THE PRACTICE OF MENTAL HEALTH NURSES: THE NEED TO INCLUDE SEXUALITY IN CONSUMER CARE

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6th May 2013
DECLARATION

I certify that this thesis is my own work, based on my personal research, and that I have acknowledged all material and sources used in the preparation of this thesis whether they be books, articles, reports, lecture notes, any other kind of document, electronic or personal communication. Published findings resulting from this work, fully acknowledges the co-authors, who have supervised my work: Professor Brenda Happell, Associate Professor Tony Welch and Doctor Graeme Browne.

I also certify that this thesis has not been previously submitted for assessment in any other course or at any other time in this course, unless by negotiation, and that I have not copied in part or whole or otherwise plagiarised the work of other students and/or persons.

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ABSTRACT

Sexuality is fundamental to health, quality of life, and general well-being. For consumers with enduring mental illness their sexual desire, capacity and ability to maintain previous sexual activities or make decisions about sex may be altered by their illness, or side effects from psychotropic medications. The inclusion of sexual concerns in care has been identified as a low priority in nursing. It has been suggested that nurses, including those working in mental health settings lack preparation, confidence and the skill base to address sexual concerns of consumers. The aim of the research was to explore nurses’ attitudes and practices in assessing and supporting the sexuality of consumers, and to explore the usefulness of the BETTER model to support them to improve this area of practice. The BETTER Model was developed to assist oncology nurses to include sexual health and sexuality concerns in their assessments. An exploratory qualitative research study was conducted utilising individual in-depth interviews with 14 mental health nurses from inpatient and community settings in three stages over a two year period. Initial findings identified: low priority towards sexual concerns; avoidance of the issue; and referring to other professionals, even though they acknowledged that others also evade this topic. Avoiding embarrassing consumers, gender and boundary concerns, sexual side effects if psychotropic medication, and the fear of negatively influencing adherence to medication, were particularly influential. At stage 2 participants described including sexual concerns in their practice, arising from awareness building and improved insight that sexual concerns are a legitimate aspect of care, rather than following the structured approach of the BETTER model. Two years later, at stage 3, participants continued to include the sexual concerns of consumers in their practice, considering this an important component of holistic practice. The findings informed the development of the 5A’s framework for including sexual concerns in mental health nursing practice. The framework explains how the experience of applying these skills
facilitated acknowledgement of the important role they play in supporting consumers who are experiencing sexual concerns.
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PUBLICATIONS AND PRESENTATIONS ARISING FROM THE RESEARCH

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Publications arising from the research


**Conference Presentations**

Quinn, C. (2011). The ins and outs of talking about sex with consumers. 37th Annual International Australian College of Mental Health Nurses Conference, Gold Coast.

Quinn, C. (2011). No more medication, I’d have to fake it if you make me take it. 37th Annual International Australian College of Mental Health Nurses Conference, Gold Coast.


Quinn, C. (2010) Lets talk about the “S” word. 36th International Australian College of Mental Health Nurses Conference, Hobart.


Quinn, C. (2009). We’re waiting for it to happen, and when it does, what do we say? Talking with mental health consumers about their sexual health concerns. The North Queensland Regional Branch of ACMHN 10th Annual Tropical Symposium Mental health problems: Anytime, anywhere, anyone Capricorn Resort Yeppoon.

Quinn, C. (2009). We all think about it, now it’s time to talk about it. Exploring mental health nurses experience in discussing sexuality issues with consumers. 3rd Annual Symposium ACMHN, Gold Coast Branch.


Statement of Contribution of Others

Full disclosure as to the contribution of others for each of the above listed publications from this research is contained in Appendix 2.

Additional Publications Having Relevance to the thesis

The following publications, while having relevance to the thesis, are not included in it but require mention.


Quinn, C. (2011). No more medication, I’d have to fake it if you make me take it. *International Journal of Mental Health Nursing*. 20, Supplement 1, 1-21.


CHAPTER ONE:
BACKGROUND, AIM AND QUESTION

“Begin at the beginning and go on till you come to the end: then stop”
(Carroll 1949 p.155)
Getting started: How my interest began

At the time this journey commenced, I was practising as a mental health nurse in a community adult mental health clinic. The core role for nurses (for the purpose of this thesis the term nurse unless otherwise stated, refers to mental health nurse) at the clinic was providing case management for adult mental health consumers. Many of the consumers attending the clinic were prescribed depot antipsychotic medication. Talking with these consumers I became aware that a large number were experiencing problems with their sexual function. Some consumers shared their thoughts with me, believing their sexual problems were related to the psychotropic medications they had been prescribed. I became concerned about the effect this was having for these consumers and angry that the medication prescribed to help these consumers was resulting in so much personal distress for them. The reported incidence of sexual problems in the product information from pharmaceutical companies did not reflect the level of concern reported to me.

My initial reaction was to locate a scale, The Arizona Sexual Experience Scale (McGahuey et al. 2000). The scale has a male and female version, used to evaluate the rate of problems associated with sexual function. I familiarised myself with both versions of the scale and made a number of copies thinking that if I was to simply ask enough consumers to fill in the scale, I would have evidence that the reported level of sexual function problems were greater than those reported by the pharmaceutical companies.

I was confident in my ability to discuss sexual concerns with male consumers, but was concerned that raising the topic with female consumers might raise concern from both the female consumer and colleagues. I asked a number of female nurse colleagues if they would score the scale with female consumers. I was surprised by their reactions. They were
uncomfortable with the wording and content of the scale and found certain aspects confronting. They made it very clear they would not feel comfortable using the scale with consumers.

I commenced a literature review into issues around sexual health and sexuality experienced by consumers, including problems with sexual function and nursing responses toward these sexual concerns. From the literature reviewed a manuscript was prepared and published in the International Journal of Mental Health Nursing (Appendix 3). During clinical supervision I was asked the question of what I wanted to achieve. My reply reflected my desire to see a change in nursing practice where nurses include the sexual concerns of consumers in their assessments and address these concerns in their provision of care, which led to applying for ethics approval to complete a study investigating the topic.

The importance of sexuality was fundamental to this topic so it was there where my review of the literature began in providing definitions of sexuality and sexual health, followed by a discussion regarding the sexual rights of all people. An examination of some of the historical ideals that have shaped society’s views towards human sexuality with particular reference to religion and medicine is provided. This chapter concludes by stating the aims of the research along with the research question that informed this thesis.

I have chosen to use the term consumer when referring to people accessing mental health services in preference to other commonly used terms such as patient, client, service user. Consumer is the term used in Australian and jurisdictional policy document and therefore appears the most appropriate to use in this context.
Importance of sexuality

Sexuality is a recently coined term first used in the field of botany, and later transferred to a human context during the early 19th Century to describe reproduction (Schultheiss & Glina 2010). Understanding sexuality is complex due to the many individual interpretations of the term, where meanings are influenced by culture, religion, politics, and various individual factors (World Health Organization 2006). For the purposes of this thesis sexuality will primarily be considered from a Westernised perspective, primarily discussing literature related to Australian, European and American societies. Sexuality is part of being human and therefore, cannot be removed from who and how we view ourselves (Foucault 1998; Heaphy 2007; McInnes 2003; Wilmoth 2007). Sexuality has an influence on our personality along with all aspects of our lives (Duldt & Pokorny 1999; Gamlin 1999).

Sexuality is considered fundamental to one’s health, quality of life, general well-being and is considered a quality of life issue (Crouch 1999a; Katz 2005a; McInnes 2003; Odey 2009; Ruane & Hayter 2008; Sharpe 2003). It is not just about physical sexual acts but also about the emotional and psychological health of a person (Duldt & Pokorny 1999; McCarthy & Bodnar 2005; Odey 2009). Healthy sexuality is similar for both women and men in that it usually involves shared pleasure, a way to deepen intimacy, and as a tension reducer that can assist one to deal with the stressors of life and tensions within relationships (McCarthy & Bodnar 2005).

