EXPLORING SEXUALITY ATTITUDES AND KNOWLEDGE IN NURSING: AN EDUCATION PROGRAM

A DISSERTATION SUBMITTED TO THE FACULTY OF THE AMERICAN

ACADEMY OF CLINICAL SEXOLOGISTS AT MAIMONIDES UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY
IN
CLINICAL SEXOLOGY

BY

EILEEN M. VOLPE, MSN, ARNP, CST

AND

JOYCE C. WERTHEIMER, MSW, CST

ADVISOR

WILLIAM A. GRANZIG, Ph.D., MPH, FAACS

NORTH MIAMI BEACH, FLORIDA

MAY 2004

May 31, 2004
DISSERTATION APPROVAL

This dissertation submitted by Eileen M. Volpe and Joyce C. Wertheimer has been read and approved by three faculty members of The American Academy of Clinical Sexologists at Maimonides University.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form, and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Signature Date

_____ _____
William A. Granzig Ph.D., MPH, FAACS
Advisor and Committee Chair

_____ _____
Mary D. Lutzo, Ph.D., RN, FAACS
Committee Member

_____ _____
Charlotte Willis, Ph.D., LCSW, FAACS, ADC
Committee Member

ACKNOWLEDGEMENTS

We would like to take this opportunity to express our extreme gratitude to all those who have made this dissertation a success and a reality.

First of all, we would like to thank Dr. William Granzig, our professor, advisor, and mentor. Without his extreme patience, instruction, and guidance, we wouldn't have been able to accomplish this today. Thank you for all your continued efforts and your on going work in the field of human sexology.

To Dr. Lutzo, Thank you, for your advice, enthusiasm, dedication and the availability of your time. Thank you for believing in this research and your dedication to the nursing profession.

To Dr. Willis, Thank you, for making yourself so readily available, for all your support and encouragement and for offering your assistance in bringing this dissertation to fruition.

To Health First, Thank you, for the use of your facility and the support of your Institutional Review Board.

To Wyeth and Solvay, Thank you, for your generous donation, your time, and your contribution to the dinner for the study participants.

To our study participants, Thank you for believing in our educational program, participating in our study, and answering with honesty.

To Dr. Diane Otto, What a find you are! Thank you for all your help with the statistics.

Last but not least, a special thanks with love to our families and friends who have been patient, loving, supportive, understanding and who have helped to make our dream become a reality.

ABSTRACT

This study examined the attitudes and knowledge towards patient sexuality of nurses working in a Central Florida integrated health care system. The convenience sample consisted of 18 female registered nurses who participated in a hospital based three-hour sex education program developed specifically for nurses. The educational program included lecture, games, and role-play and was offered in classroom format at the hospital's education center. The study hypothesized that following completion of the education program there would be an alteration in sexuality knowledge and improvement in attitude as measured by the revised Sexual Knowledge and Attitude Test (SKAT).

Pretest-posttest design was used for the study. The (SKAT) was given to determine sexual knowledge level and sexual attitudes. A multiple choice questionnaire was given to establish demographic details and nursing practice related to sexuality. Results of the study demonstrated no significant alteration in attitude pre- or posttest among the study participants. There was a significant increase in knowledge following completion of the program. Analysis of the data indicated that attending a sexuality education program increases the likelihood that the nurse will address patient sexuality issues in future practice.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF GRAPHS

Page

I. INTRODUCTION

A. Background of the Problem

The phenomenon of sexuality is a deep, pervasive aspect of the total human experience and contributes to life in positive, healthy ways. Illness, both chronic and acute, often has a significant impact on sexuality. Many patients plagued with illness suffer insult to their sexuality and consequently rely on myths, misconceptions and misinformation as they cope with sexual concerns and dysfunctions. Attending to sexuality has been identified as an integral aspect of nursing care by a number of organizations including the American Nurses' Association (ANA). Sexuality is an important quality of life issue that nurses should not ignore for two reasons: First, patients expect and deserve high quality care; nursing care that ignores this important aspect of life is substandard. Second, standards of practice related to sexuality exist (ANA & Oncology Nursing Society). This is the standard to which nurses are held and one that may be considered a legal standard (Wilmoth & Spinelli, 2000). Despite this, it has been noted that lack of knowledge about sexuality, conservative attitudes, and anxiety when discussing sexual concerns is widespread among nurses (Hart, et al 1995). Matocha and Waterhouse (1993) studied the extent to which nurses in various settings discussed sexual concerns using the Survey on Sexuality in Nursing Practice (SSNP). They found that over one third of the nurses surveyed never assessed sexual concerns, discussed sexuality with their clients, or provided teaching about sexuality.

Nurses' understanding of their patients' sexual functioning often revolves around patients' ability, diagnosis, partnering and desire. Nurses spoke of their own uneasiness about discussing sexual matters with their patients. This discomfort may arise from their own lack of understanding of the sexual behavior of the sick or disabled, or from the

general societal attitude of privacy in sexual matters (Shah, 1991). Hughes (2000) emphasizes the fact that many nurses do not realize the importance of sexuality and believe that the patient will bring up the subject if it is a priority. Patients may recognize they have sexual concerns, yet few broach the subject with health care providers.

Fisher and Levine remind us that, according to Maslow, the fulfillment of the human need for love, intimacy, and sexual gratification are critical aspects of the mature, healthy personality. Sexual health must therefore be addressed as a significant and integral element of total health care. Patients continue to look toward health care professionals for guidance and advice, thus demonstrating their need for health personnel who are competent in providing sex education and counseling. Since nurses have an important role in daily patient management, they have an excellent opportunity to provide such counseling (Fisher & Levine, 1983).

B. Purpose of the Study

The purpose of this project is to design a three hour education program that will assist nurses in the provision of sexuality counseling to their patients by enhancing nurses' attitudes toward their own sexuality as well as that of their patients. The program proposes to increase the sexuality knowledge base of the nurse through lecture, discussion, class participation, role-play, and games. These educational methods were developed to provide the nurse learners with education tips for sexuality education, supply them with the tools necessary to obtain a patient's brief sexual history, and offer the nurse learners effective communication techniques.

C. Statement of the Problem

Validation of the program, carried out through pretest/posttest with registered nurses working in an integrated hospital health care system, seeks answers to the following questions:

1. Do nurses routinely discuss sexuality with their patients as part of nursing care?
2. Are nurses comfortable discussing sexuality with their patients?
3. Will a three hour sexuality education program alter the attitude and knowledge of nurses when discussing sexual issues with patients?
4. Does the education level of a nurse influence the likelihood that the nurse will address sexuality issues with the patient?

The study hypothesis states that following completion of the sexuality education program there will be an alteration in sexuality knowledge and improvement in attitude as measured by the revised Sexual Knowledge and Attitude Test (SKAT).

D. Definition of Important Terms

Nursing is the skillful assessment of an individual's health status, and the application of knowledge in practice with the goal of having the individual attain optimal health (Krueger et al, 1979). The nurse's unique function is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery that the individual would perform unaided if the individual had the necessary strength, will, or knowledge. The nurse does this in such a way as to help that person gain independence as rapidly as possible (Marriner & Tomey, 1994)).

Sexuality includes an individual's self concept, shaped by personality, sexual feelings, attitudes, beliefs and behaviors, expressed through a heterosexual, homosexual,

bisexual or transsexual orientation (Hodgson, 2001). Sexuality can be described as everything that makes us man or woman, feelings about one's body, the need for touch, interest in sexual activity, communication of one's sexual needs to a partner, and the ability to engage in sexual activities (Wilmoth, 1996).

Sexual dysfunction is the inability to express one's sexuality consistently with personal needs and preferences. It is a state in which problems with sexual function exist. It addresses physiological and psychological alterations related to desire**,** arousal, and orgasm (Hart, 2003). Sexual dysfunction is affected largely by the diagnosis and treatments of many disease entities. For example, cancer, cardiac issues, and gynecological problems can be significant sources of emotional distress (Hughes, 2000).

According to the US National Center for Health Statistics, a chronic illness is defined as an illness that lasts for 3 months or more and affects one or more of the body's functions (Webster, 2000). Chronic illness includes conditions that may affect respiratory, immune, neurological, circulatory and reproductive systems.

II. REVIEW OF THE LITERATURE

A. Sexuality

A review of the literature details the detrimental effect that illness can have on patient sexuality. The need for nurses to address such challenges with the patients they treat was demonstrated consistently throughout the literature review. The literature also repeatedly addresses patients' specific sexual needs, for example, to be offered education and options with regard to the dysfunction that illness may inflict on their sexual lives.

While sexuality education and counseling has been recognized as a standard of care for nursing (ANA & Oncology Nursing Society), it is our belief that, despite this, most nurses fail to address this most sensitive patient issue. The literature cites lack of knowledge, negative attitudes toward patients' sexual choices, insufficient time, and embarrassment as restraints to nurses' offering sexuality support to patients. As a means of countering these deterrents, the researchers chose to develop a program that would dispel some of this negativity and embarrassment. The program was designed to provide nurses with basic knowledge and suggestions for offering patient sexuality education, thus enabling the nurses to use a quick, comfortable, and non- judgmental approach.

Sexuality is an important part of the total person and is integral to health, quality of life, and general well being. Sexuality affects the way we relate to ourselves, our sexual partners, and all other people (Renshaw, 1984). A healthy attitude about sexuality can provide numerous benefits, including a link with the future through procreation, a means of pleasure and physical release, a sense of connection to others, and a contribution to self-identity (Fogel & Lauver, 1990). Sexuality is not just about intercourse; it is about the concept of people as men and women, about how they feel about themselves as sexual beings.

Sexuality is a multi-faceted possession of every human being and is constantly evolving. One's sexuality experiences are influenced by a variety of sources. Culture, religion, emotion, attitudes, self-esteem, sexual identity and physical being all contribute to one's sexual expression. These factors are in a constant state of change as one experiences different aspects and stages of life. Experiences of one's own sexuality are in a continuous process of change and development. The diagnosis of a physical illness often serves to alter the course of sexual development and the way in which people express their own sexuality (Levine, 1992).

Sexuality also affects the way people see themselves and would like to be seen, their appearance and behavior, and their desire to attract those who matter to them. It is about the fears and fantasies people have about themselves and others (Crouch, 1999). The concept of sexuality includes comfort with one's gender identity, acceptance of one's body appearance, the ability to develop and maintain an intimate relationship, the need to touch and be touched, the ability to communicate feelings and thoughts in an intimate relationship, as well as the ability to engage in satisfying sexual activities with or without a partner (Wilmoth, 1998).

Sexuality is a pervasive dimension of personality, deeply linked to the need for intimacy; it is related to the emotional and social dimensions of self. Components of sexuality include:

- Biological sex, which relates to the physical and anatomical features that characterize male and female
- Gender identity, which is the sex to which the individual feels he or she belongs (generally, individuals are socialized into a gender identity that confirms biological sex)

- Sex role conditioning, which describes pressure placed by society on individual behavior to confirm gender identity
- Sex role stereotypes, which are simplistic classifications of sexual identities
- Other aspects of sexuality include sexual orientation and sexual appearance (Palmer, 1998).

To many women, sexuality includes feelings about their body appearance, their femininity, their ability to bear children, and their ability to function sexually. Sexuality is an integral part of a woman's personality, with emotional, intellectual and sociocultural components. Feelings about sexuality change as a woman moves through the life cycle and different issues emerge as priority concerns, depending upon her age, developmental stage, and stage of her family (Sheehy, 1995).

Whipple and Komisaruk (1999) describe sexuality as the totality of a being, including all the qualities that make people who they are. It is an important aspect of health, enhancing quality of life, fostering personal growth, and contributing to human fulfillment. It can be expressed in any area of the body, not just the genitals, and is not defined by age. The phenomenon of sexuality is a deep, pervasive aspect of the total human experience and contributes to life in positive, healthy ways. Sexuality is related to overall adjustment to chronic illness and enriches life quality (Hart et al., 2003). The Hite report states that, in an ideal world, sexuality would become just a simple joy, a recognition of one's sexual feelings, and from there letting all humans define their sexuality as it is most comfortable for them at any given time, in any given situation (Hawker,1998).

In 1975, the World Health Organization defined human sexuality as the integration of somatic, emotional, intellectual, and social aspects in ways that are positively enriching and that enhance personality and love (WHO, 1975). Almost 30

years later, despite the integral role that human sexuality plays throughout a person's entire life span, sexuality remains taboo as a subject for many health care workers.

B. Sexuality in Nursing Practice

Two major issues impact sexuality and nursing practice. The first is about appreciating that sexual health and sexuality can be significantly affected by illness and treatment, while the second relates to the negative attitudes that nurses may hold towards their clients (Palmer, 1998). To deal with the sexual components of illness and health, nurses should recognize their own sexual dimensions as valuable and integral parts of themselves and integrate the goals of nursing with the sexual being. An individual's sexuality is not always understood and recognized by nurses. Some nurses have conservative and rigid attitudes regarding sexuality and undertake nursing interventions that may have a detrimental effect on patients' sexual health (Crouch, 1999). If nurses understand their own attitudes concerning human sexuality, biases may be reduced and communication could be enhanced. Nurses should have the courage to look at their attitudes without being defensive. Without this acceptance of self, the nurse's effectiveness is limited, as information conveyed on a verbal level may be contradicted by nonverbal communication. In other words, the information, attitude, vocal quality, and body language must be consistent (Payne, 1976).

