Nurses' Attitudes and Beliefs towards Discussing Sexuality with Patients

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ABSTRACT

Tampereen ammattikorkeakoulu
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Sexuality is a fundamental part of being human. A person's sexuality or sexual health can be temporarily or permanently altered by illness or treatment. Nurses are well suited to deal with patients' needs regarding sexuality, because nurses are in constant contact with patients and because of the intimate nature of care that nurses provide. Research suggests that nurses acknowledge their responsibility and understand the importance of counselling their patients in sexuality but find it difficult to make it part of their daily work.

The purpose of this Bachelor's thesis was to research and compile knowledge on nurses' attitudes and beliefs towards discussing sexuality with patients and identify factors affecting those attitudes and beliefs. The objective is to help nurses and nursing students in gaining understanding of their own attitudes and beliefs towards discussing sexuality with patients. Nine articles on the topic were collected, analysed and reviewed using the literature review method.

The results show that nurses are neither comfortable nor confident in their ability to discuss sexuality with patients. Nurses assume to know what patients want and need in terms of sexuality. Additionally, despite thinking that discussions of sexuality are relevant to patient care, nurses do not actually take time to discuss sexuality with patients. Among other factors, age, training and experience contribute to the ease and confidence in bringing up the topic of sexuality with patients.

Contemporary nurse education does not prepare nurses to deal with patients' sexuality. It does not challenge the beliefs and values about sexuality that nurses have gained from life experiences, which are not grounded in objective evidence and reflect common prejudices and generalisations. Sexual history taking and sexual counselling should be included in nurse education programmes so that nurses learn to acknowledge sexuality as a clinical issue and help them feel confident in their ability to do so. Further research needs to be made into the factors affecting the inclusion of sexuality in nurse education.

Key words: nurse, patient, communication, sexuality, attitudes and beliefs.

TIIVISTELMÄ

Tampereen ammattikorkeakoulu
Tampere University of Applied Sciences
Degree Programme in Nursing
Option of Medical Surgical Nursing

EGHOLM, AUREL:
Sairaanhoitajien seksuaalisuuteen liittyvien asenteiden ja uskomusten ilmeneminen potilaskeskusteluissa

Opinnäytetyö 36 sivua, joista liitteitä 9 sivua
Huhtikuu 2015

Seksuaalisuus on oleellinen osa terveyttä. Joskus kuitenkin sairaus tai sairauteen liittyvä hoito voi vaikuttaa siihen heikentävästi. Seksuaalisuuden ongelmien käsittelyssä sairaanhoitajat voivat läsnäolonsa ja luottamuksellisen potilassuhteensa kautta luontevasti tukea potilaan seksuaaliterveyttä. Kuitenkin toisinaan hoitohenkilökunta kokee aiheen arkaluontoiseksi ja haasteelliseksi lähestyä.

Opinnäytetyön tarkoituksena oli tutkia ja koota tietoa sairaanhoitajien asenteista ja uskomuksista liittyen seksuaalisuuteen potilaskeskusteluissa. Tutkimuksessa pyrittiin myös selvittämään asenteisiin ja uskomuksiin vaikuttavia tekijöitä. Selvityksen tavoitteena on tarjota hoitotyön ammattilaisille ja opiskelijoille näkökulmia omien valmiuksien arviointiin. Keskeiseksi materiaaliksi valikoitui yhdeksän tutkimusta, joiden sisältöjä vertailtiin kirjallisuuskatsauksen keinoin.

Tutkimustulokset osoittavat sairaanhoitajien kokevan epämukavuutta ja epävarmuutta seksuaalisuutta käsittelevissä potilaskeskusteluissa. Vaikka keskusteluja pidetään hoitotyölle välttämättöminä ja seksuaalisuutta tärkeänä osana hyvinvointia, seksuaalisuuden käsittely potilaskeskusteluissa oli tutkitun aineiston valossa harvinaista. Keskusteluja rajoittaviksi tekijöiksi mainittiin muun muassa hoitajien ennakkoluulot ja oletukset potilaan tarpeista ja kiinnostuksesta. Iällä, koulutuksella ja kokemuksilla ilmeni olevan vaikutuksia aiheen käsittelyn helppouteen ja luontevuuteen.

Hoitotyön koulutus ei vaikuta tukevan sairaanhoitajien valmiuksia käydä keskusteluja seksuaalisuudesta eikä riittävällä tavalla haastavan sairaanhoitajien henkilökohtaisia näkemyksiä seksuaalisuudesta. Paremmalla perehdytyksellä voitaisiin parantaa hoitajien itseluottamusta ja aloitteellisuutta seksuaalisuutta käsittelevissä potilaskeskusteluissa. Lisätutkimusta kaivataan selvittämään, miten seksuaalisuus voitaisiin paremmin huomioida hoitotyön koulutuksessa.

Avainsanoja: sairaanhoitaja, potilas, seksuaalisuus, kommunikaatio, asenteet ja uskomukset.

CONTENTS

ABBREVIATIONS AND TERMS

CASP	Critical Appraisal Skills Programme
TAMK	Tampere University of Applied Sciences

1 INTRODUCTION

Sexuality is a fundamental part of being human (WHO 2006, 5). The many definitions of sexuality, with their slight variations, speak of the importance to the biological, psychosocial and cultural wellbeing of humans (Rush et al. 1995, 298; Saunamäki et al. 2010, 1308).

