

Why Don't Healthcare Professionals Talk About Sex? A Systematic Review of Recent Qualitative Studies Conducted in the United Kingdom

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ABSTRACT

Introduction. Sexuality is considered to be an important aspect of holistic care, yet research has demonstrated that it is not routinely addressed in healthcare services. A greater understanding of this can be achieved through synthesizing qualitative studies investigating healthcare professionals' experiences of talking about sex. In doing so, policy makers and healthcare providers may be able to better address the sexual issues of service users.

Aim. To gain an in-depth understanding of healthcare professionals' subjective experience of discussing sexuality with service users by identifying the factors that impede and facilitate such discussions.

Main Outcome Measures. Review of healthcare professionals' experience of discussing sexuality with service users.

Methods. Electronic databases and reference lists of published articles were searched in July 2011. Primary research studies were included in the review if they explored health professionals' experiences of discussing sexuality with adult service users, used qualitative methods, and were conducted in the United Kingdom over the last 10 years. Each study was reviewed and assessed. A secondary thematic analysis method was used where key themes were extracted and grouped and key concepts were explored.

Results. Nineteen interconnected themes emerged relating to healthcare professionals' experience of discussing sexuality with service users, including fear about "opening up a can of worms," lack of time, resources, and training, concern about knowledge and abilities, worry about causing offense, personal discomfort, and a lack of awareness about sexual issues. Some themes were particularly marked relating to the sexuality of the opposite-gender, black and ethnic minority groups, older and nonheterosexual service users, and those with intellectual disabilities.

Conclusions. The majority of healthcare professionals do not proactively discuss sexuality issues with service users, and this warrants further attention. An understanding of the perceived barriers and facilitators indicates that interventions to improve the extent to which sexuality issues are addressed need to take organizational, structural, and personal factors into consideration. **Dyer K and das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. J Sex Med 2013;10:2658–2670.**

Key Words. Sexuality; Staff; Qualitative Research; Literature Review; Healthcare System

Introduction

Sexuality has been defined as the way people experience themselves and each other as sexual beings [1] encompassing sexual activity, sexual orientation, gender identity and roles, eroticism, pleasure, intimacy, and reproduction [2]. Sexuality is now identified as a fundamental and natural

need within everyone's life regardless of age or physical state [3] and is considered an important aspect of holistic (health) care [4].

Yet recent research from the United Kingdom has overwhelmingly demonstrated that issues of sexuality are not frequently addressed in the healthcare system. One survey found that although 60% of healthcare professionals (HCPs) agreed

that sexual issues ought to be addressed as part of the holistic care of patients, only 6% initiated discussion on a frequent basis [5]. HCPs in this study identified a number of personal and organizational barriers to having such discussions, including lack of training (79%), lack of time (67%), and embarrassment (50%). These barriers have been identified in other UK studies, as well as fears of opening a "floodgate," concerns about not being able to cope with the issues raised, lack of policy, believing that it is not their responsibility or outside their purview of care, religious views, and homophobia [6,7]. In addition, a number of service user characteristics have been found to affect the HCP's decision about whether to discuss sexual issues, including the patient's age (61%), physical well-being (54%), gender (52%), and whether they were in a stable relationship (42%) [5].

These quantitative studies have offered a useful starting point to understanding why sexual issues are infrequently addressed in the healthcare system. However, efforts to improve this aspect of healthcare will require a greater in-depth understanding of how these barriers operate, as well as how HCPs think these could be overcome. Qualitative research can be used to interpret the findings of quantitative studies by privileging HCPs' subjective accounts. However, the generalizability of these studies is limited by small sample sizes, to the unique population being studied, and to the researchers' subjective interpretation of the data [8]. A broader use of the findings may be possible if individual qualitative studies in this area could be synthesized to identify similar themes across various studies, hence the current review. It is hoped that by identifying these barriers, as well as the factors that facilitate discussions about sexuality between HCPs and service users, policy makers and healthcare providers will be able to better address the sexual issues of service users.

However, there is considerable disagreement among qualitative researchers over the appropriateness of attempting to review and integrate individual qualitative studies [9–11], and where a researcher stands in this debate is likely to be dependent on their ontological, epistemological, and methodological position [12]. Within a post-modernist epistemology, it is perhaps inappropriate to synthesize individual qualitative studies, as study findings are specific to a particular context at a particular point in time [12]. This review, however, operates on the assumptions that it is both possible, and desirable, to integrate qualita-

tive research in order to build a picture of the empirical work which could better inform healthcare policy and practice. However, it is acknowledged that the meaning of the concept of "sexuality" (as well as sexual morals and tolerance levels) is highly dependent on time and culture, and that this meaning could be tragically lost if it is detached from its context by transferring it to a new setting. It is for this reason that this review has been limited to include only studies from the United Kingdom and to those published over the last 10 years.

Aim

This review aims to synthesize the findings from multiple qualitative studies in order to gain an in-depth understanding of HCPs' subjective experience of discussing sexuality with service users by identifying the factors that impede (barriers) and facilitate (facilitators) such discussions in clinical practice.

