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Discussing sexual and relationship health with young people in an acute children's hospital

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Abstract

The barriers to initiating and holding conversations about sexual and relationship health with young people are under researched within the acute paediatric care setting, with the majority of research focussing on these discussions within primary care settings. This qualitative research study aimed to explore how healthcare professionals discussed sexual and relationship health with young people within an acute care context. Six semi-structured focus groups were held with healthcare professionals ($n = 24$) from within an acute children's hospital. This inquiry highlighted different approaches of professionals to initiating and engaging in conversations with young people, which included avoidance, reluctance and confidence. The professionals' ability to open dialogues with young people was influenced by their levels of knowledge and information, their personal beliefs and the availability of private time and space. Those conversations that did take place focussed on physiology, fertility or medication and did not frequently explore issues of relationships and sexuality. Further training and education is needed to equip staff to initiate and engage in discussions about sexual health.

Keywords

focus group, healthcare professionals, relationships, sexual health, young people

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Introduction

The United Kingdom has the highest rates of teenage birth and abortion rates in Western Europe (UNICEF, 2001) and an increasing incidence of risky sexual behaviour (Johnson et al., 2001). Pregnancy rates amongst teenagers in France, Germany and the Netherlands are much lower than the UK; one factor that may influence this could be the detailed education young people in these countries receive in primary and secondary schools, health services and youth services (World Health Organisation [WHO], 2006b). Effective sex and relationship education (SRE) has been seen as one of the key interventions to inform young people about sexual health and make them take responsibility for their actions (DFEE, 2000). Despite this, research has demonstrated that the education delivered in schools may not address the needs of young people, who continue to report a lack of sexual health knowledge and dissatisfaction with current education programs (Coombe, 2000; United Kingdom Youth Parliament, 2007). The attendance of young people at personal, social, health and economic education (PSHE) sessions, which include SRE, is not at present compulsory in schools in the UK as parents can decide to withdraw their children from these sessions.

Attendance in SRE lessons in schools may not reach a difficult to access population, since 7% of young people do not attend school regularly and 4.4% of young people miss 20% or more of lessons (Verhoeven et al., 2003). Young people need accurate information from varied and multiple professional sources (Department for Children, Schools and Families [DCSF], 2008) and to achieve this information should be available in all settings where young people access services. This 'invites a wide range of healthcare providers to reconsider their possible role in promoting sexual health' (Verhoeven et al., 2003: 11) and the research team considered that one such environment could be an acute paediatric hospital.

Background

Research exploring the varied health and social care environments in which sex education is delivered by healthcare professionals has focussed on primary care settings, including drop-in centres (Ingram and Salmon, 2007), general practitioner centres (Gott et al., 2004; Kim et al., 2008), schools (Jourdan et al., 2010; Mason, 2010) and clinics close to colleges (Perry and Thurston, 2007). Often professionals have reported feeling unprepared to discuss a range of sexual health issues with young people (Verhoeven et al., 2003; Tsai, 2004) and using sexual language with young people has been reported as anxiety provoking (Risen, 1995). This anxiety can result in professionals avoiding these conversations, which can limit the collection of a comprehensive sexual health history (Tsai, 2004) and reduces the chance of open discussions with young people (Mulvey et al., 2000). The above barriers to discussing sexual health are consistently reported across different countries and cultures, both within acute and primary care settings (Mulvey et al., 2000; Verhoeven et al., 2003; Tsai, 2004; Kim et al., 2008).

Research within the adult acute care environment has demonstrated that those with long-term illnesses are often not informed of the consequences of their illness on their sexual health (Sarkadi and Rosenqvist, 2001; Gott and Hinchliff, 2003) and nurses do not take time to discuss sexual concerns with patients (Saunamaki et al., 2010). This is despite there being a clear connection between sexuality and health status (WHO, 2006a). Patients with cancer (Hordern and Street, 2007; Hordern et al., 2009) and cardiovascular disease (Jaarsma et al., 2010) are examples of two groups where barriers between professional and patient sexual health dialogues exist. These barriers include lack of time, embarrassment, belief that the

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topic is not of relevance to their patients, fear of opening Pandora's box and not being able to deal with the outcome of a discussion (Hordern et al., 2009) and a lack of knowledge (Jaarsma et al., 2010).

