests that SABS scores are not influenced unduly by social desirability bias (Reynolds & Magnan, 2005). Internal consistency reliability of the SABS in the current study was 0.70.

A demographic sheet was used to obtain information about levels of professional education, years worked as a nurse, and characteristics of the work environment.

**Results**

Total SABS scores ranged from 18 to 62 (\( M = 32.24, SD = 7.67 \)), with higher scores indicating more barriers to incorporating consideration of patient sexuality into nursing practice. The magnitude of the inter-item correlations in this study was small to moderate. Only three inter-item correlations were greater than 0.40. Nurses who felt more confident in their ability to address patients’ sexual concerns (Item 4) were more apt to make time to discuss sexual concerns with their patients (Item 2), \( r = 0.55, p < 0.001. \) In contrast, nurses who believed that sexuality was too private an issue to discuss with patients were more apt to believe that hospitalized patients (Item 11) were too sick to be interested in sexuality (Item 10), \( r = 0.42, p < 0.001, \) and were more likely to refer the patient to the physician (Item 8), \( r = 0.44, p < 0.001. \)

The means and standard deviations for each of the 12 SABS items are reported in reverse rank order in Table 2. As shown, the greatest barrier to incorporating consideration of patient sexuality into nursing practice came from the nurses’ perception that patients do not expect nurses to discuss sexual concerns (Item 4). Nurses’ understanding of the effect of patients’ diseases and treatments on patient sexuality ranked lowest as a potential barrier (\( M = 2.37 \)).

Further analyses were undertaken by dichotomizing item response options at the midpoint (between 3 and 4 after reverse coding) to evaluate percent agreement and disagreement with each item (see Table 2). The majority (72.3%) of the nurses believed that giving patients permission to talk about sexual concerns was a nursing responsibility (Item 9). However, 78.3% believed that patients did not expect nurses to discuss sexual concerns (Item 1), and nearly half of the nurses (44.2%) thought that sexuality should be discussed only if initiated by the patient (Item 6).

Most nurses (85.8%) indicated that they understood how diseases and treatments might affect the sexuality of patients in their care (Item 12), but only half (51.7%) of the nurses were confident in their ability to address patients’ sexual concerns (Item 4). With respect to privacy and comfort, most nurses (81.7%) did not believe that sexuality was too private an issue to discuss (Item 11); however, nearly half of the nurses (47.9%) felt uncomfortable talking about sexual issues (Item 5) and the majority (63.2%) considered themselves to be less comfortable than their colleagues when it came to discussing patients’ sexual concerns (Item 3). Nurses were nearly equally divided on their views regarding how essential discussion of sexuality was to patients’ health outcomes (Item 7), their level of discomfort discussing sexual issues (Item 5), confidence in their ability to address sexual concerns (Item 4), and whether the nurse or the patient should initiate the discussion of sexual issues (Item 6).

**The Relationship of Personal and Environmental Factors to SABS Responses**

Age and years employed as a
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nurse did not correlate significantly with total SABS scores. However, ANOVA did reveal a significant main effect for type of patient cared for (medical, surgical, or oncology) $F(2, 145)=5.59, p=0.005$. Post hoc analyses using a Least Significant Difference correction showed that the mean SABS score of nurses caring for surgical patients ($N=32, M=41.69, SD=8.29$) was significantly higher than the mean SABS scores of both medical nurses ($N=57, M=38.39, SD=7.23, p=0.046$) and oncology nurses ($N=59, M=36.23, SD=7.15, p=0.001$). An estimate of Omega square (0.06) was consistent with a medium effect size (Cohen, 1977), which suggests that the amount of variance in SABS scores among medical, surgical, or oncology nurses was meaningful and warrants further investigation.

A $t$-test was used to determine whether SABS mean scores differed for nurses attending sexuality seminars ($M=33.07, SD=7.81$) compared to nurses who had not attended sexuality seminars ($M=39.56, SD=7.11$). A non-significant Levene test ($p=0.429$) confirmed that the two samples were drawn from populations of equal variance. Analyses using the $t$-statistic showed that SABS