Sexuality is an essential part of being human and therefore it must be incorporated into nursing for the sake of the patient and nurse as people (Webb 1985, 147, a). This refers to the holism of nursing, which views patients "as individuals with subjective and unique experiences" (Saunamäki et al. 2010, 1309). These unique and subjective experiences of the patient, including sexuality, must be incorporated into nursing to make it holistic. Nurses are responsible for nursing practice and have a duty to inform and give advice about nursing care and treatments including sexuality (Saunamäki et al. 2010, 1309).

It is important to remember that people are sexual beings at every age and every stage of life. As life goes on, people have experiences that have implications for their sexuality. Illness and medical treatment can affect these experiences negatively. Therefore it can be said that out of healthcare providers nurses are well suited to deal with patients' needs regarding sexuality (Sung & Lin. 2012, 498).

According to Saunamäki et al. (2010, 1309), nurses acknowledge their responsibility to discuss sexuality with patients but in practice do not approach patients concerning the topic. This phenomenon is also confirmed by Magnan et al. (2006, 448), who state that nurses understand the importance of counselling their patients in sexuality but find it difficult to make it part of their daily work. This Bachelor's thesis concentrates on researching and compiling knowledge on nurses' attitudes and beliefs towards discussing sexuality with patients and identifying factors affecting those attitudes and beliefs.

The subject of sexuality needs to be given more attention in nursing education as well as nursing practice because currently it is inadequately covered (Rush et al. 1995, 298; Billington 2012, 1109; Sung & Lin 2012, 498). Therefore it is evident that more

information on the subject is needed. This has motivated me to take up the subject in this Bachelor's thesis.

2 THEORETICAL STARTING POINTS

The following section provides background information that is necessary to understand the topic in the context of this Bachelor's thesis.

2.1 Defining sexuality

Sexuality is more than genital sex, but for most people intercourse, genital touching or other forms of physical pleasure are important or have been important at some point in life and in relationships. For some, sexuality can be a way to derive physical pleasure and nothing more, and for others it can be part of a complex relationship of physical, psychological, spiritual, and emotional aspirations and responses (Nay et al. 2007, 77.)

The World Health Organization (2006) defines sexuality as "a central aspect of being human throughout life and encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction". The experience and expression of sexuality is different for everyone. Some people might not express or experience sexuality at all. Sexuality can be influenced by biologic, psychological, spiritual, social, and cultural factors (WHO 2006, 5).

When dealing with a patient, sexuality can include issues stemming from the patients relationship with their partner. Issues such as the couple's sexual history, the partners' ability to function sexually, communication issues, and relationship stresses must be taken into consideration (Southard & Keller 2008, 213.)

2.2 Sexuality and illness

A person's sexuality or sexual health can be temporarily or permanently altered by illness or treatment. For example the body image and self-esteem can adversely be affected by trauma, illness or treatment (Southard & Keller 2008, 214). Communication is important for a functioning sexuality. When a patient has an illness and a sexual relationship may not be possible for some time, it can have negative consequences to the relationship with their partner. Nurses can help prepare patients for the things that

might have an effect on their sexuality relating to having an illness and receiving treatment for an illness. In this way, the patients and their partner will be well informed and able to prepare themselves for what is to come (Rasmusson & Elmerstig 2013, 362.)

2.3 Addressing sexuality in nursing practice

Sexuality is an issue in nursing practice because of the intimate nature of care that nurses give patients and the effect that an illness can have on a patient including their sexuality (Higgins et al. 2006, 345). The constant contact and the close relationship that nurses have with patients provide an opportunity to discuss sexuality and sexual health (Southard & Keller 2008, 213).

The challenge for nurses is to create an environment and atmosphere that tells patients that sexuality is a subject that they can openly talk about. For this to happen, nurses need to accept for themselves that sexuality is an important aspect of care and realise that patients want and need them to initiate conversations about sexuality and sexual health (Higgins et al. 2006, 346.)

2.4 The nurse–patient relationship

Crucial to any interaction between a nurse and a patient is the nurse–patient relationship. The nurse–patient relationship is considered a therapeutic relationship as well as a professional one. Its progressive aim is to enhance the patient's physical, psychological and spiritual well-being. Communication between the nurse and the patient is the foundation on which the relationship is built. Imperative to open communication is trust: a nurse–patient relationship needs to be based on trust. Confidentiality makes the relationship safe allowing the patient to comfortably disclose personal information and ask questions (Webb 2011, 20-24, b; NMC 2013.)

It is essential that the nurse treats every patient as an individual with respect, a non-judging attitude and genuine concern. The nurse should take into consideration the patient's needs, feelings and thoughts in understanding his/her situation. There are

inherent inequalities in the nurse–patient relationship. Often the patient is vulnerable, dependent and unable to choose the professional caring for him/herself. Boundaries are an important part of the relationship because they protect both the nurse and the patient by imposing legal, ethical and professional standards. These standards ensure that the focus of the relationship remains on the patient's needs and keeps the relationship professional (Webb 2011, 25, 26, b; NMC 2013.)

2.5 Values

What each individual thinks about sexuality and how he/she relates to it, in what he/she does about it, and who he/she is in relation to it, is socially, culturally an ideologically shaped. In other words everything we think about or do in relation to sexuality is shaped by societal norms or values. The values of society do not stop at the bedroom door and chances are they do not stop at the hospital door either (Price 2009, 32.) Guthrie (1999, 313) supports this statement in saying that the views of society can be clearly seen in the way nursing has dealt with sexuality.