The roles adopted and/or anxieties experienced by healthcare professionals in discussing sexual and relationship health with young people in acute settings are under reported (Jolley, 2001). Research from over a decade ago identified staff knowledge gaps (Popovitch, 1996) and negative beliefs and opinions towards young people's sexual activities and an unease with discussing sexuality issues (Pitts et al., 1996), yet there is little up-to-date evidence relating to how these gaps and beliefs have changed over time. It is reported that healthcare professionals do not always recognise that young people may require sexual health assessment before they are 16 years of age (Kelton, 1999). The social construction of sexuality may also negatively impact on specific groups of young people, with those with chronic long-term conditions and complex needs not being perceived as sexual beings (Finnegan, 2004; Treacy and Randle, 2004).

Young people are required within our existing social systems to have opportunity and access to sexual and relationship health advice and education with the aim of promoting safe sexual practice, limiting risky behaviour and developing socially and emotionally within the context of relationships. Young people with long-term conditions may need additional and specialist support to help them to adopt safe sexual practices in line with their condition and gain confidence in managing their sexual self (DoH, 2003; Finnegan, 2004). An acute paediatric environment in which professionals are able to demonstrate their willingness to provide confidential sexual and relationship advice to young people could provide them with an opportunity to discuss sexual health worries or concerns. The extent to which professionals in an acute paediatric hospital discuss sexual or relationship health with young people is not currently known. The barriers to initiating and holding these conversations with young people are under researched and explored within the acute paediatric care setting.

Aim of the study

The aim of this study is to explore healthcare professionals' experiences of talking to young people about sexual and relationship health within an acute children's hospital.

Methodology

The data collection and findings presented in this paper form part of the preliminary and exploratory phase of a larger action research study that is entitled 'Discussing sexual and relationship health with young people within an acute paediatric hospital'. An action research approach was chosen to underpin the overall research study, as the project aimed to facilitate change within the organisation as part of the research process itself (Patton, 2002; Somekh et al., 2005). The preliminary phase of data collection aimed to provide information regarding the current practice, experiences and views of healthcare professionals within the acute trust.

Ethical issues

The study received ethical approval through the National Research Ethics Service and research governance approval was obtained from the trust's local research committee.

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All healthcare professionals gave informed written consent to take part in the focus groups. Ground rules were discussed and agreed at the beginning of each focus group, which outlined that if bad practice was divulged then this would have to be followed up within the designated trust reporting systems. This did not need to be actioned during data collection.

Focus groups

The research question aimed to explore how professionals discussed sexual health with young people within the acute care context and it was hoped that focus groups would elicit data regarding these conversations and gain insight into the barriers and enablers that professionals experienced in practice. Focus groups have been defined as 'a carefully planned discussion, designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment' (Krueger, 1994: 6). Details of a cross section of staff ($n = 100$), were obtained through the human resources department and these professionals were sent an invitation letter and information sheet to their workplace. In addition, posters were put up within the staffrooms in clinical areas asking for volunteers to take part. In total 40 people contacted the research team to participate in the study.

The optimal number of participants needed to effectively run a focus group is much debated, but consensus seems to indicate that 6–10 participants is deemed adequate to ensure an active but focussed discussion (Morgan, 1997). Some studies have reported successful interaction when using as few as four participants (Kitzinger, 1995) and larger groups have been linked to interruptions, overlapping conversations and sub-group discussions (Twinn, 2000). Although participants had collaborated in planning the focus group times and venues in accordance with shift patterns and availabilities (Happell, 2007), staff had to cancel attendance at short notice due to busy clinical workloads. The difficulty with attendance often meant that despite inviting and confirming 7–10 practitioners for each group, the actual number of participants was often less than anticipated. When attendance was reduced the decision was made to run smaller groups as opposed to changing to individual interviews (Reed, 2005). These decisions and discussions were made as a team after two focus groups had been held, as it was felt by the research team that a focus group was the best method to facilitate discussion. Initially the research had intended to hold four focus groups, but due to the low number of participants at each group and the high numbers of volunteers this was increased to six.

