Broaching sexual health issues with patients

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Most people associate the term "sexual health" with sexually transmitted infections, pregnancy and contraception. While these form part of sexual healthcare, sexual health itself is much broader than that – indeed, sexual health applies to each and every one of us, young and old, sexually active or not, healthy or not.

Good sexual health is an important part of identity and feelings of general well-being. The Department of Health (2001) gives the following definition: "Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings, together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease."

The World Health Organization (2011) recognised that sexual health also has social aspects and consequences, and gave the following definition:

"Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."

These definitions show that sexual health is not only concerned with physical aspects but also psychological, emotional, spiritual and social elements.

We also need to consider the issue of sexuality, which is closely linked to overall sexual health and general well-being. Most theorists argue that while sexuality is directly related to cultural, religious and social aspects of individuality, ultimately...
BOX 1. POINTS TO CONSIDER ON BELIEFS ABOUT SEXUALITY

- Do you find it difficult to talk about sex? If so, think about why?
- Consider how you express your own sexuality?
- Do you assume your patients are heterosexual?
- Do you make assumptions about the sexual behaviour of your patients? For example, do you think that because they have a long-term illness they are not interested in expressing their sexuality or in having sexual contact with their partner?
- Do you currently consider your patients’ sexuality and/or sexual health needs; if so, how?

it is natural and instinctive (Nelson, 2005). From the clothes people wear to the friends they have and the way they behave, these are all influenced by sexuality; it is inextricably linked to our identity and is the most personal and private part of our lives. Therefore anything affecting sexual health could, in turn, impact not only on physical health but also on personal identity at an emotional and psychological level.

Barriers to talking about sexual health

It is not surprising that nurses and other health professionals are often reluctant to discuss sexuality and sexual health with patients. Reasons include:

- Embarrassment;
- Lack of knowledge;
- Fear of causing offence;
- Conservative views;
- Not knowing how to broach the subject;
- Lack of time;
- The topic not being seen as a priority (Quinn and Browne, 2009; Brown et al, 2008).

Woodhouse and Baldwin (2008) said that “taboos, assumptions and anxiety can all act as barriers”, which means nurses avoid tackling sexual health. Patients may also be reluctant to broach the subject with health professionals and may be waiting for them to bring it up (Quinn and Browne, 2009).

The Nursing and Midwifery Council’s (2008) code of conduct stated that practitioners must treat all people as individuals, not discriminate, and must act as an advocate for people receiving care. Indeed, addressing sexual health and sexuality is part of providing holistic care for patients, even though sometimes it might feel difficult and awkward.

Consequences of poor sexual health

Consequences of poor sexual health are far reaching with possible physical, emotional, psychological and social effects. For example, chlamydia is the most common STI in the UK; if undiagnosed and untreated it can lead to pelvic infection and scarring of the fallopian tubes in women, which could, in turn, lead to subfertility or ectopic pregnancy (National Chlamydia Screening Programme, 2011). In men it can lead to urethral discharge, proctitis and reactive arthritis (Richens, 2004). Worryingly, up to 75% of women and 50% of men do not know they have the infection as they have no symptoms (NCSP, 2011).

Unplanned pregnancy may lead to women either having a termination or having a baby when they may not be emotionally, financially or practically ready to do so. This may lead to poorer overall general health for them and their child.

The number of people living with HIV in the UK continues to rise. It is estimated that as many as a quarter of them are unaware they have the virus (DH, 2010).

Sexual dysfunction may lead to relationship problems, and emotional conflict over sexuality and identity can lead to feelings of isolation, and emotional stress and distress. These are just some examples of the effects of poor sexual health; the list could go on.

It has been well established that there is a clear link between poor sexual health and social deprivation and that some groups are more at risk of poor sexual health than others. The DH (2010) identified young people, some ethnic groups as well as transgendered and transsexual people as more likely to experience sexual health inequalities. However, it also pointed out that little research is available about people with a disability (physical or learning, or both) and, therefore, little is known about their specific sexual health needs.

A relatively small but increasing number of older people are also being diagnosed with STIs; information on prevention in this group is important. The DH (2010) also highlighted that sexual orientation has an impact on sexual health, with figures showing that men who have sex with men have relatively high rates of HIV, while women who have sex with women have sexual health needs that are not currently being met.

