Psychosexual Nursing

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Acknowledgements

Many thanks to my colleagues Sophie Elkins and Elizabeth Holmes and also to the members of the Bath psychosexual nursing seminar group, who have helped directly and indirectly to develop my ideas about the issues discussed in this book. I also thank Jim McCarthy of Whurr Publishers for inviting me to write this book, and the staff of the Postgraduate Medical Library, Bath and Lyn Norvell of the British Library for their assistance.

This book is dedicated to John Elder whose patience and support made it possible.
General practice and specialist sexual health services need to make patients feel that they can discuss problems with their sex lives. Services need to be able to assess patients and refer them on to specialist services when appropriate. (Department of Health, 2001a)

The purpose of this book is to help nurses provide the level of psychosexual care described above. Although this book was written with practitioners who work in primary care and specialist sexual health services specifically in mind, it is hoped that it will be of benefit to practitioners working in all areas of health care. Sexual health is an integral aspect of holistic nursing care and the enhancement and protection of patients' sexual health is dependent upon the sensitivity and skills of practitioners working outside and within the areas of primary care or specialist sexual health services.

The focus of this book is on helping practitioners recognize and respond appropriately to psychosexual anxiety and distress. Recent research suggests that the sexual concerns of patients still go unaddressed and that communication with patients about sexual issues is generally inadequate (Stead et al., 2001). Psychosexual anxiety and distress occur as the consequences of changes or threats to the sexual aspects of an individual's self-concept. Such changes may occur as the consequences of illness, disability, ageing, altered sexual function, relationship difficulties, loss and other psychosocial events. Sexual distress and anxieties that go unrecognized may lead to sexual and interpersonal problems which in turn create further anxiety or distress. As a consequence, a vicious circle of altered sexual self-concept, psychosexual anxiety and distress, and alterations in sexual response and satisfaction, can become quickly established.

It is not the intention of this book to make the reader either an 'expert' in sexual matters, or a psychosexual therapist. The book aims to provide the
reader with an outline of an approach to patient care that may help to prevent sexual concerns developing into seemingly intractable sexual or relationship problems that require intensive and protracted specialist intervention. It is recognized that on occasions practitioners will encounter patients with sexual problems who will require referral for specialist help. Consequently, the help that specialist psychosexual services can offer patients and the rationale for referral to such services are discussed.

However, this book does have a number of limitations. The first and possibly most important is that psychosexual nursing skills cannot be acquired by reading a textbook. The acquisition of such skills occurs primarily through experience that is reflected upon and valued (both by the practitioner and others). Inevitably, generalizations have been made in the writing of this text and practitioners should be wary of imposing these on either their patients or themselves. Readers of this book are encouraged to read widely on this subject and recommended reading at the end of each chapter, with a selected biography of further reading at the end of the book, is indicated.
PART I

PRINCIPLES OF
PSYCHOSEXUAL NURSING
CHAPTER 1

Psychosexual anxiety and distress

Introduction

Psychosexual anxiety and distress are feelings that arise when an aspect of a person’s sexuality is disturbed by a situation or event. Sexuality is a difficult concept to define as it means different things to different people, but generally it refers to something more than just sexual acts or genitalia. Determinants of an individual’s sexuality include biological sex, gender identity, sex-role conditioning and sex-role stereotypes (ENB, 1994). Although the term ‘sexuality’ is often taken to denote something positive about the human condition, it can also serve as conduit for the expression of power, dependency, hatred, manipulation and violence (Savage, 1990). For the purposes of this book, sexuality is viewed as part of an individual’s self-concept, shaped throughout life by his or her personality and everyday interactions with others, and expressed as sexual feelings, beliefs and behaviours, through a heterosexual, homosexual, bisexual or transsexual orientation.

When thinking about psychosexual anxiety and distress, it is important to distinguish between those feelings that are a normal, almost expected, reaction to certain events – what Nichols (1993) terms ‘functional emotional processes’ – and anxiety or distress that leads to psychosexual problems, relationship difficulties or ill-health. It is the latter that is addressed primarily within this text. Psychosexual anxiety and distress may result from:

- Ill-health and/or irreversible anatomical and physiological changes.
- Altered sexual function.
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• Sexual dissatisfaction.
• Life events, such as the beginning and ending of relationships, childbirth, growing awareness of aspects of one's sexual identity, ageing, loss and bereavement.