The research team had planned that the focus groups would run as homogenous professional groups (Carey and Smith, 1994; Krueger, 1994) and be organised within these according to experience and grading of practitioners. In reality, attendance and sampling within each group was dependent on the availability of individual professionals and mixed professional heterogenous groups were held. In one instance the research team were contacted and asked to attend at the end of a team meeting, which was described as the most convenient way for the team members who had expressed an interest to be involved. This opportunity was accepted and the research team discussed concerns regarding whether individuals would feel able to decline involvement; both the importance of voluntary involvement and the need for the professionals to keep information confidential within the group setting was reinforced prior to the focus group.

The groups were run by two members from the research team. The moderator (LB) had previous experience of running focus groups and facilitated the discussion in a non-directive

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way whilst still focussing on the pre-determined questions (Kingry et al., 1990). These questions had been designed to be 'open-ended, non-judgemental and proceeded from broad to specific topics and from less to more sensitive topics' (Cote-Arsenault and Morrison-Beedy, 2005: 174). Scenarios were used to help aid the discussion and acted as an ice-breaker to the conversation. The authors believe that the focus groups encouraged an open discussion and many personal experiences were shared and some unexpected concerns and experiences were debated within the group. The format of the group encouraged everyone, even those who felt that they had 'little to say about the topic', where 'one person's revelation often encouraged others to disclose similar experiences' (Wilkinson, 1998: 119). The groups were also attended by a second member from the research team (either CS, JMcK or EP); this additional person was advised to support observation of the group interaction, make notes and supervise the recording equipment (Gibson, 2007).

In total, 24 professionals participated in the focus groups, with the groups having three, four, three, four, seven and three people attending. The different professions involved included nurses ($n=15$), allied health professionals ($n=1$), psychologists ($n=7$) and doctors ($n=1$). Unfortunately, despite having three male volunteers (from nursing, pharmacy and psychology) who were willing to attend the groups, only one managed to participate due to unanticipated clinical workloads. Therefore attendance was dominated by female healthcare professionals. The focus groups lasted between one to one and a half hours. The focus groups were digitally audio-recorded and transcribed by the research team. Due to the relatively small size of most of the groups it was easily discerned which group member was speaking and the sound quality was of a good standard.

Data analysis

The analysis in this study was guided by the papers by Twinn (2000) and Kidd and Parshall (2000). Analysis focussed on both the group and individual level, and the different topics discussed both within and across groups. As many of the groups were small in size, the analysis process took into account whether an issue was a theme for the group or merely a strong viewpoint of one or two participants and whether issues were raised spontaneously or only in response to the moderators questioning (Polit and Beck, 2008). The data was analysed independently by all four members of the research team using qualitative thematic analysis. As advocated by Kidd and Parshall (2000), coding frequently occurred in large discourse chunks, which aimed to categorise detail of the content of the discussion and the process of discussion between group members. The codes and categories that were created were discussed within the team and when disagreement or uncertainty existed the themes were taken back to the data for refinement and clarification.

The main themes were circulated after one month to the participants from the focus groups to gain some consensus as to whether this represented their experiences and views. Thirteen of the professionals responded and this led to a few minor changes to the themes. This was done in addition to the tentative main themes of each group being briefly summarised to the participants at the end of each focus group (Kidd and Parshall, 2000).

Findings

There were two main themes that arose from the data, these related to the healthcare professionals' experiences of discussing sexual and relationship health issues with young

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people and their views on the resources, training and education needed to support them in holding these conversations.

