


From Promoting Healthy Sexual Functioning to Managing Biomedical Sexual Dysfunction: Health Professional Views of Youth Sexual Health

SAGE Open Nursing
Volume 5: 1–11
© The Author(s) 2019
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/2377960819832676
journals.sagepub.com/home/son


Lucia F. O’Sullivan, PhD¹ , Jo Ann Majerovich, MD²,
and Judith Wuest, RN, PhD³

Abstract

A body of work emerging in the last few years has expanded the focus of youth sexual health to include problems in sexual functioning. Recent surveys show that rates of youth sexual functioning problems are similar to those of adults. Physicians’ lack of awareness about problems of sexual functioning has been identified as a major obstacle in treatment. Yet little is known about health-care provider (HCP) perspectives on youth sexual functioning. We conducted a descriptive qualitative study with HCPs to learn about their perceptions of adolescent sexual problems and HCP roles in managing these issues including sexual functioning. Nineteen HCPs: Family physicians, nurse practitioners, and public health nurses working primarily with youth in universities, schools, or sexual health clinics were recruited to draw on their expert knowledge and experience. All completed in-depth individual interviews. Data were analyzed using directed qualitative content analysis. Our findings illuminate inconsistent views. Some HCPs, particularly those in youth-focused services, adopt a holistic role in promoting healthy sexual functioning, and others, commonly those in general practice, attend only to biomedical issues related to sexual dysfunction. All HCPs in our study were challenged by a paucity of sexual health preparation in their formal education. HCP interest in youth sexual health affected their efforts to acquire new information and training and, along with the structure of their practice setting, influenced whether they framed their role in youth sexual health holistically within a context of social determination or constrained their role to a medical model. These findings draw attention to the need for new approaches for strengthening knowledge, training, and resources to foster HCP promotion of healthy sexual functioning and prevention of lifelong sexual health problems.

Keywords

sexual health, adolescents, health-care professionals

Date received: 20 August 2018; revised: 15 January 2019; accepted: 25 January 2019

Introduction/Background

Most research and clinical attention relevant to young people’s sexual health has focused on rates, risk factors, and prevention of unwanted pregnancy and sexually transmitted infection (STI; Leftwich & Alves, 2017; Lopez, Grey, Chen, Tolley, & Stockton, 2016; Ursu, Sen, & Ruffin, 2015; Wangu & Burstein, 2017). A body of work emerging in the last few years, however, has expanded the focus of youth sexual health to include problems in sexual functioning. Drawing from the

¹Department of Psychology, University of New Brunswick, Fredericton, New Brunswick, Canada

²Department of Indigenous Services Canada, Ottawa, Ontario, Canada

³Faculty of Nursing, University of New Brunswick, Fredericton, New Brunswick, Canada

Corresponding Author:

Lucia F. O’Sullivan, Department of Psychology, University of New Brunswick, P. O. Box 4400, Fredericton, New Brunswick E3B 5A3, Canada.
Email: osulliv@unb.ca



massive body of work on adult sexual problems, survey research has revealed high prevalence of problems in sexual functioning among adolescents and young adults (Akre, Berchtold, Gmel, & Suris, 2014; O'Sullivan, Brotto, Byers, Majerovich, & Wuest, 2014; O'Sullivan, Byers, Brotto, Majerovich, & Fletcher, 2016) at levels often similar to the high rates found in studies of adult sexual dysfunctions (Laumann, Paik, & Rosen, 2009; Mercer et al., 2003). Problems with sexual functioning in youth may be precursors to sexual dysfunction in adulthood; therefore, prevention, early detection, and treatment are important not only to improve pleasure and positive sexual functioning for youth but also to prevent future sexual dysfunction and impaired psychological well-being and quality of life in adulthood (Mitchell et al., 2013; Sandfort, 2008).

Physicians' lack of awareness about problems of sexual functioning has been identified as a major obstacle in treatment (Shivananda & Rao, 2016). Youth have limited knowledge about services for sexual problems or how to access them (O'Sullivan, Wuest, & Byers, 2018), and often appear to think that these problems are part of a typical sexual life (e.g., pain, lack of sexual interest or desire, problems getting or maintaining an erection), even though they would be cause for considerable concern among adults. Little is known about health-care provider (HCP) perspectives on youth sexual dysfunction. We report here the findings of a descriptive qualitative study of HCPs' understandings of adolescent sexual functioning and the factors that facilitate or interfere with assessment and management of youth sexual concerns.

Review of the Literature

The study of sexual functioning in adolescence is a relatively new and unexplored field. O'Sullivan and Majerovich (2008) found after surveying 171 adolescents (17–21 years) that 97% of male and 98% of female respondents had experienced a sexual problem in functioning in their lifetime. For young men, the most common problem was premature ejaculation; for young women, the most common problem was inability to climax. Performance anxiety was the second most commonly experienced problem for both young men and young women. These results were supported by observations made by the second author (JM) in her practice as a physician in a youth clinic; specifically, that many adolescents seeking care for what she assessed to be sexual function issues could not, or would not, identify them as such. Together, these findings were the catalyst for a mixed methods program of three studies conducted by our multidisciplinary team (psychologist, nurse, and physician) to explore sexual functioning problems among youth living in New Brunswick, a predominantly rural province in Eastern

Canada. The first study comprised a longitudinal survey of 405 adolescents (16–21 years). The study revealed that 79% of male and 85% of female adolescents reported a problem in sexual functioning over a 2-year period, typically anorgasmia, low satisfaction, and pain among the young women, and low sexual satisfaction, low desire, and problems in erectile functioning among the young men (O'Sullivan et al., 2016). Half of these cases were associated with high distress, and rates showed little change over time.