Psychosexual distress may be considered 'problematic' when:

• It impedes recovery from illness or adjustment to chronic health-related conditions.
• It leads or contributes to mental ill-health.
• It alters sexual function in the absence of any underlying physiological cause, or worsens sexual difficulties that are primarily organic in origin.
• It leads to sexual dissatisfaction.
• It contributes to relationship difficulties or breakdown.
• It deters an individual from establishing close, intimate relationships.

In practice, it is sometimes difficult to distinguish between where psychosexual distress that is indicative of 'functional emotional processes' ends and where psychosexual distress and anxiety associated with adverse sequelae actually begins. It is necessary to think about the role and function of such feelings for the individual concerned. When thinking about psychosexual anxiety and distress in relation to ill-health, altered sexual function and interpersonal relationships, it is possible to detect a certain 'circularity'. For example, illness or surgery may lead to psychosexual anxiety that, in turn, alters sexual functioning which results in relationship difficulties and consequently impedes recovery. Asking whether the psychosexual anxiety and distress an individual is experiencing affects adversely his or her general or sexual health, may also help. At this point, it seems an appropriate moment to stop and think about what is meant by the term 'sexual health' and the role of practitioners in general sexual health care.

**Defining sexual health**

It is generally difficult to find a definition of sexual health that captures the essential components of human sexuality in health and illness and enjoys universal acceptance (Hicken, 1994). In attempting to define sexual health, the World Health Organization (WHO) (WHO, 1986) identifies three key elements:
• A capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.
• Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships.
• Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.

Savage (1987, p. 25) notes that the above definition of sexual health is concerned with ‘reproduction and the erotic aspects of sexuality’, thereby neglecting the role of sexual health care in enhancing life and personal relationships. Often, sexual health in nursing practice is equated solely with the prevention of sexually transmitted infections or the provision of contraceptive services.

Cavicchia and Whitehead (1995) raise a number of important questions with regard to the above definition of sexual health, including how does an individual define a ‘personal and social ethic’? Given the diversity and ever-changing range of influences and opinions in society, is it ever possible to define an absolute code of behaviour that constitutes a ‘social ethic’? Furthermore, how do some individuals cope with changes in their ‘personal ethic’ that occur over time, or when their opinions and sexual behaviours may be at odds with perceived social norms. Cavicchia and Whitehead (1995) also question how realistic it is to expect individuals to free themselves from fear and shame about sexual identity and practices in a culture that they describe as being essentially ‘sex negative’. Finally, given the emphasis placed in the WHO (1986) definition on ‘freedom from organic disorders’, Cavicchia and Whitehead (1995) ask where this leaves people whose ‘organic disorders’ cannot be remedied. Does this mean that many people may never attain sexual health? These are important questions and should be kept in mind when thinking about the role of the nurse in psychosexual care as they highlight some common causes of psychosexual anxiety, distress and difficulty:

• Behaviour or feelings that are perceived as deviations from either personal or social ‘norms’.
• Internalization of the negativity surrounding sex in our society.
• Assumptions about ‘ideals’ with regard to sexual expression, gender roles and sexual relationships.

In everyday clinical practice, sexual health may either be a primary or secondary focus of nursing care, depending on the patient’s care needs
Psychosexual Nursing (RCN, 2000). Savage (1987) observes that the role of the nurse in sexual health care varies according to the nature of a patient's problems, citing three levels of sexual health care in nursing practice. The first of these is described as 'basic sexual health care' and is essentially concerned with the care of the 'non-erotic' aspects of a patient's sexuality, such as self-concept, body image, the management of body boundaries and products, and gender role. Savage (1987) notes that all nurses have a responsibility to provide this level of care. The second level of nursing care is concerned with sexual adjustment, that is helping patients to adjust to sexual changes following ill-health or injury so that patients may re-establish themselves as 'confident individuals who are as sexually active as they want to be' (Savage, 1987, p. 145). The third level of nursing care involves recognizing the ways in which psychosexual problems may be precipitated by ill-health. Savage (1987) suggests that practitioners should have some understanding of what psychosexual treatment involves in order to be able to recognize when referral is appropriate and to discuss with patients what such treatments might involve.

Discussing sexual concerns

A recurring theme of many studies exploring sexual health care and nursing practice, is the wish expressed by many patients that practitioners should initiate any discussion of sexual health, and the reluctance expressed by many practitioners to do so (Waterhouse, 1996). A number of factors may contribute towards this situation.