Healthcare professionals experiences of discussing sexual and relationship health with young people

There were many factors that influenced how comfortable or equipped healthcare professionals felt to initiate and engage in these conversations and these reflected both personal and contextual factors. The experiences ranged on a continuum from avoidance to reluctance to confidence and the findings within this theme will be discussed in relation to these differing approaches.

Avoidance

Without prompting, three of the six focus groups discussed that the context and culture of a children's acute hospital influenced how the sexual and relationship health of young people was integrated into care.

> I have been to meetings where consultants have actually said 'we are a children's service we don't have anything to do with that lets' leave it to the adult services when they get there' despite having patients who are 19, 20 the view is we are children's service and we don't talk to them about issues relating to sexual relationships. (Participant 3, focus group 3)

These professionals referred to an underlying assumption that the paediatric acute setting was not a relevant environment in which to be engaging in these conversations with young people. In addition to assumptions or beliefs within certain clinical teams, personal factors also impacted on the ability of healthcare professionals to initiate discussion relating to sexual and relationship health. These personal characteristics included an individual's upbringing and personal beliefs.

> The way I was brought up affects how I am and I think that we are adults and we have our own beliefs, opinions, and experiences and it is hard not to bring that to the table when you are talking to a young person. (Participant 1, focus group 6)

During the focus groups several of the participants were reflexive and discussed how discussing sexual health made them feel uncomfortable and embarrassed and their own private assumptions and beliefs caused them to avoid initiating conversations as they '*wouldn't know where to start*' and '*had never really had to talk about it*'.

Reluctance

Many of the participants had attempted discussions relating to sexual health, but expressed reluctance in doing so and were hesitant to know how to best approach raising these issues. Specific clinical areas caused staff to be reluctant to discuss sexual health matters, where a lack of privacy in the clinical inpatient area was seen as a challenge to initiating these conversations. Information and discussion commonly took place in the nursing station or at the bedside, with only the curtain to maintain privacy and confidentiality.

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> I don't think the way the wards are set up are very appropriate for asking these type of things, your assessment is done at the nurses' station and that is not very appropriate because there are a million and one people around. (Participant 1, Focus group 5)

The admission nursing assessment is most commonly conducted with parents present and this was felt to limit young peoples' confidentiality or their opportunity to either raise issues of concern or answer questions honestly, such as whether they were on any medication such as the contraceptive pill. Some of the participants discussed the strategies they used to negotiate time with the young person on their own.

> What we tend to do if we want to ask anything we will say to the girl come down the bathroom so we can weigh you, get her by herself and then we can ask if there is anything they want to discuss without her family being present. (Participant 2, Focus group 1)

Although parental presence was seen in most cases to negatively influence the ability of young people to talk openly about their sexual health, some professionals expressed concern that initiating and engaging in a conversation alone with young people about sex and relationships may place them in a vulnerable position.

> Participant 2: I'm not quite sure if we should have a chaperone when we have the conversation, I'm aware that it may inhibit the conversation or make it worse, for intimate examinations we tend to rely on the parents to be a chaperone but for intimate conversations, one of the anxieties for that is being misconstrued or having accusations made or causing offence because if you are talking to the child away from the parents then it is your word against theirs as to what was said and I have certain anxieties about that.
> Participant 4: A few times I have had a child, who was divulging all this information to me you know general chit chat and she was saying she was sexually active and how old her partner was etc and when dad came back in he wanted to know word for word the conversation and it is quite hard because of confidentiality. (Focus group 6)

Anxieties regarding the need to offer confidentiality to young people whilst being accountable and working within professional boundaries caused some of the participants to report concern in initiating sensitive conversations. Despite professionals demonstrating an awareness and confidence in dealing with safeguarding issues, some expressed less confidence in dealing with young people's behaviour, which may subjectively be considered risky, but was not clearly identifiable as a safeguarding issue.