Webb and Askham (1987) suggest that nursing staff tend to consider patients' sexual problems to be an inappropriate area for nursing care, citing the following reasons:

1. Sexual issues are seen as unimportant compared with the struggle to overcome disease and cope with its treatment.
2. Embarrassment on the part of nurses
3. A lack of knowledge about sexual problems

Sexuality has been identified as warranting assessment and intervention by the American Nurses Association (1974), the Nurses Association of the American College of Obstetricians and Gynecologists (1981), and the American Nurses Association and Oncology Nursing Society (1987). The North American Nursing Diagnosis Association included "sexual dysfunction" on its nursing diagnosis list in 1980. In 1986, it added "altered sexuality patterns" (Carpenito, 1989). Nursing texts have included chapters on sexuality as an integral part of nursing care, and colleges and universities are increasing the number of human sexuality courses offered to nursing students.

Sexuality is an important aspect of nursing care in a variety of settings, with clients of all ages, and in most medical diagnoses. Nurses working with clients who have undergone hysterectomies, colostomies, mastectomies and many other surgical procedures should encourage discussion of sexual concerns related to living with these changes in clients and their partners (Waterhouse & Metcalfe, 1991). In their study of nurses caring for patients with myocardial infarctions (MI), Shuman and Bohachik (1987) found that 82% believed sexual counseling should be included in the nurse's role. Despite this, 50% of these nurses did not feel comfortable providing post MI patients with sexual counseling.

In 1988, Wilson & Williams assessed the attitudes and behaviors related to including sexuality in practice to a large sample of oncology nurses. Almost 90% had offered sexual counseling to 10 or fewer patients in 6 months' time. Twenty five percent never offered sexual counseling, and the majority were not making referrals. Ironically, 91% said they would feel comfortable discussing sexuality if the patient initiated the discussion.

Although holistic care is stressed in nursing, sexuality remains to be a sensitive, infrequently addressed issue in our society, not only for health professionals, but the lay

population as well. Many health professionals are dealing with their own personal questions concerning sexuality. Few have developed the knowledge and sensitivity required to help others with these concerns (Hogan, 1980). Personal sexual feelings, behaviors, beliefs, attitudes and knowledge all influence the practice of nursing. In order to convey comfort to their clients, it is necessary that nurses be comfortable with their own behavior. Transmission of the nurse's discomfort may make patients hesitant to reveal their own sexual questions and problems.

It is common for health care workers to feel uncomfortable with assessing the sexual desires and functions of all clients (Wallace, 2000). Kautz et al. (1990) identified thirteen factors describing why nurses do not discuss patient's sexual concerns and problems. They categorized them into four groups as follows:

1. Sexual Knowledge
    - De-emphasis in RN education
2. Opinions about professional roles and tasks
    - Other RN's do not discuss sex
    - Sexuality is not seen as a problem by the nurse
    - Lack of management support
    - Unwillingness to chart
    - Insufficient time
    - RN values are different from patient's values
    - Not part of nursing role
3. Attitudes toward sexuality
    - Patients are too ill to discuss sex
    - Discussing sexuality causes the patient anxiety

4. Comfort with sexuality

- Hard to discuss sex
- Causes RN anxiety
- Discomfort asking for peer help

In this study, while nurses believed that patients were too ill, too anxious or relatively unconcerned about sexual concerns, they perceived themselves as having sufficient knowledge and willingness to discuss sexual concerns if the patient initiates the discussion. Research has shown that the majority of patients preferred to be asked about their sexual health concerns by the nurse. Nurses spoke of uneasiness in discussing sexual matters with their patients. This discomfort may rise from their own lack of understanding of the sexual behavior of persons with restricted bodily functions, or from the general societal attitude of privacy in sexual matters.

Regarding the concepts of sexual partners and disability, few nurses recognize the potential for alternate styles of sexual expression. The cultural expectation of performance along known and common sexual techniques is obvious. Yet in some patients, disabilities preclude a wide array of sexual functioning. Partners are not available to some. The opportunity for discussion of what exactly is possible for patients with varying illnesses and dysfunction is lost to some nurses, who themselves may be embarrassed with and uncertain about departures from the more common techniques (Shah, 1990).

C. The Impact of Illness on Sexuality

Sex remains an important contributor to quality of life in many patients with chronic illness, and to their partners. In a life restricted by illness, sex can be a powerful source of comfort, pleasure, and intimacy. It can serve as an affirmation of gender when other gender roles have been stripped away. For patients with chronic illness and their partners, a satisfying sex life is one way of feeling normal when so much else about their lives has changed. The effects of chronic illness on sexuality are mutifactorial and can impact all phases of the sexual response cycle (McInnes, 2003).

Parish (2002), classified the effects of chronic illness on sexuality into biopsychosocial categories as follows:

1. Biological effects:

- Sexual desire and activity may be altered by illness through interference with the hormonal, vascular and neural integrity of the genitalia, as well as the effects of medications.
- Reduced cardiovascular and pulmonary function may cause pain or fatigue which may limit or halt sexual activity.
- Surgical procedures may result in alteration of body function and appearance.
- Anxiety, grief, depression and loss of self-esteem that are associated with chronic illness can impair sexual function.
- Chronic illness often alters the relationship dynamics. The partner often assumes the role of caretaker as well as lover. Exacerbation of pre-existing relationship difficulties often occur as a result of the stress of the illness.

2. Social effects

- Society is generally uncomfortable with ill or disabled people having sex.
- Many health care workers regard declining sexual function as an inevitable consequence of aging.
- In the case of the young, chronic illness can impair sexual functioning long before a patient reaches puberty.
- The sexual concerns of single, separated and divorced patients are often disregarded.

Despite the obvious biopsychosocial impacts of chronic illness on sex and relationships, only a minority of patients receives help for sexual concerns. For example, although erectile dysfunction in diabetes is widely recognized, a Danish study found that only 10% of diabetic men attending a specialist diabetes clinic had discussed sexuality with their health care provider (Jensen, 1986).

Research has found that chronically ill patients, even those with a high level of sexual difficulties, seldom seek professional help. The data suggests that most patients want information about the effects of illness and treatment on sexuality, and they want health care personnel to initiate the discussion (Hanson & Brouse, 1983). The question is not whether sexual problems are a component of nursing care; rather, it is which nursing interventions can be used for specific sexual problems.

Human sexuality is usually simplified within the medical or clinical setting. It is often described according to the sexual response cycle, divided into the phases of desire, arousal, orgasm, and resolution. According to this model, thoughts and feelings about sex and interest in sexual activity characterize the desire phase. The arousal phase consists of a sense of sexual pleasure and accompanying physiological changes: for men, penile tumescence and erection; for women, pelvic congestion and vaginal lubrication.

Orgasm is a period of peak sexual pleasure, which in the male is accompanied by emission of semen. During resolution there is a sense of relaxation (Kaplan, 1974).

Muir (2000) identified the effects that cancer, chemotherapy, radiotherapy and bone marrow transplant can have on patient sexuality. The physical symptoms of nausea, vomiting, diarrhea, pain, mouth sores, hair loss, fatigue, muscle wasting and skin changes profoundly influence attractiveness and can result in distorted body image. Direct damage to reproductive organs often leads to infertility, which further erodes the sense of self. Premature menopause may lead to vaginal atrophy and dryness. Body irradiation in women may further exacerbate these vaginal symptoms and can cause severe vaginal stenosis, thus impairing penetrative sex. In men, irradiation may decrease testosterone levels and chemotherapy may damage the peripheral nerves thus leading to impotence.

The social consequences of cancer treatment, for example, long hospitalizations, time away from one's partner, lack of privacy, role changes, and financial difficulties may cause serious strain or breakdown in the relationship. In addition, many patients develop irrational fears that the disease can be spread through sexual intercourse, or that they will irradiate their partner if they have intimate contact. There is often a great deal of guilt in gynecologic cancers if the cancer is thought to be related to previous sexually transmitted diseases and promiscuous behavior. In addition, sexual difficulties may have occurred before diagnosis and treatment, and the illness serves to exacerbate the problem.

Because cardiac disease occurs later in life in women than men, many health care providers assume these patients are no longer interested in sexual activity. Our society does not view sexuality as an important activity of living for the aging, especially women who are ill. Yet women who suffer myocardial infarction (MI) are not likely to report decreased libido one year after the infarction occurs and even fewer cite problems with orgasm responsiveness (Baggs, 1987). Most look to resume healthy, active sex lives.

Kautz et al. (1990) found nurses to believe that patients were either too ill, too anxious, or relatively unconcerned about their sexuality. Nurses viewed themselves as having sufficient knowledge and willingness to discuss sexual concerns if the patient initiated the discussion. Ironically, the research shows that a vast a majority of male patients (97%), have at least one sexual concern, but prefer to be asked about these sexual health concerns by their healthcare provider. Seventy five percent said they would not discuss sexual matters without first being asked (Longworth, 1997). Most patients desire the chance to discuss sexual issues, yet do not verbalize their concerns unless given the opportunity in a caring and professional manner. An unaddressed sexual issue can be one of the most negative influences on the social well being of a patient. If patients receive accurate up-to-date information and support in the area of sexuality and intimacy, they will be empowered to make well informed decisions about their treatment options. This will assist them in gaining a sense of control over their bodies and their health.

D. Role of Nursing in Sexuality Education and Assessment

There are various reasons why nurses may not be discussing sexuality issues with their patients. They may not have basic interviewing skills, or perhaps the patient health history in their institution of employ does not include a sexuality component. The nurse may not feel comfortable discussing what is perceived by many as the most intimate of details, or the belief system of the nurse may radically differ from that of the patient, thus making avoidance of the subject matter a viable option.

Basic interviewing skills assist the nurse in establishing a sense of trust with the patient while maintaining professionalism. The first step in the nurse/patient interview is to complete a health history, which includes a sexual assessment. The sexual history can be introduced as an essential part of the health history and should be completed in a

location that assures privacy with no interruptions. The sexual health history helps to define the patient's needs, expectations, and behaviors (Longworth, 1997).

The format for the health history is common in most physical assessment texts and health care institutions. The format includes such things as gynecologic history for women; fathering for men; and for both men and women, sexual orientation, function, satisfaction, and problems. Contraceptive methods, HIV exposure, masturbation, alternative sexual practices and relationship with sexual partner are also included.

A brief set of questions can be added to the format to screen for sexual dysfunction, for example:

1. Do you have any concerns about your sexual functioning?
2. Has there been any change in your sexual functioning?
3. How satisfied are you with your sex life?
4. Has your medication (or condition) affected your sexual functioning?

These questions should be open-ended thereby allowing for expansion according to the responses received (Andrews, 2000). The discussion should be honest and confidential creating an atmosphere of security for both the patient and the nurse.

Herson et al.(1999) identified barriers common to nurses in their lack of provision of sexuality information as follows:

- Too little time due to reduced hospital lengths of stay limits the nurse/patient interaction.
- Nurses often feel insecure in their knowledge base.
- The nurse perceives the provision of sexual information as someone else's job.
- Personal attitudes and beliefs about sexuality often conflict with those of the patient.

- Many nurses receive minimal training on sexual health/relationship issues.
- Often the patient is not ready to learn, or the diagnoses/treatment may be so debilitating at the time, that the information is not absorbed.
- Embarrassment on the part of the patient/nurse often leads to avoidance.
- Health care workers often divorce clinical care, for example, prescription medications, from the impact it may have on sexual functioning.
- The physical environment may not provide privacy.
- Patients may harbor unrealistic expectations about sexual functioning.

The American Nurses Association and the Oncology Nursing Society published nursing practice standards (1996) that include a standard related to sexuality. This standard of practice holds nurses responsible for educating patients on the sexual side effects of treatment and may be considered a legal standard. Nurses have an ethical responsibility to educate their patients, which extends to sexuality education (Shuman & Bohachick, 1987). To attain this standard of practice, the nurse must appreciate the broad scope of sexual issues facing patients with chronic illness and be willing and able to meet this challenge. Recognizing the complexity of sexual issues, four areas of competency have been identified for the successful inclusion of sexuality into practice:

1. Comfort with sexuality
2. Excellent communication skills
3. Knowledge base about sexuality in health and illness
4. Role models to demonstrate integration of sexuality into nursing practice

Comfort in discussing sexuality with patients is the first area of competency. Nurses must be comfortable with their own sexuality, be aware of a broad range of sexual behaviors, and accept those with a sexual orientation that differs from their own. Nurses must identify and be aware of their own values, make conscious efforts not to

communicate negative thoughts or feelings, and work to suppress negative subconscious thoughts or body language (Appendix A).

For therapeutic discussions in sexuality, essential skills such as strong interviewing techniques, good listening, comfort with silence, the use of open-ended questions, reflection, and humor are required. Ways to strengthen these skills include audio taping and critiquing interactions with patients, asking co-workers for constructive criticism, and role playing. The nurse must be aware of the patient's language and definition of terms related to sexuality.

The third area of competency involves the nurse's having knowledge of sexual functioning in health and illness. Knowledge about human physiologic function, anatomy and physiology, hormone levels, and life sexual changes are essential. Knowledge of the effects of various treatments and procedures on the sexuality of the patient is imperative for successful counseling to occur.

Often the nurse has acquired the preceding competencies but is unable to put them into practice because sexuality issues are not routinely discussed in the particular work environment. Finding a nurse who has already put the competencies into practice helps. This mentor nurse can function as a role model and can assist by offering positive experiences she has had offering sexuality counseling in her practice.

Woods (1975) identifies the objectives of offering sex education to nurses as follows:

- Be open to other opinions and controversial sexual issues
- Become desensitized to sexual stimuli and resensitized in a humane way
- Openly communicate about sexual topics
- Prevent sexual dysfunction

Steps to attain these objectives can be accomplished by identifying one's own fears and discomfort in discussing sexual matters, being nonjudgmental, and being tolerant. Practicing these behaviors may encourage self-acceptance. Taking an inventory of one's own feelings and values about sexual health issues can help. Other ways to desensitize oneself are to take sex education classes and view films that portray love and sex scenes. Developing a list of sexual jargon and then saying the words out loud will help to desensitize. Role-playing is also a helpful tool that can be used to practice sexual assessment and counseling (Longworth, 1997). Group discussions with colleagues about controversial topics such as group sex, mate swapping, and homosexuality can assist the nurse to clarify her own values by listening to other's perceptions.