Simply, values are beliefs. Groups or individuals can give something value by believing that it is important. Individual attitudes are products of personal values (Altun 2002, 270.) Geckil (2012, 195) refers to behaviour and decision making as being significantly affected by values. When someone has a strong set of values it helps them in decision-making processes. Nurses should be aware of the values that affect their emotions, attitudes and behaviours. Behaviours and attitudes change as a result of changing values. Self-awareness can be a useful tool in understanding what values motivate us, and as a result it can help us understand others and what motivates them (Altun 2002, 271.)

Values and beliefs are an important part of nurses' professional identity in that those values and beliefs guide the thoughts and actions of nurses and interactions with patients. Personal values are gained through culture, experiences, education, and interpersonal relationships. It is important for nurses to know what nursing values are in order for them to internalise those values and uphold them in practice (Geckil 2012, 195, 196.)

3 PURPOSE AND GOAL

The purpose of this Bachelor's thesis has been to conduct a literature review about nurses' attitudes and beliefs towards discussing sexuality with patients by collecting, analysing and reviewing the literature about nurses' attitudes and beliefs towards discussing sexuality with patients. The research focuses on answering the research questions.

Research questions:

1. What attitudes and beliefs do nurses have towards discussing sexuality with patients?
2. What factors affect nurses' attitudes and beliefs towards discussing sexuality with patients?

The goal of this Bachelor's thesis has been to conduct a literature review that will be beneficial in informing nursing practice. Ultimately it hopes to help nurses and nursing students in gaining understanding of their own attitudes and beliefs towards discussing sexuality with patients. This thesis adds to the body of nursing knowledge.

4 METHODOLOGY

For this Bachelor's thesis, the literature review method is used. It follows the "flow of task in a literature review" presented by Polit and Beck (2012, 96), which charts the appropriate steps to take when conducting a literature review. The literature review method provides the researcher with tools to find out if something is lacking in current knowledge on a particular topic, whether conflicting information lies within a body of knowledge on a particular topic, and it will help the researcher draw conclusions about findings related to a particular topic (Polit & Beck 2012, 95).

In order to begin the literature review process, Polit and Beck (2012, 98) recommend formulating a search strategy. There are several approaches to searching for research evidence. My approach included performing a literature search using keywords in a bibliographic database. I chose to use Cumulative Index to Nursing and Allied Health Literature database (CINAHL). The literature search was performed under Boolean/Phrase search mode using "nurse", "sexuality" and "patient" as keywords. Limiting the search to full text, English only, peer-reviewed research articles refined the literature search. The literature search rendered 43 results.

Articles that dealt with paediatric nurses were excluded in order to focus the research. It is recommended to use primary sources for a literature review (Polit & Beck 2012, 95). Therefore, secondary sources such as literature reviews were excluded. Articles were not excluded based on their age. Excluding articles cannot be done solely on the basis of age, but the context in which the article has been made has to be examined. If the article studies modern themes, such as new methods or technology, then the age of the article carries weight. If the article however discusses behaviour, concepts or theories, usually this means that the significance of the article is not diminished by its age (Morse 2012, 137.)

Ten articles were chosen for review after considering the inclusion and exclusion criteria, their relevance to my research topic, and their ability to answer my research questions. These studies are presented in table 1 in a methodological matrix adapted from Polit and Beck (2012, 109) showing how the study in each article has been made.

TABLE 1. Studies included in the literature review

Author/s	Publishing Year	Country	Main Variables	Design	Sample Size	Method
Huang et al.	2013	China	Nurses' attitudes and practices	Descriptive	150 cancer nurses from 6 hospitals	Questionnaire Survey
Quinn et al.	2011	Australia	Nurses' practices	Exploratory	14 mental health nurses	Interview
Zeng et al.	2011	China	Nurses' attitudes and practice	Descriptive	202 gynecology nurses	Questionnaire
Saunamäki et al.	2010	Sweden	Nurses' attitudes and beliefs	Descriptive	100 medical/surgical nurses	Questionnaire
Julien et al.	2010	America	Nurses' attitudes and beliefs	Descriptive	576 acute care, ambulatory, perioperative nurses	Questionnaire Survey
Higgins et al.	2008	Ireland	Nurses' response	Descriptive	27 mental health nurses	Interview (Grounded Theory)
Magnan et al.	2006	America	Nurses' attitudes and beliefs	Descriptive	148 surgical, medical, oncology nurses	Survey
Ho & Fernández	2006	Spain	Professionals' opinions	Descriptive	38 nephrology, cardiology nurses and 12 medical staff	Questionnaire
Guthrie	1999	Great Britain	Nurses' perceptions	Descriptive	10 surgical nurses	Interviews (Grounded Theory)
Lewis & Bor	1994	Great Britain	Nurses' knowledge and attitudes	Descriptive	357 registered general nurses	Questionnaire

Excluded after critical appraisal

In making a literature review, Polit and Beck (2012, 111) recommend evaluating the studies chosen for a literature review. The objective is not to evaluate every study comprehensively but to assess the quality of every study so as to obtain a larger picture of the quality of that body of material (Polit & Beck 2012, 118). I have evaluated the quality of the studies included in the literature review using a critical appraisal tool adapted and modified from Critical Appraisal Skills Programme (2013). This simplified critical appraisal of the above ten studies can be seen in appendix 1. After the critical appraisal, the study made by Ho and Fernandez (2006) was excluded from the literature review, because it did not have an appropriate sample size, it did not describe the recruitment strategy, and ethical considerations were completely lacking. Additionally, the findings were not presented reliably or appropriately according to the study method. Nine articles remained for review.

In a literature review, the focus is on identifying important themes or performing a thematic analysis. A thematic analysis involves finding patterns or inconsistencies within the data or information from the retrieved studies (Polit & Beck 2012, 119). The focus of my research is on identifying themes related to my research questions and finding patterns or inconsistencies within the data under review.