Confidence

Some of the healthcare professionals in the focus groups reported feeling confident in having sexual health conversations with young people as a result of the trusting ongoing relationship that had developed over time. This ongoing contact was often within a specialist team with dedicated time in a quiet clinic room.

> I suppose on the wards it's a little bit different whereas I know my patients, I suppose on the ward it's a little bit different unless they are a regular patient and you can build up a relationship with them. (Participant 1, focus group 5)

Skills and confidence in opening sexual and relationship health discussions with young people had often developed from clinical experience over time. Although some of the

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professionals discussed confidence in initiating and holding these conversations with young people, the content often related to concrete aspects of sexual health that directly related to a young person's condition (cancer, cystic fibrosis and other congenital conditions) including fertility, physiological processes and pregnancy. On prompting, focus group 2 discussed what aspects of sexual health could be difficult to discuss.

> Participant 2: The biology stuff, the black and white stuff people are okay doing that, you give them the leaflets and set them up to do it with the young person but when it gets to the more intimate stuff about relationships and putting yourself at risk I think that's when it gets a bit more awkward for people.
> Participant 1: Yes, I think thinking about the medical bits and relationship bits separately as well, because it is quite straightforward or it seems to be to say are you pregnant because it is going to interfere with the procedure, or are you on the pill but then to start asking questions about relationships because are they at risk, or how vulnerable they are is totally different. (Focus group 2)

Many of the professionals identified that it was more difficult to discuss relationship and sexuality issues that were not seen to relate to the young person's immediate physiological or functional healthcare needs.

Healthcare professionals' views on resources, education and training

The training, education and resources that would help professionals to discuss sexual and relationship health was a question raised by the moderator at each focus group. All participants in the six groups agreed that there was a need for some training or resources and there was a debate in four of the groups as to the most appropriate format for this. This discussion focussed on the benefits and challenges of e-learning, which was seen to be more accessible than face-to-face training as there were difficulties with '*releasing staff to go on courses*' (focus group 2). However, e-learning was not seen to address the in-depth knowledge and skills needed, but could provide a short 'taster' session for a larger number of staff, where '*everyone could have a little bit*' (focus group 1). Face-to-face training was discussed as being of more relevance to 'interested staff' who would be keen to develop their skills to a higher level. This more in-depth preparation supported the discussion in the groups that there were often designated people within a clinical team who were called upon to have '*that conversation*' with young people. The groups discussed that some staff were never going to be comfortable discussing sexual health, but could have their awareness raised about the current issues relating to the sexual health of young people and where to access up-to-date resources.

Some of the group members had attended previous education and training relating to sexual health, but had found this to be too generic and did not equip them with the specific skills and knowledge needed for working with young people within an acute paediatric environment. The professionals identified that training should include communication skills, knowledge and information on sexually transmitted infections, terminology used by young people and legal safeguarding practices.

Limitations

The number of participants at each focus group was fewer than anticipated and the challenges of getting busy clinical staff to attend at the designated time created difficulties

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in running larger group discussions. Despite the small numbers it was felt that valuable data were collected and the interaction between group members elicited an interesting discussion about what could be a considered a sensitive topic.

Discussion

The healthcare professionals in this study identified that there were barriers that impeded their ability to discuss sexual and relationship health with young people. These included difficulty negotiating time and space with young people in a busy paediatric acute setting, the beliefs and assumptions of clinical teams and challenges within their own personal beliefs. These barriers led professionals to express reluctance to engage in these conversations as has been shown in previous studies about different contexts and adult populations (Lewis and Bor, 1994; Tsai, 2004; Hordern and Street, 2007). Positive influencing factors discussed included the opportunity to negotiate a private discussion with young people, which has been shown to facilitate these discussions (Klein and Wilson, 2002), and having established relationships with young people over time. Even in the instances where healthcare professionals reported feeling able to discuss sexual health, on further exploration the focus of many of these discussions was on physiological processes as opposed to wider issues of relationships, sexuality or changing feelings and emotions. Discussing the wider aspects of sexual health has been highlighted as challenging within adult nursing environments, where despite professionals believing that they were addressing sexuality and intimacy issues with their patients, they were in fact only focusing on treatment-induced symptoms and the physiological side-effects of a condition or medication (Hordern and Street, 2007). The difficulty of discussing sexuality and relationships with adult patients (Guthrie, 1999) seems to be mirrored or even exacerbated when working with young people.