Starting to talk about sexuality is the most difficult part of counseling. The first step is to identify potential areas of concern and assess the sexuality of the patient. Assessment of the effects of chronic illness and its treatments on sexuality occurs on two levels. The first provides an overview of body image, sex roles, relationships, and sexual functioning. The second level is a more problem focused assessment and can be done by a sex therapist.

First level assessment can be performed by all nurses and is best done through open-ended questions focusing on sexual roles, relationships, and functioning. When assessing sexuality, it is best to move from less intimate topics to more intimate ones. If nurses identify issues or problems that are beyond their scope of practice, they must refer to an appropriate practitioner: a sex therapist. The sex therapist would then perform a second level assessment, which is problem focused, based on the potential presence of a sexual dysfunction.

A key issue to consider when talking to the patient about sexual issues is that it is not just the patient, but his or her partner that is affected by the difficulty (Gamel et al.,

1993). It is important to remember that it is the patient's relationship that is the patient (Jones, 1999). Rosen & Leiblum (1995) recommend that for counseling to be successful, both people in the relationship need to be involved.

One of the most important qualities needed by nurses to maximize the effectiveness of sexual discussions is personal comfort regarding sexuality and illness. Annon's model is useful for nurses to reference when discussing sexuality. Annon's Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT) model provides a logical sequence for sexual assessment and progressive intervention.

The first level, Permission, requires the nurse to inform the patient that sexual concerns are a legitimate component of the ongoing care and assessment of the patient's illness. The nurse gives the patient permission to think about sexuality and illness at the same time by bringing up sexual issues. This allows the nurse to make a complete and accurate assessment of the patient's self-described sexual status and develop an appropriate plan of care. It establishes a trusting and professional relationship and empowers the patient to discuss sexual concerns. In addition, giving permission is therapeutic in itself, and can help to alleviate fear and anxiety about sexual impairment (Risen, 1995).

Limited Information, Annon's second intervention, is an educational component and may be all that is required to help patients resume normal sexual functioning. At this level, the nurse gives the patient specific, factual information directly related to their sexual concerns. Examples of this information may include written information, videos, or verbal descriptions of the side effects of certain medications/treatments. Limited information provides the patient with a foundation for reassessment of sexual beliefs and values. Psychological, cultural, and social factors that have influenced the patient's sexuality can be acknowledged and explored at this time (Longworth,1997). This is a

time for patients to realize that sexual functioning and sexual response are within their control and can possibly be changed, rather than believe something is wrong with them.

Specific Suggestions are strategies offered by the nurse to help the patient overcome sexual difficulties by advocating behavioral changes. Suggestions can include the use of vaginal lubricants, alternate sexual positions, safer sexual practices, and different means of sexual expression as well as ways to control physical symptoms.

Intensive Therapy requires referral to a highly trained and competent therapist who specializes in treating sexual disorders among chronically ill patients. This involves recognition by the nurse that expert treatment may be needed and directing the patient to the resources available.

Recognizing the pleasure that sexuality brings and the pain that its absence creates can prompt the nurse to include a sexual assessment on all patients. By legitimizing the topic of sexuality from the first nurse/patient interaction, the nurse gives the patient permission to think and talk about sexuality and its relation to illness (Hughes,2000). Because nurses are in a very intimate exchange with their patients, they are in a privileged position to educate them about the most intimate of acts related to their health and well being. A sympathetic, compassionate, knowledgeable nurse can be the key to the patient's discovery of or return to healthy sexual functioning.

III. METHODOLOGY

A. Introduction

Based upon the review of the literature, the investigators learned that assessing one's own values and attitudes and improving one's knowledge base about sexuality will increase the likelihood that nurses will address sexuality issues with their patients. The researchers, a social worker and a nurse practitioner developed and presented a sexuality education program for nurses. The study 1) determined the attitudes and knowledge base of the population of nurses attending the workshop, 2) presented a three hour sexuality education workshop, 3) assessed the impact of the workshop on those present, and 4) compared sexual attitudes and knowledge of the participants before the workshop with sexual attitudes and knowledge after the workshop.

The program was team taught by the investigators and was sponsored by Health First, a health care corporation in Melbourne, Florida. The Health First system consists of three hospital systems, numerous physician groups, rehabilitation and fitness centers, and an insurance system. Health First currently employs over 1700 registered nurses. Permission for the program was granted from the institution's Vice President of Nursing. Institutional Review Board approval was obtained.

B. Study Sample

The convenience sample consisted of eighteen female registered nurses who participated in a hospital based three hour sex education program developed specifically for nurses. All nurses within the Health First system were invited to participate in the program via flyers posted on their units and the Health First intranet system. Participation was voluntary. Participants in the program were identified by code numbers. Each study participant consented to participate in the study prior to the beginning of the program. Participants were guaranteed anonymity and offered the right

to withdraw from the program at any time. Results of the study were made available to participants at their request.

C. Study Design

The pretest/posttest design was used so that base line data about knowledge and attitudes concerning sexuality could be obtained. The pretest packet (Appendix B) was administered as the nurses entered the education center. The pretest packet included an introduction letter to the nurses detailing the program, a demographic sheet, the 35 question attitude section of Harold Lief's Sex Knowledge and Attitude Test (SKAT, 1971), and a 32 question knowledge test.

Completed pretests were sealed in envelopes and exchanged for a sexuality word search (Appendix C) that was designed to familiarize the nurses with some of the terms to be used during the education program and help to desensitize them. The nurses were also given a printed copy of the power point presentation that included the lecture content, and patient interventions for ill patients suffering with sexuality problems (Appendix D).

D. Educational Program

The educational program included lecture, discussion, class participation, role play, and games in a classroom format at the hospital's Education Center. Participants received nursing continuing education units for their participation. The Microsoft Power Point lecture focused on sexual anatomy and physiology, the sexual response cycle, chronic illness and its effect on sexuality, as well as medications. The lecture stressed the importance of body image and relationships, provided sexual jargon desensitization, and overviewed a brief nursing sexual assessment. Barriers to the provision of sexuality education were addressed, and education tools for providing sexuality support and counseling were given.

The games served to reinforce the lecture content of the program and included a Sex Ed Jeopardy game (Appendix E). For Jeopardy play, the nurse participants were divided into two groups. Topics for the game included Disease States, Libido Busters, the PLISSIT, the Sexual Response Cycle, and Medications. The participants were divided into five groups for the brainstorm and role play exercises of the program. For these exercises, each group was given a different case study that detailed a disease state and the sexual dysfunction associated with that disease. Each group was instructed to problem solve and then role play their assigned case.

The posttest was administered at the conclusion of the education program. The posttest included the attitude and knowledge sections included in the pretest and questions 1-5 from the demographic sheet (Appendix F). Completed posttests were placed in sealed envelopes and exchanged for a certificate for contact hours.

The demographic sheet contained information on age, race, gender, marital status, nursing education level, current area of nursing, and area of practice. Other items included information about previous sexuality courses offered as part of the basic nursing education experience as well as any additional sexuality education programs attended since obtaining the registered nurse degree. There were five questions on the demographic sheet relating to initiation of, comfort with, and knowledge of patient sexuality.

E. Description of the Sex Knowledge and Attitude Test (SKAT)

The SKAT was developed by Dr. Harold Lief as a teaching and research instrument. Dr. Lief, a pioneer in the field, was instrumental in creating sexual education programs in medical schools. He is a long time member of Planned Parenthood and Past President of the Sex Information and Education Council of the United States (SIECUS). In 1970, under his direction, SIECUS developed its first training manual for Planned

Parenthood sex educators. Its items have been an important tool in gathering information about attitude and knowledge. The test has been administered to thousands of nurses and medical student's pre/post courses in human sexuality to determine changes in attitudes and knowledge.

Permission to use the SKAT (1971) was obtained from Dr. Lief in a two poignant telephone conversations. For the purpose of this study, at Dr. Lief's suggestion, only the Likert scaled attitude section of the SKAT was administered. Select questions from the knowledge section were used as well. Content validity of the SKAT was provided by studies demonstrating increased sexual knowledge and liberalization of sexual attitudes following educational experiences. Alpha reliability coefficients for the attitudes scales were reported to be 0.68-0.86. This indicates moderately good to good internal consistency. The reliability for the knowledge test used the Kuder-Richardson, and was estimated to be 0.87 (Shuman et al., 1987).

The SKAT contains four attitude scales. The items are either forward or reverse scored from 1 to 5. Scores relate an individual's performance to the average performance of a specially gathered normative sample of first through fourth year medical students. The average performance on this normative sample was equated with a score of 50. In all scales, a high score implies a liberal attitude and a low score a conservative one.

The Heterosexual Relations (HR) scale measures attitudes towards premarital and extramarital heterosexual sex. Individuals who score high on the HR (above 60) regard premarital and extramarital sexual encounters as acceptable and possibly benefiting marital relations. Scores below 40 imply conservative attitudes.

The Sexual Myths (SM) scale measures acceptance or rejection of commonly held fallacies, taboos and misconceptions about sexuality. Scores above 60 indicate rejection of these misconceptions.

Scores above 60 on the Abortion (AB) scale imply that abortion is viewed as an acceptable reaction to an unwanted pregnancy. Scores address the individual's general social, medical and legal feelings about abortion. Scores below 40 indicate strongly negative feeling and support right to life attitudes.

Those scoring above 60 on the Masturbatory section (M) view autoerotic stimulation as healthy and acceptable. Scores below 40 indicate a negative and unhealthy view of masturbation.

The knowledge section of the pretest/posttest was designed by the researchers and served to support the curriculum developed and taught in the sexuality program. After discussion with Dr. Lief, it was decided that additional questions were needed to explore the educational material presented and to expand on knowledge since1971. Questions 1 to 21 originated in Lief's 1971 study and questions 22 through 32 were developed by the researchers.

IV RESULTS AND DISCUSSION

A. Research Questions

This chapter will present the findings of this study as they relate to the following questions:

1. Do nurses routinely discuss sexuality with their patients as part of nursing care?
2. Are nurses comfortable discussing sexuality with their patients?
3. Will a three hour sexuality education program alter the attitude and knowledge of
   nurses when discussing sexual issues with patients?
4. Does the education level of a nurse influence the likelihood that the nurse will address sexuality issues with the patient?

B. Demographics

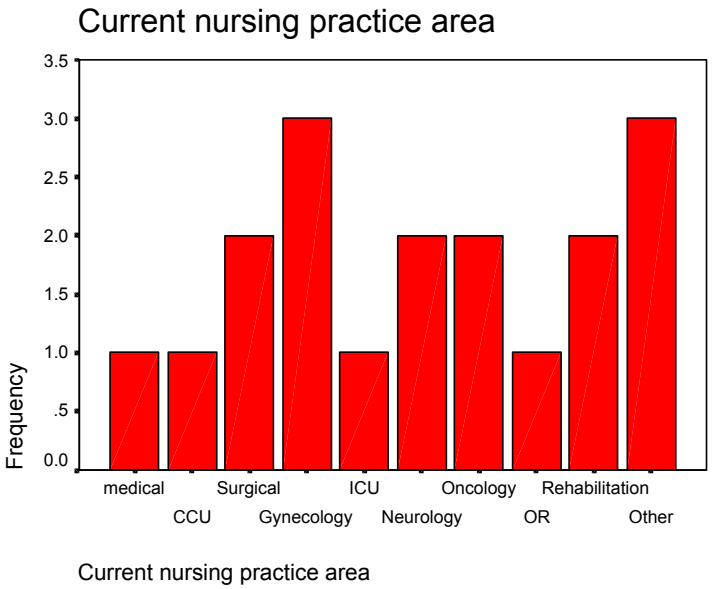
Nurses from a large health care corporation that employs 1700 registered nurses were recruited for the study. A total of 20 registered nurses registered to attend the study program. Of the 20 registered, 18 nurses participated. The distribution of the sample according to various demographic characteristics is to follow (Table 1). All nurse participants 100% (n=18) were female. The largest number of participants 61% (n=11) fell in the 40 – 49 year age range. 11.1% (n=2) were aged 30 - 39, 16.7% (n=3) were aged 50 - 59, and 11.1% of the participants (n= 2) were aged 60 - 69. 88.9% (n=16) of the participants were Caucasian, 5.6% (n=1) African-American and 5.6% (n=1) Other. The majority of the participants 66.7% (n=12) were married, 27.8% (n=5) were Divorced and 5.6% were (n=1)Widowed.