5 RESULTS

This section contains a review of the nine articles outlined in Table 1 of section 4. It includes four categories that emerged to provide answers to the research questions outlined in section 3. A summary of the results can be seen in appendix 2 presented as results matrices.

5.1 The importance of discussing sexuality with patients

The majority of articles in the literature review would suggest that nurses have a positive attitude towards the inclusion of sexuality into nursing practice and believe it is important to discuss sexuality with patients (Lewis & Bor 1994, 255, 256; Guthrie 1999, 315; Magnan et al. 2006, 451; Julien et al. 2010, 189; Saunamäki et al. 2010, 1311; Zeng et al. 2011, 284; Quinn et al. 2011, 24; Huang et al. 2013, 149). However, some of the studies report participants having conservative attitudes and showing a disregard for patients' sexuality (Higgins et al. 2008, 311, 312; Zeng et al. 2011, 248; Huang et al. 2013, 149).

The results show that the majority of nurses acknowledge their responsibility to allow patients to talk about their sexual concerns (Lewis & Bor 1994, 255, 256; Guthrie 1999, 315; Magnan et al. 2006, 451; Julien et al. 2010, 189; Saunamäki et al. 2010, 1311; Quinn et al. 2011, 24; Zeng et al. 2011, 284). There is a consensus among the studies and an understanding among the majority of participants that patients' sexuality is important, can be affected by illness and treatment, and therefore is a focus for nursing care requiring attention (Guthrie 1999, 315; Magnan et al. 2006, 451; Julien et al. 2010, 189; Saunamäki et al. 2010, 1311; Quinn et al. 2011, 24).

Slightly under half of the participants in the Chinese study by Huang et al. (2013, 149) believe that nurses have to deal with patients' sexual issues. In the Chinese study by Zeng et al. (2011, 284), about half of the participants agree that discussing sexuality is important for patient health outcomes, although a large majority of participants view sexuality as too private. The results of the Chinese study by Zeng et al. (2011, 288) would suggest that Chinese nurses have more barriers in discussing sexuality than

Swedish or American nurses and attribute it to 3,000 years of sexual repression that has led to a culture of conservativeness in China.

In the Irish study on mental health nurses' responses to issues of sexuality by Higgins et al. (2008, 312), the participants desexualise patients and do not fully acknowledge their sexual rights. The participants report lacking positive and effective role models. This is said to contribute to participants reproducing established ways of interacting with patients related to sexuality (Higgins et al. 2008, 311, 312.)

In Julien et al.'s (2010, 255) study, the participants with more knowledge about sexuality are more likely to have positive attitudes towards discussing sexuality with patients. There is a correlation between religion and knowledge. The participants claiming to be religious have lower knowledge scores. Zeng et al. (2011, 283) report knowledge as being a facilitating factor of nursing practice related to sexuality.

Higgins et al. (2008, 310, 311) explain that the beliefs and values that participants gained from previous life experience in regards to sexuality stayed with them and were not challenged even in their professional education. Quinn et al. (2011, 26) argue that attitudes about patients' sexuality are dominated by personal rather than professional values. Nurses who have the ability to include sexuality in their practice do so because of their own awareness of their beliefs, values and comfort in talking about sexuality (Quinn et al. 2011, 26).

5.2 Levels of comfort and confidence in discussing sexuality

The studies suggest that the majority of nurses do not feel comfortable when discussing sexuality with patients nor do they feel confident in their ability to do so. In seven of the nine studies, the majority of nurses either feel uncomfortable when discussing sexuality related issues with patients, insecure in their ability to discuss sexuality with patients or both (Lewis & Bor 1994, 255; Guthrie 1999, 315-320; Higgins et al. 2008, 311; Julien et al. 2010, 189; Quinn et al. 2011, 28; Zeng et al. 2011, 284; Huang et al. 2013, 149). However, in the study by Magnan et al. (2006, 451), about half of the participants report feeling confident in their ability to discuss sexuality related issues with patients and not feeling uncomfortable when discussing sexuality related issues with patients.

Saunamäki et al. (2010, 1311) report similar results with slightly higher confidence levels and with even less participants feeling uncomfortable 60% and 64% respectively.

Magnan et al. (2008, 450) report that participants who are more confident in their ability to address patients' sexual concerns are also more likely to take time to discuss sexuality with patients. Julien et al. (2010, 188) show that participants more confident in discussing sexuality are more likely to understand how disease and treatment affect patients' sexuality and are more likely to discuss sexuality with patients. Saunamäki et al. (2010, 1312) report a positive correlation between the level of confidence and attitudes towards patients' sexuality, meaning participants who feel more confident in their ability to discuss sexuality with patients have more positive attitudes towards patients' sexuality. There is a correlation between work experience and the level of confidence meaning that participants with more work experience or older nurses are more likely to be confident in their ability to discuss sexuality with patients. Furthermore, participants with additional education in sexuality are more likely to discuss sexuality with patients than participants with no additional education (Saunamäki et al. 2010, 1312.)

According to Quinn et al. (2011, 24), age, training and experience contribute to the ease and confidence in bringing up the topic of sexuality with patients. Huang et al. (2013, 150) show that participants with more than ten years of experience and more than thirty years of age have less barriers to discussing issues of sexuality with patients than younger participants with less experience. They suggest that the work and life experience that older nurses have can explain why they might feel more comfortable talking about sex with patients. Julien et al. (2010, 189) report similar findings where participants less than forty years old with less than ten years of experience have more barriers to discussing sexuality with patients than older nurses with more experience.

