Expert opinion

Sexual health and living with a urinary catheter

Abstract

Information and discussion about sexual health for clients living with an indwelling urinary catheter will most often be asked of nurses. The purpose of this paper was to review local studies and other published literature to seek evidence-based solutions to assist nurses to provide effective care to this client group.

Key words: urinary catheter, sexuality, nursing, evidence based care.

Sexual health for the person with an indwelling urinary catheter in situ is an issue that has received little attention in both nursing practice and literature. More than 25 years ago, Hogan wrote about her optimism that sexual health would become integral to nursing practice in the future. Hogan's vision was that nurses would be comfortable with their sexuality and dealing with the sexuality of others. She perceived nurses in the future as being able to assess an individual's sexuality in the same way as other basic needs, and predicted that they would be able to identify problems accurately and intervene appropriately.

Almost two decades later, Atkinson reflected that this vision had not been realised, despite more up-to-date studies and literature supporting the need for action. Sexual health is perhaps not given the same priority as, for example, pressure area care, where the cost-effectiveness of intervention is more apparent. Catheterisation has physical, mental and social implications far beyond permitting drainage of urine. Sex and sexuality is of particular importance. For the male client, urinary catheterisation is an invasion of his masculinity, while the sexuality of a woman with an indwelling urinary catheter for continuous urinary drainage is seldom considered.

This article focuses on the area of sexual health for clients living with an indwelling urinary catheter, and has reviewed local studies and other published literature to seek evidence-based solutions to provide effective nursing care to this group of clients.

The issue

Holistic nursing care and the continuum of life are about understanding the whole body, yet the topic of sexual health for clients living with an indwelling urinary catheter was neglected within the scope of holistic nursing care. Published data show the use of indwelling urinary catheters is widespread. Authors have also shown that, in modern Western society, sexual activity and the expression of physical intimacy are not visualised as an integral concept in a disabled or visibly ill person's life.

The World Health Organization (WHO) defines sexual health as “...a state of physical, emotional, mental and social well-being in relation to sexuality”; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual health is a nursing issue and an indwelling urinary catheter is a fact of life for many people. Providing advice and assistance about learning to live with a catheter and how to maintain it will most often fall to nurses.

Quality of life

According to Hogan, “The changed life continuum was first described with reduction and negligence, indicating a sense of giving up and accepting things as they were. Daily living with a urinary catheter and sexual life problems also meant changed life quality.”
One of the most important aspects of living with an indwelling urinary catheter is the concept of quality of life. It has an effect on the autonomy, quality and continuum of life, and the person’s body image, self-esteem and sexual health. Sexual health, when a client has a catheter, is an aspect of care not often discussed, but it may be of major importance to some clients and their partners. This reluctance by nurses to discuss this issue may be obvious and hence a barrier for clients wanting to discuss sexual health. Researchers have identified some of the barriers to open discussions with health professionals; they include societal taboo, media perception relating to sexual health in older or ill people, lack of education, fear, and maintenance of self-image.

Sexual health in older people

Sexual activity continues across the lifespan, yet older people live in a society that perceives them incapable of a sexual relationship and therefore not requiring of support, advice or education in this area. Sexual health needs are often a delicate balance of emotional and physical issues, so the person, when seeking advice, may be worried and concerned about misconceptions.

Atkinson affirms that upbringings and belief are imprinted in the formative years, and that societal values are deterrents to older people requesting advice as it is perceived as not necessarily the ‘done thing’. This negative stereotype is supported in the media, where a positive image of ageing and sexuality is not portrayed. During 1998 in America, the National Council on Aging surveyed 1300 people aged 60 years and over. This survey revealed that sexual activity played an important role in relationships among older men and women.

Body image

Milligan in a review of the literature on male urinary catheterisation, stated concern that, in the wider community, ‘... sexuality merely meant sex... and not the broader range of issues such as body image and self-esteem’. Published papers were found that were devoted to the individual topics of sexual health, catheter maintenance and catheter troubleshooting, but proportionally fewer papers were devoted to a combination of both, and the effect living with an indwelling urinary catheter has on a person’s body image. Ignoring the issue is unacceptable, particularly when a client may have a diminished level of self-confidence relating to physical and sexual adaptations to the urinary catheter.

The maintenance of self-image is important and links inextricably to life contentment, but is not related to age or gender. Van Ooijen & Charnock noted that approximately 12 months would lapse before a client may adapt to a form of “aesthetic harmony” when living with an indwelling urinary catheter. Other authors suggest that the adaptation for some is far longer and not necessarily an acceptance, more a resignation. For these clients, their body image seems irreparably impaired and tarnished.

To put this in context, during 2001, Royal District Nursing Service-South Australia (RDNS-SA) researchers surveyed women living with chronic illness about their sexuality. One respondent in that research, Ann, spoke about what she described as “unexplored territory”:

“I'm sure it will come up one day but I don't know how to broach the subject (the catheter) really... I mean telling somebody who’s meeting you in a wheelchair, that's quite embarrassing, so telling somebody about the catheter is totally off the wall”.