Methods

Stage 1: Systematic Literature Search

First, a series of a priori inclusion/exclusion criteria were defined. Studies were included in the review if they

1. Included HCPs as participants. HCPs were defined as persons who work with people with illness or disability (studies that included HCPs *and* service users were also included; however, only the analysis of the former was extracted for the purpose of this review);
2. Explored HCPs' experience of discussing sexuality with adult service users (i.e., over the age of 18);
3. Involved primary research studies (i.e., not systematic reviews, opinion pieces, or editorials);
4. Used a qualitative method of data collection and analysis (studies that used a mixed-method design were included; however, only the qualitative data were extracted for the purpose of this review);
5. Were published within the last 10 years (2001–2011);
6. Were carried out in the United Kingdom.

A systematic search was conducted on the Medline, EMBASE, PsycINFO, and British Nursing Index electronic bibliographic databases in July 2011. Together these databases represent the disciplines of medicine, nursing, and social sci-

ences. Alerts were then set up on these databases to highlight new relevant studies published between the initial searches until the time of analysis.

Across all databases, groups of terms were combined relating to three specific parameters: (i) terms relating to sexuality; (ii) terms relating to the HCPs' experience of communicating with service users; and (iii) terms relating to the qualitative research design. Where possible, subject headings were selected and exploded in order to retrieve articles where different authors may have used different terminologies for the same concept. Where subject headings were not available, free-text search terms were used.

Reference lists of each article identified as being relevant were then searched to identify further potential research studies. Finally, Google Scholar was searched using the keywords (*staff OR HCP AND (sexuality OR sexual)*) (limiting to the years 2001–2011), and the first 100 results were checked.

All citations were initially checked for relevance by checking the title by the first author (K.D.). Where there was not enough information in the title to ascertain whether the research was appropriate for inclusion, the abstract was examined. Where there was not enough information in an abstract (or where an abstract was unavailable), full text versions were obtained. This list was appraised by the second author (R.d.N.). The majority of citations were excluded at this stage because they were not specifically concerned with HCPs' perceptions of discussing sexuality with service users or because they were not primary qualitative research.

Six articles were located from the database search [13–18] and two additional articles were identified from checking reference lists [19,20]. One other article was also identified through reference lists [21]; however, it was not included as it was clearly a duplication of another article included in the review (this was acknowledged by the authors). No additional articles were identified through searching Google Scholar.

Eight articles were therefore included in the final review [13–20]. It was apparent that some articles reported on findings from the same study, which was evident from the authors, location, and sample size being the same (articles 14–17 reported on findings from the same study and articles 18 and 20 reported on findings from the same study). Nevertheless, it was decided that all articles would be included in the review given that the data were analyzed with different aims and objectives in mind.

Stage 2: General Characteristics

The following information was abstracted from the articles: study aims, sample size and composition, study location, data collection method, data analysis method, and key findings. This coding frame was developed based on those used in previous qualitative systematic reviews (e.g., see [8,22–24]).

Stage 3: Critical Appraisal

Critical appraisal (or assessment of study quality) is required in order to avoid over- or under-reliance of certain findings, which could potentially distort the synthesis [25]. It is generally agreed that the methods developed for assessing quantitative research are inappropriate for reviewing qualitative research [26,27], yet to date no common ground has been established regarding the most useful of these [11].

This review utilized the quality assessment framework published by the UK National Centre for Social Research [28], which was applied to each of the eight articles. Although the application of this was based upon the authors' subjective judgment to some extent, it was made more transparent through the use of an appraisal system. A grade of A–D was allocated to each of 18 appraisal questions based on the following system: A (No or few flaws), B (Some flaws), C (Significant flaws), and D (Untrustworthy). The coding was conducted by both authors independently, and disagreements were addressed through discussion. The grades were then converted to numbers and the mean was taken to generate an overall grade. The appraisal questions were therefore equally weighted in determining the overall grade.

Based on this appraisal system, six of the articles [13–17,19] were allocated a grade B, one article [18] was allocated a grade C, and one article [20] was allocated a grade D. Despite the apparent flaws of some of the articles, all eight were included in the review for the following reasons: First, it has been recommended that rather than using qualitative research tools to inform a decision of whether to include or exclude an article (as in the context of quantitative research), they are best used as a process of exploration and interpretation [11,28]. Second, it was felt that, despite their flaws, each article could contribute something of value to the review.

Stage 4: Synthesis of Findings

A diverse range of methods for synthesizing qualitative research findings has been used by research-

ers, but there is no consensus on the most appropriate of these [11,29]. This review utilized an inductive secondary thematic analysis approach. This approach was chosen because it could be used to conduct an interpretative synthesis while still preserving the individual integrity of individual studies by remaining “close” to the primary data. Other reviews using secondary thematic analysis have been successfully able to achieve this balance (e.g., see [23,30,31]).