The experiences in this study ranged on a continuum from avoidance to confidence; these differences are important to understand in order to inform the design of education and training to equip clinical staff to meet the needs of young people in their care. Education has been demonstrated to make a noticeable difference in the knowledge levels of and reported confidence of healthcare staff in discussing sexual and relationship health matters with patients (Mulvey et al., 2000; Stokes and Mears, 2000; Saunamaki et al., 2010). Only one of the 25 professionals involved in this study had received any formal post-registration training regarding sexual health and others reported minimal recall of this subject being covered on their pre-registration training programmes. It has been noted that currently education and training for medical staff and nurses in relation to sexual health at undergraduate level and post-graduate level is inadequate (Treacy and Randle, 2004; Johnston, 2009; Saunamaki et al., 2010). Recent initiatives have attempted to address these inadequacies by providing resources and increased levels of information (Royal College of Nursing (RCN) e-learning), but these focus on sexual health within adult fields of practice or community settings. These professional–patient relationships and contexts may not be comparable to an acute paediatric setting.

The findings from this study demonstrate that specific education and training is required within a paediatric context to address the particular problems healthcare professionals can face when working with young people within a hospital setting. In order to equip and encourage staff to move from a position of avoidance to one of confidence, education and training must include not only factual information, but must also address communication skills and challenge both personal beliefs and assumptions regarding sexual health and the

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culture within which professionals work (Guthrie, 1999; Hordern et al., 2009). As seen in these findings, it was embedded culture and personal characteristics that were most likely to lead to healthcare staff avoiding these discussions and these aspects may be the hardest areas in which to affect change. Training would hope to equip staff with transferable critical thinking and communication skills, which would enable them to analyse their personal assumptions and beliefs and how these influence their interactions with young people in their care.

This research study will lead to the design and implementation of training that aims to include both e-learning and face-to-face sessions, which will be informed by the data from these focus groups. This training will be evaluated within an ongoing process with the trainees to judge the impact of the training on their practice and the culture in which they work.

Conclusion

The focus groups identified that healthcare professionals can often feel reluctant to engage in conversations about sexual and relationship health with young people within the context of an acute children's hospital, due to concerns about lack of knowledge and information. The discussions that do address sexual health within this context tend to focus on fertility, physiology and medication, with only a very limited focus on exploring young people's experiences, understanding, beliefs and emotions. The reluctance is exacerbated by the nature of the busy clinical area and the presence of parents. There is a need for more training designed specifically for professionals working with young people in this area; this training should encompass different agencies and different learning approaches.

Key points

- Health professionals often feel reluctant to engage in conversations about sexual and relationship health with young people due to concerns about lack of knowledge and information.
- The focus of sexual health discussions tend to be on fertility, physiology and medication and not on exploring young peoples' experiences, understanding, beliefs and emotions.
- Frequently only designated people within a clinical area or clinical team engage in conversations about sexual and relationship health.
- The nature of the busy clinical area and the presence of parents can act as a barrier to professionals discussing sexual and relationship health.
- Healthcare professionals need further education and training to equip them with skills to talk to young people about sexual and relationship health.

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Conflict of interest statement

None declared.

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References

Carey MA and Smith MW (1994) Capturing the group effect in focus groups: a special concern in analysis. *Qualitative Health Research* 4: 123–127.

Coombe C (2000) Keeping the education system healthy. Managing the impact of HIV/AIDS on education in South Africa. *Current Issues in Comparative Education* 3(1): 1–13.

