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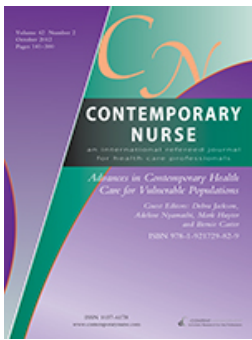
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EDITORIAL

**The three developmental phases of addressing sexuality in nursing care:
Where do we go from here?**MARK HAYTER, DEBRA JACKSON*, BERNIE CARTER[†] AND ADELINE NYAMATHI[‡]Faculty of Health and Social Care, University of Hull, Hull, UK; *Faculty of Health, University of Technology, Sydney, NSW, Australia; [†]School of Health, University of Central Lancashire, Preston, Lancashire, UK; [‡]School of Nursing, University of California, Los Angeles, CA, USA

Patient sexuality and sexual health can be one of the most delicate areas, provoking strong reactions for nurses and patients alike. One universal trait which human beings ascribe to is the fact that we are all sexual beings – but it is often among the most vulnerable and/or marginalised that this aspect of care can be neglected. This editorial endeavours to explore the way in which the issue of sexuality has developed in nursing over the last four decades and in so doing, address future trajectories. It is intended to describe a process by which sexuality has developed as an issue in all *general* areas of practice – leaving to one side services that, by their very nature, have always directly addressed sexuality. Nursing is essentially entering a process midstream by attempting to address the sexual dimensions of patients and thereby incorporating such traits into nursing care. It also suggests that – out of the most extreme cases of social oppression and stigmatisation involving prejudice towards sexual minorities and negative attitudes towards sexual expression by the ill, the disabled and the elderly – some good eventually emerges.

When the definitive history of HIV, as well as AIDS, is written it will, inevitably, contain a record of tragedy and loss, communities ravaged and the oppression of individuals and groups based purely on their sexuality or marginalised social status. It is not necessary to rehearse the way in which most of society – including many health professionals – responded in the mid-to-late 1980s as HIV emerged (Hayter, 1996, 1997). The ensuing marginalisation and stigmatisation of sexual minorities also needs little explanation here – it happened on a grand scale. Driven by fear and ignorance – but also, we suspect, by the sense among many that HIV finally legitimised them to express their prejudices. These were dark times and healthcare did not, universally, respond well to this new disease and the accompanying

issues of sexuality, sexual orientation and lifestyles that were different from the norm.

However, our view is that we can now look back and also see something more positive emerging from this period. It marks the origin of the debate around human sexuality and nursing practice and begins a process that we believe can be conceptualised with three distinct developmental phases: (1) emerging into the light; (2) tentative steps; and (3) the next chapter.

PHASE 1: EMERGING INTO THE LIGHT

The struggle to convince many practitioners that sexuality is an essential element of nursing care has been challenging – even in an era where the concept of holistic care was accepted. Many held that this private topic should stay that way – private; or, held quite negative views on sexuality generally and sexual minorities specifically. One aspect of care, which has often been negated, is that expressing sexuality is mainly due to the fact that the nursing profession struggled to address the sexuality aspect of the human experience for patients.

As HIV/AIDS emerged and forged this issue into a larger forum, a triumvirate emerged, in particular, sexuality, sexual orientation and sexual practices became positioned on the healthcare agenda unlike previous decades. Sexuality also became much more prominent in social discourse and much of this can be undoubtedly negative, bringing to prominence an area of life neglected and ignored. The primary issue in this phase was to simply achieve the recognition that sexuality was an integral part of holistic nursing care. We suggest that this argument has, mainly, been successful – and credit to those pioneers who laboured long and hard conducting training, research and generating a published discourse on this subject at the time. We would also suggest that HIV/AIDS also did so much to drive the ‘patient’ advocacy movement

forward. Anyone who ever attended an international AIDS conference can attest to the power of AIDS activist groups within the HIV therapy and services arena; but that deserves other attention.

PHASE 2: TENTATIVE STEPS

The gradual acceptance of sexuality as part of holistic nursing care marks this second phase – although it is clear that these phases overlap. In this period, there is growing evidence that the discipline of nursing started to address human sexuality which birthed evidence that some attention was being paid to this element of holistic care. Admittedly, much of this attention focused on issues more akin to dignity and basic necessities, namely, wearing clothes rather than nightwear, single gender wards etc. However, this period also saw more specific sexual health issues come to the fore; for instance, challenging the ‘heterosexual assumption’ made about our patients. This phase seems marked by the growing realisation that patients are also sexual beings and that this requires recognition. In other words, nurses were cognisant of the fact that sexuality should be addressed – but questioned strategies. This phase also coincides with the emergence of the term ‘sexual health’ into mainstream health discourse. This term simply did not exist prior to the late 1980’s and its advent cannot be understated in understanding how recognition of sexuality as an integral aspect of nursing care developed.