Other survey research conducted in this period expanded our knowledge of youth sexual problems even further. In a study of 3,700 sexually active Swiss young men (18–25 years), almost half reported persistent premature ejaculation (44%) and erectile dysfunction (51%; Akre et al., 2014). In the United Kingdom, a national survey of adolescents (16–21 years) found 9% of males and 13% of females had experienced a distressing sexual problem of at least 3 month's duration (Mitchell et al., 2016). One third (36%) of the males and 42% of the females had sought help but rarely from a HCP. Analysis of data from youth (15–24 years), collected in the French national sexual and reproductive health survey, showed that 48% of females and 23% of males reported at least one sexual dysfunction (Moreau, Kågesten, & Blum, 2016). Although limited in number, these surveys demonstrate that distressing and persistent problems in functioning can emerge early in individuals' sexual lives.

In the second study in our program of research, we conducted a descriptive qualitative study with 53 heterosexual youth to explore their perceptions of their experiences with sexual problems. We identified that youth engaged in an intentional process of 'figuring it out' directed toward improving their sexual experiences (O'Sullivan et al., 2018). Although help seeking was one strategy used by youth, they rarely mentioned seeking help from HCPs for issues requiring medical solutions, such as STIs, pain, or oral contraceptives. One reason for this finding might be the current gaps in health professional education regarding sexual health. Shindel and Parish (2013) in a review of research found that many physicians avoided routine inquiry about sexual well-being because of limited training, lack of knowledge or comfort, or conservative attitudes about sexual practices. Most youth consult HCPs for a range of health issues creating opportunities for dialogue about sexual health. But little is known about whether or how HCPs address sexual issues with youth in primary care or public health settings.

Thus, our third study was a descriptive qualitative study designed to gather HCPs' understandings of sexual functioning among young people. The objectives guiding this study were to explore (a) whether and how providers incorporated sexual functioning into their

understanding of adolescent sexual health, (b) the perceived roles of HCPs in addressing youth sexual health, and (3) factors that facilitate or counter effective provision of sexual health care.

Methods

Design

A qualitative descriptive design is particularly useful in health research for gathering information from those directly involved in the situation of interest (Bradshaw, Atkinson, & Doody, 2017). Qualitative description involves an inductive approach whereby the researcher engages in conversation with the participant to develop an understanding of the phenomenon that reflects the participant's insider view as interpreted by the researcher. Thorne (2008) noted that clinicians' experiential knowledge is a rich source of hard-earned insights about clinical patterns that is not available elsewhere.

Sample

We recruited via word of mouth and snowball sampling a purposive sample of 19 HCPs working in a range of settings to participate in individual interviews. To ensure a range of perspectives, we periodically considered the makeup of our sample (e.g., gender, geographic location, type of practice, expertise) to guide purposeful recruitment. We recruited the first 10 participants from provincial lists of family physicians (FPs), nurse practitioners (NPs), and public health nurses (PHNs) working primarily with youth in universities, schools, or sexual health clinics in order to draw on their expert knowledge and experience. However, because many youth only have access to primary care from FPs or NPs in general practice, emergency rooms, or walk-in clinics, we subsequently sampled HCPs who practiced at these sites and whose practice included patients across the life span.

The sample consisted of 12 FPs, 3 NPs, 3 PHNs, and 1 gynecologist. The inclusion criteria were that HCPs

had to be actively working with youth in their practice. With one exception, NPs and PHNs were engaged in practice that focused primarily on youth sexual health. Of the 12 FPs, 4 practiced in a university health service, 1 in an emergency department, 4 in private practice, and 3 in community health clinics. The gynecologist was in private practice. Six FPs were males; the remaining 13 HCPs were females (See Table 1).

After obtaining participant consent, in-depth individual interviews were conducted by the third author, an FP with expertise in youth care and qualitative interviewing. Interviews were chosen because they allow researchers to explore in-depth each participant's unique perspective on a topic about which little is known (Bradshaw et al., 2017). Using questions arising from our previous research and experience, we constructed an interview protocol to explore how HCPs define sexual health in young people including whether sexual functioning was considered, related sexual health training and experience, how they addressed these issues (if at all), their understanding of their roles in providing care, and the resources and barriers they encountered. The interviewer used the protocol to guide, but not to structure the discussions, while allowing participants to explore issues in depth in line with guidelines for conducting in-depth interviews (Berg, 1998). Follow-up probes allowed the interviewer to gain more depth regarding emerging salient issues. All interviews took place in a private setting of the participant's choice. Interviews were digitally recorded and took approximately 60 minutes. Interviews were professionally transcribed; identifiers were removed. Participants received \$200 compensation for their time. This study was approved in full by our institution's research ethics board.

Analysis

We analyzed interview data using directed qualitative content analysis (Hsieh & Shannon, 2005). Initial coding and categorizing by the third author (JW) occurred concurrently with data collection, which was

Table 1. Health-Care Provider Demographics and Practice History.