Table 1: Demographics

		n=x	Percentage
Gender	Female	18	100
	Male	0	0
Age	30 - 39	2	11.1
	40-49	11	61.1
	50-59	3	16.7
	60-69	2	11.1
Race	Caucasian	16	88.9
	African American	1	5.6
	Other	1	5.6
Marital Status	Widow	1	5.6
	Married	12	66.7
	Divorced	5	27.8
Nursing Education	Associate	5	27.8
	Diploma	3	16.7
	BSN	5	27.8
	MS	5	27.8
Years in Nursing	3 to 5	1	5.6
	6 to 10	1	5.6
	11 to 15	2	11.1
	> 15	14	77.8

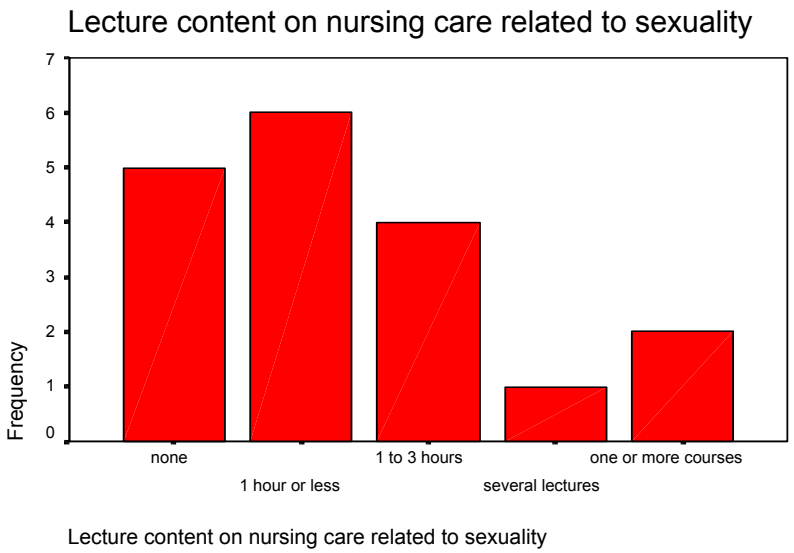
The study participants practiced nursing in a variety of settings. Half of the nurses were working in staff nurse positions 50% (n=9). 16.7% (n=3) were clinical nurse specialists, 11.1% (n=2) staff development, 5.6% (n=1) nurse manager, 5.6% office nurse, and 11.1% (n=2) identified themselves as other. Most had been practicing nursing for greater than 15 years 77.8% (n=14), 11.1% (n=2) 11-15 years, 5.6% (n=1) had been practicing 6-10 years and 5.6% (n=1) 3-5 years. (Graph A).

Graph A



The level of education varied, with 16.7% (n=3) holding a diploma in nursing, 27.8% (n=5) an associate degree in nursing, 27.8% (n=5) a baccalaureate in nursing and 27.8% (n=5) a master's degree in nursing. Most participants 66.7% (n=12) reported less than 3 hours of lecture content on human sexuality while in nursing training, 22.2% (n=4) reported several lectures and 11.1% (n=2) reported one or more courses received during nursing training (Graph B). Only 16.7% (n=3) participants reported any clinical experience incorporating sexuality in nursing care as part of their nursing education. 83.3% (n=15) stated that they received no training incorporating sexuality into their clinical practice.

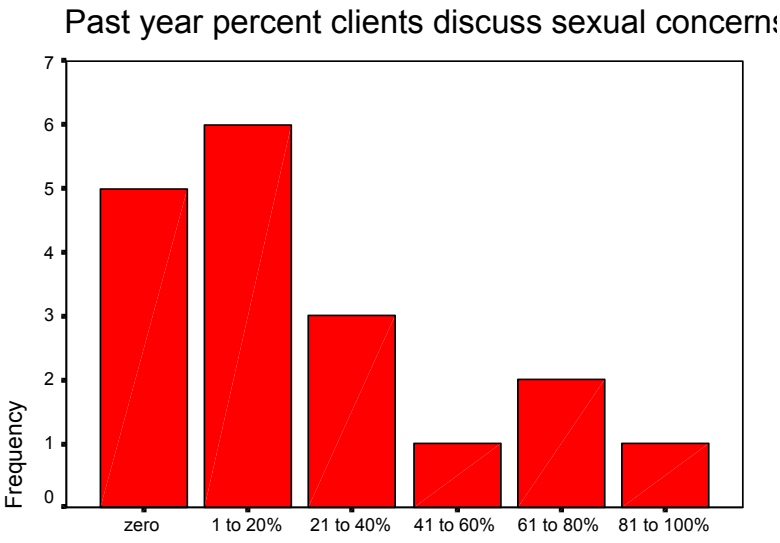
Graph B



Lecture content on nursing care related to sexuality

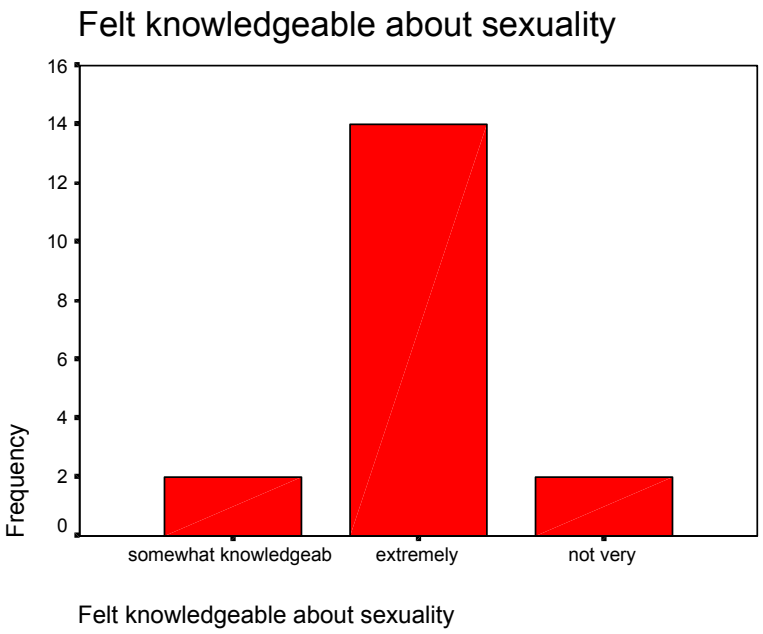
The majority of the participants 77.8% (n=14) offered to discuss patient sexual concerns less than 40% of the time (Graph C), despite the fact that 88.9% (n=16) felt knowledgeable about sexuality (Graph D), and 72.3% (n=13) usually or always felt comfortable discussing sexual matters (Graph E).

Graph C

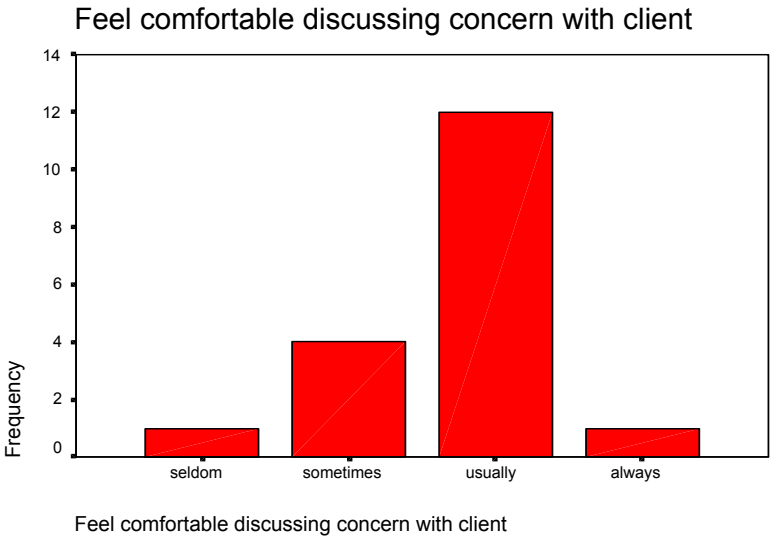


Past year percent clients discuss sexual concerns

Graph D

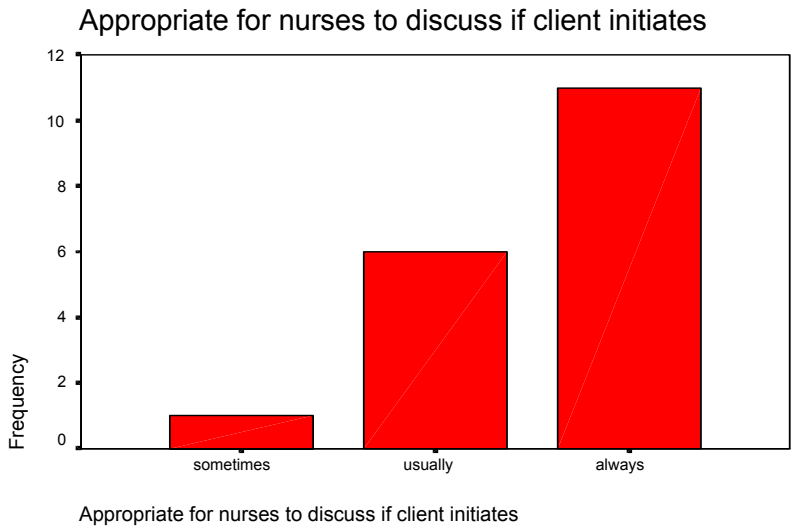


Graph E



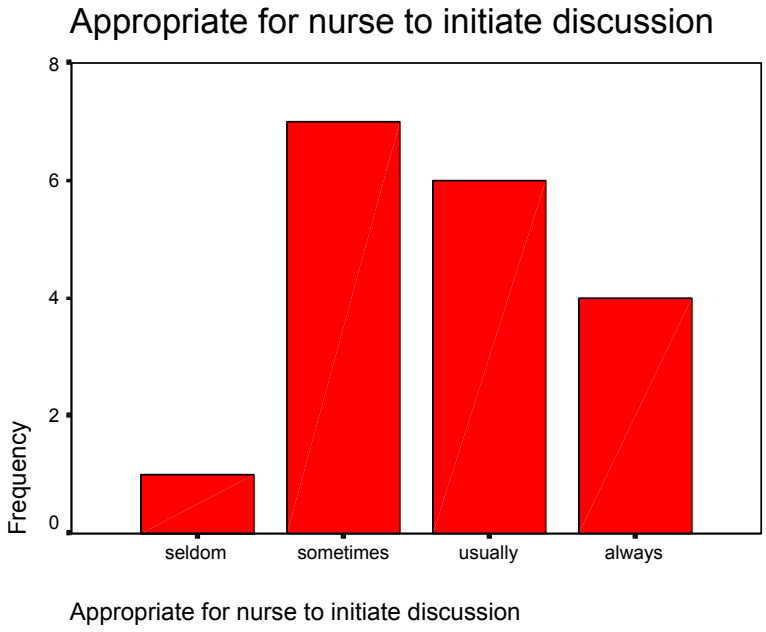
61% (n=11) of the participants felt it was always appropriate for nurses to discuss sexuality issues that are client initiated, 33.3% (n=6) felt it was usually appropriate and 5.6% (n=1) sometimes felt it appropriate (Graph F).

Graph F



If the sexuality discussion was nurse initiated only 22.2% (n=4) felt it was always appropriate for the nurse to initiate the discussion, 33.3% (n=6) usually, 38.9% (n=7) sometimes, 5.6% (n=1) seldom (Graph G).

Graph G



Cross tabulating nursing education level with the appropriateness of nurses initiating sexuality discussion found 22.2% (n=4) of the BSN/MSN nurses always initiate

discussions about sexuality with the patient. The findings suggest that Associate Degree nurses are more likely to initiate discussion than the majority of the BSN group (Table 2).

Table 2 : Crosstabulation Appropriateness vs. Education Level:

appropriate for nurse to initiate discussion * highest level of nursing education Crosstabulation

Count

		highest level of nursing education				
		Associates	MS	Diploma	BSN	Total
appropriate for nurse to initiate discussion	seldom			1		1
	sometimes		1	2	4	7
	usually	5	1			6
	always		3		1	4
Total		5	5	3	5	18

Cross tabulating nursing education level with the amount of lecture content on human sexuality found no significant difference among the groups (Table 3)

Table 3: Crosstabulation Lecture vs. Education

how much lecture content on human sexuality in nursing training * highest level of nursing education Crosstabulation

Count

		highest level of nursing education				
		Associates	MS	Diploma	BSN	Total
how much lecture content on human sexuality in nursing training	none	2		2	1	5
	1 hr or less		4			4
	1 to 3 hours		1	1	1	3
	several lectures	2			2	4
	one of more courses	1			1	2
Total		5	5	3	5	18

C. Attitudes

Lief (1971, p. 10) conducted his factor analysis identifying four underlying factors of Heterosexual Relationships (HR), Sexual Myth (SM), Abortion (A) and Autoeroticism (M). Factor Analysis of the item response of the 18 Nurse Participants was also conducted using Reliability Analysis Alpha for SPSS for Windows 11.0 which resulted in three factors. The three factors were Heterosexual Relationships (HR), Sexual Myth (SM), and a combining of Abortion (A) and Autoeroticism (M) into one factor. This showed that while the Nurse Participant group was substantially smaller then the 1171 participants reported in Lief's study, the Nurse Participants showed similar characteristics (Table 4).

Table 4: Reported Alphas

Scale Designation	Beck Sample alpha	C-V Sample alpha	Experimental alpha
Heterosexual Relationships	0.86	0.86	0.70
Sexual Myth	0.71	0.68	0.71
Abortion	0.80	0.77	**0.63
Autoeroticism	0.81	0.84	

** Abortion + Autoeroticism combined

Histograms and exploratory data analysis was conducted for the pre- and post-test results of the Attitudes of the Nurse Participants. It was determined that there was no significant change in attitudes after the three-hour education program was conducted.

D. Knowledge

Data analysis of Dr Lief's True/False questions of the knowledge section demonstrated no

significant change in knowledge pre- or posttest. There was a significant difference in questions K22 – K32 which were the multiple choice questions designed by the study authors. The nurse participant answers to questions K22 – K32 are given below. The correct responses to each question are in bold type.