It was decided what all sections of articles labeled “results” or “findings” would be classed as data and included in the overall synthesis [31]. The reviewed articles were first read independently, and salient points from each article were listed. Similar points, within and between articles, were then grouped to form a theme. A suitable phrase that best described the theme was created as the thematic label. This is not an exact science, but only a method to condense information into meaning units. Therefore, there may be overlaps between some themes, but these were retained as distinct to permit an in-depth examination of the data.

Results

The general characteristics of the reviewed articles and critical appraisal are presented in Tables 1 and 2, respectively.

Aims of Included Studies

It was felt that all eight articles offered a clear statement of the study aims and purpose. While it was felt that six articles adequately addressed their original aims via their findings and conclusions [13–17,19], in two articles the experiences of HCPs were not explored in enough depth to achieve these aims [18,20]. Despite the differences in specific aims across the eight articles, all explored HCPs' perceived barriers to discussing sexuality issues with service users and five studies explicitly explored how these barriers could be overcome [13–15,17,19].

Samples

Together, the eight articles reported on data from a total of 181 HCPs working in primary care ($N = 57$), cancer services ($N = 43$), intellectual disabilities services ($N = 71$), and in a Disability and Rehabilitation Team (DART) ($N = 10$). Five articles provided a reasonable description of the sample composition [14–18], but three did not provide sufficient demographic information (i.e., the gender, age range, and/or roles of participants) [13,19,20].

Most articles described participants recruited through self-selected methods [13–17] (although some used purposeful sampling to maximize diversity [14–17]), and participants in the others were approached directly and asked to take part in the study [18–20]. Five articles considered how the sampling method used could create bias in terms of a possible overrepresentation of HCPs who have an interest in sexuality issues or of those who are already doing good work in the area [13–16]. However, the findings did not demonstrate wide-scale good practice, and therefore it seems unlikely that the samples were positively skewed [13]. Other limitations of achieved sample coverage were also acknowledged, such as an overrepresentation of some Primary Care Trusts [15,17] and small sample sizes [18,19], both of which could limit the generalizability of the findings to other healthcare settings and staff populations. Only one article reflected on the possible reasons for non-participation in the study; general practitioners (GPs) reported a lack of time [17].

Study Location

In one article, the location could not be determined [19], most likely for confidentiality reasons given that the data were collected from one multidisciplinary team. One article reports on data collected across a range of 20 intellectual disability services in the United Kingdom [13], which makes drawing wider inference from the findings more feasible. The other articles report on data collected in Sheffield [14–17] and Leeds [18,20], indicating that there is clearly an overrepresentation of data drawn from Yorkshire, England.

Ethical Considerations

Some consideration of ethical issues was evident in all but one article [14–20]. However, in one of these, it was simply an acknowledgement that local ethical approval had been granted [20]. The majority of articles considered issues of confidentiality and anonymity [14–17,19], and informed consent [16–19]. Only one article explicitly stated that transcripts were sent to participants for verification [19], which is beneficial to improve the credibility and face validity of the findings. In the other articles, it is not known how data were presented to participants or if member checking occurred.

Data Collection

Seven articles (i.e., three out of four studies) report on data collected using face-to-face semistructured