	Health-care providers (<i>N</i> = 19 total)		Family physicians (<i>N</i> = 12)		Nurse practitioners (<i>N</i> = 3)		Public health nurses (<i>N</i> = 3)		Gynecologist (<i>N</i> = 1)
	<i>M</i>	Range	<i>M</i>	Range	<i>M</i>	Range	<i>M</i>	Range	
Age	42.8	31–59	43.7	31–59	45	42–50	39	33–43	39
Years of practice	17.05	2–25	16.3	2–35	22.3	20–26	17.7	11–23	9
Percentage of practice with youth	57.6	10–100	44	10–95	100	95–100	80	40–100	30

guided by the primary research questions and was discussed with the interviewer (JM) as interviewing proceeded. After the first nine interviews, we discussed the emerging findings in depth in the context of the interview transcripts identifying gaps and leads that required more exploration. This dialogue influenced recruitment and interviewing decisions. As coding proceeded, we modified categories and added new categories to capture all dimensions of the data in an iterative process (Morgan, 1993). Coding in content analysis focuses both on manifest content (i.e., visible, obvious components) and latent content (i.e., interpretation of the underlying meaning of the text; Graneheim & Lundman, 2003). Based on our past qualitative analysis, we used some grounded theory analytic techniques such as constant comparison of codes, reduction, and identification of contextual factors that influenced variation in participant perspectives to facilitate our descriptive analysis (Wuest, 2012). Patterns among categories were identified and confirmed by examination of their variation across cases. These approaches added to the rigor of the analysis and were employed in ways consistent with the purpose of the research that is to yield a rich description of HCP perspectives on youth sexual problems and their management (Bradshaw et al., 2017).

Results

Most HCPs initially defined youth sexual health biomedically, focusing on STIs, birth control, pregnancy, and basic sexual education. They had to be prompted to discuss whether they viewed sexual functioning as falling under the rubric of sexual health. In general, those HCPs whose practice was primarily with youth expressed broad, inclusive views of sexual problems for youth that took into account attitudinal, psychological, emotional, physical, biomedical, and social factors that affect youth sexual functioning. In contrast, only three of the FPs working in general practice shared this holistic perspective. About half of these FPs were surprised that they were asked about management of sexual functioning in youth: 'I didn't realize it was a big issue in that age group.' Some clearly expressed their limitations, 'The physical things we can address. I've always felt unprepared to talk to patients about the relationship side of sexual difficulties.' Factors that influenced the variation in these perspectives were identified as (a) education, interest, mentorship, and experience in youth sexual health and (b) structure and philosophy of health services. These factors affected both how HCPs circumscribed youth sexual functioning problems, but also how they viewed their roles in addressing these and other sexual problems.

Education, Interest, Mentorship, and Experience in Youth Sexual Health

Education. Irrespective of the discipline, most HCPs were educated in sexual health from a biomedical perspective with a focus for youth on STIs, birth control, pregnancy, and sexual education. HCPs reported little course-related education in sexual functioning and said what was included was 'not geared for youth at all.' Clinical training was scarce for most, often occurring largely by chance. For example, one physician spoke of the good fortune in having a couple of placements with 'forward thinking' FPs who were 'open and uninhibited and able to speak about sexual function as well as the nuts and bolts of physiology and pathophysiology. So we did actually talk a little bit about orgasm and g-spots and pleasuring.'

Although clinical rotations were rarely focused on sexual health, some offered opportunities for specific exposure. One HCP was placed in a youth sexual health clinic as part of training in gynecology; another gained understanding of transgender issues in an endocrinology rotation, and one more was introduced to HIV issues in an infectious disease setting. Thus, for most, education and clinical training opportunities in sexual health, especially with youth, were generally haphazard and even recent graduates felt that their preparation was lacking. One summarized this view by saying, 'I think for a lot of sexual health, it's not that we are ignoring things, it's just that we've not even been taught to think about.'

Interest. Some HCPs with an interest in sexual health recognized that 'you need to educate yourself' and, as students, they had intentionally sought electives and clinical placements where they could gain expertise in related areas such as adolescent health; lesbian, gay, bisexual, and transgender (LGBT) health; transgender health; harm reduction; maternal addiction; and abortion. But one observed that the number in his class who purposefully obtained such extra knowledge was very small. Some nurses reported that employment experiences with marginalized populations such as teen mothers, LGBT youth, or in addiction were stepping off points for changing their professional focus to youth. One NP became more interested in youth sexual health when government sexual health clinics restricted services to youth under 20 years of age and her practice became inundated with older youth seeking sexual health services.

However, some HCPs hold personal beliefs about youth sexuality that contribute to a lack of interest and heightened resistance to developing personal knowledge in the field. Some HCPs spoke of harm caused by colleagues who refused to address youth sexual health

matters that violated their personal beliefs. One harm was the provision of misinformation such as 'abortions cause cancer' or that herpes lesions were warts. Other examples of potential harms included poor workups and risk factor assessment, refusal to prescribe contraception, and resistance to discussion of LGBT issues. One FP observed that when youth cannot talk to their doctors about 'the way they have sex, [it's because] they don't feel like it's a safe place. They don't feel comfortable. The patient feels ashamed or afraid to talk about it.'

But for other HCPs, interest in youth sexual health fostered individual investment in learning more about adolescent development as well as appropriate teaching approaches, risk and protective factors, and resources. One nurse took solace in the realization that she could still practice effectively even if she did not have all the answers: 'If youth know that you care and will research and find out the information, that is really what makes a difference.' Similarly, a physician noted that there are many missteps along the way but 'you apologize, you move forward, and try not to repeat those mistakes with another [patient].'