22. How long should a patient who had an uncomplicated heart attack wait prior to resuming sexual intercourse?

a. 1-2 weeks b. 3 months c. 6 weeks d. 6 months

Correct Answers Pretest	Correct Answers Posttest
22.2% (n=4)	100% (n=18)

23. When taking a patient's sexual history, what types of questions should be asked?

a. confrontational b. direct **c. open-ended** d. judgmental

Correct Answers Pretest	Correct Answers Posttest
72.2% (n=13)	100% (n=18)

24. Annon's model is used for:

a. viewing sexual relationships b. measuring sexual dysfunction
c. defining sexuality **d. sexual assessment**

Correct Answers Pretest	Correct Answers Posttest
55.6% (n=10)	77.8% (n=14)

25. Another name for mutual body-pleasuring exercises is called?

a. masturbation b. sexual intercourse **c. sensate focus** d. fellatio

Correct Answers Pretest	Correct Answers Posttest
33.3% (n=6)	61.1% (n=11)

26. Nurses can increase their comfort level in discussing sexual concerns with patients in a number of ways:

a. watching educational videos
b. role playing with nurses
c. taking a sexuality education course
d. all of the above

Correct Answers Pretest	Correct Answers Posttest
88.9% (n=16)	83.3% (n=15)

27. Nurses should discuss patients sexual concerns:

a. early in the treatment
b. only if the partner is there
c. when another nurse is present
d. only if the patient asks

Correct Answers Pretest	Correct Answers Posttest
88.9% (n=16)	100% (n=18)

28. Which of the following ways may cancer affect sexuality?

a. loss of sexual desire
b. infertility
c. distorted self image
d. loss of pubic hair
e. all of the above

Correct Answers Pretest	Correct Answers Posttest
100% (n=18)	100% (n=18)

29. Which of the following is a phase of the sexual response cycle?

a. climax phase
b. erection phase
c. arousal phase
d. lubrication phase

Correct Answers Pretest	Correct Answers Posttest
55.6% (n=10)	72.2% (n=13)

30. All of the following medications have a negative effect on libido except:

a. SSRI's
b. H2 Blockers
c. Calcium Channel Blocker's
d. Tamoxifen

Correct Answers Pretest	Correct Answers Posttest
5.6% (n=1)	50.0% (n=9)

31. Alcohol, drugs and tobacco most often negatively affect a person's sexual performance.

a. True b. False

Correct Answers Pretest	Correct Answers Posttest
100% (n=18)	88.9% (n=16)

32. The PLISSIT stands for:

a. Permission, Limited Information, Specific Information, Treatment
b. Performance, Lubrication, Sexual Information, Intense Therapy
c. Pregnancy, Liability, Sexual Intercourse, Treatment
d. Permission, Limited Information, Specific Information, Intensive Therapy

Correct Answers Pretest	Correct Answers Posttest
66.7% (n=12)	88.9% (n=16)

E. Nursing Practice

Posttest questions regarding nursing practice found a significant change in future nursing practice regarding sexuality counseling. At the completion of the posttest nurses were asked to answer the following five questions:

Following completion of this program: To what extent will your nursing practice involve the following activities? (Circle the appropriate word.)

33. With what percentage of your clients will you offer to discuss sexual concerns?

	PRETEST	POSTTEST
a. zero	27.8% (n=5)	10.5% (n=2)
b. 1% to 20%	33.3% (n=6)	21.1% (n=4)
c. 21% to 40%	16.7% (n=3)	5.3% (n=1)
d. 41% to 60%	5.6% (n=1)	5.3% (n=1)
e. 61% to 80%	11.1% (n=2)	31.6% (n=6)
f. 81% to 100%	5.6% (n=1)	15.8% (n=3)

34. Do you think it is appropriate for nurses to discuss sexual concerns with clients if the client initiates the discussion?

	PRETEST	POSTTEST
a. never	0%	0%
b. seldom	0%	0%
c. sometimes	5.6% (n=1)	0%
d. usually	33.3% (n=6)	33.3% (n=6)
e. always	61.1% (n=11)	66.7% (n=12

35. Do you think it is appropriate for nurses to initiate discussion of sexual concerns with clients?

	PRETEST	POSTTEST
a. never	0%	0%
b. seldom	5.6% (n=1)	0%
c. sometimes	38.9% (n=7)	5.6% (n=1)
d. usually	33.3% (n=6)	61.1% (n=11)
e. always	22.2% (n=4)	33.3% (n=6)

36. To what extent do you feel knowledgeable about sexuality?

	PRETEST	POSTTEST
a. not at all knowledgeable	0%	0%
b. not very knowledgeable	11.1% (n=2)	0%
c. somewhat knowledgeable	11.1% (n=2)	61.1% (n=11)
d. very knowledgeable	0%	33.3% (n=6)
e. extremely knowledgeable	77.8% (n=14)	5.6% (n=1)

37. Do you feel comfortable discussing sexual concerns with clients?

	PRETEST	POSTTEST
a. never	0%	0%
b. seldom	5.6% (n=1)	0%
c. sometimes	22.2% (n=4)	22.2% (n=4)
d. usually	66.7% (n=12)	66.7% (n=12)
e. always	5.6% (n=1)	11.1% (n=2)

SUMMARY AND RECOMMENDATIONS

A. Introduction

The purpose of this study was to design a three hour education program that would assist nurses in the provision of sexuality counseling to their patients by enhancing nurses' attitudes and knowledge toward their own sexuality as well as that of their patients. The program proposed to increase the sexuality knowledge base of the nurse through lecture, discussion, class participation, role-play, and games. The study 1) determined the attitudes and knowledge base of the population of nurses attending the workshop, 2) presented a three hour sexuality education workshop, 3) assessed the impact of the workshop on those present, and 4) compared sexual attitudes and knowledge of the participants before the workshop with sexual attitudes and knowledge after the workshop.

The population for this study was registered nurses from an integrated health care system in Central Florida. Eighteen female registered nurses attended the program which was offered in a classroom setting in the health care system's corporate education building.

Data was collected using pretest/posttest design with multiple choice questionnaires. Respondents were asked to place all answers directly on the questionnaires and seal them in manila envelopes prior to returning them to the study investigators. The questionnaires contained three parts in the pretest and two parts in the posttest. The pretest consisted of a demographic sheet, a 35 question attitude scale and a 32 question knowledge test and took 30 minutes to administer. The posttest consisted of the 35 question attitude scale and the 32 question knowledge test and questions 1-5 of the demographic sheet which identified nursing practice. All posttests were completed in 20 minutes.

Data were computed using the Statistical Package for the Social Sciences (SPSS).

B. Summary of Findings

This education program was found to be useful with registered nurses in a hospital setting. Following completion of the program, the data analysis provided the following answers:

1. Nurses do not routinely discuss sexuality with their patients, but are more likely to do so if the patient initiates the discussion.
2. Nurses believe they are comfortable discussing sexuality with their patients.
3. Sexuality education programs can positively alter the knowledge of nurses when discussing sexuality with their patients.
4. Attending a sexuality education program increases the likelihood that the nurse will address patient sexuality issues in future practice.
5. Following completion of this program there was no clinically significant change in nurse attitudes.

It is not enough to teach the basic facts of human sexuality without exposing nurse learners to the cultural, historical and humanistic approaches of sexuality. It appears to be equally important to teach nurses communication techniques, desensitization, and basic skills that will allow them to put this knowledge into use. Using interactive techniques such as role play, requires the participants to be involved in the process, and encourages even the most shy and embarrassed nurse to participate. It has been shown that practice encourages confidence. The nurse must integrate all that has been learned into daily practice. This will then provide patients with the best possible care related to sexuality and illness.

The Permission stage of Annon's (1975) PLISSIT model involves letting the patient and the partner know that issues regarding sexuality are legitimate nursing concerns. It serves to foster open communication between the patient and the nurse, as

well as the patient and the partner. By asking the patient "How has this illness affected your sexuality," the nurse legitimizes sexuality as an appropriate topic of conversation. Just as the patient needs permission to think and talk about sexuality issues during illness, so too does the nurse need to feel permitted to talk about such delicate issues. Sexuality education programs serve to give permission to the nurse to discuss the topic of sexuality, thus legitimizing sexuality as an everyday function of the nurse when administering patient care.

When discussing delicate issues such as abortion, homosexual relationships, masturbation, and premarital sex, the aim of sexual education is not to try to change the nurse learners' beliefs, but to encourage nurses to be more aware of their own personal bias. As professionals in the health care field, it is important for nurses to provide patient care in a non-judgmental environment and reign in their own beliefs, attitudes, and body language to prevent them from impacting patient care. To be effective in providing the best care possible, nurses do not necessarily need to be liberal in their attitudes, but must accept the differences in beliefs, values, and attitudes of the patients that they care for. It is our belief that this transformation in nursing can be achieved through a combination of training, dissemination of knowledge, and the teaching of appropriate communication skills.

C. Limitations of this Study

This study was limited to a self-selected population in one health care system in a conservative, non metropolitan community. Although all registered nurses in the system were invited to participate, sample size was small (18). Participation in the study was entirely voluntary, producing selection bias as the sample who attended may be significantly different from those who chose not to attend. The possibility of the

Hawthorne effect exists since the nurses knew that their knowledge and attitudes were being tested.

D. Implications and Recommendations

The positive changes in knowledge and behavioral intentions found as a result of this program have paramount implications. First, a study is needed to determine if nursing practice is truly affected after attending a sexuality workshop. A replication of the above study followed by a 3 month, 6 month and 12 month assessment of behavioral changes in nursing practice would support that belief. Identifying time constraints and embarrassment as reasons for the poor attendance at the program, perhaps a self instructional module that uses video tape or an interactive computer program would be more likely to meet the needs of nurses who are busy struggling time, careers, and family obligations.

Patient needs could be better addressed if both practicing nurses and nursing students were exposed to sexuality material and given the tools with which to impart sexuality information. The addition of specific sexual history questions to hospital admission forms was identified as a true need in clinical practice. Equipping the nurses with appropriate communication techniques through periodic skill review and unit based in-services would support the incorporation of sexuality knowledge into practice. Improvements in nursing curriculum could be achieved by increasing the amount of time nursing students are taught about patient sexuality, and incorporating sexuality teaching into the student's clinical experience.

When patients are diagnosed with a chronic illness, they often feel that their sexual relationship has come to an end. These feelings can be very traumatic and unnecessary. By recognizing that sexuality is an essential part of every human being, and that sexual expression is vital to good health and recovery, a knowledgeable and

compassionate nurse can serve as the key to the patient's return to healthy sexual functioning.

The most difficult part of sexuality support and counseling is getting started. By identifying the need, and asking the first question, most nurses will find that their patients have been waiting for someone to address this sensitive subject with them and will be quite honest concerning the impact that disease has had on their sexuality.

REFERENCES

Andrews, W.C., (2000). Approaches to taking a sexual history. *Journal of Women's Health Gender Based Medicine*, (9), supplement 1: S21-S24.

Andrist, L.C. (1988). Taking a sexual history and educating clients about safe sex. *Nursing Clinical North American*, 23 (4), 959-973.

Annon, J.S. (1975). The Behavioral Treatment of Sexual Problems. Vol.1, Honolulu: Enabling Systems, Inc.

Baggs, J.G. & Karch, A.M. (1987). Sexual counseling of women with coronary heart disease. *Clinical aspects of coronary disease*, 16, (2) 154-159.

Brown, H.P. & Knotson, M.N. (2001). Clinician-patient communication. *The Female Patient*, (Nov), 8-10.

Calandra, J., & Peterson, R. (2001). Midlife sexuality, understanding the social, biological and emotional factors for women, *Nurse Week*, 1-10.e-Journal article: http://www.nurseweek.com/cc/cc206ahtml.

Childerston, J.K. (2002). Sex busters and boosters: making sense of sexual pharmacology. *Marriage and Family: A Christian Journal*, 5 (3), 1-17.

Chin, P. & Kramer, M. (1995) Theory and Nursing: a systematic approach. St. Louis: Mosby.

Crouch, S. (1999). Sexual health: Sexuality and the nurses' role in sexual health. *The British Journal of Nursing*, 8 (9), 601-606.

_____. (1999). Sexual Health: An overt approach to sexual health education. *The British Journal of Nursing*, 8 (10), 669-675.

DuBeau, C. E. Geriatric Medicine: an Evidenced-Based Approach. 4th edition. 157-165. New York: Springer-Verlaq.

Fisher, S.G., & Levin, D. (1983). The knowledge and attitudes of professional nurses caring for oncology patients. *Cancer Nursing*, 2, 55-61.

Flynn, P. M., McNeil, J., & Cruckshank, D.J. (2000). Sexual health after gynecologic cancer. e-Journal website: http://www.sexualhealthmatters.com/vliss4/article7.html.

Foley, F., Sanders ,A. (2003). Ferkauf Graduate School Of Psychology, Albert Einstein College of Medicine,Yeshiva University, NY, USA. International MS. Support Foundation Tuscan, AZ 85730. Sexuality, Multiple Sclerosis & Women. e-Journal website: http://www.imssf.org/sex3.shtml.

Gamel, C., Davis, B.D., & Hengeveld, M. (1993). Nurses' provision of teaching and counseling on sexuality: a review of the literature. *Journal of Advanced Nursing,* 13, 1219-1227.

Gallo-Silver L. (2000). The Sexual Rehabilitation of Persons with Cancer. *Cancer Practice,* Jan-Feb 8 (1), 10-15.

Gregory, P. (2000). Patient assessment and care planning: sexuality. *Nursing Standard,* 15 (9), 38-41.

Hart, L.K., Fearing, M.O., Milde, F.K., & Cox, D.M. (2003). Sexual dysfunction: the teaching of renal dialysis and transplant recipients. e-Journal website: http://eneph.com/feature_archive/sexual/v24n11p621.html.

Hawker, A. (1998). Sexuality and reproduction: major issues for women. e- Journal website: http://www.dinf.ne.jp/doc/english/asia/resource/z00ap/z00ap00303.htm.

Herson, L., Hart, K., Gordon, MJ., Rintala, DH. (1999). Identifying and overcoming barriers to providing sexuality information in the clinical setting. *Rehabilitation Nurse,* July-Aug 24 (4),148-151.