Table 1 General characteristics of the included studies

Study reference	Aims	Sample size	Sample composition	Location	Data collection method	Data analysis method	Key findings
Abbott and Howarth, 2007 [13]	To explore how able, or willing, staff are to address sexuality issues in intellectual disability services.	N = 71	Managers and support staff in intellectual disability services	20 services in UK England = 11 Scotland = 4 Wales = 1 Northern Ireland = 4	Semistructured interviews	Grounded Theory Constant comparative method (Glaser and Strauss, 1967 [38])	The majority of staff said that they did not feel confident working with intellectual disabilities in the area of sexuality and relationships, especially those that are gay, lesbian, or bisexual. Barriers: concern about intrusiveness/appropriateness of the topic, lack of confidence or willingness to engage in the work, lack of policy and training, and concerns about the reactions of others (particularly parents/carers). Facilitators: policy guidance, education, and training.
Gott et al., 2004 [14]	To identify the barriers perceived by GPs and practice nurses to inhibit discussion of sexual health issues in primary care and explore strategies to improve communication in this area.	N = 57	22 GPs (13 male and 9 female aged 34–57) 35 practice nurses (35 female aged 32–60)	Sheffield, England, UK	Semistructured interviews	Thematic Analysis Assisted by QSR NUD*IST	The term “can of worms” summarized participants’ beliefs that sexually related issues are problematic. Barriers: sensitivity and complexity of the topic, constraints of time and expertise, discussing sexual health with patients of the opposite-gender, black and ethnic minority groups, middle-aged and older patients, and nonheterosexual patients. Facilitators: training, providing patient information and expanding the role of the practice nurse. However, limitations of these approaches were also identified.
Gott et al., 2004 [15]	To explore how GPs perceive and manage later life sexual health problems.	N = 22	GPs (13 male and 9 female aged 34–57)	Sheffield, England, UK	Semistructured interviews	Grounded Theory National Centre for Social Research “Framework” approach (Ritchie and Spencer, 1994 [39])	GPs did not address sexual health proactively with older people. Barriers: sexual health was equated with younger people and not seen as a legitimate topic for discussion with older people. Many beliefs were based on stereotyped views of ageing and sexuality rather than personal experiences of individual patients. Facilitators: education and training.
Hinchliff et al., 2004 [16]	To explore the barriers related to gender that GPs face when discussing sexual health matters in primary care consultations.	N = 22	GPs (13 male and 9 female aged 34–57)	Sheffield, England, UK	Semistructured interviews	Thematic Analysis Assisted by QSR NUD*IST	GPs were virtually unanimous in believing that patients preferred to see a same-sex GP regarding sexual health. Barriers: becoming “deskilled” in dealing with sexual matters of opposite-sex patients. Discussion may also be hindered if the patient is male, as reproductive issues provided an appropriate context to asking about sexual health.
Hinchliff et al., 2005 [17]	To explore the difficulties GPs experience when dealing with the sexual healthcare of gay and lesbian patients.	N = 22	GPs (13 male and 9 female aged 34–57)	Sheffield, England, UK	Semistructured interviews	Thematic Analysis Assisted by QSR NUD*IST	Nonheterosexual orientation could form a barrier to talking about sexual health matters for almost half of the sample. Barriers: ignorance of lesbian and gay lifestyles and sexual practices, concerns about appropriate language to use, and assumptions about the nature of gay men’s relationships. Facilitators: training, taking a proactive role during consultations, not making assumptions about the patients’ sexual orientation, and having a nondiscriminatory policy.
Stead et al., 2003 [18]	To identify the level of information currently provided on sexual issues in ovarian cancer, the opinions of HCPs about sexual issues, and any training needs of medical staff.	N = 58	27 doctors and 16 nurses treating women with ovarian cancer 15 women with ovarian cancer across three hospitals	Leeds, England, UK	Semistructured interviews	Frequency counts and qualitative comments summarized	The majority of staff thought that most women with ovarian cancer would experience a sexual problem, but only a quarter of doctors and a fifth of nurses actually discussed sexual issues with the women. Barriers: the belief among HCPs that it is not their responsibility to discuss sexual issues, embarrassment, lack of knowledge and experience, and lack of resources to provide the support if needed.
Rubin, 2005 [19]	To explore the reasons given by a Disability and Rehabilitation Team (DART) for perceived difficulties in discussing sexual problems with male patients with multiple sclerosis and to compare them with a group of patients.	N = 10	DART comprising nurses, occupational therapists, speech and language therapists, and a physiotherapist	UK	Focus group (semistructured interview schedule)	Grounded Theory (Strauss and Corbin, 1990 [40])	Barriers: worry about intrusiveness, not having enough information to give to patients was perceived as embarrassing, and lack of training. Facilitators: team members identified that nurses are the best people to deal with sexual issues.
Stead et al., 2002 [20]	To explore the psychosexual effects of ovarian cancer and the level of communication between women and HCPs about sexual issues.	N = 58	27 doctors and 16 nurses treating women with ovarian cancer 15 women with ovarian cancer across three hospitals	Leeds, England, UK	Semistructured interviews	Grounded Theory (Strauss and Corbin, 1990 [40])	All but one health professional thought that medical staff should discuss psychosexual issues; however, only four clinicians and five nurses did so. Barriers: the belief among HCPs that it is not their responsibility to discuss sexual issues, embarrassment, inexperience, lack of time, and lack of knowledge about the effects of ovarian cancer on sexual functioning.

GP = general practitioner; HCP = healthcare professional; QSR NUD*IST = QSR International and Nonnumerical Unstructured Data * Indexing Searching and Theorizing

Table 2 Critical appraisal of the included studies

Appraisal question	Study reference							
	Abbott and Howarth, 2007 [13]	Gott et al., 2004 [14]	Gott et al., 2004 [15]	Hinchliff et al., 2004 [16]	Hinchliff et al., 2005 [17]	Stead et al., 2003 [18]	Rubin, 2005 [19]	Stead et al., 2002 [20]
1 How credible are the findings?	B	B	B	B	B	C	B	D
2 How has knowledge/understanding been extended by the research?	B	B	B	B	B	B	B	C
3 How well does the evaluation address its original aims and purpose?	B	A	A	A	A	C	A	D
4 Scope for drawing wider inference—how well is this explained?	B	B	C	C	B	B	B	D
5 How clear is the basis of evaluative appraisal?	B	B	C	D	C	D	A	C
6 How defensible is the research design?	B	C	C	C	C	C	A	D
7 How well defended is the sample design/target selection of cases/documents?	B	B	B	B	B	C	C	D
8 Sample composition/case inclusion—how well is the eventual coverage described?	C	B	B	B	A	B	C	C
9 How well was the data collection carried out?	B	B	C	B	B	D	B	B
10 How well has the approach to, and formulation of, the analysis been conveyed?	C	C	C	C	C	D	C	D
11 Contexts of data sources—how well are they retained and portrayed?	C	B	B	C	C	D	B	D
12 How well has diversity of perspective and content been explored?	B	B	B	C	B	D	B	D
13 How well has detail, depth, and complexity (i.e., richness) of the data been conveyed?	B	B	B	B	B	D	B	D
14 How clear are the links between data, interpretation, and conclusions—i.e., how well can the route to any conclusions be seen?	B	B	B	C	B	C	C	D
15 How clear and coherent is the reporting?	B	A	B	C	B	B	B	D
16 How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	D	D	D	C	C	D	D	D
17 What evidence is there of attention to ethical issues?	D	B	C	B	B	C	A	C
18 How adequately has the research process been documented?	C	B	B	B	B	B	B	D
Overall grade	B	B	B	B	B	C	B	D