Sexuality is also closely related to personal identity, comfort with one’s identity, and the notion of gender (Price 2009). Sexuality can be used as a way of describing oneself to others, for example being gay, lesbian, heterosexual, bisexual, transgender identities (a variety of individuals, behaviours, and groups that depart from normative gender roles) or intersex (a group of conditions where a person is born with a discrepancy between
the external genitals and the internal genitals that doesn’t seem to fit the typical definitions of female or male) (LGBTI) (McCarthy & Bodnar 2005; Odey 2009; Wilmoth 1998) and a way to describe one’s sexual lifestyle, for example, being in a committed or open relationship or being celibate (McCarthy & Bodnar 2005). However, the attitudes of others, especially those attitudes that define specific behaviors as acceptable or unacceptable (DeLamater & Friedrich 2002) can have strong influences on our understanding of sexuality along with the cultural values of society at the particular time (Price 2009).

**Sexual health**

Similar to the challenges in understanding and defining sexuality, arriving at an agreed definition for sexual health is problematic due to the influences of culture, religion, politics, and individual factors regarding the way we personally view what is considered as normal sexual behaviour. 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 (World Health Organisation 2001). Sexual health however, is often disrupted due to unsafe sexual activity or harmful sexual practices one might engage in (World Health Organisation 2006) or from the impact of illness (Krebs 2007, McInnes 2003, Peck 2001) or from the ill effects of medical treatments (McInnes 2003, Warner et al. 1999).

**Sexual rights**

Sexual rights incorporate the ideals of those stated in human rights where the rights of all people are respected (World Association for Sexual Health 2008). Sexual rights are concerned with human dignity, respecting a person’s sexual autonomy, and being aware that the moralistic views held by one, or a group of people is no reason for restricting the sexual lives of others (Dixon-Mueller
et al. 2009). The inclusion of sexuality within health care has been strongly promoted by the World Health Organisation (2001, 2006) who asserts that all people should be able to enjoy and control sexual and reproductive behaviour with freedom from fear, shame, guilt, and false beliefs.

Experiencing safe sexuality is not only an essential right, but it must be recognised and protected by society (Saunamaki et al. 2010). Ensuring social justice in relation to sexuality requires governments to create policies to prevent sexual discrimination and sexual abuse, and to promote sexual health and sexual rights (Berer 2004; Dixon-Mueller et al. 2009). The actualisation of sexual rights is only a possibility if all people respect the autonomy, dignity and equal rights of others, their sexual partners, as well as their own integrity and self-worth (Dixon-Mueller et al. 2009). People must feel safe to seek pleasure, have access to correct information, be free from the criticism of others, and services to assist them in avoiding the risk of unplanned pregnancy, or sexually transmitted illnesses (Dixon-Mueller et al. 2009; Ruane & Hayter 2008). Despite this, many sexual behaviours, and practices remain highly stigmatised (Berer 2004).

**Historical developments towards our current understandings of sexuality**

Since the emergence of civilisations efforts to contain and control sexual behaviours, and defining the boundaries of what society might consider as normal has occurred (Goodwach 2005). In Western societies, sexuality came under the control of the Church where right from was defined within a religious context such as sins of the flesh (Foucault 1998; Parker 2009). This control dates to the 3rd Century, where St. Augustine pronounced that the sex life of Christians should only occur within the context of marriage, for the sole purpose of procreation. A powerful religious message that continues to influence today’s society (Bullough 1994).
In the 18th Century a link begins to emerge between what was regarded as abnormal sexual expression with mental illness. Tissot (1760) published on the dangers of masturbation. He thought of semen as an essential oil, and excessive loss from non-procreative sex could result in cloudiness of ideas and likelihood of madness and for women engaging in non-procreative sexual activities increased the risk of hysterical fits (Bullough 1994; Wong 2002). During this time, gaining pleasure from sex was viewed as a form of disease or sickness (Tepper 2000). Sexual activity outside of marriage was considered unnatural and deviant (Goodwach 2005; Grey 1993; Leiblum & Rosen 2000) and as a demonic force that could destroy families and society providing the Church with a platform to instil fear upon society (Francoeur & Hendrixson 1999; Grey 1993). Sexuality was described as a taboo topic (Schultheiss & Glina 2010) a silent secrecy (Foucault 1998).

During the 19th Century, male sexuality was expressed in terms of power and influence. Men were believed to possess a greater libido than that of women and masturbation continued to be viewed with disapproval (Price 2009). Women had the role of serving men and were not meant to enjoy sex (Bullough 1994; Schultheiss & Glina 2010). The role of upper class women was to ensure family values and bear children (Price 2009). Lower class women were considered to possess increased libidos and required sexual satisfaction (Price 2009). At this time, mental illness in women was attributed to a disease of their womb called hysteria, a condition where women presented with unmanageable emotions (Keel 2005).

Towards the end of the 19th Century, medical opinion began to challenge religious beliefs regarding sexuality (Chiang 2010). Krafft-Ebing (1895), who agreed with Tissot that masturbation was a source of mental illness (Bullough 1994) and argued that sexual behaviour was controlled by the brain and as such, was a neurological issue, and not a spiritual one. Krafft-Ebing held the
view that people who were not heterosexual were suffering a neurotic degeneracy (Chiang 2010). He also warned that there are increased risks of incest, paedophilia, and bestiality from those with a mental illness, instilling a widespread fear of the dangers if people with mental illness were to have a sexual life (Krafft-Ebing 1895).

Havelock Ellis (1897-1928), explored what it meant to be heterosexual, homosexual, and bisexual. For Ellis, sexuality has different meanings for different people, and what may be considered as abnormal by some, can be perfectly normal for others. He challenged the accepted notion of the time (Krafft-Ebing 1895; Tissot 1760) that masturbation caused mental illness and argued that homosexuality could not be considered a vice (Leiblum & Rosen 2000).

Despite Ellis’ work, the medical profession during the early 1900s continued to hold the view that a deficiency in sexual hormones would delay psychosexual development and result in schizophrenia (Hoskins 1943) and being sexually promiscuous could cause insanity (Francoeur & Hendrixson 1999; Kelly & Conley 2004). Furthermore, if these “so called” promiscuous people were to marry each other and reproduce the progressive degenerative strains they possessed would result in increased mental illness within society (Bullough 1994). As such the medical evidence of the time was beginning to form strong opinion for controlling the sexual lives of mental health consumers.

Sigmund Freud (1905) theorised that sexuality began in infancy and not at puberty, which led to him mapping a series of psychosexual developmental stages. There is the oral stage from years 0-2, the anal stage from 2-3 years, the phallic stage from 4-5 years, the latency stage from age 6 through to puberty, and then there is the genital stage from puberty into early adulthood (Goodwach 2005). For Freud sexuality was linked to the way one’s
personality develops (Leiblum & Rosen 2000). According to Goodwach (2005), Freud viewed sexual thoughts and feelings as instinctive drives that we all possess, and that these build up within us demanding relief, which Freud referred to as the pleasure principle, which is kept in check by the person’s ego, this process Freud referred to as the reality principle (Goodwach 2005). Freud’s influences upon academics and medical professionals was unrivalled, and has been described as an ability to cultivate disciples (Bullough 1994) who believed in his theories and in his treatments, and his claims that following these treatments can lead to cures for patients. Freud argued the most common disorders seen in his practice related to problems associated with sexual function (Hartmann 2009). He held strong convictions that in order to treat these problems one needs to understand that the causes are more than simple organic failings and that in order to treat what he called ‘physical impotence’ (Freud 1912), one must delve into the person’s mind and examine the person’s interpersonal relationships (Hartmann 2009).

Alfred Kinsey (1948, 1953) conducted the first large-scale surveys of sexual behaviour in the United States, demonstrating the disparity to what society believed to be normal sexual behaviour to what sexual behaviour was actually occurring within society (Brown 2004; Bullough 1998). At the time of Kinsey’s reports, being non-heterosexual was considered not only as a form of mental illness, but also anti-nationalistic by American politicians and authorities (Schultheiss & Glina 2010). As Kinsey states:

“There is a tendency to consider anything in human behavior that is unusual, not well known, or not well understood, as neurotic, psychopathic, immature, perverse, or the expression of some other sort of psychologic disturbance” (Kinsey 1953 p. 195).
Kinsey came to the conclusion that because sexual behaviours were so varied and that what is considered normal alters over time that an agreed definition of what is considered normal sexual behaviour was simply too difficult (Brown 2004; Drew 2003).