<table>
<thead>
<tr>
<th>Item</th>
<th>Percent Agreement</th>
<th>Percent Disagreement</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients expect nurses to ask about their sexual concerns.</td>
<td>21.6</td>
<td>78.3</td>
<td>4.19 (1.14)</td>
</tr>
<tr>
<td>2. I make time to discuss sexual concerns with my patients.</td>
<td>29.7</td>
<td>70.2</td>
<td>4.07 (1.26)</td>
</tr>
<tr>
<td>3. I am more comfortable talking about sexual issues with my patients than are most of the nurses I work with.</td>
<td>36.8</td>
<td>63.2</td>
<td>3.79 (1.28)</td>
</tr>
<tr>
<td>4. I feel confident in my ability to address patients’ sexual concerns.</td>
<td>51.7</td>
<td>48.3</td>
<td>3.42 (1.34)</td>
</tr>
<tr>
<td>5. I am uncomfortable talking about sexual issues.</td>
<td>47.9</td>
<td>52.1</td>
<td>3.38 (1.48)</td>
</tr>
<tr>
<td>6. Sexuality should be discussed only if initiated by the patient.</td>
<td>44.2</td>
<td>55.8</td>
<td>3.32 (1.48)</td>
</tr>
<tr>
<td>7. Discussing sexuality is essential to patients’ health outcomes.</td>
<td>58.1</td>
<td>41.9</td>
<td>3.12 (1.35)</td>
</tr>
<tr>
<td>8. When patients ask me a sexually related question, I advise them to discuss the matter with their physician.</td>
<td>35.8</td>
<td>64.2</td>
<td>2.96 (1.35)</td>
</tr>
<tr>
<td>9. Giving a patient permission to talk about sexual concerns is a nursing responsibility.</td>
<td>72.3</td>
<td>27.7</td>
<td>2.79 (1.35)</td>
</tr>
<tr>
<td>10. Hospitalized patients are too sick to be interested in sexuality.</td>
<td>25.8</td>
<td>74.1</td>
<td>2.62 (1.42)</td>
</tr>
<tr>
<td>11. Sexuality is too private an issue to discuss with patients.</td>
<td>18.2</td>
<td>81.7</td>
<td>2.37 (1.28)</td>
</tr>
<tr>
<td>12. I understand how my patients’ diseases and treatments might affect their sexuality.</td>
<td>85.8</td>
<td>16.2</td>
<td>2.37 (1.19)</td>
</tr>
</tbody>
</table>

Note: Scale range is 1-6; higher values indicate a higher level of disagreement.
scores were significantly lower, \(t(145) = -4.38, p<0.001\), for nurses attending sexuality seminars compared to nurses not attending sexuality seminars. However, these results should be interpreted cautiously because it is not clear whether attendance at sexuality workshops resulted in fewer barriers or whether nurses with fewer barriers were more apt to attend sexuality workshops.

An analysis of the relationship of age and years worked as a nurse to each of the 12 items on the SABS yielded five weak, but statistically significant, correlations. With respect to age, older nurses were more apt to identify sexuality as too private an issue to discuss with patients, \(r=0.17, p<0.05\). Length of time worked as a nurse was associated significantly with less discomfort talking about sexual issues, \(r = -0.17, p<0.05\); belief that hospitalized patients are too sick to be interested in sexuality, \(r=0.23, p=0.004\); tendency to direct patients to discuss sexually related questions with the doctor, \(r=0.23, p=0.005\); and belief that sexuality was too private an issue to discuss with patients, \(r=0.24, p=0.003\).

Additional analyses were conducted to determine whether mean responses on individual items differed depending upon whether nurses were caring for surgical, oncology, or medical patients. A significant main effect was observed for three items: (a) discussing sexuality is essential to patients’ outcomes, \(F(2, 145)=6.16, p=0.003\); (b) hospitalized patients are too sick to be interested in sexuality, \(F(2, 144)=6.07, p=0.003\); and (c) sexuality is too private an issue to discuss with patients, \(F(2, 145)=5.93, p=0.003\). Post hoc analyses using a Bonferroni correction showed significant differences in the following areas: (a) viewing sexuality as essential to patients’ health outcomes was more of a barrier for surgical nurses (\(M=3.81\)) than it was for oncology (\(M=2.81, p=0.002\)) or medical nurses (\(M=3.05, p=0.029\); (b) compared to oncology nurses (\(M=2.14\)), medical nurses (\(M=3.00\)) believed more strongly that hospitalized patients were too sick to be interested in sexuality (\(p=0.003\)); and (c) compared to oncology nurses (\(M=1.96\)), both medical nurses (\(M=2.53, p=0.048\)) and surgical nurses (\(M=2.84, p=0.005\)) believed more strongly that sexuality was too private an issue to discuss with patients.

**Limitations of the Study**

The small sample size and the use of a convenience sample drawn from nurses working at one metropolitan medical center located in the Midwest limit the generalizability of the findings of this study.

**Discussion**

An important and unexpected finding of this study was that the majority of nurses surveyed did not believe that patients expect nurses to ask about sexual concerns. To what extent this belief might influence nursing behavior must be determined. Waterhouse and Metcalfe (1991) speculated that nurses may be less apt to offer sexual counseling to patients if they perceive that patients do not believe that sexuality is appropriate for nurses to address. Other researchers have reported that health professionals modify their behavior based on expected patient responses. For example, Schnarch (1981) reported that the likelihood of a physician discussing sexual concerns with a patient will be influenced by the physician’s perception of the patient’s probable response. Similarly, Kautz et al. (1990) noted that adherence to the belief that “discussing sexuality causes the patient anxiety” (p. 74) was the most common barrier nurses faced when addressing patients’ sexual concerns.

Adherence to the belief that patients do not expect nurses to discuss sexual concerns may keep nurses from entering into socially sensitive conversations with their patients. In general, talking about sexuality (as well as madness, criminality, fecal incontinence, and death) is not seen as a suitable topic for public discourse (Giddens, 2001). Lawler (1991, p. 90) suggests that sexuality “lies on the margins of what is considered dangerous and potentially polluting.” By avoiding discussion of patient sexuality, nurses subconsciously could be protecting both patient and self from drifting to the edge of what is considered socially acceptable. Affect is a key factor in the formation of social relations (Crossley, 1995). Thus, if nurses believe that the nurse-patient relationship is based on trust and geared to promoting comfort and well-being, a socially acceptable interaction would avoid discussion of topics that might elicit a negative affect (such as discomfort or anxiety) in either the patient or the nurse.