interviews with HCPs, the other using a semistructured focus-group method [19]. It was felt that only two articles adequately justified their reason for choosing their method [13,19]. Two articles reported that researchers made field notes [14,19]; however, only the latter article made reference to these in the findings section, so it is unclear how they were used to aid analysis in the other.

Five articles contained some information about the content of the topic guide [13,14,16,17,19], which was useful as it made the link between the data collection and analysis more transparent. In one article, the content of the topic guide was vague [19], but it is important to consider that the content of the interview itself may have been left deliberately broad. Two articles did not disclose the content of the topic guide at all [15,20], which made it difficult to assess whether the study was adequately designed to address the original aims of the research. Six articles reported using audiotape [13,14,16,17,19,20], and half of the articles reported that the raw data were then transcribed verbatim [14,16,17,20]. In the other four articles, the method for preserving raw data was not stated.

Data Analysis

All but one article [18] stated their underlying theoretical framework; four articles claimed to use a Grounded Theory approach [13–15,20] and two articles claimed to use Thematic Analysis [16,17,19]. The other article, while using a qualitative method of data collection, did not use a recognized method of qualitative analysis [18]. This article simply stated that “qualitative comments were summarized” and the analysis appeared to be largely quantitative. Five articles reported that coding was carried out by multiple analysts [13–15,17,19], which has the potential to enhance the credibility of the findings. Four of these five articles acknowledged that any discrepancies were discussed until consensus was reached [14,15,17,19] and in the other article [13] it is not known whether there were any discrepancies between the two researchers or how they were resolved.

It was felt that none of the articles justified their approach or explained the analysis process in adequate depth, and as a result it was often difficult to understand how the themes were derived. While this did not affect the feasibility of synthesizing the findings from the articles, it did mean that it was not possible to explore the impact of theoretical framework on the interpretation. Furthermore, none of the articles reported on whether

saturation of data was achieved, and authors in only two articles critically considered their role as researcher and how this may have impacted on the data collection and analysis process [16,17].

Reporting

It was evident that the majority of articles did include original data in their reporting of the findings in the form of direct quotations from participants [13–17,19]. This was advantageous as it allowed the subjective experiences of the participants to be represented to a reasonable degree. It also meant that a distinction could be made between the original data and the authors' interpretation. This may have been difficult otherwise, particularly as most authors adopted a descriptive writing style. In the two articles that had undertaken relatively simple qualitative analysis [18,20], it could not be determined at all what was the original data and what was the researchers' analytical interpretation.

It is important to consider that examples of good practice in terms of HCPs discussing sexuality with service users appeared to be somewhat underrepresented in the articles, and it is unclear whether this was a reflection of the content of the original data, or of possible bias in the information that the authors chose to present. In one article [16], nine out of the 22 GPs interviewed said that they felt comfortable talking about sexual matters in consultations, but this was not expanded upon. Further analysis of the interviews of these participants may have been useful to gain an alternative perspective on the barriers and facilitators to having such discussions about sexuality.

Synthesis of Themes

The review found that the majority of HCPs included did consider it important to discuss sexuality [14,15,18–20]. However, despite this apparently widespread recognition, the main theme across all of the included articles was that sexuality is not routinely discussed in healthcare services. Nineteen main interconnected themes were drawn out from the secondary thematic analysis related to the reasons why HCPs do, or do not, initiate discussions with service users (i.e., the barriers and facilitators). These themes are presented in Table 3, and the most common are discussed below.