A commonality with Ellis, Freud and Kinsey was that all three agreed that sexuality has the power to define who we are as human beings (Parker 2009). The two decades following Kinsey’s first report resulted in widespread changes in public opinion towards sexuality (Bullough 1994) with further developments and challenges to the medical dominance of sexuality allowing treatment openings for nurses, psychologists, social workers and a new profession, the sex therapist (Bullough 1994).

One such challenge to the medical dominance is seen in the work of Masters and Johnson (1966) who developed the human response cycle as a method to describe normal sexual responses. They reported that aside from obvious anatomic differences, men and women, women are “homogeneous in their physiologic responses to sexual stimuli” (Masters & Johnson 1966 p.285) and responded sexually in the same way (Drew 2003). Any variation would be classified as a problem requiring intervention (Pacey 2008; Tiefer 1996; Tepper 2000). The rigid approach of the model has come under scrutiny (Pacey 2008; Tepper 2000) along with the heteronormativity of the model, where gender sensitivity and the needs of women are lacking (Goodwach 2005; Tiefer 1991). This biological focus disregards the importance of pleasure, satisfaction, and the importance of sexuality in relationships (Whipple 2002). They did however establish that there was no medical evidence that masturbation leads to mental illness (Masters & Johnson 1966).
Since the late 1960s society began developing a more liberal and accepting view towards human sexuality (De Santis & Vasquez 2010) however within psychiatry sexuality remained a taboo and discussing sexual concerns with consumers was considered inappropriate (Kelly & Conley 2004). Moreover it is reported that some psychiatrists during the 1970s continued to hold the view that non-heterosexual sexual activity could be a contributing factor to the development of schizophrenia, and discussing sexuality concerns with consumers was considered inappropriate (Kelly & Conley 2004).

Within health care (Hinchliff et al. 2005) and in mental health (Wright & Anthony 2002), a connection between homosexuality being viewed as abnormal appears to have remained (Stein & Bonuck 2001). Gay men (Beehler 2001) and lesbian women (Welch et al. 2000) have reported that care from health professionals was hampered by the homophobic beliefs (Kautz et al 1990; Rondahl 2009; Skelton & Matthews 2001). The avoidance by health professionals may result from pre-existing biases such as homophobic beliefs that people who identify as LGBTI, are in some way immoral, sick, second-rate, and not normal (Hinchliff et al. 2005; Tate & Longo 2004), or it may be a reflection of the difficulties health professionals have in general towards discussing sexual concerns (Beehler 2001).

Sexual myths refer to beliefs and attitudes held by people that usually do not have a factual base, but are widely held to be true (Davis & Lee 1996; Evans 2000; Myers 1981) and have a strong connection to our current understandings towards sexuality. Sexual myths are widespread (Evans 2000) resulting in harm and personal suffering. Many can be traced to
religious ideals (Myers 1981). Sexual myths commonly refer to sexual practices towards gender stereotypes (Davis & Lee 1996; Evans 2000). Myths and fears around sexuality, sexual health, and sexual acts form barriers that nurses need to be aware of to improve their practice and to assist consumers overcome the devastating effects the myths can have (Evans 2000).

Further, is the widespread myth within our society that men should be able to have an erection on demand, that they should always be ready and able to perform reproductive sex (Drew 2003) and are left with feelings of inadequacy if they are unable to do so (Drew 2003). Leading from this belief then, is that women, should be responsive towards this male need and be ready to oblige, and women are made to feel abnormal or guilty if they are not ready to participate (Drew 2003). Other myths around sexuality can be traced back to religious ideals, where non-marital sex has been frowned upon (Myers 1981).

It has been argued that for many people, in western societies there remains continued feelings of guilt and social pressure over sexual acts due to the strong influence of religious beliefs and myths have had upon our society (Drew 2003; Evans 2000). For example some view stemmed from beliefs that people affected with mental illness are possessed, evil and deformed, and that the sexuality of these people normal, dangerous, and should not be encouraged (Tepper 2000). It has been advocated by Evans (2000) to dispel sexual myths, we need to talk about sex, to challenge false beliefs and the stigmas associated with these myths. Dispelling myths through understanding and deconstructing their origins and meanings, and providing education around sexual facts, is an effective method in challenging sexual myths and the associated stereotypes and stigma (Evans 2000).
The medicalisation of sexuality

Medicalisation refers to how medicine exercises authority over a particular area of our lives (Corrigan & Matthews 2003; Tiefer 1996). Fundamental to the medicalisation of any phenomenon is the understanding that the problem can be corrected by a medical treatment (Çorrigan & Matthews 2003), in this case, sexuality (Bullough 1998; Levinson & Giami 2006; Tiefer 2010).

Foucault (1998) described the work of Ellis and Freud, as the commencement of Western societies attempts to categorise people’s pleasures, and led to the medical profession exercising its powerful control over sexual behaviours:

"... in a word, the opening up of the great medico-psychological domain of the perversions, which was destined to take over from the old moral categories of debauchery and excess" (Foucault 1998 p. 118).

The result was an over-emphasis and medicalisation of sexual problems as sexual diseases and sexual dysfunctions (Tiefer 1996). Medical practitioners who were already considered experts who possessed unquestionable knowledge and authority over bodily function, illness and disease, were now considered to be experts on sexuality, and sexual behaviour (Bullough 1998). Medical practitioners were viewed as having social authority, protecting marriage and reproduction (Levinson & Giami 2006), offering little consideration towards their patient’s relationships (Goodwach 2005).

The medicalisation of sexuality has resulted in over-complicating what might be considered as common problems, and transforming these into “medical disorders” (Tiefer 2010 p. 193) with a dedicated interest towards treatments for sexual health related problems that favour problems experienced by
males, and a lack of treatments or concern for problems experienced by women (Pacey 2008), for example the use of Viagra, allowing men to experience erections on demand (Drew 2003). The influence of gender favouritism is evident within the medicalised research on sexuality, where the needs of women have received little attention (De Santis & Vasquez 2010; Pacey 2008). The masculine point of view driving this gender favouritism has resulted in a situation where the sexual behaviour of men has been studied more often than the sexual behaviour of women (Atwood & Klucinec 2007). Because of this gender favouritism within the literature, there exists a far greater body of knowledge around male sexuality than there is for female sexuality.

Towards the closure of the 20th Century western societies have focussed upon sexual performance (Price 2009). The view of sexuality had moved from one of relationships and lifestyles to the importance of sexual performance with a healthy sexual state for all ages being based upon the vigour and performance of that seen in young adults (Price 2009). During this past decade, the medicalisation of sexuality has moved towards an obsession with medication cures (Drew 2003; Price 2009) where the assumption is that for sexual function problems, a pharmaceutical medical solution exists (Levinson & Giami 2006). What results from this medicalised approach is avoidance of and minimisation of the importance towards any discussion around the sexual health concern and a disregard for holistic biopsychosocial approaches towards the treatment and support of one’s sexual issues (Tiefer 2010).

**Aims of the research**

Acknowledging the importance of sexuality to health and identity, and that one’s sexuality can be disrupted as a result of illness or from the side effects of medication, creates a need to include sexuality in the provision of health
care. Additionally, historical viewpoints have often drawn parallels to what has been considered as abnormal sexuality within society with those considered by that society as mental illness. Mental health nurses need to recognise the importance of sexuality for consumers along with the need to support consumers in addressing their sexual concerns. As such, this research considers the following aims:

- To explore current practices of mental health nurses in addressing sexual concerns with mental health consumers;
- To explore whether the BETTER model was useful to mental health nurses in discussing the sexual concerns of mental health consumers;
- To develop strategies to improve the practice of mental health nurses towards the sexual concerns of consumers; and
- To make recommendations towards the inclusion within mental health nursing practice and education of the importance of engaging with consumers on the sexual concerns they might be experiencing.