5.3 Initiating discussions about sexuality

There are common assumptions among the majority of participants that patients do not expect nurses to ask about their sexual issues, or that patients are too sick to be interested in sexual issues, or that if a sexual problem existed patients would talk to nurses about it. Nearly half of the participants believe sexual issues should be discussed

only if initiated by the patient (Guthrie 1999, 315; Magnan et al. 2006, 451; Higgins et al. 2008, 311; Julien et al. 2010, 189; Saunamäki et al. 2010, 1311; Quinn et al. 2011, 24, 25; Zeng et al. 2011, 283, 286; Huang et al. 2013, 149). For this reason, the participants do not initiate discussion, but rather wait for patients to initiate discussion about sexuality with them. When patients initiate discussion about sexuality, about one third of the participants in the studies by Saunamäki et al. (2010, 1311) and Magnan et al. (2006, 451), compared to the majority of the participants in the studies by Quinn et al. (2011, 24, 25), Zeng et al. (2011, 283, 286), Julien et al. (2010, 189), and Higgins et al. (2008, 311), referred patients to another clinician such as the physician or psychiatrist to answer their sexuality related questions. Julien et al. (2010, 188) point out that the participants who believe sexuality is too private are more likely to also believe that sexuality should be discussed only if initiated by the patient and are more likely to refer patients to the physician.

According to Quinn et al. (2011, 24), the participants who initiate the topic of sexuality do not always initiate it during assessment, but wait till the nurse–patient relationship reaches a point of trust to start discussing issues of sexuality with patients. The participants in the study by Zeng et al. (2011, 283) identify that a good nurse–patient relationship is a facilitating factor of nursing practice related to sexuality.

Magnan et al. (2006, 452) suggest that if the aim of the nurse–patient relationships is to promote trust and comfort, then participants are avoiding topics that might not be socially acceptable and have a negative effect on the nurse–patient relationship. They go further by suggesting that participants are acting subconsciously when avoiding discussion about sexuality with patients. Higgins et al. (2008, 313) suggest that participants use subconscious strategies to avoid discussions on sexual issues to protect themselves from embarrassment and fears. These subconscious strategies or beliefs that guide actions include participants assuming that patients would become upset if participants were to discuss sexuality with them or participants assuming that if a patient had a sexual problem they would ask a nurse about it or believing there is a lack of resources, such as time (Higgins et al. 2008, 313).

5.4 Taking time to discuss sexuality with patients

Despite thinking that discussions of sexuality are relevant to patient care, nurses do not actually take time to discuss sexuality with patients. The results show that the majority of participants do not take time to discuss sexuality with patients (Lewis & Bor 1994, 255; Guthrie 1999, 315; Magnan et al. 2006, 451; Higgins et al. 2008, 313; Julien et al. 2010, 189; Saunamäki et al. 2010, 1311; Quinn et al. 2011, 24, 25; Zeng et al. 2011, 283, 283; Huang et al. 2013, 149). The studies that report participants taking time to discuss sexuality with patients report about one third of nurses doing so (Lewis & Bor 1994, 255; Saunamäki et al. 2010, 1311; Quinn et al. 2011, 24, 25; Zeng et al. 2011, 283, 283; Huang et al. 2013, 149). According to Julien et al. (2010, 256), male nurses are more likely to discuss sexuality with their patients than female nurses.

To explain why they do not take time to discuss sexuality with patients, participants mention heavy workloads, staff shortages, and a lack of resources such as time or a private area for discussions (Guthrie 1999, 317; Higgins et al. 2008, 313; Quinn et al. 2011, 24; Zeng et al. 2011, 284). Participants also draw attention to the fact that discussing sexuality with patients is not a priority for the healthcare establishment (Guthrie 1999, 317; Quinn et al. 2011, 24). According to Zeng et al. (2011, 283), participants identify the availability of a private area as a facilitating factor of nursing practice related to sexuality.

According to Magnan et al. (2006, 452), this disparity between what nurses believe and what nurses do in practice can be explained by a cognitive dissonance or a situation involving conflicting attitudes, beliefs or behaviours that come from how nurses perceive their roles compared to how they actualise their roles. Quinn et al. (2011, 26) suggest heavy workloads and lack of privacy may also be used as justification for avoiding sexual conversation. Even when ward areas are quiet and nurses have time to discuss sexuality with their patients they do not (Guthrie 1999, 317; Magnan et al. 2006, 452).

6 DISCUSSION

Discussing sexuality can be difficult for nurses due to their personal belief system surrounding sexuality, sexual education, comfort with one's sexual identity, and sexual practices. The results show that nurses are likely to refer patients to another clinician such as the physician or psychiatrist. Quinn et al. (2011, 25) name a study in which 70% of patients experiencing sexual dysfunction had never been asked about their sexual functioning during a psychiatric consultation with their psychiatrist, despite the fact that they would have welcomed the opportunity to discuss sexuality. Saunamäki et al. 2010, 1313) describe a study in which patients would have discussed issues of sexuality if the physician had addressed the topic.