First, it is important to acknowledge that sexuality is a personal and private part of life for most people, and that privacy needs to be respected by both practitioner and patient (Clifford, 2000a, p. 12). Psychosexual care requires practitioners to remain alert to their patients' expressed and unexpressed needs. The skill required of the practitioner is to demonstrate respect for patients' privacy at the same time as attending to their patients' needs. To do this the practitioner needs to listen with close attention to the feelings that are being expressed, as well as to think about what is not being said.

Bor and Watts (1993) note that the context or setting in which conversations with patients take place directly influences the purpose of the discussion, its aims and the content of what can be discussed. Where the patient's presenting problem is primarily of a sexual nature (e.g. urogenital symptoms), most patients anticipate that their sexual relationships will be discussed from the outset. However, both
practitioners and patients may experience greater uncertainty and ambivalence about whether or how to discuss sexual problems that are associated with other medical or psychosocial problems (e.g. erectile dysfunction secondary to diabetes) or concern matters not directly related to medical treatment (Bor and Watts, 1993). It is important to note that, even in contexts where discussion of sexual behaviour and sexuality is expected, embarrassment may still lead to the avoidance of certain subjects (Meerabeau, 1999).

Practitioners carry out many physically intimate acts in their everyday clinical practice which might be regarded as sexual if the context or practitioner's motivation were different (Savage, 1987; Lawler, 1991). Savage (1990, p. 25) suggests that 'with this background of intimacy it is difficult to maintain an image of sexual neutrality when nurses invite their patients to give voice to sexual concerns'. This is made more difficult by a 'sexualized' stereotypical image of nurses which leads some patients, relatives and colleagues to target nurses for abuse and sexual harassment. Burnard (2000) notes that when nurses working in the community encounter patients who want to talk about issues relating to sexuality, they need to consider not only if it is appropriate to talk about such matters in another person's home but also whether it is safe to do so. Practitioners may also avoid talking to patients about sexuality when the patient's sexual identity or behaviours pose a direct challenge to aspects of the practitioner's sexuality (Savage, 1987; Guthrie, 1999).

Some practitioners desist from discussing patients' sexual concerns because they fear that addressing this subject merely increases a patient's anxiety. However, this has not been shown to be the case in a number of studies (Waterhouse, 1996). Related to this is the concern that patients may want practitioners to be 'experts' in sexual problems, a role that most practitioners feel they could, and possibly should, not fill (Savage, 1987). Again, no support for this anxiety has been identified in relevant research (Waterhouse, 1996). Other factors identified by some practitioners for not initiating any discussion of patient's sexual concerns is the perception that other nurses do not discuss sex as part of their clinical practice (Kautz et al., 1990), and the lack of time and opportunity to do so (Guthrie, 1999).

Poor training or education in sexuality and sexual health is sometimes cited as a reason for not addressing patients' needs in these areas (RCN, 2000) and this has received considerable attention in certain quarters (Hicken, 1994). There is, however, no conclusive evidence that sexuality education influences clinical practice (Waterhouse, 1996). Some studies have reported notable changes in clinical practice following appropriate
education (Matocha and Waterhouse, 1993), whereas others have noted only small changes (Lewis and Bor, 1994) or no change at all (Kautz et al., 1990).

A key question for practitioners considering initiating any discussion of sexual concerns is if a difficulty is identified, what happens next? How do I respond? An approach that is suggested in many nursing texts is the ‘PLISSIT’ model.

**The ‘PLISSIT’ model of sexual counselling**

PLISSIT is an acronym for:

- Permission giving.
- Limited Information.
- Specific Suggestions.
- Intensive Therapy.

This model was developed to describe an approach to individual sex therapy which was primarily behavioural in orientation (Annon, 1976) and which enjoys some popularity as a model for sexual counselling (Butler and Joyce, 1998). In nursing, it serves both as a means of assessing sexual health needs (McNall, 2000; RCN, 2000) and as a model for sexual counselling and teaching within clinical practice (Waterhouse, 1996; Muir, 2000; White, 2001). As a model for sexual counselling within nursing practice it is essentially a form of ‘advisory counselling’ in that much of the communication is from practitioner to patient (Nichols, 1993). Advisory, as opposed to personal, counselling tends to be concerned with giving information and advice, and is generally directive in nature (Nichols, 1993, p. 143).