Hodgson, I. (2001). Sexual health: an introduction/ sexuality and sexual health: an introduction. e- Journal website: http://www.bradford.ac.uk/staff/ijhodgson/Teaching%20summaries/Sexuality%20slides.htm.

Hordern, A, (2000). Intimacy and Sexuality for the Woman with Cancer. *Cancer Nursing,* 23 (3), 230-236.

Hughes, M.K. (2000). Sexuality and the cancer survivor. *Cancer Nursing,* 23 (6), 477-482.

Ineffective Sexuality Patterns 706-721. e- Journal website: http://connection.lww.com/Products/carpenito10e/documents/ineffectivesexualitypatterns.pdf.

Jensen, S. (1986). Sexual dysfunction and diabetes mellitus. a six-year follow-up study. *Archives in Sexual Behavior,* 15, 271-284.

Kaplan, H.S., (1974). The New Sex Therapy, Active Treatment of Sexual Dysfunctions, New York: Brunner/Mazel.

Kelly, Gary. (2001). Sexuality Today, The Human Perspective. New York: McGraw-Hill.

Krueger, J.C., Hassell, J, Goggins, D.B., Ishimatsu, T., Pablico, M.R., & Tuttle, E.J. (1979). Relationship between nurse counseling and sexual adjustment after hysterectomy. *Nursing Research,* 28 (3), 145-150.

Landrum, P.A., Beck, C.M., Rawlins, R.P., & Williams, S.R. (1993). Mental Health: Psychiatric Nursing – a holistic life cycle approach. St. Louis: Mosby.

Lewis, S., Bor, R. (1994). Nurse's knowledge of and attitudes towards sexuality and the relationship of these with nursing practice. *Journal of Advanced Nursing,* (20), 251-259.

Lief, H., Payne T. (1975). Knowledge and attitudes. *American Journal of Nursing,* 75 (11), 2026-2027.

Longworth, J, (1997). Sexual assessment and counseling in primary care. *Nursing Practitioner Forum*, 8 (4), 166-171.

Marriner-Tomey, A. (1994). Nursing Theorists and Their Work. St. Louis: Mosby.

Matocha, L.K. & Waterhouse, J.K. (1993). Current nursing practice relating to sexuality. *Research in Nursing Health,* 16, 371-378.

Mayo Clinic (2000). Female sexuality after cancer. e-Journal website: http://www.mayoclinic.com/invoke.cfm?id=SA00071.

McInnes, R., A. (2003). Chronic illness and sexuality. *Medical Journal of Australia,* 179 (5), 263-266.

Muir, A. (2000). Counseling patients who have sexual difficulties. *Professional Nurse,* 15 (11), 723-726.

Muskoka-Parry South Unit Sexuality after Childbirth. e -Journal website: www.mpshu.on.ca/pregnancy/sexafter.htm.

National Cancer Institute. Sexuality & Reproductive Issues, The Prevalence and Types of Sexuality Dysfunction in People with Cancer (2003). Cancer.gov.1-34. e-Journal website: http://www,cancer.gov/cancerinfo/PDQ/supportivecare/sexualityhealthprofessional.

Nelson, J.R. (1999). Introduction to Counseling Skills. London: Sage.

Nusbaum, M.R., Gamble, G., Skinner, B., & Heiman, J. (2000). The high prevalence of sexual concerns among women seeking routine gynecologic care. *The Journal of Family Practice*, 49 (3), 229-232.

Palmer, H. (1998). Exploring sexuality and sexual health in nursing. *Professional Nurse.* 14 (1), 15-17.

Parish, K.L. (2002). Sexuality and hemophilia: connections across the life-span. *Haemophilia,* 8, 353-359.

Payne, T. (1976). Sexuality of nurses: correlations of knowledge and behavior. *Nursing Research*, 25 (4), 286-292.

Phillips, P. (2003). Transition to professional nursing. e-Course website: http://chua2.fiu.edu/faculty/phillips/NUR3055/transSexuality.htm.

Post Partum Counseling: A quick Reference Guide for Clinicians Association of Reproductive Health Professionals. e-Journal website: www.arph.org.

Risen, C. (1995). A guide to taking a sexual history. *Psychiatric Clinics of North America*, 18 (1), 39-53.

Rosen, R. & Leiblum, S. (1995). Treatment of sexual disorrders in the 1990's: An integrated approach. *Journal of consulting and clinical psychology*, 63 (6), 877-890.

Semmens, P. J. & Nolan, E., (2002). Heart Disease, High Blood Pressure & Sexuality, University of Michigan Health System. e- Journal website: www.med.umich.edu/libr/aha/umheartdismm.

Shah, H.S. (1991). Nurses views on sexuality: why, what, and how to change. *Journal of Nursing Staff Development.* 275-279.

Sheehy, G. (1995). New Passages: Mapping Your Life Across Time. New York: Random House.

Shuman, N. A., & Bohachick, P. (1987). Nurses attitudes towards sexual counseling. *Dimensions of Critical Care Nursing*, 6 (2), 75-79.

Stead, M.L., Fallowfield, L, Brown, J.M, Selby, P. (2001). Communication about sexual problems and sexual concerns in ovarian cancer: qualitative study, *British Medical Journal*. 323, 836-837. e-Journal website: www.bmj.com.

Steinke, E.E., & Pattterson, P. (1995). Sexual counseling of MI patients by cardiac nurses. *Journal of Cardiovascular Nursing*, 10 (1), 81-87.

Steinke, E. Research Work Group (2001). Myth vs reality: talk about sex with MI patients. *American Association of Critical Care Nurses*, 18 (12). e- Journal website: www.aacn.org/AACN/aacnnews.nsf/getarticlefive1812.open/document.

Sutter Health. The new mom, post partum adjustments. e-Journal website: http://babies.sutterhealth.org/afterthebirth/newmom/nmppadjustments.html.

The Merck Manual Of Geriatrics Men's & Women's Health Issues. (2003). Sexuality 1-7 e- Journal website: http/www.merck.com/mrkshared/mm-geriatrics section14/ch14.jsp.

Tomilinson, J, &. Milgram, E.C. (1999). Taking a sexual history. *Women's Journal of Medicine* 170, 284-286. e-Journal website: emilgrom@fammed.medsch.ucla.edu.

Webster's New World Medical Dictionary on line. (2000). e-Web site: http://www.medterms.com/script/main/art.asp?articlekey=2731.

Whipple, B. & Komissaruk, B.R. (1999). Beyond the G spot: recent research on female sexuality. *Psychiatry Annex*, 29 (1), 34-37.

William, H.A., Wilson, M.E., Hongladarom, G. & McDonell, M. (1986). Nurses attitudes toward sexuality in cancer patients. *Oncology Nursing Forum,* 13 (2), 39-43.

Wilmoth, M.C. (1998). Sexuality and resources for cancer professionals and their patients. *Cancer Practice*, 6, 346-348.

_____. (1996). Psychosocial dimensions of oncology nursing care. *Sexuality*, 5, 103-107

_____. (1994). Nurses and patients' perspectives on sexuality: Bridging the gap. *Innovations in Oncology Nursing*, 10, 34-36.

Wilmoth, M.C. & Spinelli, A. (2000). Sexual implications of gynecologic cancer. *JOGNN*, 29 (4), 413-421.

Woods, N.F. (1975). Human Sexuality in Health and Illness. St. Louis: Mosby.

Woody, J. D. (1992). Treating Sexual Distress: Integrative Systems Therapy. Newbury Park: Sage.

World Health Organization. Education and Treatment in Human Sexuality: The Training of Health Professionals . Technical Report Series, 572. Geneva, Switzerland: World Health Organization, 1975

APPENDIX A

SEXUAL HEALTH VALUES CLARIFICATION EXERCISES

Instructions:

1. *Identify which behaviors are acceptable to you and for others to understand.*
2. *Discuss your feelings and values conveyed by your responses and those of others*

	Okay for me	Okay for Teens	Okay for adults	Okay for Elders
Homosexuality				
Masturbation				
Abortion				
Sex Education				
Sex without marriage				
Oral-genital sex				
Anal intercourse				

3. *Which of the above are appropriate in settings such as: nursing homes, hospitals, day care centers, or private homes?*
4. *Define the word "Promiscuous."*

Longworth, Judith, 1997

APPENDIX B

Volpe, Wertheimer
Dissertation
April 29, 2004

Dear Nurse,

Nurses are working at the forefront to provide high quality, holistic care to their patients. The changes that have evolved in the healthcare industry over the past decade have significantly altered the role of the nurse, broadening the scope of practice. As patients liver longer and high tech medical treatments enhance the quality of their lives, the nurse has had to fine tune the interplay between the physical and psychological needs of the patient. Recognizing this, the American Nurses Association has employed standards of practice related to sexuality. Despite this there is little research on the topic and few schools of nursing offer courses in human sexuality as part of their curriculum. This project has been designed to assist nurses in the provision of sexuality counseling to their patients. Your participation in this project is greatly appreciated.

The following pages contain a series of questions. Some may be difficult to answer and are personal in nature. For the sake of the study, we ask that you be honest in each of your answers. Please be assured that confidentiality is of the utmost importance to us. We ask that you refrain from identifying yourself on the following pages and ask for assistance from one of the authors of this study if you have any questions.

If you are interested in the results of this study, please email one of the authors listed below and we will be happy to share the results with you. Thank you so much for your time and participation.

Sincerely,

Eileen M. Volpe MSN, ARNP, CST
Hibiscus OB/Gyn Associates, PA
330 E Hibiscus Blvd
Melbourne, FL 32901
321-725-1530
eileen.volpe@bellsouth.net

Joyce C. Wertheimer, MSW, CST
4197 Briarcliff Circle
Boca Raton, FL 33496
(561)445-5200
JoyC2000@aol.com

If calling please leave a message identifying yourself as a study participant, and leave a return phone call number. One of the study authors will contact you as soon as possible.

PRE TEST PART I: KNOWLEDGE

Each of the following statements can be answered either True of False. Please indicate your position on each statement using the following alternatives:

T. True **F. False**

Be sure to answer every question on the line below:

1. Pregnancy can occur during natural menopause (gradual cessation of menstruation).
   _____
2. A woman does not have the physiological capacity to have as intense an orgasm as a man.
   _____
3. There is no difference between men and women with regard to the age of maximal sex drive.
   _____
4. The use of the condom is the most reliable of the various contraceptive methods.
   _____
5. There are two kinds of physiological orgastic responses in women, one clitoral and the other vaginal.
   _____
6. Impotence is almost always a psychogenic disorder.
   _____
7. In some successful marriages sex adjustment can be very poor.
   _____
8. A woman who has had a hysterectomy (removal of the uterus) can experience orgasm during sexual intercourse.
   _____
9. In responsive women, non-coital stimulation tends to produce a more intensive physiological orgastic response than does coitus.
   _____
10. Masturbation by a married person is a sign of poor martial sex adjustment.
    _____
11. The onset of secondary impotence (impotence preceded by a period of potency) is often associated with the influence of alcohol.
    _____
12. Direct contact between penis and clitoris is needed to produce female orgasm during intercourse.
    _____
13. For a period of time following orgasm, women are not able to respond to further sexual stimulation.
    _____
14. Impotence in men over 70 is nearly universal.
    _____
15. Certain conditions of mental and emotional instability are demonstrably caused

by masturbation.

_____

16. More than a few people who are middle-aged or older practice masturbation.

_____

17. Menopause in women is accompanied by a sharp and lasting reduction in sexual drive and interest.

_____

18. Douching is an effective form of contraception.

_____

19. Sexual maladjustment is a major cause of divorce.

_____

20. A woman's chances of conceiving are greatly enhanced if she has an orgasm.

_____

21. For some women, the arrival of menopause signals the beginning of a more active and satisfying sex life.

_____

KNOWLEDGE

Please circle the correct answer:

22. How long should a patient who had an uncomplicated heart attack wait prior to resuming sexual intercourse?
    a. 1-2 weeks b. 3 months c. 6 weeks d. 6 months

23. When taking a patient's sexual history, what types of questions should be asked?
    a. confrontational b. direct c. open-ended d. judgmental

24. Annon's model is used for:
    a. viewing sexual relationships b. measuring sexual dysfunction
    c. defining sexuality d. sexual assessment

25. Another name for mutual body-pleasuring exercises is called?
    a. masturbation b. sexual intercourse c. sensate focus d. fellatio

26. Nurses can increase their comfort level in discussing sexual concerns with patients in a number of ways:
    a. watching educational videos b. role playing with nurses
    c. taking a sexuality education course d. all of the above

27. Nurses should discuss patients sexual concerns:
    a. early in the treatment b. only if the partner is there
    c. when another nurse is present d. only if the patient asks

28. Which of the following ways may cancer affect sexuality?

a. loss of sexual desire
b. infertility
c. distorted self image
d. loss of pubic hair
e. all of the above

38. Which of the following is a phase of the sexual response cycle?
a. climax phase
b. erection phase
c. arousal phase
d. lubrication phase

39. All of the following medications have a negative effect on libido except:
a. SSRI's
b. H2 Blockers
c. Calcium Channel Blocker's
d. Tamoxifen

40. Alcohol, drugs and tobacco most often negatively affect a person's sexual performance.
a. True
b. False

41. The PLISSIT stands for:
a. Permission, Limited Information, Specific Information, Treatment
b. Performance, Lubrication, Sexual Information, Intense Therapy
c. Pregnancy, Liability, Sexual Intercourse, Treatment
d. Permission, Limited Information, Specific Information, Intensive Therapy

PRE TEST Part II: ATTITUDES

Please provide your reaction to each of the following statements on sexual behavior in our culture, using the following alternatives:

Strongly agree - SA
Agree - A
Uncertain - U
Disagree - D
Strongly disagree - SD

Please be sure to answer every question **(Circle the appropriate response)**

1. The spread of sex education is causing a rise in premarital intercourse.
SA A U D SD

2. Mutual masturbation among boys is often a precursor of homosexual behavior.
SA A U D SD
3. Extramarital relations are almost always harmful to a marriage.
SA A U D SD

4. Abortion should be permitted whenever desired by the mother.
SA A U D SD
5. The possession of contraceptive information is often an incitement to promiscuity.