Nurses tend to have assumptions about what patients expect. They believe patients do not expect nurses to ask about their sexual issues, or they believe patients are too sick to be interested in sexual issues, or that if a sexual problem existed, patients would talk to nurses about it (Guthrie 1999, 315; Magnan et al. 2006, 451; Higgins et al. 2008, 311; Julien et al. 2010, 189; Saunamäki et al. 2010, 1311; Quinn et al. 2011, 24, 25; Zeng et al. 2011, 283, 286; Huang et al. 2013, 149). There is a disparity between what nurses assume patients expect and what patients actually expect. Zeng et al. (2011, 288) report a study in which 79% of cancer patients said that sexual activity is an important part of their lives. Southard and Keller (2008, 214) say that most patients feel receiving information on potential changes in sexual activity because of their disease is important. It is suggested that patients want and expect nurses to discuss sexuality with them (Southerd & Keller 2008, 216). In a study conducted in 1991, people in general believed nurses should discuss sexual concerns with patients (Saunamäki et al. 2010, 1313). According to Guthrie (1999, 315), in a study of healthy people, 92% of respondents thought that nurses should discuss sexual matters with patients.

If discussing sexuality is difficult for nurses, then discussing sexuality is difficult for patients as well. If society influences the way sexuality is viewed, then it is fair to assume that nurses and patients within the same society are influenced similarly in terms of sexuality (Guthrie 1999, 313). In light of the results, it is understandable that few patients are desperate enough to have the comfort and confidence to raise the topic of sexuality with nurses (Higgins et al. 2006, 346).

Patients want their nurses to be technically competent and are more concerned with physical than psychological care. Although there may be patients for whom sexuality may not be an urgent issue there may equally be patients for whom it may be very much an issue, and therefore the opportunity for discussion needs to be available to all patients (Guthrie 1999, 317.)

There are implications to not providing patients with information in regards to how their disease and treatment may affect their sexuality. Patients may feel that what they are going through is not a commonly occurring problem, leading to patients feeling worried and alone with their problem. This may make it even harder for patients to bring up the subject with nurses. The responsibility to provide patients with information and guidance related to sexuality lies with the healthcare provider responsible for their care (Rasmusson & Elmerstig 2013, 362.)

According to Magnan et al. (2006, 452), health professionals modify their behaviour based on expected patient responses. If nurses were to know that patients want and expect them to ask about their sexual concerns and knew that patients would not feel uncomfortable if they were to do so, then perhaps nurses would be more willing to approach patients concerning the topic.

6.1 Recommendations

Contemporary nurse education does not prepare nurses to deal with patients' sexuality. It does not challenge the beliefs and values about sexuality that nurses have gained from life experiences, which are not grounded in objective evidence and reflect common prejudices and generalisations. Sexual history taking and sexual counselling should be included in nurse education programmes so that nurses learn to acknowledge sexuality as a clinical issue and help them feel confident in their ability to do so (Quinn et al 2011, 26.)

Nurses need to be provided education in sexuality and communication skills so that the learned knowledge can be put to practice (Zeng et al. 2011, 289) Education strategies must take into consideration nurses' communication styles and socio-cultural beliefs

and values focusing on knowledge, skills, comfort, and confidence levels (Julien et al. 2010, 190). Additionally, nursing practice is improved if registered nurses undertake further education (Saunamäki et al. 2010, 1314).

In addition to education in sexuality itself and associated skills such as communication teaching and counselling skills, the focus of education needs to be aimed at helping nurses to become aware that everyone has personal biases and that part of the professional role is learning to provide a non-judgmental environment by separating these from patient care. In order to understand their own sexuality, nurses must be able to understand the biological, psychological and social aspects of sexuality as a whole (Lewis & Bor 1994, 257.) To build this type of self-awareness, nurses must reflect on attitudes individually and collectively to gain insight into their own behaviour and the behaviour of others (Guthrie 1999, 320). Further research needs to be made into the factors affecting the inclusion of sexuality in nurse education.

6.2 Trustworthiness

The term trustworthiness is used when speaking about qualitative research, such as the present study. In order for research to be trustworthy, it must be believable and consistent over time or dependable. It must show that the researcher has been objective or confirmable. Credibility refers to whether the truth has been portrayed from within the data chosen for research. The credibility of research is increased when multiple sources are used, such as in this study, to draw conclusions about what constitutes the truth through what is called triangulation. Trustworthiness of the present study is increased due to its sound methodology and critical appraisal of the studies under review (Polit & Beck 2012, 197.)

The confirmability of research can be achieved through reflexivity or critically reflecting on one's self and personal values that may affect interpretation. Reflexivity was achieved on a personal and group level. I constantly reflected on the values that I hold that may have an effect on my ability to interpret and portray the data objectively. Reflexivity was enhanced through peer critique and guidance from my supervisor during Bachelor's thesis seminars at TAMK (Polit & Beck 2012, 175.)

Generalisability refers to how the findings of a study can be generalised across groups and settings. Transferability refers to the meaningfulness of findings from qualitative research. The generalisability and transferability of research can be said to have an impact on how valuable research is considered. Generalisability and transferability of the findings of the present study are increased because the studied material includes articles from different cultures, geographical regions or countries and participants from different professional specialty areas (Polit & Beck 2012, 175.)

6.3 Limitations of the study

On one hand a major limitation of this study is the fact that I am new to conducting research and have done it exclusively by myself. This has the potential to increase researcher bias. However, a study should be evaluated on its own merits and not based on the credentials of the author (Coughlan et al. 2007, 659). The critical appraisal shows that the material chosen for the literature review is not perfect. Any research conducted by humans will be subject to human error and by its very nature all research is flawed.

6.4 Ethical considerations

Forms of research misconduct include plagiarism, fabrication of results, or falsification of data. These have not played a part in the making of this Bachelor's thesis. Misrepresentation of the original sources has been avoided to my best ability. I claim no conflict of interest that has had an effect on the Bachelor's thesis process. I carry all the expenses related to making this Bachelor's thesis (Polit & Beck 2012, 168-169).