Cote-Arsenault D and Morrison-Beedy D (2005) Maintaining your focus in focus groups: avoiding common mistakes. *Research in Nursing & Health* 28: 172–179.

Department for Children, Schools and Families [DCSF] (2008) *The Children's Plan*.

DFEE (2000) *Developing a Policy for Sex and Relationship Education*.

DoH (2003) *Framework for the Provision of Sexual Health Services in School Settings. Teenage Pregnancy in the North West*. Liverpool: Government Office for the North West.

Finnegan A (2004) Sexual health and chronic illness in childhood. *Paediatric Nursing* 16(7): 32–36.

Gibson F (2007) Conducting focus groups with children and young people: strategies for success. *Journal of Research in Nursing* 12(5): 473–483.

Gott M, Galena E, Hinchcliff S and Elford H (2004) 'Opening a can of worms': GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice* 21(5): 528–536.

Gott M and Hinchliff S (2003) Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. *Family Practice* 20: 690–695.

Guthrie C (1999) Nurses' perceptions of sexuality relating to patient care. *Journal of Clinical Nursing* 8: 313–321.

Happell B (2007) Focus groups in nursing research: an appropriate method or the latest fad? *Nurse Researcher* 14(2): 18–24.

Hordern A, Grainger M, Hegarty S, Jefford M, White V and Sutherland G (2009) Discussing sexuality in the clinical setting: the impact of a brief training program for oncology health professionals to enhance communication about sexuality. *Asia-Pacific Journal of Clinical Oncology* 5(4): 270–277.

Hordern AJ and Street AF (2007) Communicating about patient sexuality and intimacy after cancer: mismatched expectation and unmet needs. *Medical Journal of Australia* 186(5): 224–227.

Ingram J and Salmon D (2007) 'No worries!'. Young people's experiences of nurse-led drop-in sexual health services in South West England. *Journal of Research in Nursing* 12: 305–315.

Jaarsma T, Stromberg A, Fridlund B, De Geest S, Martensson J, Moons P, et al. (2010) Sexual counselling of cardiac patients: nurses' perception f practice, responsibility and confidence. *European Journal of Cardiovascular Nursing* 9(1): 24–29.

Johnson AM, Mercer CH, Erens B, Copas AJ, McManus S, Wellings K, et al. (2001) Sexual behaviour in Britain: partnerships, practices and HIV risk behaviours. *The Lancet* 358(9296): 1835–1842.

Johnston JH (2009) The preparation of child health nurses in sexual health education: An exploratory study. *Nurse Education Today* 29: 845–849.

Jolley S (2001) Promoting teenage sexual health: an investigation into the knowledge, activities and perceptions of gynaecology nurses. *Journal of Advanced Nursing* 36(2): 246–255.

Jourdan D, McNamara PM, Simar C, Geary T and Pommier J (2010) Factors influencing the contribution of staff to health education in schools. *Health Education Research* 25(4): 519–530.

Kelton S (1999) Sexuality education for youth with chronic conditions. *Pediatric Nursing* 25(5): 491–497.

Kidd PS and Parshall MB (2000) Getting the focus and the group: enhancing analytical rigor in focus group research. *Qualitative Health Research* 10(3): 293–308.

Kim SH, Lee Y and Park JT (2008) Patients' perspective on sexual history taking in Korea. *Patient Education and Counseling* 70: 370–375.

Kingry M, Tiedje L and Friedman L (1990) Focus groups: a research technique for nursing. *Nursing Research* 39(2): 124–125.

Kitzinger J (1995) Introducing focus groups. *British Medical Journal* 311: 299–302.

Klein JD and Wilson KM (2002) Delivering quality care: adolescents' discussion of health risks with their providers. *Journal of Adolescent Health* 30: 190–195.

Krueger RA (1994) *Focus Groups: A practical Guide for Applied Research*, 2nd edn. Thousand Oaks, CA: Sage Publications.