Self-esteem

Self-esteem refers to general feelings of self-worth. Loss or lowered self-esteem is linked to an alteration in body image. In a 2004 RDNS-SA survey on living with a urinary catheter, one woman’s response to her catheter was “... oh how abhorrent, I can’t bear it, it was a dreadful thing to contemplate...”21. Men’s responses included “… the best word I can think you can use [is] ‘not natural’”, and “… having a catheter in now stops me from doing a lot of things”.

Other responses ranged from “… having a catheter was good – there were no problems with that... when I wore jogging trousers I could even go outside for a walk” to “I felt ridiculous, having a tube hanging out down there. It was so abnormal” to one respondent calling her urine bag her “bundle of joy”.

These snippets of conversations impart emotive and powerful images of the reality of living with an indwelling urinary catheter; kernels of concern can be extrapolated relating to body image and self-esteem despite the participants acknowledging the benefits the catheter brought to their lives. Part of the nursing assessment process is to recognise and validate these concerns and address them early in the client and nurse relationship.

Myths and misunderstandings

Issues of sexual health and the inclusion of this within the nursing curriculum remain critical to the lowering of barriers and in addressing this issue. Van Ooijen & Charnock stated “The important issue is for the topic to be on the agenda at all times and for nurses to realise that sexuality falls within the remit of holistic nursing care”. Guthrie proposed that it was a lack of time and heavy nurse workloads that limited opportunities for discussion. Guthrie further advocated the importance that should be placed on any discussion around the topic of sexual health in those clients living with an indwelling urinary catheter and that, if that discussion took place, it should be seen as a
fulfilled opportunity for both parties. In the surveys published in the literature, nurses expressed their concerns over the lack of these opportunities and their sense of being poorly trained and ill equipped to deal with these issues comfortably and yet they expressed the goal of care to remain open and conducive to client need.\(^5, 6, 8, 12, 14\).

Guthrie\(^8\) also cited comments from nurses, for example: “You are so concerned about the other problems they are coming in with that you’re not really concerned with sexuality”; “If somebody wanted to speak about it I would chat about it with them, but I wouldn’t initiate the conversation”; “It’s not the sort of thing you’re really meant to speak about…”; and “You brush over things…. you brush over sexuality a lot.”

Despite acknowledging a responsibility to address the issue of sexual health issues, nurses, for a number of reasons, either contextual or inherent, are reluctant to participate in discussions with clients on this issue\(^6, 8-10\). Researchers suggest that nurses engage a number of behaviours, or defence mechanisms, to avoid an open discussion\(^9\). These behaviours may include the following:

- **Distancing, abruptness and isolation.** These behaviours are utilised in the nurse and client relationship to avoid potentially embarrassing conversations relating to sexual health as nurses express the concern that clients may overstep the professional boundaries\(^9\).

- **Avoidance.** This is an abdication of responsibility\(^9, 19\).

- **Development of barriers.** Only clinical issues relating to the urinary catheter are discussed. This prevents clients from feeling sufficiently at ease, and ultimately will deny them validation of their issue\(^6\).

- **Use of routine behaviours.** Nurses relegate their client interactions to clinical matters and thus procrastinate on the issue\(^6\).

- **Infantilising the client.** This makes the client feel disempowered in relation to their issue and reinforces the perception that the client group is asexual\(^7\).

- **Silence.** This equals the death of any conversation\(^15\).

To counter these behaviours, the authors suggest that nurses should create an open and non-judgemental environment that permits validation of client concerns and an arena in which to listen\(^1, 9\).

**Considerations for nursing practice**

Van Ooijen & Charnock\(^14\) noted the comments of a person who said that nurses did not give information about how to make adjustments to sexual health, and who suggested that nurses raise the topic in the same way they provide information about preventing bedsores. Some of the hidden dimensions of living with a urinary catheter, such as sexual activity and making appropriate body and psychological adjustments, provide considerable challenges to clients; these require sensitivity and support from health professionals\(^21\). Some areas of nursing practice that can be considered when working with clients with a catheter and discussing sexual health are as follows:

- **Communication.** Communicate in a way that is open and honest; this validates clients’ concerns and provides a meaningful and productive discourse\(^8\).

- **Terminology.** Use language that is appropriate to meet the client’s level of comprehension\(^15\).

- **Training.** The premise of educating nurses to provide this level of information to clients is well grounded in theory. Develop knowledge and skills around sexual health through programmes that equip nurses with sufficient communication skills to put this knowledge to use. Declaration of sexual health as a nursing responsibility will not equip nurses with sufficient practical skills to match this delicate task\(^8, 20\).

- **Advocacy and validation.** Offer critical tools in the development of appropriate assessment, including quality of life indicators which are meaningful to client needs. Nurses need to drive research and development to provide all health workers with research-based documents for use in urinary catheter management and sexual health\(^1\).