### Overview of thesis

This chapter has provided an introduction to sexuality; sexual health; sexual rights and provided a brief historical journey through to the present day examining the controlling ownership of sexuality by religious and medical authorities and societies’ response towards this regulation. The chapter concludes by stating the research aims and research question. This leads to Chapter 2, the literature review, which is presented in three major sections. The first of these sections presents the literature discussing sexuality as it relates to consumers; the second section, the literature concerning sexuality and nursing; and the third section presents sexual intervention models, along with a critique of these models and my reasons for choosing the BETTER model for this research. Chapter 3 discusses the methodology for this exploratory qualitative research study that was conducted over three stages.
Individual in-depth interviews were conducted with 14 mental health nurses at three stages over two years. Chapter 4 presents the findings in a series of publications that arise from the research. The discussion of these findings, a justification for the chosen research design, limitations of the research, along with my recommendations occur in Chapter 5.
CHAPTER TWO:  
THE LITERATURE REVIEW

“No patient was ever ‘ruined’ by kindness and sympathy - but many have suffered needlessly from the lack of these qualities in their nurses”  
(Travelbee 1964 p.70)
Introduction

This chapter presents the literature relevant to this study, including: the effects of illness on sexual functioning and sexual safety issues; the attitudes of consumers towards the inclusion of care regarding sexual concerns; the role of nurses and the barriers to the delivery of care inclusive of sexual concerns; sexual intervention models utilised in other nursing specialties to assist in improving this area of care, a critique of these models, and the reasons for choosing the BETTER model as a framework to trial with mental health nurses.

Literature review method

Relevant literature was located via a computerised search of the data bases: Cumulative Index to Nursing and Allied Health Literature (CINAHL) with Full Text; Ebsco; MEDLINE; ProQuest Dissertations and Theses Database (PQDT); PsychARTICLES; Psychological Abstracts (PsycINFO); PubMed Central; ScienceDirect; and Scopus. The key words used for the search were sexuality; sexual health; sexual safety; sexual side effects; and these were combined with the words assessment; interventions; nursing; mental health nursing; mental illness; and psychiatry. Limitations were imposed on the search sites to include articles from 1985 to the time of the initial search along with limiting to literature pertaining to adults. Further to this, a review of the reference lists contained in articles also occurred to locate further literature that was possibly missed during the above search.

A search for grey literature was also undertaken, using the World Wide Web and combinations of the above mentioned key words. An additional search was undertaken of the web sites for the following organisations: the Australian Bureau of Statistics; Australian Nursing and Midwifery Council; National Centre in HIV Epidemiology and Clinical Research; Department of
Health Services, Victoria; New South Wales Department of Health; Queensland Health; Sexual Health and Family Planning of Australia; World Association for Sexual Health; and the World Health Organisation.

Subsequent searches have replicated the initial search to locate more recent literature and literature possibly missed during the initial search.

SECTION 1: SEXUALITY AND CONSUMERS

Sexuality and enduring illness

Enduring illness can have profound negative effects on relationships and sexual satisfaction (McInnes 2003). Enduring illness affects not only the person's physical state, it also can impact on a person's psychological and social well-being (Basson et al. 2010; McInnes 2003), and can affect self-image, erotic desires, emotional and sexual intimacy with their partner, and impact on reproductive decisions (Basson et al. 2010; Nusbaum et al. 2003; Warner et al. 1999). The diagnosis of illness can alter the course of sexual development and the way in which people express their sexuality (Basson et al. 2010; Nusbaum et al. 2003, Peck 2001; Warner et al. 1999) and although enduring illness and treatment can disrupt or permanently alter a person's ability to maintain their previous sexual patterns and create a strain on their sexual relationships, the person concerned remains a sexual being (Krebs 2007; McInnes 2003).

Sexuality and enduring mental illness

Consumers perceive themselves as sexual beings despite their diagnosis (Volman & Landeen 2007), however, the notion that consumers might want to form sexual relationships has often been met with disapproval from others (Earle 2001). Society is generally uncomfortable and remains ambivalent to the notion that consumers might still want, or have sex (Herson et al. 1999).
It is frequently assumed that because of enduring illness, a discussion about sex is irrelevant because consumers are unlikely to form a relationship or because of the stereotyped view of them being asexual (Lyon & Parker 2003).

Diagnosis plays a role in a consumer’s ability to form close sexual relationships (Raja & Azzoni 2003). SANE Australia (2009) a non-profit organisation that provides advocacy for improved services for consumers, reports that close to half of the consumers in their sample of 424, were not in a close relationship with another person, a figure nearly twice that of the national average (Australian Bureau of Statistics 2009). Eighty seven per cent of these participants reported the need for physical intimacy, however of these, 13% reported neither touching nor having been touched by another person in over a year (SANE 2009). Sexuality is regarded as an important component to quality of life (Mick et al. 2004), a positive personal affirmation (Volman & Landeen 2007), and Deegan (2001) has hypothesised that falling in love could possibly be a healing process for consumers.

Research exploring the sexual lives of consumers (Cook 2000) reported that 51% of consumers lacked a satisfying sex life, 47% lacked a satisfying social life, and 40% lacked warmth and intimacy. The impact of illness on one’s self esteem, the loss of interest in sex (McCann 2000), and lack of privacy from hospitalisation (Herson et al. 1999; Magnan et al. 2005; Nakopoulou et al. 2009) were reported as major disruptions to their sexual relationships. It has been observed that over time for consumers diagnosed with schizophrenia a deterioration of social and socio-sexual functioning occurs and that this group report a higher rate of separation from partners than observed in the general population (Fortier et al. 2003). The lack of a satisfying social life has been linked to reduced interest in dating (Cook 2000). Furthermore, it is suggested that the skills required to form sexual relationships are not well developed for this consumer group resulting in difficulties finding a partner (Fortier et al.)
or it may be a reflection of the broader society where there are few role models to learn from regarding how to form and maintain sexual relationships (DeLamater & Friedrich 2002).

Social stigma can impact on self-image, making it more difficult for consumers to have sexual experiences, and share themselves with a sexual partner (Volman & Landeen 2007). Consumers may feel embarrassed, anxious (Cook 2000), afraid of being labelled, or ridiculed by clinicians for wanting sex (Keel 2005; McCann 2010). For consumers, it is not about their inability to discuss their sexual concerns, but more about nurses not creating opportunities (Wright & Pugnaire-Gros 2010) or providing permission for consumers to discuss the topic (McCann 2010).

**Sexual safety, abuse, exploitation and vulnerability**

Safety is a major concern for mental health services. Traditionally, the focus has primarily been on the safety of clinicians (Cowman & Bowers 2008; McKinnon & Cross 2008). Increasingly there is interest in examining safety from a consumer perspective (Hovey et al. 2011; Thomas 2008; Wood & Pistrang 2003). Services are recognising their duty of care towards the safety of consumers from the unwanted behaviours of others, and the need to provide protection for consumers from their own behaviours when unwell (Department of Health Services, Victoria 2009).

The World Report on Violence and Health (World Health Organization 2002) has indicated that the effects of abuse can continue well after abuses have ceased impacting on both one’s physical health and mental health. The trauma of sexual abuse can result in: depression; poor self-esteem; anxiety problems; sexual performance problems; substance abuse issues; suicide, and self-harm behaviours (Boutcher & Gallop 1996; Elliott et al. 2004); psychosis; dissociative disorder (Read et al. 2006; Warne & McAndrew
2005); and an increased risk of developing PTSD (Coverdale & Turbott 2000; Read et al. 2006).

Sexual safety, abuse, exploitation, vulnerability and consumers

The incidence of adult sexual abuse within the general population has been estimated at 22% in women and 3.8% in men (Elliott et al. 2004). For consumers it has been reported that 68% of females and 40% of males have a history of sexual assault (Goodman et al. 2001). A more conservative rate of sexual assault at 40% amongst adult consumers has been reported (Coverdale & Turbott 2000) and in a sample including male and female consumers, Warne and McAndrew (2005) estimated that 50% of female consumers have a history of childhood sexual assault. These reported rates remain significantly higher than those reported within the general population, where one in three girls and one in six boys will be sexually abused before the age of eighteen (Australian Institute of Criminology 2006). These figures suggest that consumers are more likely to experience sexual abuse than the general population (Agar et al. 2002; Earle 2001; Goodman et al. 2001).

An alarming proportion of female inpatient consumers report being sexually harassed or sexually assaulted (Hatch-Maillette & Scalora 2002; Barlow & Wolfson 1997). A study conducted in the United Kingdom between November 2003 and September 2005 (National Patient Safety Agency 2006) reported 122 incidents relating to the occurrence of sexual safety. A United States study where a random selection of 142 consumers participated, examining the harmful and traumatic experiences of being admitted to an inpatient facility reported that 8% of participants had experienced sexual assault during their admission (Frueh et al. 2005).