Ultimately, many sexual health problems are a matter of public health, and nurses and midwives have a duty to improve public health whenever they have the opportunity to do so.

Sexual health in practice

Sexual health is a matter of concern for all health professionals and is part of a holistic approach to care throughout life. Nurses can use some simple strategies to help them overcome their own possible discomfort and anxieties, while also helping patients to talk about this part of their lives. First, practitioners need to take some time to consider their own beliefs, choices and assumptions about sex, sexuality and sexual health (Box 1).

Nurses should be mindful that society and many structures within it usually assume heterosexuality (Burrows, 2011). In other words, we tend to assume patients are heterosexual unless they tell us otherwise. As such, the language we use also assumes this, for example “your wife” or “your husband”. This could make it difficult for someone to say they have a same-sex partner so nurses should use more neutral language such as “your partner”. It is worth remembering that estimates of the number of people living in the UK who are lesbian, gay or bisexual varies between 0.3% and 10% (Burrows, 2011).

Practitioners may also assume that older people no longer have sexual health needs or that they are not concerned with expressing their sexuality. However, NICE (2004) argued that sexuality and the ability to express it remain important, regardless of age.

Broaching the topic

Many health professionals deal with sexual health and sexuality on a daily basis, for example those who work in genito-urinary clinics or community contraception clinics. Many practice nurses and school nurses also deal with sexual health matters regularly. However, for those nurses who are less comfortable initiating a discussion about sexual health with patients it may be helpful to consider the Extended PLISSIT (Ex-PLISSIT) model of intervention.

The PLISSIT model was developed by Annon in 1976 and further developed to the Ex-PLISSIT model by Davis and Taylor (2006). This model has different levels of intervention (Box 2). In the Ex-PLISSIT model, the permission-giving stage is asked for at every stage of the process rather than just at the start; this is what led to the term, Ex-PLISSIT.
**BOX 2. THE DIFFERENT LEVELS OF INTERVENTION IN THE EX-PLISSIT MODEL**

**Permission giving**
This is the first step and is aimed at opening up discussion about sexual health and assessing patients’ needs. Here nurses may want to ask whether patients are in a relationship or if they have any concerns about the sexual side of their relationship; they need to make it clear to patients that they are willing to talk about this area.

Practitioners need to be explicit about what they are talking about (sex and sexual health) rather than just asking vague questions like “Do you have any further questions?”

This is called explicit permission giving and runs throughout this entire intervention model. Permission is given at all stages.

**Limited information**
This is where nurses can give some general information, for example about the effect of an illness (or medication) on sexual function. This gives them an opportunity to correct any inaccurate information patients may have. Practitioners could also back up what they tell patients by offering them written information, for example booklets or leaflets.

**Specific suggestions**
Here the aim is to start solving specific problems patients may have. It requires taking a detailed history from the patient and identifying specific problems. Practitioners may need to refer to another health professional if they feel they do not have enough knowledge or skills to help patients at this level.

**Intensive therapy**
This is the final stage of the intervention. Intensive therapy requires advanced knowledge and skills on the part of the health professional involved. It is important that nurses know exactly which services are available for patient referral – for example psychosexual counselling – so that appropriate help can be given.

Source: Davis and Taylor (2006)

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Chlamydia is the most common sexually transmitted infection in the UK.

**Conclusion**
Nurses should always consider patients’ sexual health as part of a holistic approach to care. It is an extremely important area in all our lives; the consequences of poor sexual health are costly, not only to the individual but also to the health service. Sexual health is also a rewarding area of healthcare, where sometimes the most basic information can make a huge difference to someone’s life.

Practitioners deal with sensitive and private issues, and people often feel at their most vulnerable, so it is important to understand that many patients will welcome the opportunity to discuss concerns about their sexual health – being given permission to discuss this area will often be enough to alleviate any worries they may have. It is important that nurses and midwives offer patients this opportunity and are willing to listen and approach this area with a non-judgmental and open-minded attitude, regardless of their own personal beliefs and assumptions. NT

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**References**
National Chlamydia Screening Programme (2011) The National Chlamydia Screening Programme Media Information Pack. tinyurl.com/screening-media