Some HCPs in general practice reported ways that they strengthened their personal capacity in youth sexual health. One purposefully opened his doors to youth, cultivated relevant professional networks, and served on national committees focusing on related issues. Another who had previous experience in sexual health clinics contributed to strengthening school-based sexual health services for youth in her community. A relatively new practitioner spoke of 'learning on the fly' by reading, extrapolation, and reflecting on encounters with youth. 'The things you practice you get good at, and the things you shy away from, you don't delve into, you're afraid of, you don't explore, you don't become learned and you don't get any better.' Mentorship was another useful vehicle for learning.

Mentorship. Working with experienced colleagues and attending continuing education sessions helped HCPs 'to learn what I knew I didn't know and to learn about what I did not realize I didn't know.' Mentorship was important, particularly in clinic environments where teamwork, group problem-solving, and clinical conferences were common. Having the opportunity to discuss situations with colleagues and discover 'how they approach something you've been struggling with' was considered highly valuable especially for professionals moving into new areas of practice. A gynecologist spoke of strengthening her skills in treating challenging sexual issues by seeking help from more experienced colleagues and attending grand rounds. One FP recalled that in the sexual health clinic, 'My training came from

the nurses who worked there. I would be able to take the care so far and I would say, 'what would you do from here?' and they would tell me. It was great teamwork.' But equally important, because of long waiting lists for specialist referrals, was specialist willingness to provide guidance to FPs who directly sought help or had sent them referrals for investigation of common issues such as pain during sex. Such direction helped FPs conduct early investigations and sometimes find solutions that eliminated the need for referral and ultimately expanded the FP's skill set.

Experience. All HCPs working with youth spoke of the importance of practice experience such as 'working in the settings [youth clinics, schools], having discussions with clinicians, and trial and error' for establishing competence in youth sexual health. Many HCPs said that although they felt reasonably competent handling medical dimensions of youth sexual health, they needed help 'with the psychological part, the pleasure and function.' A key challenge was learning how to ask routinely about desire and pleasure, not merely 'How's your sex life?' One nurse observed that most HCPs are not comfortable talking about issues such as sexual pleasure noting, 'I'm 41 years old and no HCP has ever asked me if I enjoy sex.'

Competence arose in large part from the volume of clients that an HCP saw. Because many young women purposefully seek female physicians or NPs for sexual health issues, these providers gained expertise from 'just doing it over and over.' As well, HCPs working with youth over time acquired 'a good sense of the issues youth experienced and some of the solutions.' Exposure to similar sexual issues repeatedly permitted HCPs to talk more confidently to young people. They also benefited from what youth shared with them:

It's all about how you ask and your general interest in the topic. People will tell you in quite a lot of detail if you ask and you are genuinely interested, 'What have you done in the past that has worked?'

HCPs working in more general practice spoke of their lack of experience in identifying and managing sexual health problems with youth beyond STIs, birth control, and pregnancy. One said she might benefit from a screening tool and 'resource manual on a stick' or a cell phone app. Another suggested a problem-based learning group. But one FP felt that a more effective educational strategy would be a short placement in a high-volume youth sexual health clinic with an experienced practitioner where the provider might get more practice in an afternoon in youth sexual health issues than he or she would get in a year in their usual environment.

Service Structure and Philosophy

The structure and philosophy of the health services also influenced how HCPs perceived and integrated sexual health care for youth into practice.

Sexual health clinics, university clinics, and public health school services. HCPs working in these services had an explicit mandate to address youth sexual health in their practice. One HCP said she was acting on the responsibility to ‘ask the questions, be open to the answers, and let things go where they may.’ These HCPs recognized that youth often had concerns about their sexual lives but struggled to articulate the issue,

They have something on their mind that they want to share, but they’re not sure how they’re going to be received. If you don’t allow an opportunity for them to get around to it, they don’t get around to it.

Time to listen and build rapport and trust in clinical encounters was perceived as essential because ‘If it’s too early [when you bring up sexuality] in that therapeutic relationship, it might be seen as intimidating or intrusive.’ Within youth-focused services, taking time is possible because usual visits are 15 (university health clinics) to 60 minutes (school-based appointments), and the structure of these services permit scheduling follow-up visits within the month or sooner depending on urgency. Some clinics offered same-day appointments and frontline staff routinely conveyed openness to dealing with sexual health issues; ‘Staff ask when they make appointments so that they don’t book time for a sore throat when the issue is sexual.’

In some services, scripts or assessment forms guide early interactions with youth and facilitate building a relationship; in other clinical situations, practitioners start with the concern that brought the youth to see them using it as a springboard to expand the boundaries of the visit.

For example, questions from youth about side effects of medications such as antidepressants related to sexual functioning may lead to a better discussion of other relationship issues than direct questioning. All HCPs in these health services identified the website supported by the Society of Obstetrics and Gynecologists of Canada, Sex and U (<https://www.sexandu.ca/>) to be an important resource for both youth and practitioners. In addition, there was support within these services for professional practice initiatives to facilitate ongoing learning activities. However, HCPs noted difficulty finding continuing education programs that addressed sexual health, particularly the sexual health of youth. Some turned to continuing medical education in women’s health. One nurse observed that no certificate programs in sexual health

were available for nurses, although there was a small section in the community health nurse program. Occasionally, continuing education occurred as a result of HCPs or nonprofit groups organizing interdisciplinary educational opportunities, including lectures or conference groups in response to an identified gap in knowledge such as transgender issues. Some professional interest groups such as public health or school health organized regular conferences in which sexual health sessions were available.