Consumers are unlikely to discuss being sexually abused unless directly asked (Agar et al. 2002; Cook 2000; Elliot 1997; Read et al. 2007).
Consumers who do report sexual abuse are at times labelled as fabricating the story of abuse for some form of secondary gain, or being attention seeking (Keel 2005). A study by Agar and Read (2002) found those consumers who disclose sexual abuse to clinicians that only 21.7% received any treatment for the effects of the abuse. Further to this, Read et al. (2006) report that female consumers who have experienced sexual abuse, 78% of these were not asked about their abuse during their initial assessment (Read et al. 2006). It has been proposed that this might reflect the clinical focus of inpatient units with a primary aim in stabilising consumers presenting in crisis, and on symptom reduction, rather than finding solutions for the psycho-social problems of consumers (Read et al. 2006).

Male sexual vulnerability is thought to be under-reported (Crome & McCabe 1995; Denborough 2005; Elliott et al. 2004). For example, where long term hospitalisation occurs or in prison settings, it is more common where up to 25% of males in these settings aged between 18 and 25 years report sexual abuse (Denborough 2005). The reaction by males towards sexual abuse is similar to that of females, with a range of personal adjustment issues, family and relationship disruption, and distorted self-perceptions (Crome & McCabe 1995; Elliott et al. 2004).

**Unsafe sex and sexually transmitted illnesses (STIs)**

The transmission of STIs can be prevented by using safe sex protective behaviours (Kirby Institute 2011). High risk sexual behaviours are common within the general population (Anderson et al. 2006; Department of Health and Ageing 2010; Calsyn et al. 2010; National Centre in HIV Epidemiology and Clinical Research 2010). As a result, STI rates across age groups are increasing in Australia (Kirby Institute 2011). Within Australia, STIs are the main cause of infertility for women mostly as a result of chlamydial infection where the rate of transmission for women and men has nearly doubled.
between the years of 2004 and 2008 (Australian Department of Health and Ageing 2010). During these same years, there was a 16% increase in gonorrhoea notifications for women and infectious syphilis rates doubled for both sexes (Australian Department of Health and Ageing 2010).

In 2010 there was an estimated 29,941 people living with a human immunodeficiency virus (HIV) diagnosis in Australia (National Centre in HIV Epidemiology and Clinical Research Australian HIV 2010) with 1000 new cases of HIV being diagnosed annually (Kirby Institute 2011). HIV transmission in Australia occurs primarily through sexual contact between men. Approximately 65% of people newly diagnosed with HIV are men who had sex with men, 28.7% were exposed through heterosexual contact, 2.3% were due to injecting drug use, and a further 3% were men with a history of both injecting drug use and sex with other men (National Centre in HIV Epidemiology and Clinical Research 2011).

Unsafe sex, sexually transmitted illnesses STIs and consumers

It is difficult to determine the extent to which the risks associated with unsafe sex are exacerbated for consumers. Consumers are considered to be at high risk of infection to HIV, hepatitis B, hepatitis C and other STIs (Dyer & McGuinness 2008; Kelly & Conley 2004; Rosenberg et al. 2005). In the United States, the prevalence of HIV is reported at 0.3% of the general population (UNAIDS 2002) while the level for consumers is at 8% (King et al. 2008), a figure nearly 25% higher than that of the general population. This is of particular concern given that many consumers are poorly informed and have poor strategies to reduce the risk of HIV infection (Dyer & McGuinness 2008). For example, Kelly et al. (1995) reported that 43% of the consumers in their study believed that heterosexual women could not be infected with HIV. This misconception regarding transition is not surprising given that a recent study revealed that knowledge regarding the transmission of HIV in the
general population in the United States has not improved since 1987 (Kaiser Family Foundation 2009).

Consumers are vulnerable to sexual risk because of their illness and the frequently reported history of sexual abuse. Factors contributing to the increased risk of acquiring an STI for consumers include: impaired autonomy; increased impulsivity; increased susceptibility to coerced sex (King et al. 2008); poor education around safe sex (Cook 2000; Ford et al. 2003) where condom use is inconsistent despite understanding the sexual health risk of this decision (Cook 2000; Dyer & McGuinness 2008; Raja & Azzoni 2003); multiple sexual partners; substance use (Ford et al. 2003); engaging in sex with high-risk groups (Cook 2000; Dyer & McGuinness 2008); and casual sexual encounters or trading sex for material gain such as offering to exchange coffee or cigarettes for sexual favours (Woolf & Jackson 1996); or for food or shelter (Weinhardt et al. 1999).

The onset of mental illness often occurs during early adulthood at a time when many people enter into sexual relationships and discover their sexual self (Volman & Landeen 2007). As a result consumers are rarely provided an opportunity to learn about sexuality issues either growing up or in healthcare settings (McCann 2010; SANE 2009). Furthermore it has been reported that 32% of consumers (SANE 2009) have never been tested for an STI and 46% were not receiving regular sexual health checks, such as Pap smear tests, breast screening or checks for prostate cancer. In response to findings reporting high risk and poor opportunities to learn about sex education, it has been advocated that consumers are provided opportunities to participate in safe sex education (Ford et al. 2003). A review of the literature between 1980 and 2005 concerning safe sex education for consumers reported that small group programs run by nurses were effective in reducing risk (Higgins et al. 2006a); however Dyer and McGuiness (2008) report that consumer gains diminish over time suggesting the need for the regular provision of ongoing
safe sex education. From a consumer’s point of view, receiving safe sex education is not viewed as necessary in hospital because hospitals do not offer a private and dignified place to engage in sex (Welch & Clements 1996). Creating a situation where it is virtually impossible to put safe sex education into practice (Warner et al. 2004).

A survey of 139 inpatient consumers (Welch & Clements 1996) reported that 49% were engaging in sexual activity in their own room, 23% in the hospital grounds, 19% in bathrooms, and 16% were using other rooms and stairwells. A more recent study on inpatient units reported that 30% of the consumers in the sample of 100, engaged in sexual activity (Warner et al. 2004). Further to this, Warner et al. (2004) reports that both male and female consumers are equally likely to report sexual activity occurring within inpatient settings, with locations for sexual activity including bedrooms, dayrooms, toilets, stairwells and garden areas, supporting earlier reports.

Due to the limited information regarding the prevalence of STIs for consumers, Campos et al. (2008) conducted a detailed systematic review of the literature, identifying a further high risk sexual activity where 2-10% of consumers reported engaging in anal intercourse (Campos et al. 2008) and given the reported inconsistent use of condoms (Cook 2000; Dyer & McGuinness 2008; Raja & Azzoni 2003) the increased risks associated with the sexual practice is troubling. Consumers who engage in sexual activity while under the influence of alcohol or illicit substances are at an increased risk of doing so unsafely with increased difficulties in negotiating safer sex (Campos et al. 2008) a “double jeopardy” (Dyer & McGuiness 2008 p. 29) due to high risk sexual behaviour and associated substance abuse issues.

For consumers who experience periods of mania, sexual risk taking behaviour has been frequently reported. A study examining the sexual risk behaviours of 101 consumers diagnosed with bipolar disorder (Meade et al.
2008) reported that: 69% had unprotected sex, 39% had multiple partners, and 10% engaged in sex trading. McCandless and Sladen (2003) reported that women with bipolar disorder can experience sexual impulsivity with negative effects on usual sexual behaviours and these behaviours may conflict with their cultural or religious belief systems resulting in possible conflict in their interpersonal relationships (McCandless & Sladen 2003).

There are specific gender-related concerns for female consumers such as unplanned pregnancy, inadequate gynaecologic and breast examinations and sexual partner violence. Female consumers report having more sexual partners than males and the experience of sexual violence (Dickerson et al. 2004), are at an increased risk of unplanned pregnancies (Lyon & Parker 2003), and are more likely to experience birth fatalities than the general population (Dickerson et al. 2004; Lyon & Parker 2003). These specific concerns for female consumers highlights the need for sexual health education and strategies to minimise the victimisation of female consumers.