An alternative explanation has to do with the apparent disparity between what nurses believe and what they do. Most nurses (72.3%) in this study believed that giving patients permission to talk about sexual concerns was a nursing responsibility, but only one-third reported actually making time to discuss sexual matters with their patients. Research suggests that most patients want and expect nurses to discuss sexuality (Waterhouse & Metcalf, 1991). Therefore, the nurses’ perceptions that patients do not want to discuss sexual issues are not grounded in fact, but may be a way of reducing the cognitive dis-
sonance that comes from how nurses perceive their professional roles compared to how they actualize their roles.

Most nurses (70.2%) in this study reported not making time to discuss sexuality with their patients. The reasons for this were not entirely clear. Other studies indicated that a lack of time and a heavy workload are reasons frequently given by nurses for not addressing patient sexuality (Guthrie, 1999; Lewis & Bor, 1994). Jarrett and Payne (1995), however, observed that even during quiet times, nurses were unlikely to engage patients in one-on-one conversations. It is not possible to tell from current data whether workload and time constraints were legitimate reasons for nurses not discussing patients’ sexual concerns. It does seem clear, however, that most nurses in the present study did not make a conscious deliberate decision to make time to discuss sexuality with their patients.

The finding that nearly half of the nurses (47.9%) in this study were uncomfortable discussing sexuality is comparable to the 50% reported by Shuman and Bohachick (1987) but greater than the 33% reported by Williams et al. (1986). The sample in the current study comprised nurses working with oncology, medical, and surgical patients. In contrast, Williams et al. (1986) sampled oncology nurses only whereas Shuman and Bohachick (1987) sampled cardiac nurses only. Because the current authors found no difference in the mean discomfort levels reported by nurses working with oncology, medical, and surgical patients, they are somewhat reluctant to attribute differences in the percentage of nurses reporting discomfort across studies to work area alone. Instead, it seems more plausible that the 33% reported by Williams et al. (1986) might have been inordinately low due to a testing effect because all nurses in that study were attending a 2-week cancer nursing workshop in which some of the content addressed patient sexuality.

The majority of nurses (74.1%) in this study did not believe patients were too sick to be concerned about sexuality, but less than half of the nurses surveyed believed that discussing sexuality was essential to patient health outcomes. Comparing nurses across service areas showed that surgical nurses were less likely than oncology nurse to consider sexuality essential to patients’ health outcomes. These findings are comparable to those reported by others. Guthrie (1999), for example, found that sexuality was not considered a priority by nurses working in an acute surgical setting. Similarly, Kautz et al. (1990) found that nurses working in the intensive care unit (ICU) or the operating room (OR) rated concerns about patient sexuality as less of a problem than nurses working in other areas of the hospital. These claims could be dismissed as a means of avoiding the issue, but they may be valid. The immediacy of physical and physiological problems confronting surgical, ICU, and OR patients often takes precedence over the patient’s psychosocial concerns. A study by von Essen and Sjoden (1991) found that intraoperative patients want their nurses to be competent technically and were more concerned with physical than psychological care. Consequently, when nurses focus on the physical and physiological problems of their surgical and ICU patients, they are apt to perceive that their actions are more congruent with patient expectations of their role.

Implications for Practice

Educational programs are needed to help nurses develop both comfort and confidence in dealing with patient sexuality. To influence comfort, feelings and emotions about patient sexual health concerns should be explored in a safe, supportive environment. Role-playing with a clinical nurse specialist, social worker specializing in sexuality, or a sex therapist may be helpful. Because confidence develops with mastery and mastery develops with practice, nurses should be encouraged to make time to practice discussing sexuality with their patients. Waterhouse and Metcalf (1991) recommend initiating sexuality communication by asking patients how their illness has affected the way they see themselves as male or female. The question could then be followed by asking patients if they have any concerns about how their disease or treatment will influence their sexuality.

In the current study, nurses working with medical, surgical, and oncology patients differed in the number and types of barriers that keep them from addressing patient sexuality. Further research is needed to identify specific factors, such as length of stay, patient acuity, nature of the patient illness, potential of illness-related sexual dysfunction, that might account for these differences.

Conclusion

This study described attitudes and beliefs that might act as barriers to incorporating patient sexuality assessment and counseling into nursing practice. What nurses believe patients expect from them, time availability, personal comfort, and confidence in the ability to address issues related to human sexuality were important barriers to incorporating sexuality assessment and counseling into nursing practice.
The use of a small, Midwestern convenience sample limits the generalizability of findings from this study. Replication using a larger, more geographically diverse sample should be undertaken to ensure the representativeness of findings.

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care and inspire us to new joy in nursing. Take a look at your facility’s quality improvement efforts with these goals in mind, and you’ll be on the road to transformational change that will empower your practice.

References

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