Another strength of youth-focused services was well-established linkages for testing or referrals for counseling, social welfare, abortion, gynecology, urology, mental health, or addictions, facilitating more rapid follow-up to meet youth needs.

Benefits also were evident in team practices at clinics where HCPs could draw on each other’s diverse expertise or interests, such as for transgender issues. Within the university settings, HCPs had access to additional resources such as university counseling, special interest groups, and residence dons and proctors. PHNs had access to similar referral resources as well as guidance counselors and child protective services. One noted the significance of such resources, ‘If I’ve made them comfortable enough to tell me about it, I want to be able to do something about it.’

General practice settings. In general practice in private offices, community clinics, or emergency rooms, youth sexual health was not an explicit priority and was only one of many health issues managed with patients of all ages. Those general practitioners (GPs) with an interest or previous experience in sexual health practice reported efforts to make youth sexual health a priority but encountered challenges.

Duration of the clinical encounter influenced the extent to which HCPs could extend a consultation to include sexual health issues especially when the patient’s presenting condition was something else. HCPs reported that they were constrained by the expectation that they see a certain number of patients each day. Salaried HCPs sometimes had more latitude with scheduling than did physicians on fee-for-service billing unless they were practicing in high-demand areas such as emergency rooms. One FP in a fee-for-service practice explained the difficulty,

So in an average day, if you see 34 patients, and you spend about 8 to 10 minutes per patient, that’s already 6 hours of your day. And then if you spend another 5 minutes charting per patient, I’m already at an eight and a half hour day without lunch, without the other paperwork that’s non-patient related. So to add another question [to the assessment] is easy for others to suggest, but not always easy to incorporate.

Another FP elaborated on the challenge of integrating a range of routine adolescent screenings, such as bike helmet use, the drug talk, and partners and relationships, into short appointments. He pointed out that if an adolescent disclosed a pattern of drinking alcohol to excess every second weekend, the FP would likely not get to the next topic because he would spend the time discussing alcohol. Although he often asked youth to return for follow-up visits, he noted that many did not come back. Another FP was frank about simply not including youth sexual health in his general practice observing, 'If I've never asked about it [sexual functioning] and not many young people come forward with it . . . then we need to develop a short way to ask these questions and incorporate them routinely.'

However, other HCPs reported juggling their schedules to deal with sexual health issues especially for those patients who they perceived as vulnerable because of mental health, poverty, or sexual orientation. One said, 'I'm not going to brush someone off in five minutes and then have them never come back.' Another described how he created flexibility to see some youth a little longer,

Our clinic manager tries to structure the day because I do enjoy working with young people and sexual health issues, so she'll try and set it up so that I have a diabetes patient and then a sexual health patient, and then a hypertension patient and a sexual health patient.

Unlike their counterparts in youth-focused services, many HCPs in general practice settings expressed concern about the lack of structured access to and knowledge of resources to assist youth. They noted that services such as a sexual assault crisis center are excellent but only available in larger centers. 'Mental health could take ages [to get an appointment]. And the problem with that is youth probably would not talk to them about those kind of problems at the first interview.' Gynecologists have very long wait lists, especially for sexual functioning problems. One GP summed it up, 'I don't think I have very good resources,' and another said, 'to be honest, I don't have any resources.'

HCPs felt the need for a centralized referral service or at least a list of resources for sexual health: 'I think we need to do a better job figuring out where resources are in each community and having physicians know it.' Several called for an expansion of sexual health clinic services to a wider age range of youth because these clinics are safe, gender-sensitive, nonjudgmental places where youth 'don't have to wonder if their doctor's going to pray for them instead of giving them hormone therapy.'

Health-care professionals in general practice faced the same challenges in staying up to date on sexual health

practice as did those practicing primarily with youth. However, those in rural practices where coverage by other HCPs was unavailable were often unable to attend ongoing education opportunities or conferences 'even if it was only an hour away.' Several felt that few online opportunities existed in sexual health education and suggested the need for a virtual sexual health clinic.

Provider Perspectives and Perceived Roles in Addressing Sexual Functioning

How HCPs understood youth sexual functioning and their professional role in addressing this issue was influenced by the previous factors, that is, their education, interest, mentorship and experience in youth sexual health, and the service structure in which they practiced.

Youth-focused settings. In general, HCPs who reported interest, knowledge, and experience in youth sexual health and who worked in a professional environment with a mandate to address youth sexual health demonstrated a wide and holistic understanding of sexual health among youth. These practitioners focused on promoting healthy sexual functioning and helping youth to 'take control of their own sexual health and health seeking behavior.' They spoke of sexual functioning contextually in terms of such social determinants as poverty, family structure, substance use, relationship history, gender, abuse history, social support, housing, mental health, and access to the health-care system. Hence, their practice included considering how these dimensions affected youth sexual health and sexual functioning.

Sexual education for youth was seen as fundamental to healthy sexual functioning. A key concern was providing youth with accurate information through dialogue, written information, or credible websites so that youth were equipped to make healthy decisions.

The specific focus depended on individual needs and included such issues as basic anatomy ('You can't assume that girls know they have a clitoris even if they have been sexually active'), sexual readiness, what sex feels like, validation that sex should be enjoyed, the range of what is normal, masturbation, and risky behaviors.