**Policy considerations**

Historically, there was no need to provide policies regarding sexual activity between consumers due to the wide held beliefs that consumers were asexual; leaving clinicians in a position where they would judge what was appropriate and inappropriate in the absence of guidelines to assist their decisions (Dobal & Torkelson 2004). During the 1990s, studies (Buckley & Wiechers 1999; Coverdale et al. 1997) challenged earlier beliefs suggesting consumers are sexually active. Despite this, sexual activity by consumers remained prohibited by service policy, ignored by clinicians, or at times dealt with by clinicians who would humiliate the consumers involved (Dobal & Torkelson 2004).
When sexual relationships occur between consumers in inpatient facilities, the situation often becomes problematic, raising “complex legal, ethical, personal and professional dilemmas” (Earle 2001 p. 433) that nurses find difficult to overcome. There is a duty by the service provider to provide treatment and protection to consumers (Buckley & Wiechers 1999) and therefore, sexual relationships between consumers raise unique difficulties regarding consent (Warner et al. 2004).

Guidelines provided within Australia (Department of Health Services, Victoria 2009; New South Wales Health 2004; Queensland Health 2004) warn of the possible negative impact of sexual activity between consumers in acute care environments, and as such encourage a stance where such sexual activity is not to occur in acute units. The needs of consumers requiring lengthy admission however differ from those in acute care settings. These guidelines do not provide direction for services other than acute care environments. The challenge for mental health services is to find a common ground within policy, where the consumer’s rights to sexual intimacy (Ruane & Hayter 2008; Welch & Clements 1996) are balanced with the service’s responsibility to protect consumers from harm (Deegan 2001; Dobal & Torkelson 2004). Over this past decade services have begun to recognise the need to provide clinicians with guidelines and policy regarding consumer sexuality, but many are zero-tolerant (Dobal & Torkelson 2004), where clinicians are encouraged to police and actively prevent sexual interactions between consumers.

However, despite having a zero tolerance policy, consumers continue to engage in sexual activity (Higgins et al. 2008; Warner et al. 2004). Zero-tolerant policy towards consumer sexual activity combined with the negative attitudes of clinicians towards consumer sexual activity are considered barriers to the development of future intimate relationships for consumers (McCann 2010). According to Deegan (2001) what results is a failure of
services to allow consumers to have private sexual relationships, where they can express their sexuality in a dignified manner.

Warner et al. (2004) has encouraged mental health services employing what could be described as zero-tolerance policy, review them, accept that sexual activity by consumers within services occurs, and that services ensure that condoms, safe sex education and safe sex information are made available for consumers. Such policy needs to provide clear guidelines for nurses, removing the need for personal opinion and decisions that can be difficult for them to make (Welch & Clements 1996). However, Ruane and Hayter (2008) observed that when more comprehensive policies are in place, that are supportive of consumer relationships, and there is personal freedom to seek intimacy, love and comfort, these policies are not well adhered to by nurses. They suggest this reflects that the personal views of nurses out way their professional obligations to adhere to policy, and recommend further attention to assist nurses to view consumer sexual relationships in a more positive manner where facilitation rather than restriction becomes the norm (Ruane & Hayter 2008).

Problems with sexual function

Volpe and Wertheimer (2004 p.4) define sexual function problems as the “… inability to express one’s sexuality consistently with personal needs and preferences. It is a state in which problems with sexual function exist”. Nevertheless within psychiatry there is strong reliance on the Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision [DSM IV TR] (American Psychiatric Association 2000) for defining problems. The DSM IV TR (American Psychiatric Association 2000) discusses sexual function problems as they relate and impact on the person experiencing the problem with little consideration to the impact on the consumer’s partner (Goodwach 2005; Pacey 2008), and disregards any sexual difficulties that might arise
from a disease or illness process (Krebs 2007), such as reduced libido often seen in depression, resulting in these issues being poorly recognised and under-diagnosed (Krebs 2007). In a critique of the DSM IV TR, Tiefer et al. (2002 p. 227) states that the approach assumes a simplistic view that: “… if the sexual parts work there is no problem. If the parts do not work, there is a problem”.

There also tends to be a male focus in the consideration of human sexuality. For example the DSM-IV-TR (American Psychiatric Association, 2000) adopts the Masters and Johnson (1966) sexual response cycle as a baseline for defining normal sexual response. The stages of the sexual response cycle do not adequately represent the sexual responses of women (Goodwach 2005; Tiefer 1991). Furthermore, many women can also experience sexual problems resulting from fear of sexual acts or the possible consequences of pain during intercourse (Tiefer et al. 2002), fear of unplanned pregnancy and of acquiring an STI, the possible loss of one’s partner, or the loss of one’s reputation that are not well considered in the DSM-IV-TR (Tiefer et al. 2002).

**Sexual function problems and mental illness**

Experiencing disruption to one’s normal sexual function is common within the general population, where it is estimated that 20 to 30% of men and 40 to 45% of women have their lives disrupted due to problems with their sexual function (Lewis et al. 2004).

Disagreement exists on the level of sexual function problems experienced by consumers due to varied treatment practices across mental health services, the inconsistencies in measuring the problem, and co-morbid health issues of consumers in research samples (Montejo et al. 2010; Perlman et al. 2007; Smith et al. 2002; U’cok et al. 2008). A common ground is that sexual function problems experienced by consumers is a far greater problem than
that experienced by the general population (Perlman et al. 2007; Smith et al. 2002; U’cok et al. 2008). For instance, problems with sexual function have been reported in up to 54% of consumers diagnosed with schizophrenia (Apantaku-Olajide et al. 2011, Perlman et al. 2007). While Smith et al. (2002), estimate the prevalence at rates as high as 60% in men and as high as 93% in women, and Basson et al. (2010) claim that up to 90% of consumers experience some form of sexual function problem, Montejo et al. (2010) reports more conservative rates of approximately 50% of males and 37% of females. U’cok et al. (2008) in their study of 827 adult consumers (547 males) aged between 18 and 45 years, found that 52.6% experienced problems with sexual function, and that 73.5% of these consumers had never been asked about their sexual functioning during a psychiatric consultation, concluding that these problems are disregarded by psychiatrists and under-reported due to lack of clinical interest (U’cok et al. 2008).

The experience of sexual function problems for this consumer group leads to distress (Apantaku-Olajide et al. 2011), unhappiness, depression and frustration (Stevenson 2004), medication adherence issues (Kodesh et al. 2003; Sullivan & Lukoff 1990), and difficulties in forming or maintaining existing sexual relationships (Basson et al. 2010). For consumers diagnosed with schizophrenia it has been reported that before the onset of illness, a lack of interest in forming sexual relationships is more common in male consumers than in healthy males (Kelly & Conley 2004). Lack of sexual activity and sexual interest may also result from having low social confidence, limited experience with personal relationships or from the lack of interest and anhedonia associated with the negative symptoms of schizophrenia (Savlon et al. 2007).

Sexual side effects from psychiatric medications can have a negative effect upon a consumer’s quality of life reducing self-esteem and causing possible problems with their relationships (Berner et al. 2007). Female consumers are
concerned with weight gain, and the impact on body image, along with concerns regarding reduced or increased libido, and experience sexual function problems more often than men (Apantaku-Olajide et al. 2011). Male consumers frequently voice concerns around erection problems such as difficulties ejaculating and the impact on their self-beliefs regarding masculinity (Volman & Landeen 2007). The concern experienced by consumers may well be so distressing that an exacerbation of psychotic symptoms may occur (Apantaku-Olajide et al. 2011; Kelly & Conley 2004). However where the problem was related to medication, and the medication is ceased, sexual functioning usually improves (McCann 2003) and the distress experienced by the consumer eases (Stevenson 2004).

Sexual function problems such as loss of interest, poor arousal, and difficulties in achieving orgasm are reported in 50-90% of consumers diagnosed with a depressive illness (Balon 2006; Basson et al. 2010; Perlman et al. 2007; Schweitzer et al. 2009; Werneke et al. 2006). Assessing whether the problem is related to depression (Basson et al. 2010), or as a side effect from antidepressant medication is difficult to ascertain (Schweitzer et al., 2009; Werneke et al. 2006). Sexual side effects are commonly experienced due to antidepressant medications, and are the most common side effect of the selective serotonin reuptake inhibitors antidepressants (Balon 2006; Basson et al. 2010; Schweitzer et al. 2009). Common symptoms of depression such as: social isolation; loss of interest in daily activities; anger and irritability; loss of energy; and feelings of poor self-worth, can all have a negative impact on one’s sexual function (Balon 2006; Basson et al. 2010; Schweitzer et al. 2009). Similar to consumers diagnosed with schizophrenia, it should be acknowledged that problems with sexual function are significantly underreported by consumers with a diagnosis of depression unless they are specifically asked (Balon 2006). A further stressor adding to the sexual tensions for depressed consumers is that the consumer’s partner can assume that because of depression that the consumer might not want to
engage in sex, resulting in feelings of rejection and possibly makes the problem worse for the consumer (Crowe 2004).