- **Developing personal comfort with our own sexuality.** It is advised in the literature that, in order for nurses to be completely comfortable in addressing sexual health issues for clients living with an indwelling catheter, they need to first have developed a degree of personal comfort with their own sexuality\(^6, 7, 17, 20\).

Sex is more than intercourse – nurses may influence the perception that clients hold by expanding the definitions of sexual health. As people age, other options to express sexuality may be more comfortable and fulfilling. Touch can be an alternative to intercourse or it may mean holding each other, cuddling or massage. Nurses must also consider cultural and social diversity when discussing sexual health.

**Practical advice from the literature**

The literature provides evidence on the optimal approach to providing clients with information about sexual activity while living with an indwelling urinary catheter. Opinion varies within the available literature as to the practicality of sexual activity with a catheter in situ\(^22\), caution being mingled with
practicalities. Most authors are positive in their views of the person’s need to fulfill a level of sexual expression during this period of alteration to their continuum of life so that the quality of life is minimally disrupted. Some authors advise clients to remove their urinary catheter prior to intercourse and replace it once finished. Caution is advised with this practice, as frequent insertions of catheters may increase bacterial load and transfer to the bladder, causing a urinary tract infection (UTI). It is the authors’ opinion that the catheter should remain in situ during intercourse.

There is a debate running throughout the literature on what is the most comfortable and appropriate site for catheter placement during intercourse. The suprapubic catheter is, for obvious reasons, the superior choice for those clients who wish to maintain, or restart, an active sexual life, yet wish to keep the invasion of the mechanical device to a minimum.

**Male perspective**

One male respondent perceived the catheter as one way of preserving his sexual activity, and described his only problem was that the catheter valve was uncomfortable during intercourse when he folded it down the side of his penis and therefore he wanted a longer catheter.

Some practical advice in the literature is to suggest to the client, prior to commencing intercourse, to ensure the urinary collection device is emptied and secured to the thigh to prevent traction or trauma. Once erection is achieved, fold the catheter along the shaft of the penis and roll a lubricated condom, as per manufacturer instructions, along the shaft of the penis and secure it to ensure the condom remains in situ. Once intercourse is complete, the condom should be removed, and the penis, catheter and testicular area washed and dried well to prevent maceration and bacterial count, thereby reducing the incidence of a UTI.

**Female perspective**

Suggest to the client that, prior to commencing sexual activity, they ensure the urinary collection device is emptied and secured to the upper thigh to prevent trauma or traction. The catheter can be tucked to one side and secured to the upper thigh to prevent friction during intercourse. Suggest to the client to have on hand a warmed lubricant to prevent vaginal friction during intercourse.

Once intercourse is completed, wash the perianal area and dry the area thoroughly to decrease bacterial load and transfer, to reduce the incidence of a UTI. Then return the catheter and urinary collection device to their usual position, secure, and ensure the catheter and tubing is not twisted. Some women with a degree of leg spasm will perhaps experience a greater degree of comfort in the left lateral or rear entry position.

**Suprapubic urinary catheters**

For one male, whose experience is cited, the suprapubic catheter had simplified the opportunity for sexual relationships. Many participants cited perceived that a suprapubic catheter would be more acceptable to others because it was not in the genitalia. The suprapubic catheter is therefore the preferred catheter of choice, especially for those clients who wish to remain sexually active, or recommence a long-term sexual relationship. The suprapubic catheter also decreases the possibility of a UTI or bladder infection, urethral stricture, and trauma.

Suggest to the client that, prior to commencing intercourse, they ensure that the urinary collection device is emptied and secured to the upper hip and that the catheter is laid across the abdomen, in line with the collection device, and secured to prevent traction or trauma. Once intercourse is completed, return the catheter to its normal position, secure it and ensure that the suprapubic site is washed and dried thoroughly to prevent incidence of increased bacterial load leading to a UTI.

Importance should be placed on always providing advice and information in a practical manner to facilitate open discussion and questioning. Encourage clients to communicate with their partners and consider other sexual activities such as cuddling, massage or different positions during sex.

**Conclusion**

Empathy, understanding and advocacy are valuable qualities for nurses. It is generally accepted that for nurses to genuinely relate in a meaningful way with their clients, they need to add layers of warmth, harmony and connection to the relationship. Humanistic studies affirm that nurses need to fully engage these qualities and pursue avenues of more layered education to meet a growing client demand into the future. In this way they may enhance the continuum and quality of life valued by their clients.

It is critical for nurses to engage both life experience and technical expertise to ensure that clients are fully equipped with information and education to manage a urinary catheter. It is important that nurses acknowledge all of the issues of the day-to-day management of urinary catheters that clients, who live with an indwelling urinary catheter or suprapubic catheter, may experience, including those issues pertaining to intimacy and sexuality.
Further research is needed to explore more of the issues – from a patient perspective – of the lived experience of managing an indwelling urinary catheter or suprapubic catheter.

References