SA A U D SD

6. Relieving tension by masturbation is a healthy practice.
SA A U D SD
7. Premarital intercourse is morally undesirable.
SA A U D SD
8. Oral-genital sex play is indicative of an excessive desire for physical pleasure.
SA A U D SD
9. Parents should stop their children from masturbating.
SA A U D SD
10. Women should have coital experience prior to marriage.
SA A U D SD
11. Abortion is murder.
SA A U D SD
12. Girls should be prohibited from engaging in sexual self-stimulation.
SA A U D SD
13. All abortion laws should be repealed.
SA A U D SD
14. Strong legal measure should be taken against homosexuals.
SA A U D SD
15. Laws requiring a committee of physicians to approve an abortion should be abolished.
SA A U D SD
16. Sexual intercourse should occur only between married partners.
SA A U D SD
17. The lower-class male has a higher sex drive than others.
SA A U D SD
18. Society should offer abortion as an acceptable form of birth control.
SA A U D SD
19. Masturbation is generally unhealthy.
SA A U D SD
20. A physician has the responsibility to inform the husband or parents of any female he aborts.
SA A U D SD
21. Promiscuity is widespread on college campuses today.
SA A U D SD
22. Abortion should be disapproved of under all circumstances.
SA A U D SD
23. Men should have a coital experience prior to marriage.
SA A U D SD
24. Boys should be encouraged to masturbate.
SA A U D SD
25. Abortions should not be permitted after the twentieth week of pregnancy.
SA A U D SD
26. Experiences of seeing family members in the nude arouse undue curiosity in children.
SA A U D SD
27. Premarital intercourse between consenting adults should be socially acceptable.
SA A U D SD

28. Legal abortion should be restricted to hospitals.
SA A U D SD

29. Masturbation among girls is a frequent cause of frigidity.
SA A U D SD

30. Lower-class women are typically quite sexually responsive.
SA A U D SD

31. Abortion is greater evil than bringing an unwanted child into the world.
SA A U D SD

32. Mutual masturbation in childhood should be prohibited.
SA A U D SD

33. Virginity among unmarried girls should be encouraged in our society.
SA A U D SD

34. Extramarital sexual relations may result in a strengthening of the marriage relationship of the persons involved.
SA A U D SD

35. Masturbation is acceptable when the objective is simply the attainment of sensory enjoyment.
SA A U D SD

Sex Knowledge and Attitude Test (SKAT)

PART III: DEMOGRAPHICS

To what extent does your current nursing practice involve the following activities? (Circle the appropriate word.)

1. **In the past year, with what percentage of your clients have you offered to discuss sexual concerns?**

   a. zero b. 1% to 20% c. 21% to 40%
   d. 41% to 60% e. 61% to 80% f. 81% to 100%

2. **Do you think it is appropriate for nurses to discuss sexual concerns with clients if the <u>client</u> initiates the discussion?**

   a. never b. seldom c. sometimes d. usually e. always

3. **Do you think it is appropriate for <u>nurses to initiate</u> discussion of sexual concerns with clients?**

   a. never b. seldom c. sometimes d. usually e. always

4. To what extent do you feel knowledgeable about sexuality?

a. not at all knowledgeable b. not very knowledgeable c. somewhat knowledgeable d. very knowledgeable e. extremely knowledgeable

5. Do you feel comfortable discussing sexual concerns with clients?

a. never b. seldom c. sometimes d. usually e. always

Please provide the following information about yourself:

What is your gender?

_____ Male _____ Female

What is your age?

_____ 20 – 29
_____ 30 – 39
_____ 40 – 49
_____ 50 – 59
_____ 60 – 69

What is your race?

_____ Caucasian
_____ African-American
_____ Hispanic
_____ Other

What is your marital status?

_____ Single
_____ Married
_____ Other
_____ Widowed
_____ Divorced

What is your highest level of <u>nursing</u> education?

_____ Associate degree
_____ Diploma
_____ PhD / EdD / DNSc
_____ M.S.
_____ B.S.N.

How many years have you been a registered nurse?

____1-2 ____3-5 ____6-10 ____11-15 ____>15

What is your primary current practice position?

_____ Staff nurse
_____ Nurse manager
_____ Clinical specialist
_____ Office
_____ Other
_____ Staff development
_____ Faculty
_____ Case Manager
_____ Home Care

What is your current nursing practice area? (Check all that apply.)

_____ Medical
_____ Surgical
_____ Orthopedics
_____ Neurology
_____ Oncology
_____ ER
_____ OR
_____ Nursery
_____ Post-partum
_____ Gerontology
_____ Pediatrics
_____ Rehabilitation
_____ CCU
_____ Gynecology
_____ ICU
_____ Community Health
_____ Anesthesiology
_____ Recovery Room
_____ AIDS
_____ Labor & delivery
_____ Infectious disease
_____ Psych/mental health
_____ QA/UR/risk management

How much lecture content on <u>human sexuality</u> was included in your basic nursing education?

a. none b. 1 hour or less c. 1 to 3 hours
d. several lectures e. one or more courses

How much lecture content on <u>nursing care related to sexuality</u> was included in your basic nursing education?

a. none b. 1 hour or less c. 1 to 3 hours
d. several lectures e. one or more courses

Did your basic nursing education include any <u>clinical experiences</u> incorporating sexuality as part of your nursing care?

a. none b. 1 experience c. 3-5 experiences
d. 5-10 experiences e. > 10 experiences

Thank you for taking the time to complete this questionnaire.

APPENDIX C

Human Sexuality

Word Search

S C X O V A E R E **P E R M I S S I O N**
Q E P **V A G I N A L D R Y N E S S** R B
C Z X R **I N T E R C O U R S E** K I E O
A H O U H I` **V A G I N I S M U S** H S D
R R Q O A M V J Q M O **Q** O L K E J T Y
O T **W E L L N E S S** Y **P** R E P N O E I
U V P V D A I H R W V **G** G S D V E E M
S D L E H O L T V O T **A** A T U M M M A
A S J N A L P Z Y G N **T** S O L L A W G
L I M I T E D I N F O R M A T I O N E
E R E C T I L E D Y S F U N C T I O N
I N T E N S I V E T H E R A P Y A S E
S E X U A L R E S P O N S E C Y C L E
P L I S S I T L O S **I M P O T E N C Y**
A T T I T U D E H R E S O L U T I O N
S N O I T S E G G U S C I F I C E P S
O D I B I L N **D Y S P A R E U N I A** M
T O U C H V **E F I L F O Y T I L A U Q**

PLISSIT
PERMISSION
LIMITED INFORMATION
SPECIFIC SUGGESTIONS
INTENSIVE THERAPY
SEXUAL RESPONSE CYCLE
LIBIDO
AROUSAL
ORGASM
RESOLUTION
ERECTILE DYSFUNCTION
VAGINISMUS
SEXUALITY
QUALITY OF LIFE
DYSPAREUNIA
TOUCH
WELLNESS
ATTITUDE
IMPOTENCY
VAGINAL DRYNESS
BODY IMAGE
ESTEEM
INTERCOURSE

APPENDIX D

LET'S TALK ABOUT PATIENT SEXUALITY
Program Outline
THURSDAY April 29, 2004
Dinner Program 5:30pm – 9 pm

I. DINNER – (30 minutes)

II. Completion of Pre Test (30 minutes)

III. Collection of Pre Test - Distribute Education Packets, Word Search, Post Test (5 minutes)

IV. Introduction – Joyce and Eileen, Purpose of study, APA, Wellness, Holistic Health, Touch, Intimacy influence on Recovery (10 minutes)

V. Anatomy and Physiology /Sexual Response Cycle (15 minutes) - E

VI. Disease States/Medications(15 minutes) E

VII. GAME – (15 minutes)

VIII. Taking a Sexual History (15 minutes) J

IX. BREAK (15 minutes)

X. Communication Techniques/ Patient Interventions/Sensate Focus (20 minutes) J

XI. Case Studies (20 minutes)

XII. Distribution of Post Test and Certificate of Completion (20 minutes)

Total Time – 180 minutes
3 Contact Hours for Nurses
Include web sites and drugs

APPENDIX D

COMMON COMPLAINTS FROM PATIENTS WHO SUFFER FROM CANCER AND CHRONIC ILLNESS

Pain
Body image concerns
Nausea, Vomiting, Diarrhea
Feeling less feminine, or less masculine
Decreased intensity of orgasms
Decrease in sexual desire
Ovarian dysfunction
Reentering the Dating Scene
Fatigue
Depression
Sudden menopause symptoms
Loss of sexual sensations
Vaginal dryness
Erectile dysfunction
Vaginal stenosis
Fear of spreading disease to partner

INTERVENTIONS TO ENHANCE PATIENTS SEXUAL HEALTH

1. Discuss possible sexual limitations which will help to limit anxiety
2. Plan love-making during times of medication peaks
3. Choose coital positions that preserve energy and are more comfortable
4. Engage in non-sexual touching, hugging, self pleasuring
5. Discuss concerns and feelings with partner
6. Use pillows for comfort and balance
7. Experiment with dilators, vibrators or other sexual toys
8. Wear sexy lingerie to cover appliances, scars and wigs to cover hair loss
9. Use moonlighting, candles music to create a romantic atmosphere
10. Use vaginal lubricants
11. Empty bladder and bowel prior to sexual activity
12. If using a catheter check with physician about removing it temporarily or folding it over on the abdomen
13. Avoid oral and anal intercourse during periods of radiation, use condoms after chemotherapy, and radiation
14. Flush toilet two times after chemotherapy and radiation treatments
15. Use dental dams prior to having oral sex if receiving treatments
16. Address options about sperm banking prior to having radiation

APPENDIX D

COMMON COMPLAINTS FROM PATIENTS WHO SUFFER FROM CARDIAC DISEASE

Fear
Chest Pain
Anxiety
Fatigue

INTERVENTIONS TO ENHANCE PATIENTS SEXUAL HEALTH

1. Be well rested and avoid sex after a heavy meal
2. Create a romantic atmosphere, play relaxing music
3. Use long acting nitrate or skin patch prior to intercourse to help with angina pain
4. Take emphasis off sexual activity by focusing on touch, sharing closeness and mutual masturbation
5. Limit sexual activity to usual sex partner to minimize emotional stress
6. Be alert to warning signs during sexual activity: chest pain, shortness of breathe, dizziness, irregular heart beat
7. Avoid use of recreational drugs (i.e.cocaine, pot), they may lead to chest pain or MI
8. Avoid sexual stimulation of rectal area, because this can cause activation of a vagus nerve. This may lead to decreased cardiac performance and chest pain.
9. General rule for testing sexual fitness: ability to climb up two flights of stairs without symptoms
10. After a complicated MI sexual activity should be resumed slowly and gradually (usually 1-2 weeks)
11. Try positions that conserve energy: side by side, sitting in a chair, partner on top
12. For single patient's: thoughts of entering a new relationship may cause increased anxiety

APPENDIX D

COMMON COMPLAINTS FROM PATIENTS DURING THE POST PARTUM PERIOD

Pain from c-section or episiotomy
Fatigue
Vaginal bleeding or discharge
Decreased sense of attractiveness
Fear of injury
Baby crying
Decreased sexual desire
Dyspareunia
Vaginal dryness
Leaking of milk

INTERVENTIONS TO ENHANCE PATIENTS SEXUAL HEALTH

1. Discuss feelings openly with partner about resuming sexual activity
2. Plan times to make love when rested and least likely to be disturbed
3. Try nursing baby prior to sexual activity or wear a bra
4. Use alternate ways to show affection and express sexual feelings: hugs, kisses, caressing, and massage
5. Choose sexual positions that allow the woman to control the depth of penetration
6. Place a cushion under hips to reduce pressure on tender areas, episiotomy or tear
7. Intercourse can be safely resumed when bleeding is stopped and healing is complete (approx. 4-6 weeks)
8. After a cesarean section try positions that do not put pressure on the abdomen
9. Use vaginal lubrication and engage in more foreplay to help with vaginal dryness
10. Do Kegel exercises to strengthen pelvic floor muscles to reduce risk of incontinence and to promote orgasm
11. Be patient, if pain persists after child birth call a physician
12. Nap when baby naps
13. Recognize that it takes time to adjust to the needs of a new baby
14. Try to relax, have fun, and be aware that there will be temporary changes in your body

APPENDIX D

MEDICATIONS THAT MAY CAUSE SEXUAL DYSFUNCTION

Drugs

Type	Medication	Effects
Cardiac		
	Beta Blockers	ED, ▼ libido, ▼ infertility
	Vasodilators	ED
	Calcium Channel Blockers	ED
	Digoxin	ED, ▼ libido
Lipid Lowering	Gemfribrozil	ED, ▼ libido
	Clofibrate	ED, ▼ libido
Gastrointestinal	H2 Blockers	ED, ▼ libido
	Anti-cholingerics	ED, ▼ libido
Neurological	Anticonvulsants	ED, ▼ libido
Oncological	Tamoxifen	▼ libido
	Prednisone	▼ libido
	Most Antineoplastics	ED, ▼ libido
Psychiatric	Anti-psychotics	Anorgasmia, ED
	Anti-depressants	ED, ▼ libido
	MAO inhibitors	ED, ▼ libido, Anorgasmia
	SSRI's	ED, ▼ libido, Anorgasmia
	Lithium	ED
Ophalmologic	Carbonic Anhydrase Inhibitors	▼ libido
Recreational	Alcohol	▼ libido, ED, Anorgasmia, EI
	Narcotics	ED, Anorgasmia, ▼ libido
	Tobacco	ED

Suggestions for Reducing Sexual Side Effects

1. Wait for spontaneous remission of side effects
2. Decrease (▼) medication to a lower dose
3. Try a partial or complete drug holiday
4. Change to a different medication with fewer sexual side effects

APPENDIX E

Sex Ed Jeopardy

Disease States – what am I?