PHASE 3: THE NEXT CHAPTER

A critical step in this phase has been the recognition that sexuality is more than mere ‘sexual activity’ – and a step that was reflected in the dignity, self-esteem and privacy agenda which is composed of nursing care. But, it could be argued that that agenda was also emblematic of the general anxiety which can be attributed to knowing about sexuality, yet, not being equipped or comfortable to address these issues with patients. Effectively addressing sexuality in clinical care relies on the skills to communicate about this sensitive issue with patients and also the knowledge base to support that communication. We believe that the former is well developed among most practitioners. Further, most nurses are used to speaking to patients about the most difficult and intimate areas of their lives. It is the second element where we believe the development of ‘phase 3’ lies – the sexuality knowledge base.

The specific knowledge base is composed of two arms: (1) sexuality and (2) sexual health evidence base as it relates to specific client groups. As care providers, nurses are aware of the need to avoid a ‘one size fits all’ approach, but there is growing evidence of the *particular* sexual dimensions of various health issues. These issues can focus on stage-of-life issues, such as particular issues for children with disorders of sexual development (Sanders, Carter, & Goodacre, in press), adolescents and young people (Kang, 2009), social disparity issues, such as those faced by the homeless, or disease-related issues such as those that may be associated with disease processes or treatment.

While it is adequate to recognise that sexuality is important (phase 1), and that it should be addressed (phase 2), for practitioners, it is imperative that questions need to be raised which heighten the provision of healthcare. Specifically, practitioners should seek out evidence pertinent to their client group and how to adequately address these services:

- How can diabetes affect sexuality – in men, women?
- How can neurological conditions affect sexual satisfaction?
- After a myocardial infarction – when can sexual activity be resumed?
- What sexual positions could be suggested for patients with severe mobility problems?

Similar issues arise for health professionals working in an acute child healthcare setting who feel uncomfortable about asking either the child or the parent questions about sexual and relationship health (Bray, McKenna, Sanders, & Pritchard, 2012). This is of concern as children and adolescents are often preoccupied with puberty, sexual health, their sexuality and relationships. Studies of nurses working in child healthcare generally show an acceptance of the nurses’ role within sexual health, but also demonstrate a lack of knowledge (Johnston, 2009) and a sense of uncertainty about how to manage this aspect of care. Bray et al. (2012) noted that some healthcare professionals talked of avoidance and reluctance to engage in dialogue about sexual and relationship health because of personal beliefs that the discourse was inappropriate for a children’s setting.

However, a sexual health dialogue occurred if it tended to focus on ‘fertility, physiology and

medication, with only a very limited focus on exploring young people's experiences, understanding, beliefs and emotions' (Bray et al., 2012). Concerns about whether a health professional should be chaperoned whilst asking intimate and/or sexual health and relationship questions were raised; perhaps reflecting safeguarding issues and wider concerns about talking about sex and the perceived need to protect children and young people from any mention of the word.

Considering these types of issues can illuminate this critical discussion, and will be a catalyst, ultimately enhancing an understanding of how patients and clients manage their sexuality. In seeking to understand young women's experiences of being diagnosed and living with a sexually transmitted infection (STI), nurse researchers have been able to highlight the influence of romantic love on young women's attitudes to condom use (East, Jackson, O'Brien, & Peters, 2007), difficulties young women can have in negotiating safer sex (East, Jackson, O'Brien, & Peters, 2011a; Hayter & Harrison, 2008), how women manage the flow of information about their STI status, healthcare experiences of these young women (East, Jackson, O'Brien, & Peters, 2011b) and how living with STI can affect a young woman's whole sense of herself (East, Jackson, Peter, & O'Brien, 2010; East, Jackson, O'Brien, & Peter, 2012).

This has generated further discussion in the literature (East, Jackson, Peters, & O'Brien, 2011; Hayter, 2010), thus contributing to a published discourse that could assist nurses and other health providers to deliver more appropriate sexual healthcare for young women.

The history of sexuality in nursing care is a relatively short one and shows how much ground has already been covered. Our analysis is that more can and will be done. What we believe is that good eventually emerges from the most adverse situations in health – and that sexual health is a paradigm example of that. It is perhaps fitting to recall remarks attributed to the late Richard Wells, UK Royal College of Nursing and HIV and Sexuality Nursing pioneer: 'AIDS brought out the worst and best in health care professionals'. We believe it is the 'best' that has endured and stood the test of time.

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