HCPs in three articles referred to discussing sexuality as opening “a can of worms” or “Pandora's box” [14,18,19]. This analogy was used to express their feelings about addressing a sensitive

Table 3 Themes and the articles that endorse them

Theme	Study reference							
	Abbott and Howarth, 2007 [13]	Gott et al., 2004 [14]	Gott et al., 2004 [15]	Hinchliff et al., 2004 [16]	Hinchliff et al., 2005 [17]	Stead et al., 2003 [18]	Rubin, 2005 [19]	Stead et al., 2002 [20]
Fear of opening up a can of worms	+		+			+		+
Worry about causing offense	+		+			+		+
Concern about the reactions of parents/residential staff	+		+			+		+
The service user should raise it first	+		+			+		+
Personal discomfort	+		+			+		+
Language barriers	+		+			+		+
Service user may sexualize the consultation	+		+			+		+
Concern about own knowledge and abilities	+		+			+		+
Access to training	+		+			+		+
Lack of recent experience	+		+			+		+
Time and resources	+		+			+		+
Availability of written information	+		+			+		+
Availability of policy guidance	+		+			+		+
Do not consider it their responsibility	+		+			+		+
Communication between professionals	+		+			+		+
Not giving "permission" to raise the issue	+		+			+		+
Assume it is not an important issue	+		+			+		+
Lack of awareness of range of sexual issues	+		+			+		+
Assuming the cause of the sexual issue	+		+			+		+

Key: + = theme present; - = theme not present

and complex issue within the time and resource limitations of the organization in which they work [14]. Indeed, HCPs in six articles identified that organizational factors (such as limited time, resources, and lack of privacy) can prevent them from having such discussions [14–17,19,20]. The difficulty appeared to be not with initiating the discussion per se, but that “once you’ve opened up that can of worms, you’ve got to follow it through” (practice nurse: aged 40–49) [14]. Some HCPs questioned whether it was actually fair to the patient to broach a subject they felt ill-equipped to deal with [17,19]:

“If you broach areas which are potentially incredibly complicated and insoluble and maybe you’re outside the ability to do anything about it anyway and then what good does it do to you or them?” (male GP: aged 40–49) [14].

This reflects some HCPs’ belief that they do not have the knowledge and expertise to deal with the complexities of sexual health issues, a theme identified in all eight articles. HCPs in seven articles identified education and training as a potential facilitator to help them to overcome this barrier [13–19]. Staff that had attended training on sexuality issues commented that they found it helpful and were positive about it [17].

HCPs highlighted that any training that is offered needs to be more inclusive of minority service-user populations; HCPs reported that sexuality issues in relation to intellectual disabilities [13], gay, lesbian, and bisexual issues [14,17], and older people [14,15]¹ were only very briefly covered in their curriculum, if not absent altogether. However, HCPs in four articles raised concerns about whether attending training is actually feasible given the competing pressures of limited time and resources [13,14,16,17]:

“There’s only a certain amount in the training budget and they’ll pick out what really needs doing and move the other stuff to the side” [13].

HCPs also attributed their lack of knowledge to a lack of recent experience, meaning they were not always up to date with the latest developments in the field [13,14,16,17]. For example, GPs and practice nurses reported that they have become

¹Within the context of this study, HCPs categorized older people as people in their 40s or over. In other studies, the age of older participants was not reported but they were termed “older.” To remain faithful to these studies, the authors report these participants as being “older” in the current review.

“rusty” in managing the sexual issues of opposite-gender patients due to seeing more patients of the same sex as themselves [14,16].

Six articles reported on the belief among HCPs that raising the issue of sexuality could be perceived as intrusive or inappropriate, which led to some wondering whether service users would perceive it as a legitimate topic for discussion [13–15,17–19]. Again, this theme was particularly marked in relation to certain patient groups; HCPs in primary care had preconceived ideas that sex is less openly discussed by people from black and minority ethnic groups and by older people [14,15].

There were mixed reports on whether these concerns of causing offense were based on reality or not. Two articles reported that GPs could not recall any occasions of causing offense by raising such issues [14,15], suggesting that their decision not to initiate discussions are based on preexisting beliefs and stereotypes of how they *think* people will respond rather than direct personal experiences. Indeed, one GP reported feeling surprised that Pakistani women were ready to discuss sex [14]. However, in another study, one member of a DART commented that “several of us had examples where people had told us to mind our own business” [19].

Related to this theme, six articles reported that HCPs tend to take the lead from the service user rather than initiating discussions themselves [13–15,18–20]. HCPs therefore considered it important that service users feel comfortable enough to raise sexual issues themselves [15,17,19]. Providing an environment that grants permission to discuss sexuality issues can also be achieved at the organizational level; for example, HCPs in five articles reported a general lack of written information on sexuality and sexual dysfunction [13,14,16–18], which inhibited service-user initiated discussions, and believed that having leaflets/posters available could facilitate discussion [13,18,19]. However, others predicted that patients would feel too embarrassed to pick up information in a waiting room and highlighted that if information is available, someone has to be available to answer any questions that it may raise for patients [14]. In addition, HCPs in two articles reported that the introduction of policy guidance would serve the purpose of giving work in the area of sexuality legitimacy [13] and encourage service users to be open about sexuality issues [17].

In establishing this environment, HCPs may also need to overcome their own feelings about

discussing sexuality issues. All but one article [13] reported on HCPs’ feelings of personal embarrassment/discomfort when discussing sexuality with service users. In addition, field notes from one study also indicated that HCPs were feeling embarrassed during the focus group [20]. It may also have been useful for other studies to use field notes in the same way.