$100	following surgery for this state, many women suffers with feelings of poor body image and loss of nipple sensation – **Breast cancer**
$200	If untreated post op - may present quickly with hot flashes, night sweats and vaginal dryness - **Hysterectomy**
$300	Resume sex slowly, must be able to climb 2 flights stairs, avoid anal stimulation. – **Cardiac disease**
$400	Many of the medications used to treat this disease cause one of the most untoward side effects for men, Impotency - **Hypertension**
$500	This post partum state may be the cause of vaginal dryness, decreased sexual desire and leaking milk – **Breastfeeding**

Libido Busters

$100	This feeling often occurs when one feels unworthy, fat, ugly, unpresentable and is very common after debilitating surgery – **Low self esteem**
$200	This condition often caused from lack of estrogen can make intercourse difficult and painful – **Vaginal dryness**
$300	Men often suffer from this condition of arousal secondary to antihypertensive medication-**Erectile dysfunction**
$400	Often patients assume responsibility for their illness and blame it on indiscretions in their lifestyle from the past. They experience this feeling – **Guilt**
$500	One of the side effects of chemotherapy and uncontrolled diabetes. This entity may cause an adherent vaginal discharge that makes intercourse very uncomfortable. It also occurs orally – **Candida**

PLISSIT

$100	During this phase of the PLISSIT you offer simple counseling techniques **Specific** suggestion

$200 This is the referral phase of the PLISSIT – **Intensive therapy**

$300 The nurse allows the patient the opportunity to talk about sex – **Permission**

$400 The nurse discusses the impact of illness on sexuality – **Limited information**

$500 The nurse recommends the prostate cancer support group during this phase of PLISSIT – **Intensive therapy**

Sexual Response Cycle

$100 This response is categorized by a return to a non aroused sexual state – **Resolution**

$200 This response is enhanced by touch, visual imagery, fantasy "Sexy thoughts" – **Desire**

$300 This response is identified by vasoconstriction (erection in the male) – **Arousal**

$400 Vaginal lubrication is the first indication of this state in women – **Arousal**

$500 This response involves the sympathetic nervous system and includes a physical release - **Orgasm**?

Medications

$100 This medication is given to combat vaginal atrophy and dryness - **Vaginal Estrogen**

$200 One of the side effects of many of these antidepressants is hypoactive sexual desire - **SSRI's**

$300 Most classes of these medications are shown to interfere with erectile function – **Antihypertensives**

$400 Sexual stimulation is needed to maximize the effectiveness of this little blue pill – **Viagra**

$500 This pill combining estrogen and testosterone is offered to many women suffering low desire along with other menopausal symptoms - **Estratest**

POST TEST Part II: ATTITUDES

Please provide your reaction to each of the following statements on sexual behavior in our culture, using the following alternatives:

Strongly agree - SA
Agree - A
Uncertain - U
Disagree - D
Strongly disagree - SD

Please be sure to answer every question **(Circle the appropriate response)**

36. The spread of sex education is causing a rise in premarital intercourse.
SA A U D SD
37. Mutual masturbation among boys is often a precursor of homosexual behavior.
SA A U D SD
38. Extramarital relations are almost always harmful to a marriage.
SA A U D SD
39. Abortion should be permitted whenever desired by the mother.
SA A U D SD
40. The possession of contraceptive information is often an incitement to promiscuity.
SA A U D SD
41. Relieving tension by masturbation is a healthy practice.
SA A U D SD
42. Premarital intercourse is morally undesirable.
SA A U D SD
43. Oral-genital sex play is indicative of an excessive desire for physical pleasure.
SA A U D SD
44. Parents should stop their children from masturbating.
SA A U D SD
45. Women should have coital experience prior to marriage.
SA A U D SD
46. Abortion is murder.
SA A U D SD
47. Girls should be prohibited from engaging in sexual self-stimulation.
SA A U D SD
48. All abortion laws should be repealed.
SA A U D SD
49. Strong legal measure should be taken against homosexuals.
SA A U D SD
50. Laws requiring a committee of physicians to approve an abortion should be abolished.
SA A U D SD

51. Sexual intercourse should occur only between married partners.
SA A U D SD
52. The lower-class male has a higher sex drive than others.
SA A U D SD
53. Society should offer abortion as an acceptable form of birth control.
SA A U D SD
54. Masturbation is generally unhealthy.
SA A U D SD
55. A physician has the responsibility to inform the husband or parents of any female he aborts.
SA A U D SD
56. Promiscuity is widespread on college campuses today.
SA A U D SD
57. Abortion should be disapproved of under all circumstances.
SA A U D SD
58. Men should have a coital experience prior to marriage.
SA A U D SD
59. Boys should be encouraged to masturbate.
SA A U D SD
60. Abortions should not be permitted after the twentieth week of pregnancy.
SA A U D SD
61. Experiences of seeing family members in the nude arouse undue curiosity in children.
SA A U D SD
62. Premarital intercourse between consenting adults should be socially acceptable.
SA A U D SD
63. Legal abortion should be restricted to hospitals.
SA A U D SD
64. Masturbation among girls is a frequent cause of frigidity.
SA A U D SD
65. Lower-class women are typically quite sexually responsive.
SA A U D SD
66. Abortion is greater evil than bringing an unwanted child into the world.
SA A U D SD
67. Mutual masturbation in childhood should be prohibited.
SA A U D SD
68. Virginity among unmarried girls should be encouraged in our society.
SA A U D SD
69. Extramarital sexual relations may result in a strengthening of the marriage relationship of the persons involved.
SA A U D SD

70. Masturbation is acceptable when the objective is simply the attainment of sensory enjoyment.
SA A U D SD

Sex Knowledge and Attitude Test (SKAT)

POST TEST PART I: KNOWLEDGE

Each of the following statements can be answered either True of False. Please indicate your position on each statement using the following alternatives:

T. True **F. False**

Be sure to answer every question on the line below:

8. Pregnancy can occur during natural menopause (gradual cessation of menstruation).

_____

9. A woman does not have the physiological capacity to have as intense an orgasm as a man.

_____

10. There is no difference between men and women with regard to the age of maximal sex drive.

_____

11. The use of the condom is the most reliable of the various contraceptive methods.

_____

12. There are two kinds of physiological orgastic responses in women, one clitoral and the other vaginal.

_____

13. Impotence is almost always a psychogenic disorder.

_____

14. In some successful marriages sex adjustment can be very poor.

_____

8. A woman who has had a hysterectomy (removal of the uterus) can experience orgasm during sexual intercourse.

_____

9. In responsive women, non-coital stimulation tends to produce a more intensive physiological orgastic response than does coitus.

_____

10. Masturbation by a married person is a sign of poor martial sex adjustment.

_____

11. The onset of secondary impotence (impotence preceded by a period of potency) is often associated with the influence of alcohol.

_____

12. Direct contact between penis and clitoris is needed to produce female orgasm during intercourse.

_____

13. For a period of time following orgasm, women are not able to respond to further sexual stimulation.

_____

14. Impotence in men over 70 is nearly universal.

_____

15. Certain conditions of mental and emotional instability are demonstrably caused by masturbation.

_____

16. More than a few people who are middle-aged or older practice masturbation.

_____

17. Menopause in women is accompanied by a sharp and lasting reduction in sexual drive and interest.

_____

18. Douching is an effective form of contraception.

_____

19. Sexual maladjustment is a major cause of divorce.

_____

20. A woman's chances of conceiving are greatly enhanced if she has an orgasm.

_____

21. For some women, the arrival of menopause signals the beginning of a more active and satisfying sex life.

_____

Sex Knowledge and Attitude Test (SKAT)

KNOWLEDGE

Please circle the correct answer:

22. How long should a patient who had an uncomplicated heart attack wait prior to resuming sexual intercourse?
    a. 1-2 weeks b. 3 months c. 6 weeks d. 6 months

23. When taking a patient's sexual history, what types of questions should be asked?
    a. confrontational b. direct c. open-ended d. judgmental

24. Annon's model is used for:
    a. viewing sexual relationships b. measuring sexual dysfunction
    c. defining sexuality d. sexual assessment

25. Another name for mutual body-pleasuring exercises is called?
    a. masturbation b. sexual intercourse c. sensate focus d. fellatio

26. Nurses can increase their comfort level in discussing sexual concerns with patients in a number of ways:
    a. watching educational videos b. role playing with nurses
    c. taking a sexuality education course d. all of the above

27. Nurses should discuss patients sexual concerns:
    a. early in the treatment
    b. only if the partner is there
    c. when another nurse is present
    d. only if the patient asks
28. Which of the following ways may cancer affect sexuality?
    a. loss of sexual desire
    b. infertility
    c. distorted self image
    d. loss of pubic hair
    e. all of the above

42. Which of the following is a phase of the sexual response cycle?
    a. climax phase
    b. erection phase
    c. arousal phase
    d. lubrication phase

43. All of the following medications have a negative effect on libido except:
    a. SSRI's
    b. H2 Blockers
    c. Calcium Channel Blocker's
    d. Tamoxifen

44. Alcohol, drugs and tobacco most often negatively affect a person's sexual performance.
    a. True
    b. False

45. The PLISSIT stands for:
    a. Permission, Limited Information, Specific Information, Treatment
    b. Performance, Lubrication, Sexual Information, Intense Therapy
    c. Pregnancy, Liability, Sexual Intercourse, Treatment
    d. Permission, Limited Information, Specific Information, Intensive Therapy

Following completion of this program: To what extent will your nursing practice involve the following activities? (Circle the appropriate word.)

46. With what percentage of your clients will you offer to discuss sexual concerns?

a. zero b. 1% to 20% c. 21% to 40%
d. 41% to 60% e. 61% to 80% f. 81% to 100%

47. Do you think it is appropriate for nurses to discuss sexual concerns with clients if the <u>client</u> initiates the discussion?

a. never b. seldom c. sometimes d. usually e. always

48. Do you think it is appropriate for <u>nurses to initiate</u> discussion of sexual concerns with clients?

a. never b. seldom c. sometimes d. usually e. always

49. To what extent do you feel knowledgeable about sexuality?

a. not at all knowledgeable
b. not very knowledgeable
c. somewhat knowledgeable
d. very knowledgeable
e. extremely knowledgeable

50. Do you feel comfortable discussing sexual concerns with clients?

a. never b. seldom c. sometimes d. usually e. always

Thank you for taking the time complete this questionnaire.

Health First Center for Learning
Program Evaluation 2004

Attendees: 18 Responses: 17

Program Title: Let's Talk About Patient Sexuality…An Educational Program for Nurses

Date: April 29, 2004

Your candid and complete responses are important so that we can continue to provide quality educational activities. Please mark in the column to indicate the extent of your agreement with each statement. Thank you.

Disagree ➡ ➡ ➡Agree

	Content	1	2	3	4
1.	The content was related to my practice.		*1*	*2*	*14*
2.	The content met the course objectives.			*1*	*16*
3.	The content was accurate and current.			*1*	*16*
4.	The time frame spent on each topic was appropriate.			*2*	*15*
	Teaching Methods				
1.	The teaching material was well organized.			*2*	*15*
2.	The program was logically sequenced.			*2*	*15*
3.	Effective teaching methods (lecture, handouts and audiovisual aids) were utilized.			*1*	*14*
	Setting				
1.	The room was conducive to learning.			*2*	*15*
2.	The program site was physically accessible.			*1*	*16*
	Learner Benefits				
1.	This program met my professional educational needs.			*3*	*14*
2.	This information will enhance my patient care on the unit.			*3*	*14*
	Faculty Effectiveness				
1.	The presenter, **Eileen Volpe,** was clear and to the point.				*17*
2.	The presenter demonstrated knowledge and expertise of the topic.				*17*
3.	The presenter was responsive to participant concerns.				*17*
1.	The presenter, **Joyce Wertheimer,** was clear and to the point.			*1*	*16*
2.	The presenter demonstrated knowledge and expertise of the topic.			*1*	*16*
3.	The presenter was responsive to participant concerns.			*1*	*16*
	Registration Process				
1.	If registration was required, was the registration process for this class easy for you?	Yes	17	No	*0*
2.	If not, please explain. If you need a response, please indicate your name and phone number so that we will be able to contact you: ⌘ *We almost didn't register because we were afraid we missed the 7-day deadline.*				

List strengths of this program:

- ⌘ *Interesting and informative, loved being fed and receiving prizes. Easy to follow, eye opening.*
- ⌘ *Very informative.*
- ⌘ *Great topic, great learning environment!*

List weaknesses of this program:

- ⌘ *None!*

- *New information presented regarding medications, teaching and other topics-Plissit, sensate focus.*
- *Knowledge of both speakers.*
- *Thank you for all information provided. We may be able to help patients better.*
- *Excellent information.*
- *Creatively presented.*
- *Interactive which promotes comfort with topic of sexuality.*

What topics would you like to have presented in the future?

- *I don't know if this would be related to nursing or not but I would like to know how best to speak to my teenagers about sex now that they may be thinking about it.*
- *To teach counseling skills.*

Comments:

- *Thank you. Excellent program. Would be interesting to survey attendees in 3 months and see if they are practicing what we've learned.*