Lewis S and Bor R (1994) Nurses' knowledge of and attitudes towards sexuality and the relationship of these with nursing practice. *Journal of Advanced Nursing* 20(2): 251–259.

Mason S (2010) Braving it out! An illuminative evaluation of the provision of sex and relationship education in two primary schools in England. *Sex Education: Sexuality, Society and Learning* 10(2): 157–169.

Morgan DL (1997) *Focus Groups as Qualitative Research*, 2nd edn. Thousand Oaks, CA: Sage Publications.

Mulvey G, Keogh LA and Temple-Smith M (2000) Outcomes of an educational activity with Victorian GPs aimed at improving knowledge and practices in relation to sexually transmissible diseases. *Australian and New Zealand Journal of Public Health* 24(1): 67–78.

Patton MQ (2002) *Qualitative Research and Evaluation Methods*, 3rd edn. London: Sage Publications.

Perry C and Thurston M (2007) Meeting the sexual health needs of young people: a model that works? *Child: Care, Health and Development* 34(1): 98–103.

Pitts M, Burtney E and Dobraszizyc V (1996) There is no shame in it any more: how providers of sexual health advice view young peoples' sexuality. *Health Education Research* 11(1): 1–9.

Polit DF and Beck CT (2008) *Nursing Research. Generating and Assessing Evidence for Nursing Practice*, 8th edn. Philadelphia, PA: Lippincott Williams & Wilkins.

Popovitch DM (1996) Sexuality in early childhood: pediatric nurses' attitudes, knowledge and clinical practice. *Pediatric Nursing* 26(5): 484–492.

Reed J (2005) Using action research in nursing practice with older people: democratizing knowledge. *Journal of Clinical Nursing* 14(5): 594–560.

Risen CB (1995) A guide to taking a sexual history. *Psychiatric Clinics of North America* 18(1): 39–53.

Sarkadi A and Rosenqvist U (2001) Contradictions in the medical encounter: female sexual dysfunction in primary care contacts. *Family Practice* 18: 161–166.

Saunamaki N, Andersson M and Engstrom M (2010) Discussing sexuality with patients: nurses' attitudes and beliefs. *Journal of Advanced Nursing* 66(6): 1308–1316.

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Somekh B, Burman E, Delamont S, Meyer J, Payne M and Thorpe R (2005) Research communities in the social sciences. In: Somekh B and Lewin C (eds) *Research Methods in the Social Services*. London: Sage Publications.

Stokes T and Mears J (2000) Sexual health and the practice nurse: a survey of reported practice and attitudes. *British Journal of Family Planning* 26(2): 89–92.

Treacy V and Randle J (2004) Breaking sexuality taboos. *Paediatric Nursing* 16(2): 19–22.

Tsai YF (2004) Nurses' facilitators and barriers for taking a sexual history in Taiwan. *Applied Nursing Research* 17(4): 257–264.

Twinn S (2000) The analysis of focus group data: a challenge to the rigour of qualitative research. *Nursing Times Research* 5: 140.

UNICEF (2001) *A League Table of Teenage Births in Rich Nations*. Florence: UNICEF Innocenti Research Centre.

United Kingdom Youth Parliament (2007) *Sex and Relationship Education - Are you Getting it*? London: United Kingdom Youth Parliament.

Verhoeven V, Bovjin K, Helder A, Peremans L, Hermann I, Van Royen P, et al. (2003) Discussing STIs: doctors are from Mars, patients from Venus. *Family Practice* 20(1): 11–15.

Wilkinson S (1998) Focus groups in feminist research: power, interaction, and the co-construction of meaning. *Women's Studies International Forum* 21(1): 111–125.

World Health Organisation (WHO) (2006a) *Defining Sexual Health: Report of a Technical Consultation on Sexual Health*. Geneva: WHO.

WHO (2006b) *Adolescent Pregnancy: Unmet Needs and Undone Deeds. A review of the Literature and Programmes*. Geneva: World Health Organisation.

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