Again, this theme of personal discomfort discussed in relation to particular patient groups. For example, GPs in two articles reported feeling less comfortable discussing sexuality issues with opposite-gender patients, which was partly due to concerns that they may “sexualize the consultation” [14,16]. However, it is important to note that gender was not cited as a barrier by the majority of participants across the articles.

Some attitudes toward discussing sexuality with particular patient groups were more negative: for example, one GP referred to older peoples’ sexuality as “distasteful” [15] and another admitted to finding some nonheterosexual acts “personally repugnant” [17]. One HCP also questioned the ethics of prescribing Viagra to gay men:

“I think it’s a slightly inappropriate use of resources really, but it’s probably just my prejudices, I’m prepared to admit that . . . particularly if they’re not in a stable relationship, I don’t see it’s appropriate” (male GP, aged 50 years) [17].

However, it is important to note that these ageist and homophobic viewpoints did not appear to be shared by the majority of HCPs. Most were keen to increase their knowledge of nonheterosexual sexual practices and lifestyles [17] and to reconcile their own views about nonheterosexuality [14].

HCPs in five articles expressed views that sexuality-related issues were outside of their responsibility or professional role [14,16,18–20]. For example, GPs expressed concerns about whether sexual health should actually be considered a “medical” issue or not [14]. In the focus-group study [19], there was unanimous agreement that it should be the nurse’s role. However, nurses expressed concerns about “opening up” such issues and then not being able to refer onto specialist services or prescribe medication [14]. Related to this, two articles highlighted that strategies are needed to improve communication between HCPs to decide who will talk about sexuality and when [18,19], although the latter article used a relatively simple analysis and did not explore this in detail.

Five articles reported on a lack of awareness among HCPs that sexual issues are an important

issue [14,15,18–20]. For example, two articles reported that some HCPs working with women with ovarian cancer had never thought about it before [18–20]. Of the participants that were aware of the impact of ovarian cancer on sexual functioning, only a few out of the wide range of possible problems were named [18]. Other articles also indicated that HCPs associate sexuality and sexual health with a relatively small number of issues [14–17,19,20];

“You automatically think of risky behaviour. You think of contraception and you think young people” (female GP: aged 50–59) [15].

HCPs in three articles acknowledged that they tended to think of sex as less relevant and less important to older people [14,15,18], an attitude that could form a barrier to addressing sexual issues with people of an older cohort. In addition, HCPs working in services for people with intellectual disabilities expressed the view that service users are “confused” about their sexual identity and that same-sex sexual encounters are often an expression of a sexual need in an environment with little choices rather than an expression of a non-heterosexual orientation [13]. By some HCPs holding assumptions such as these ones, it could mean that that some service users’ issues, particularly those of gender and sexual minorities, are overlooked.

Discussion

The synthesis supports previous quantitative research findings that HCPs do not routinely raise issues of sexuality with service users, and similar barriers were identified [5–7]. A model has been developed to represent the main barriers and facilitators perceived by HCPs to discussing issues of sexuality (Figure 1). The components of the model include organizational, structural, and personal factors. The themes are considered to be intricately linked and have a combined effect on HCP's decision whether to initiate discussions of sexuality with service users. In addition, the barriers seem to be exacerbated when HCPs work with certain service-user populations: those of the opposite-gender, black and minority ethnic groups, older service users, nonheterosexual service users, and those with intellectual disabilities.

Factors within the organization seemed to determine how and whether HCPs discussed issues of sexuality with service users. HCPs identified that a

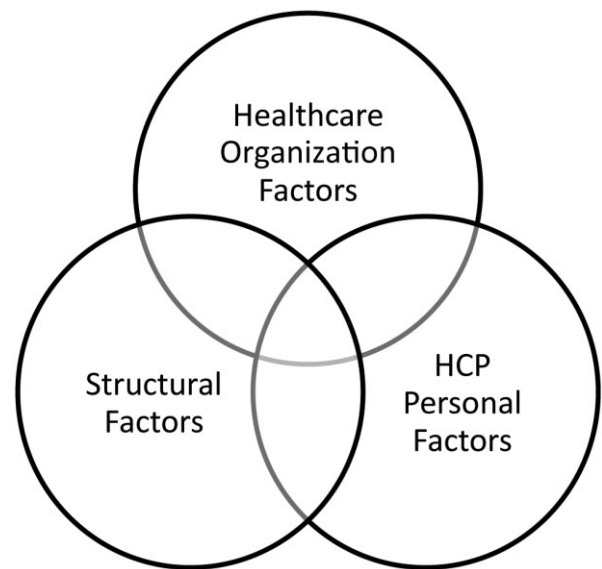


Figure 1 Factors influencing healthcare professionals' (HCPs') discussion of sexuality with service users

lack of time, resources, policy, and training can prevent them from “opening up the can of worms.” Indeed, previous research has indicated that training in sexual issues can facilitate increased comfort in having discussions [32,33]. In addition, an organization's shared values, norms, and practices are likely to guide the HCP's behavior.