In addition, these practitioners routinely introduced topics such as communication in relationships, ability to talk to parents or others about sex, the meaning and scope of consent, the effects of substance use, available support services, as well as specific aspects of sexual functioning issues (pleasure, desire, performance, and pain). One emphasized,

The goal is that you [youth] have a healthy sexual life, it's an important part of life. It's not something to be embarrassed about, it's not something wrong, it's an important

part of life to figure out how to get it working positively for you as a person.

Most said personal interactions with youth depended on taking time to build a relationship where it was safe for youth and HCPs to share concerns and ask questions. Being purposeful and intentional in asking about sexual satisfaction ‘right along with STIs and immunization’ also helped to normalize talking to health professionals about sexual health concerns. Responding to a youth’s questions with, ‘A lot of people wonder about that’ fostered discussion. One FP said it was important to convey that youth,

can talk about things that gross them out. They say, ‘Oh, this is so awkward, I can’t believe we are talking about this!’ But at the end, they have a lot of information, their questions are answered, and I hope they feel proud of themselves.

Consultations for specific medical problems provided an opportunity to ‘open the door a bit wider’ to address sexual functioning, although some youth ‘shut down,’ for example, when an FP inquired about communication with a partner related to an STI. A routine Pap examination often led to an exchange about comfort and pleasure during intercourse and provided opportunities to discuss strategies such as varying positions, ensuring arousal. Pain during intercourse was commonly discussed with young women, ‘Nobody’s talked to them about foreplay before, how necessary it is, how a male’s body is different to a female’s body.’ Once physical problems such as STIs or lesions were ruled out, such discussions included how to slow things down, how to enjoy each other without intercourse, the role of foreplay, talking with the partner, and lubrication. In such cases, the goal was to prevent young women from believing that having intercourse would always hurt and to give them tools to have more enjoyment. One FP said he always inquired about sexual abuse history by observing, ‘sometimes people who have this sort of pain have had an unwanted sexual encounter in the past.’ Most HCPs were attuned to the potential negative effects of substance use on sexual response. Difficulties with premature ejaculation or ability to become aroused eroded young men’s confidence and several HCPs spoke of prescribing short-term Viagra to ‘reset confidence and get things back on track.’

A few HCPs with interest in youth sexual health who worked in more general settings practiced in similar ways to those who worked only with youth but within the time constraints of their practice. One spoke of trying to create a climate where things can emerge by sending parents from the room, before exploring whether youth are in a relationship and whether it is monogamous, noting

that often youth do not disclose. Some HCPs found that they needed extra support to fulfill this role. One PHN reported being employed part time by an FP to work with youth around sexual health issues because, ‘they need more time, [time] that he’s not able to provide, so he books those clients . . . a half an hour or 45 minutes with me to do full counseling.’

General practice settings. In contrast to the upstream sexual health promotion approach of youth-focused providers, many HCPs who worked in a general practice setting with clients of all ages perceived their role as preventing or responding to youth sexual problems primarily by responding to presenting medical concerns. One said,

Some [youth] will come in for a sexually transmitted illness and it’s part of my screening to talk to them about that and contraception. But I don’t know that I always talk to them about how is their sex life, how is their libido, how are their relationships while they’re here. Well it’s the other part, the medical part, that seems to be a key focus for me.

Most HCPs said that issues related to sexual health or functioning were rarely raised by youth:

Most issues are related to STD issues that the younger people want to be checked for. Very rarely do I get any questions about performance, except from the men. The young women don’t tend to, in my experience, have those kinds of questions in that age category.

One FP noted how hard it is for young men to raise these issues, ‘They talk about their sore knee or their sore back and then they’ll say ‘oh, by the way, doc, um, you know, I’m having troubles here. I may need some help. Maybe I need Viagra.’ Because of this reluctance to share such concerns, some HCPs have become very direct, ‘I think the best way is to, in a busy practice, come right out and ask the questions.’ Another FP noted, ‘Uncommonly, I see young girls who talk to me about climax and orgasm and things like that.’ When youth raise concerns about sexual functioning such as arousal, desire, and pain, many constrain their role to exploring ‘with the patient to determine whether there are any medical issues related to these things.’

HCPs spoke of several reasons for confining sexual health practice to the ‘medical part [STIs, contraception]’ and avoiding issues such as desire or satisfaction. One FP said,

It doesn’t fit in our flow chart of disease. Right? Our flow chart of disease are things that are gonna kill you. And sexual health isn’t going to kill you. Maybe it will

make you depressed which then leads to suicide and then that kills you. But not being able to have a good sexual experience doesn't cause death.

Unlike their counterparts in youth-focused services, most did not extend the boundaries of the consultation to include sexual functioning issues even when the opportunity was there because of time. One HCP observed,

It's usually a frustrating thing because they're here for another reason and then they bring up that they need birth control or something. So you're already sorta pressed for time and I, no, I generally don't ask [about sexual functioning].

Another reason for the limited investment is that HCPs have been socialized to view this as an adult issue, 'I don't ask young people about their sex and libido and drive and things that I would think of asking more middle-aged persons.' Similarly, few explained the side effects of drugs such as antidepressants or birth control unless youth asked or returned with a complaint, although they did tell older adults. A reason given was feeling ill-prepared to manage youth sexual health, 'I don't bring it up because I don't know if I have anything to offer. I don't know if I understand even what the problems are, to be honest.'