**Consumer perspectives regarding sexual health care**

There is a paucity of literature exploring the experiences and concerns from a consumer viewpoint. One such study by McCann (2010) investigated the views of 30 consumers diagnosed with schizophrenia. These consumers spoke about sexual safety concerns, the lack of opportunity for sexual health education, and the experience of sexual side effects. Further to this, McCann (2000; 2010) found that consumers are willing and open to discussing a range of intimate and sexual concerns and were not distressed by these discussions. Both of these important studies support the views of other researchers (Kelly & Conley 2004; Sharkey 1997; Waterhouse & Metcalfe 1991) that consumers are receptive to having their sexual concerns assessed.

Consumers report a lack of sexual knowledge and a need for professional support around their sexual concerns. In a convenience sample of 424 consumers (SANE 2009), 65% reported a lack of sexual related knowledge. Making sense of one’s body and feelings is a normal human need; however consumers report being poorly supported by health professionals with regard to their sexual health knowledge needs (SANE 2009).

The literature suggests consumers are more concerned about the sexual side-effects of medication than any other type of side effect (Deegan 2001; Schweitzer et al. 2009). Moreover, sexual side effects are a major reason for consumers deciding to cease medication (Basson et al. 2010). Consumers want to know about what side-effects could occur from psychotropic medications before they experience them and before they observe these side effects in other consumers (Happell et al. 2004). However there is a clinical
cultural belief that consumers should simply accept the doctor’s order without question to take medications that have been prescribed for them (Repper & Perkins 2003) and that non adherence, when viewed from a medicalised lens, is an irrational and irresponsible action (Repper & Perkins 2003) resulting from a lack of insight about the need to follow the recommendations of the doctor.

SECTION 2: SEXUALITY AND NURSING

Avoiding sexuality in nursing

During the mid-1970s, the American Nurses' Association (1974) included sexuality as an area for nursing assessment in their Standards of Practice. Accordingly these standards signify a shift from a medicalised model to a holistic person-centred model of care for nursing (American Nurses' Association 1974). In response to this and some 16 years later, Kautz et al. (1990), reported that nurses (n=312) believed that those under their care are simply too unwell or too anxious to be concerned about sexual concerns. As a result, these nurses avoided the inclusion of sexual concerns in their practice although they believed they had sufficient knowledge to discuss sexual concerns if the person initiated the discussion (Kautz et al. 1990). A further study by Woolf and Jackson (1996) examined the effectiveness of a specific sexual health program for consumers. The content covered safe sex, STIs, sexual assertiveness skills, and condom use. The authors reported that 72% of the nurse participants would discuss the topic only if the consumer brought it up, and 10% of the nurses had never discussed sexual concerns with a consumer (Woolf & Jackson 1996). Supporting these findings are those of Katz et al. (2005a) who reports that most nurses don’t ask about sexual concerns and feel uncomfortable with the subject. These findings suggest that nurses continue to have difficulty integrating awareness into their care (Magnan et al. 2005) and exhibit hesitancy and lack of comfort in
discussing consumer sexual concerns despite recognition that addressing sexual needs is part of a nurse’s professional role (ANMC 2006; Krebs 2007; Roper et al. 1985). A further reason for avoidance has been put forward by Challinor (2008) that nurses might put their own needs such as avoiding embarrassment and not having time, before the needs of the person.

Sexuality is a common issue faced by nurses in the provision of care (Higgins et al. 2006a; Katz 2005a). Nevertheless nurses are likely to wait for the consumer to initiate discussion regarding sexual concerns (Shell 2007), or believe that such a discussion is someone else’s responsibility such as that of a doctor (Nakopoulou et al. 2009). This trend of avoidance towards discussing sexual concerns has been frequently documented within nursing literature for more than 30 years (Boutcher & Gallop 1996; Fisher & Levin 1983; French 2010; Gamlin 1999; Katz 2005a; McCann 2003; Roy 1983; Young 1987). Avoidance may result in the consumer’s sexual concerns simply being ignored (Herson et al. 1999; Katz 2005; McCann 2000). While the following quote by Anthony Grey is not referring directly to mental health consumers, it remains one that is apt, that is by avoiding discussing this topic with the consumer results in keeping the person in a state of: “… ignorance and in emotional confusion about intimate aspects of their personal lives is to do them a crippling disservice” (Grey 1993 p. 117).

Avoidance of sexual concerns is not unique to nursing. It has been established that other health care professionals also avoid the topic (McInnes 2003; Stevenson 2004; U’cok et al. 2007; U’cok et al. 2008). The reasons given are similar including: the complexity of the issue; finding an appropriate time to discuss the concerns; personal discomfort; and that the topic is not a priority (Stevenson 2004; U’cok et al. 2007).

The result of avoiding the topic of sexual concerns creates what Katz (2005a p. 241) describes as a “deafening silence”, where nurses simply disregard
the topic and are more consumed in discussing what nurses consider routine topics such as discharge planning (Guthrie 1999). In discussing avoidance of sexual concerns, French (2010) provides the following reasons: that the topic is a private matter for the person concerned; that it can be like opening a can of worms; that these issues can be time consuming; that the person will get the wrong idea; and that it is just a topic that nurses simply do not consider. However taking a more cynical point of view, Tiefer (1996) puts forward that a possible reason for this avoidance is that health professionals and society are far more comfortable joking about sex, than they are talking about sex.

Avoiding bringing up sexual concerns because it might be akin to opening a ‘can of worms’ is frequently cited within the literature (Katz 2005a; Krebs 2007; Shell 2007) where we are informed that nurses are not prepared to deal with sexual concerns because of their lack of knowledge, lack of expertise, and lack of comfort with the topic (Albough & Kellog-Spadt 2003; Herson et al. 1999). Then there are the fears of being judged in a negative manner by co-workers (Kautz et al. 1990; Skelton & Matthews 200001), along with a fear of possible legal or professional ramifications (Albough & Kellog-Spadt 2003; Krebs 2007), fear of embarrassing the consumer (Herson et al. 1999; Higgins et al. 2008, Magnan et al. 2005; Shell 2007), or considering the topic not a priority of care (Magnan et al. 2005). Using arguments such as heavy workloads or that the consumer is not ready to learn (Herson et al. 1999; Krebs 2007; Magnan et al 2005; Nakopoulou et al. 2009; Shell 2007) as reasons to avoid the topic might also be used as excuses to avoid sexual conversations, and steer conversations towards what Skelton and Matthews (2001) have described as safer topics, to avoid personal embarrassment. For nurses to assist consumers with their sexual concerns, they need to examine their own attitudes, fears and beliefs towards sexual concerns (McCann 2000).
Nursing as an interpersonal process

The importance within nursing of utilising a theory has been discussed in terms of creating purpose and providing focus, where specific goals and outcomes are stated, leading to coordinated and less fragmented care (Colley 2003; Wilson & Kneisl 1988; Gary & Kavanagh 1994). Nursing theory examines aspects of nursing, assisting nurses to organise thoughts and ideas, and helps nurses to understand what they do, and why they do what they do as professionals (Daniels 2004; George 2010).

Joyce Travelbee (1971) was a psychiatric nurse theorist who believed nursing care was lacking compassion and the nursing profession was possibly losing its value towards the qualities of the heart of nursing, that being sympathy and compassion (Rich 2003). Travelbee felt nurses require assistance to appreciate the humanness of the person requiring care and nurses also require some assistance to recognise their own humanness (Travelbee 1971). For this to occur, nursing needs: “… a humanistic revolution - a return to focus on the caring function of the nurse - in the caring for the caring about ill persons” Travelbee 1971 p.2).