Ethics need to be considered when human or animal subjects are involved in conducting research. No human or animal subjects were studied or used when conducting my research. This eliminates the need to directly consider ethics in this study in terms of human or animal subjects. However, ethical considerations need to be made towards the ethicality of the studies under review in this study. This is due to the fact that the studies under review study human subjects or more specifically nurses. The human rights of the participants in the studies under review have been protected and their participation was

voluntary in all cases. However, not all the studies under review mentioned or received permission from an ethics committee (Polit & Beck 2012, 150-175.)

7 CONCLUSION

This thesis explores nurses' attitudes and beliefs towards discussing sexuality with patients and factors affecting those attitudes and beliefs. The results show that nurses have open minds towards the inclusion of sexuality into nursing practice and believe it is important to discuss sexuality with patients. They also feel uncomfortable when discussing sexuality with patients and do not feel confident in their ability to do so. They tend not to take time to discuss sexuality with patients. The factors affecting nurses' attitudes and beliefs towards discussing sexuality with patients are varying and complex. However, cultural influences and societal values play a substantial role in what nurses believe.

The goal of this thesis was to help nurses and nursing students in gaining understanding of their own attitudes and beliefs towards discussing sexuality with patients and possibly in identifying factors that may affect those attitudes and beliefs. The purpose was to bring to the attention of nurses and nursing students not only an awareness of what values they hold towards discussing sexuality with patients, values that can quite often be limiting nurses in their capacity to carry out nursing in a truly holistic manner, but to also encourage them to develop self-awareness in all aspects of life. Self-awareness is the key that I want to pass on through this work. It is the key that opens the door to a less chaotic and more balanced world.

The thesis process is quite long
It's hard at times but if you stay strong
In the end you will succeed
Be happier and better for it
Through it you will grow and grow
And in the end time will show
That maybe after all is done
It was worth it and quite fun

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APPENDICES

Appendix 1. Critical appraisal tool

This is a simplified critical appraisal tool. Its purpose is not to comprehensively assess the quality of each individual study, but to present an overall picture of the quality of the articles in this thesis. There are questions adapted from CASP (2013), which make up the critical appraisal and a results matrix, which represents the results. The results matrix lists the studies and their publishing year in the left column and the questions on the top row (Q1, Q2, Q3, etc.). There is a results matrix key, which depicts the following. The answers are colour coded, 'Yes' indicated by green, 'Cannot tell' indicated by yellow, and 'No' indicated by red. The more affirmative 'Yes' answers there are or the greener the table appears points to the studies being of a higher quality, overall. The more 'No' and 'Cannot tell' or the redder and yellower the table appears indicates the opposite.

Critical appraisal questions:

Q1: Is there a clear statement of the aim?
Q2: Is the methodology appropriate for addressing the research goal?
Q3: Is the research design appropriate to address the aims of the research?
Q4: Was the recruitment strategy appropriate to the aims of the study?
Q5: Was the data collected in a way that addressed the research issue?
Q6: Has the relationship between the researcher and participants been adequately considered?
Q7: Have ethical issues been taken into consideration?
Q8: Was the data analysis sufficiently rigorous?
Q9: Is there a clear statement of findings?
Q10: Does the study make a contribution?

Critical appraisal results matrix key.

Yes	
Cannot tell	
No	

Critical appraisal results matrix.

Author/s, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Huang et al. 2013										
Quinn et al. 2011										
Zeng et al. 2011										
Saunamäki et al. 2010										
Julien et al. 2010										
Higgins et al. 2008										
Magnan et al. 2006										
Ho & Fernández 2006										
Guthrie 1999										
Lewis & Bor 1994										

Appendix 2. Results matrices

What attitudes and beliefs do nurses have towards discussing sexuality with patients?	
Author/s, Year	**The importance of discussing sexuality with patients**
Huang et al. 2013	47% participants believed nurses have to deal with patients' sexual issues. YES. 88% believed nurses should have knowledge to solve those sexual issues and 77% showed an interest in the possibility of taking education in patients sexual issues (p.149)
Quinn et al. 2011	There was an understanding by most of the participants that patients sexuality is important, can be affected by illness and treatment and therefore is a focus for nursing care requiring attention (p.24)
Zeng et al. 2011	77% of participants viewed sexuality as too private but YES. 62% acknowledged that it is within the responsibilities of the nurse to allow patients to talk about their sexual concerns (p.283). 49% agreed that discussing sexuality is essential to patient health outcomes (p.284)
Saunamäki et al. 2010	92% of participants understood how treatment and disease might affect their sexuality. 62% said giving the patient permission to talk about sexuality is a nursing responsibility and 59% agreed that discussing sexuality is important for patient health outcomes (p.1311)
Julien et al. 2010	The majority of participants did think that giving a patient permission to talk about sexual concerns is a nursing responsibility, claimed to understand how disease and treatment affects patients sexuality and did not think sexuality is too private to discuss (p.189)
Higgins et al. 2008	Participants desexualised patients and thought that discussing patients sexuality was inappropriate (p.312) By avoiding conversations about sexuality participants thought they were protecting themselves and patients from transgressing social and professional taboos (p.311)
Magnan et al. 2006	72% of participants agreed that giving patients permission to talk about sexual concerns is a nursing responsibility. 81% and 85% of

	participants did not think sexuality was too private to discuss and understood how disease and treatment can affect patients sexuality (p.451)
Guthrie 1999	Nurses acknowledged their responsibility to discuss sexuality with patients (p.315)
Lewis & Bor 1994	86% felt that sexuality counseling is within the responsibility of the nurse (p.255) 55% of participants thought it was relevant to include a sexual history on admission (p.256)