Structural factors represent the economic, political, and organizational aspects of wider society over which HCPs have little personal control. Barriers such as lack of time, resources, and policy are likely to be influenced by the wider economic climate, current government incentives, and restrictions. In addition, the view that raising sexuality issues could be perceived as offensive, as well as the categorization of older people and people with intellectual disabilities as “asexual” is likely to be underpinned by wider societal images [34,35]. Furthermore, the dominant discourse in society that heterosexuality is the “norm” has dangerous implications as it serves to reinforce stereotypes that homosexuality is not “normal.”

Personal factors relate to the knowledge, motivation, and the personal attitudes of individual HCPs, which could work to impede or facilitate discussions. This is consistent with previous findings that suggest that increased knowledge [36] and more liberal sexual attitudes facilitate the discussion of sexual issues [33]. It is also important to note that these personal beliefs are likely to be underpinned by wider societal views, as well as personal upbringing and religious beliefs. In addi-

tion, HCPs' interpretations of the concept of sexuality could act as a "filter" to whether and which issues are raised.

Before considering the implications of this model and review in general, it is important to consider the limitations of this review. This was a relatively small systematic review based on eight articles. However, as some articles reported on findings from the same study, the review was only based on four unique studies. It may have been useful for the inclusion/exclusion criteria to be less stringent so that a greater number of articles could be included in the review (e.g., by including non-UK studies and those conducted more than 10 years ago). However, issues such as sexuality are temporally and culturally determined, and widening the inclusion criteria would have made it difficult to meaningfully synthesize information.

The secondary thematic analysis methodology was useful for identifying whether the same themes had been identified across studies with different samples. However, this method is susceptible to imprecision because this approach only captures the themes that were (subjectively) determined by the authors of the reviewed articles to be of particular significance; failure to identify a theme does not mean that it does not exist.

Some of the limitations relate to the data from the primary studies themselves. For instance, in reporting information on the sample, it would have been useful for more authors to have considered assessing reasons for nonparticipation, so that there is the potential for future research to increase the participation of currently underrepresented groups. As most of the studies were conducted in Yorkshire, it is not known whether the attitudes and opinions of HCPs in this area differ significantly from elsewhere in the United Kingdom, which could limit the generalizability of the synthesis.

In terms of the perceived utility of findings, all eight articles contained some reference to how the study could be utilized to enhance existing knowledge and understanding. All the authors considered how the findings have extended upon previously conducted research and how the study could be used to improve healthcare practice. However, only one article considered how the study may have implications for the development of policy [13]. Two articles identify that future research is currently underway to expand upon the findings [15,19], but disappointingly none of the articles identify areas where future research is necessary. Only one article reflected on the possibility that presentation bias may have occurred during

the interviews [15], that is, HCPs may not want to disclose information that could be perceived negatively. This is surprising considering that *all* of the studies required HCPs revealing rather personal information about their own attitudes and clinical practice.

This review highlights that further training needs to be available for all HCPs, which mirrors the recommendation made in the National Sexual Strategy for Sexual Health and HIV [37]. Training should include psychosocial aspects of sexual issues to reduce the "overmedicalization" of these concerns and should be inclusive of a wide range of service-user populations. Training could also be used to help professionals to recognize and address their own "deep rooted" beliefs and presumptions about sexuality, which are likely to be underpinned by wider societal discourses.

However, HCPs questioned the feasibility of implementing such training programs, namely, due to time and resources. This suggests that interventions need to focus not only on the HCPs themselves but also on the wider healthcare context in which they work. Unfortunately in the current economic and political climate, it may be these factors that are more difficult to overcome. A number of other facilitators were suggested, for example, having written information available and the development of policy at a structural level could be a proactive way of constructing an environment that grants permission for service users to raise sexuality issues. It would be useful for future research to evaluate the effects of the above interventions.

Finally, only one article in the review explored how the level of communication between HCPs could work to impede or facilitate discussions of sexuality [19]. Interestingly, this article was unique in that it was the only study exploring the experiences of a multidisciplinary team rather than individual HCPs. Currently, there are no other studies with which to make a comparison, and therefore it would be useful for future research to examine whether this theme is transferable to other teams.

Conclusions

This review of eight articles indicated that although the subject of sexuality is not routinely addressed in healthcare services, HCPs did believe that it should be. A number of barriers have been identified, which were particularly marked in relation to the sexuality of black and minority ethnic groups, people with intellectual disabilities, and

with older and nonheterosexual service users. Potential strategies (facilitators) to overcome these barriers have also been discussed, such as training, policy development, having written information available for service users, and communication between professionals. However, limitations of implementing these were also identified. Interventions to improve the extent to which service users' sexuality issues are addressed in healthcare services need to take structural, organizational, and personal factors into consideration.

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