‘Permission giving’, the first level of the PLISSIT approach, involves ‘conveying to the patient that sexuality is a suitable subject for discussion and providing assurance that concerns and practices are normal’ (Waterhouse, 1996). Waterhouse (1996) suggests that all nurses should be able to function at this level and notes that most nurses can also intervene at the next level by providing ‘limited information’. This involves providing limited factual information which is relevant to the patient’s primary health concerns or problem. Limited information may also involve addressing any myths or misconceptions the patient may have. Making ‘specific suggestions’ to help patients who are experiencing particular sexual difficulties is deemed to be beyond the knowledge and
Psychosexual anxiety and distress

skills of most practitioners (Waterhouse, 1996). This level of intervention is generally provided by nurses who have completed training at a 'specialist practitioner level' (RCN, 2000; White, 2001). Patients with long-standing sexual problems or severely stressed relationships may require 'intensive therapy' and this should only be undertaken by practitioners who have completed specialist training in, for example, psychosexual therapy or relationship counselling (Waterhouse, 1996; RCN, 2000; White, 2001). Accordingly, most practitioners would be expected to refer patients who require help at this level.

One of the tenets of this approach is the validation of patient’s sexuality and sexual expression. Webb (1985) suggests that practitioners who understand the diversity of human sexual expression:

> can validate the “normality” and acceptability of any sexual practice which is freely consented to and pleasurable to participants, and help lift the unnecessary burdens of guilt which can interfere with sexual enjoyment. (Webb, 1985, p. 155)

However, as Savage (1987) observes, many nurses, like much of the general population, retain certain ‘limiting assumptions’ about human sexuality. The first of these is the ‘heterosexual assumption’. Linked closely to this is the ‘intercourse assumption’ that equates ‘sex’ with penile–vaginal penetration, thereby ignoring other forms of sexual expression. The final assumption Savage (1987) notes is to do with age, specifically the denial of sexuality in both children and the elderly. It would seem that for many nurses even providing care at the first level of the PLISSIT model for certain patients might prove problematic.

The second and third levels of the PLISSIT model – ‘limited information’ and ‘specific suggestions’ – are interventions that may help prevent the development of psychosexual anxiety and distress in patients undergoing changes in health or treatment, and correspond to the notion of ‘informational and educational care’ described by Nichols (1993). As with any form of informational care:

> the work of assessing a person’s knowledge and expectations must be emphasized to the same degree as actually giving information – that is prior to and after the communication of significant information, it becomes standard practice to check what a person knows, how accurate and complete this is, and what expectations they generate from the material (Nichols, 1993, p. 79)

The PLISSIT approach to sexual counselling may benefit patients who are experiencing sexual difficulties that are the consequence of problems
such as ignorance, misunderstanding or some degree of unjustified guilt or anxiety (Bancroft, 1989). Bancroft (1989) notes that although many professionals are able to offer this type of ‘simple counselling’, it does have certain requirements, the importance of which should not be underestimated. Chief among these are that practitioners feel relaxed and comfortable with sexual issues, have sufficient knowledge to be confidently informative and are skilled at recognizing communication difficulties and teaching basic communication skills.

The notion of ‘expertise’ permeates the PLISSIT approach as it is applied to nursing care. One of the advantages of this model is that it allows practitioners to intervene at a level commensurate with their knowledge and skills as well as their level of personal comfort. This perceived strength of the PLISSIT model may also be its primary weakness in terms of psychosexual care. First, the focus of the PLISSIT approach is on practitioner-directed ‘problem-solving’. Implicit in this is the notion that the solutions to a patient’s difficulties lie outside the patient (in the form of the practitioner’s knowledge or skills), whereas one of the major premises of psychosexual care is recognizing ‘that patients have the information within themselves that can enable them to resolve their sexual problems in a way that will suit them best’ (Wakley, 1998, p. 149). Although the PLISSIT model places emphasis on ‘knowing’ and ‘doing’, little attention is given to the practitioner’s ‘professional use of the self’ in this process, which is an essential aspect of what has been termed ‘psychosexual awareness’ (Clifford, 1998b; Clifford, 2000a). In psychosexual care, like emotional care in general, the process is as important as the content. Indeed, the PLISSIT model, like the ‘nursing process’ (see Fabricius, 1991), rather than reducing the depersonalization and distance in the nurse–patient relationship, may actually act as a means of defence against awareness in practitioners, of a patient’s emotional distress.

**The presentation of psychosexual problems**

The presentation of psychosexual distress is often indirect or covert. Many patients with psychosexual problems seldom come straight to the point when attempting to disclose their difficulties, as they often fear looking ignorant because of using the wrong words, causing offence by being too explicit or have no way of conceptualizing what is wrong (Selby, 1989, 2000). Consequently, any mention of a sexual difficulty is often extremely tentative and couched in euphemism (Ramage, 1998).