Discussion

Our findings illuminate the inconsistency among HCP perceptions of their roles related to youth sexual health and functioning. The World Health Organization (2006) defined sexual health not just as 'the absence of disease, dysfunction or infirmity' but also in terms of pleasure and positive functioning. Most HCPs who practiced primarily in youth focused-services held an upstream perspective and focused on promoting healthy sexual functioning within the context of a wide range of social determinants. This is encouraging given that the World Health Organization (2010, p.17) indicated that 'the shift from treating sexual ill-health to promoting sexual well-being' was taking longer than expected to materialize in sexual health programs.

In contrast, we learned that HCPs working in general practice settings were more likely to constrain their practice in youth sexual health to managing related medical issues and many were ill-prepared to address sexual functioning concerns in terms of both knowledge and resources. Given how little research or clinical attention has been given to problems in sexual functioning for young people in light of efforts to prevent, protect, or delay youth sexual activity, this discovery perhaps is not surprising. Indeed, studies indicating that young people

experience sexual functioning problems are fairly new (Akre et al., 2014; Mitchell et al., 2016; O'Sullivan et al., 2016). Our findings serve as a call for HCPs to begin considering these issues more fully given that rates of distressing and persistent problems are high, as are the corresponding personal and interpersonal costs for young people. When HCPs believe that sexual functioning is a problem that youth would never experience, or a natural consequence of experiences meant only in adulthood, they omit assessment and treatment of sexual functioning. Left untreated, young people are at risk for transitioning into adult sexual dysfunction (O'Sullivan et al., 2016).

Our findings also highlight key factors that contribute to differences among provider perspectives on roles in youth sexual functioning. All HCPs in our study were challenged by a paucity of sexual health preparation in their formal education, a finding that is well established in the literature (Shindel & Parish, 2013). Some were frank about their lack of knowledge and their avoidance of issues beyond more medical issues, such as birth control and STIs, a finding that is worrisome. However, we also learned that HCPs' interest in sexual health affected how they sought and used continuing education, online resources, mentoring, and collaboration with supportive colleagues to rectify knowledge and experience gaps. Most important was the evidence that these practitioners took a holistic approach to promoting healthy sexual functioning in youth. Some purposefully worked in youth-focused practices; others continued to work in more general practice but were creative in finding ways to integrate a focus on youth sexual health into their care. To our knowledge, research has not previously shown the importance of practitioner interest in youth sexual health as an indicator of their scope of practice in this field.

How HCPs were able to provide sexual health care for youth also was influenced by service structure and philosophy, particularly the time available for each visit, mechanisms for referral, availability of resources, and supports for ongoing education. Our findings show that flexible scheduling supported holistic youth-focused services by giving HCPs the latitude to deal with issues as they arose. In such settings, HCPs used open and nonjudgmental approaches to facilitate youth disclosure of problems in sexual functioning. There is an extensive body of work demonstrating the value of ensuring a nonjudgmental context for confidential care of young patients (McKee, Rubin, Campos, & O'Sullivan, 2011; Romero et al., 2017).

In contrast, time constraints were cited by some in HCPs in general practice as reasons for not exploring sexual functioning with youth and partially explain why some limit their care to biomedical issues related to sexual problems. However, interested practitioners developed innovative scheduling approaches or alternate strategies, such as partnering with another practitioner to ensure

youth needs were met. Our findings also demonstrate that some HCPs who were less interested or comfortable with these youth sexual issues still saw the need to be responsible and responsive. They sought easily integrated short tools to help support these conversations in their busy practices, an approach that is not so holistic as youth-centered services, but has the potential to strengthen approaches to youth sexual care in general practices.

The structure of services also influenced referral mechanisms, resources, and access to continuing education. Youth-focused services had established processes that supported practitioners in these areas. However, our findings show that GPs, particularly those in rural practices, faced many more challenges because few structural processes were in place to support them in these important components of sexual health care for youth. In particular, ongoing education was scarce. Coverage for general practice that permitted opportunities to work in clinics with a high volume of young patients was described as valuable for developing competence and comfort in sexual health issues.

Strengths and Limitations

As with all qualitative research, the purpose was to generate new perspectives on a topic that might then be investigated further. We do not suggest that our findings characterize all HCPs. Their perspectives may, however, provide some important insights into the ways in which HCPs are addressing problems in sexual functioning. A limitation of the sampling employed is that our participants represent more FPs than other types of HCPs, including those whose patients are primarily youth. Future research could involve prospective card methods to gain additional insights into how HCPs interact with young people about these issues. This method, when banked with qualitative interviews, has been used successfully in the past to address sensitive topics such as this one (O'Sullivan, McKee, Rubin, & Campos, 2010).

Implications for Practice

Learning to inquire beyond presenting problems, such as pain and depression, to explore whether they are confounded by common sexual complaints, such as low desire or arousal, erectile, or orgasm difficulties, is important. In lieu of such opportunities, online resources and expansion of continuing education materials could provide needed supplements.

Conclusions

This study was designed as an initial investigation into how HCPs incorporate sexual functioning into their

understanding of youth sexual health and the ways in which they address these issues in the care that they provide. We found that HCP *interest* in youth sexual health affected their efforts to acquire new information and training and, along with the structure of their practice setting, influenced whether they framed their role in youth sexual health holistically within a context of social determination, or constrained their role to a medical model.

Acknowledgments

The authors gratefully acknowledge the support of Mary Byers in helping to coordinate data collection.


Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The study was funded by the Canadian Institutes of Health Research (#MOP210316; O'Sullivan, Principal investigator).

ORCID iD

Lucia F. O'Sullivan  <http://orcid.org/0000-0003-0124-6267>

References

- Akre, C., Berchtold, A., Gmel, G., & Suris, J. C. (2014). The evolution of sexual dysfunction in young men aged 18–25 years. *Journal of Adolescent Health, 55*, 736–743.
- Berg, B. L. (1998). *Qualitative research methods*. Needham, MA: Allyn & Bacon.
- Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research, 4*, 1–8.
- Graneheim, U. H., & Lundman, B. (2003). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, 105–112.
- Hsieh, H., & Shannon, S. E. (2005). Three approaches to content analysis. *Qualitative Health Research, 15*, 1277–1288.
- Laumann, E. O., Paik, A., & Rosen, R. C. (2009). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association, 281*, 537–544.
- Leftwich, H. K., & Alves, M. (2017). Adolescent pregnancy. *Pediatric Clinics of North America, 64*, 381–388.
- Lopez, L. M., Grey, T. W., Chen, M., Tolley, E. E., & Stockton, L. L. (2016). Theory-based interventions for contraception. *Cochrane Database Systematic Review, 11*, CD007249.
- McKee, M. D., Rubin, S. E., Campos, G., & O'Sullivan, L. F. (2011). Challenges of providing confidential care to adolescents in urban primary care: Clinician perspectives. *Annals of Family Medicine, 9*, 37–43.

- Mercer, C. H., Fenton, K. A., Johnson, A. M., Wellings, K., Macdowall, W., McManus, S., . . . , Erens, B. (2003). Sexual function problems and help seeking behaviour in Britain: National probability sample survey. *British Medical Journal*, *327*, 426–427.
- Mitchell, K. R., Geary, R., Graham, C., Clifton, S., Mercer, C. H., Lewis, R., . . . , Wellings, K. (2016). Sexual function in 16- to 21-year-olds in Britain. *Journal of Adolescent Health*, *59*, 422–428.
- Mitchell, K. R., Mercer, C. H., Ploubidis, G. B., Jones, K. G., Datta, J., Field, N., . . . , Wellings, K. (2013). Sexual function in Britain: Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet*, *382*, 1817–1829.
- Moreau, C., Kågesten, A., & Blum, R. (2016). Sexual dysfunction among youth: An overlooked health concern. *BMC Public Health*, *16*, 1170.
- Morgan, D. L. (1993). Qualitative content analysis: A guide to paths not taken. *Qualitative Health Research*, *3*, 112–121.
- O'Sullivan, L. F., Brotto, L. A., Byers, E. S., Majerovich, J. A., & Wuest, J. (2014). Prevalence and characteristics of sexual functioning among sexually experienced middle to late adolescents. *Journal of Sexual Medicine*, *11*, 630–641.
- O'Sullivan, L. F., Byers, E. S., Brotto, L. A., Majerovich, J., & Fletcher, J. (2016). A longitudinal study of problems in sexual functioning and related sexual distress among middle to late adolescents. *Journal of Adolescent Health*, *59*, 318–324.
- O'Sullivan, L. F., & Majerovich, J. (2008). Difficulties with sexual functioning in a sample of male and female late adolescent and young adult university students. *Canadian Journal of Human Sexuality*, *17*, 109–121.
- O'Sullivan, L. F., McKee, M. D., Rubin, S. E., & Campos, G. (2010). Primary care providers' reports of time alone and the provision of sexual health services to urban adolescent patients: Results of a prospective card study. *Journal of Adolescent Health*, *47*, 110–112.
- O'Sullivan, L. F., Wuest, J., & Byers, E. S. (2018). Figuring it out: How late adolescent and young adult men and women perceive and address problems in sexual functioning. *The Journal of Sex Research*. doi:10.1080/00224499.2017.1416451
- Romero, L. M., Olaiya, O., Hallum-Montes, R., Varanasi, B., Mueller, T., House, L. D., . . . , Middleton, D. (2017). Efforts to increase implementation of evidence-based clinical practices to improve adolescent-friendly reproductive health services. *Journal of Adolescent Health*, *60*, S30–S37.
- Sandfort, T. G. (2008). Long-term health correlates of timing of sexual debut: Results from a national US study. *American Journal of Public Health*, *98*, 155–161.
- Shindel, A., & Parish, S. (2013). Sexuality education in North American medical schools: Current status and future directions. *Journal of Sexual Medicine*, *10*, 3–18.
- Shivananda, M., & Rao, T. S. (2016). Sexual dysfunction in medical practice. *Current Opinion in Psychiatry*, *29*, 331–335.
- Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.
- Ursu, A., Sen, A., & Ruffin, M. (2015). Impact of cervical cancer screening guidelines on screening for Chlamydia. *Annals of Family Medicine*, *13*, 361–363.
- Wangu, Z., & Burstein, G. R. (2017). Adolescent sexuality: Updates to the sexually transmitted infection guidelines. *Pediatric Clinics of North America*, *64*, 389–411.
- World Health Organization. (2006). *Defining sexual health*. Retrieved from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/
- World Health Organization. (2010). *Developing sexual health programs: A framework for action*. Geneva, Switzerland: Author.
- Wuest, J. (2012). Grounded theory: The method. In P. Munhall (Ed.), *Nursing research: A qualitative perspective* (pp. 225–256). Sudbury, MA: Jones & Bartlett.