What attitudes and beliefs do nurses have towards discussing sexuality with patients?	
Author/s, Year	**Levels of comfort and confidence in discussing sexuality**
Huang et al. 2013	Only 20% of participants felt comfortable talking about sexuality with patients (p.149)
Quinn et al. 2011	Due to a lack of confidence most participants avoided the topic with patients. The topic was out of their comfort zone and area of expertise (p.24, 25)
Zeng et al. 2011	Only 35% of participants were confident in their abilities to address issues of sexuality while only 34% felt comfortable (p.283)
Saunamäki et al. 2010	60% of participants reported feeling confident in their ability to address patients' sexual concerns while 64% disagreed with the statement "I feel uncomfortable talking about sexual issues" (p.1311)
Julien et al. 2010	The majority of participants felt uncomfortable talking about sexual issues and did not feel confident in their ability to address patients' sexual concerns (p.189)
Higgins et al. 2008	Participants reported feelings of discomfort (p.311)
Magnan et al. 2006	51% agreed with the statement 'I feel confident in my ability to address patients' sexual concerns'. 52% disagreed with the statement 'I am uncomfortable talking about sexual issues' (p.451)
Guthrie 1999	Participants did not generally feel comfortable or confident in their ability to discuss sexuality with patients. Talk was limited to routine topics (p.315-320)
Lewis & Bor 1994	54% felt embarrassed when discussing sexuality (p.255)

What attitudes and beliefs do nurses have towards discussing sexuality with patients?	
Author/s, Year	**Initiating discussions about sexuality**
Huang et al. 2013	44% of the participants in the study believed that if a sexual problem existed that patients would come and talk to nurses about it (p.149)
Quinn et al. 2011	The majority of participants waited for patients to approach them with their sexuality concerns and tended to refer patients to another practitioners for help (p.24, 25)
Zeng et al. 2011	63% of participants assumed that patients are too sick to talk about sexual concerns (p.283) 47% of participants believed patients expect nurses to ask about their sexual concerns although 59% believed sexuality should be discussed only if initiated by patients (p.286) 52% said that they refer patients to the physician when patients ask a sex related question (p.284)
Saunamäki et al. 2010	94% of the participants did not agree that patients expect nurses to ask about their sexual concerns. 28% of participants refer their patients to a physician when patients ask them a sexuality related question and 43% or almost half think sexuality should be discussed only if initiated by patient (p.1311)
Julien et al. 2010	The large majority of participants did not believe patients expect nurses to ask about their sexual concerns and felt sexuality should be discussed only if initiated by the patient and a majority of participants would refer patients to the physician if they asked participants a sexuality related question (p.189)
Higgins et al. 2008	Participants avoided taking the lead in any discussion about sexuality and when it was brought up by the patient, participants would ignore the topic or avoid the real issue and would refer the patients to the psychiatrist (p.311, 312) Participants assumed that patients would talk to them if they had a sexual problem and assumed that clients would get upset if participants would speak with them (p.313)
Magnan et al. 2006	78% of participants believed patients do not expect nurses to ask about their sexual concerns and 44% believed sexuality should be discussed only if initiated by the patient. 35% of participants said that when a patient asked a them a sexually related question that they

	would refer patients to the physician (p.451)
Guthrie 1999	Participants felt that it is up to the patient to initiate discussion on sexuality. There was an assumption on the part of the participants that patients do not want to discuss sexual concerns with nurses (p.315)
Lewis & Bor 1994	Cannot tell

What attitudes and beliefs do nurses have towards discussing sexuality with patients?	
Author/s, Year	**Taking time to discuss sexuality with patents**
Huang et al. 2013	Only 28% of participants claimed to conduct some education about sexual issues (p.149)
Quinn et al. 2011	10/14 participants indicated that they had never initiated an inquiry into patients' sexuality. 4/14 said they did include discussions of sexuality when admitting a patient (p.24) Most participants do not raise the topic of patient sexuality during assessments (p.25)
Zeng et al. 2011	Only 34% made time to discuss sexual concerns with patients (p.283)
Saunamäki et al. 2010	Only 19% of the participants agreed with I make time to discuss sexuality with my patients (p.1311)
Julien et al. 2010	The large majority of nurses did not make time to discuss sexual concerns with patients (p.189)
Higgins et al. 2008	Participants physically avoided patients and deflected conversation (p.313)
Magnan et al. 2006	70% of participants did not make time to discuss sexual concerns with patients (p.451)
Guthrie 1999	Did not generally talk to their patients concerning sexuality (p.315)
Lewis & Bor 1994	Only 35% sometimes or always included questions about sexuality when admitting a patient (p.255)

What factors affect nurses' attitudes and beliefs towards discussing sexuality with patients?	
Author/s, Year	
Huang et al. 2013	Experience, age (p.148, 149)
Quinn et al. 2011	Age, training, experience, workload, not a priority for healthcare organisation (p.24)
Zeng et al. 2011	Limited resources, education, experience, fear, knowledge (p.283-285, 288)
Saunamäki et al. 2010	Education, age, experience, confidence (p.1311, 1312)
Julien et al. 2010	Age, experience, confidence (p.188, 189)
Higgins et al. 2008	Fear, limited resources, life experience, culture, values (p.310, 311, 313)
Magnan et al. 2006	Age, confidence, experience (p.450, 452)
Guthrie 1999	Workload, limited resources, fear, not a priority for healthcare organisation, social upbringing (p.315, 317, 319)
Lewis & Bor 1994	Knowledge, gender, religion (p.255, 256)