Travelbee acknowledged Victor Frankl, a survivor of Auschwitz in the development of her theory. Frankl was responsible for the development of logotherapy (Frankl 1963). The following assumption from Travelbee’s theory is based upon Frankl’s logotherapy theory that:

“Individuals can be assisted to find meaning in the experience of illness and suffering. The meanings can enable the individual to cope with the problems engendered by these experiences” (Travelbee 1971 p. 158).
The purpose of nursing according to Travelbee (1971) is achieved through the establishment of a human to human relationship and the development of the therapeutic relationship where the nurse:

“… assists an individual, family or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences” (Travelbee 1971 p.7).

Figure 2: Travelbee’s human to human relationship model

Original encounter represents the first impression where the nurse and consumer perceive each other in stereotyped roles where their past experiences create preconceived beliefs about each other (Travelbee 1971). During the next stage, emerging identities, the nurse and consumer begin to perceive each other as unique individuals and a relationship or bond begins to develop (Travelbee 1971). Empathy, the third stage is where the nurse uses their skills to share in the consumer’s experience (Travelbee 1971). The result of this empathic process is the ability to understand the behaviour of the person along with the desire to understand them (Travelbee 1971). The fourth stage is sympathy. Sympathy involves the provision of interventions to alleviate the consumer’s distress. It is at this stage that an emotional and a physical caring are required (Travelbee 1971). At this stage, the nurse and consumer are relating to each other as human being to human being (Travelbee 1971) where the consumer exhibits both trust and confidence in the nurse. The final stage is rapport, which is characterised by nursing
actions that alleviate the consumer’s distress (Travelbee 1971). According to Travelbee (1971) nurses are able to establish rapport because they possess:

“… the necessary knowledge and skills required to assist ill persons, and because she is able to perceive, respond to, and appreciate the uniqueness of the ill person” (Travelbee 1971 p. 155).

There remains a strong emphasis on the value and importance of the therapeutic relationship within contemporary nursing (Caldwell et al. 2010; Hewitt & Coffee 2005; O’Brien 2001; Perraud et al. 2006). The nurse consumer relationship is considered a trusting relationship where values are respected and where nurses not only provide advice and information but also encourage consumers towards self-help (Moyle 2003). However a therapeutic relationship can only be achieved when nurses strive to achieve it, making it a priority for their role (Travelbee 1971). Travelbee claimed that the interpersonal process is purposeful where there is mindful intention behind nursing actions, to connect with consumers during their journey toward recovery (Rich 2003).

In the absence of a strong therapeutic relationship, both consumers and nurses may feel uncomfortable discussing sexual concerns (Perlman et al. 2007). Through the development of a therapeutic relationship, nurses are able to gain improved understandings into the consumer’s needs, and help dispel myths and stereotypes about human sexuality (Holmes & O’Byrne 2006). The therapeutic relationship allows an opportunity to explore the situation with the consumer and to find a therapeutic connection (Higgins et al. 2006b; Shattell et al. 2007). The responsibility of the nurse is to assist consumers and their significant others to find meaning in their experience of illness (Travelbee 1971), and finding meaning of this experience can only occur when nursing has a holistic approach towards care (Wright & Pugnaire-Gros 2010).
Holism: viewing the whole person in nursing

Defining sexual health within the context of the definition provided by the World Health Organisation (2006) where sexual health is to be viewed in relation to one’s physical, emotional, mental and social well-being, allows nursing to have a person centred holistic approach to human sexuality (De Santis & Vasquez 2010). Health and sexual functioning have been described as having an intimate connection (Bartlik et al. 2005) and as such it is impossible to provide holistic care without including one’s sexual health.

Holism involves understanding the consumer as a whole, being able to understand the relationships between the biological, psychological, social and spiritual dimensions of the consumer (Povlsen & Borup 2011; Zahourek 2008). Fulder (2005) describes holism as being an aspiration, a direction nurses must work towards achieving. Holism occurs when nurses demonstrate a commitment to provide individualised consumer care (Fitzgerald 2002) and where nurses recognise that the whole is greater than its parts (Fulder 2005; Zahourek 2008). It is also considered an ideal which is fundamental to mental health nursing and an essential ingredient for helping consumers (Brimblecombe et al. 2007; Fothergill et al. 2011).

From a holistic viewpoint, it is the ability of nurses to see the person in the consumer, their perceptions, their experiences, and their world (Povlsen & Borup 2011) or as Travelbee (1971) stated, appreciating the uniqueness of the person. Without an accurate understanding of the consumer’s experience of the problem, health care needs become difficult to meet (Shattell et al. 2007). Considering the role of the nurse in a biopsychosocial context (Roper et al. 1985), it is important that nurses acknowledge and accept that sexuality is an aspect of one’s unique human character (Cort et al. 2001) and sexual health as an important part of consumer care (Earle 2001). To provide holistic
care nurses have a responsibility to engage with consumers on sexual concerns in an informed and sensitive manner (Katz 2005b; Higgins et al. 2008; Jolley 2002; Wright & Pugnaire-Gros 2010) and whatever the cause of the sexual concern, the treatment requires a holistic approach to achieve resolution of the problem (McCann 2000).

**Ensuring a standard of nursing practice**

The provision of quality care within health is an increasingly important issue (O’Brien et al. 2004). The development, use, and ongoing monitoring of professional standards of practice assists services to provide quality care (Neville et al. 2008; O’Brien et al. 2004) by ensuring that health professionals are held accountable for the provision of safe, competent and ethical care (Peternelj-Taylor & Bode 2010). Standards of practice are authoritative statements (Peternelj-Taylor & Bode 2010) that reflect our current state of understanding and knowledge along with our values and priorities (Beal et al. 2007; Peternelj-Taylor & Bode 2010).

The National Competency Standards for registered nurses by the Australian Nursing and Midwifery Council (ANMC) have adopted a holistic approach for the promotion of professional nursing practice that is inclusive of sexual concerns, in stating:

> “The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately” (ANMC 2006 p. 2).

The development of standards that include sexuality is considered an important strategy to improving this area of nursing practice (ASHHNA 2011;
Krebs 2007). However, the Standards of Practice for Australian Mental Health Nurses (Australian College of Mental Health Nurses 2010) make no mention of sexuality in their standards, and therefore one could pose that there is no expectation for mental health nurses to include consumer sexual concerns in care, which may well reflect the wide-spread avoidance of sexuality in mental health nursing.

**Nursing barriers to the inclusion of sexuality in care**

Despite the importance of adhering to professional practice standards and the significance for nurses in establishing therapeutic relationships, at times nurse attitudes are negatively reflected in the nurse-consumer relationship (Shattell et al. 2007). This is particularly true when it comes to the sexual concerns of consumers (Higgins et al. 2008; Shattell et al. 2007) where it has been observed that these concerns are not always understood and recognised by nurses due to avoidance issues, and are further complicated by conservative views and rigid attitudes held by some nurses (Crouch 1999a; Ruane & Hayter 2008). Personal sexual feelings, behaviours, beliefs, attitudes and knowledge, all influence the practice of nursing (Nakopoulou et al. 2009). Illustrating this, Ruane and Hayter (2008) provide the example where the religious and moral beliefs of nurses can have a role in the development of negative and possible restrictive practices towards consumers’ sexual relationships. Even when nurses are at times tolerant of some sexual behaviour such as masturbation, sexual relationships between consumers are generally perceived as wrong (Ruane & Hayter 2008). A further personal barrier occurs when nurses are not comfortable with their own sexuality, creating a need for nurses to reflect on their personal prejudices and views regarding sexual topics (French 2010; Katz 2005a). Personal barriers might also arise as a result of their family upbringing where in some families topics related to human sexuality are never discussed (Kautz et al. 1990; Price 2009). And finally, sexual concerns are often
overlooked due to the way nurses view sexuality in terms of sex and sexual function (Mick 2007). This narrow view of sexuality can result in lost opportunities to support the person, along with reduced opportunity for nurses to understand the person’s sexual concerns and how these concerns impact on their quality of life (Mick 2007). Narrow personal views can also result in fear of providing any care towards anything loosely defined as being sexual. Evans (2000) discusses how these fears create barriers to the therapeutic relationship, and refers to the fear as institutionalized erotophobia, a fear of sex.

To improve practice around sexual concerns, there is a need to explore existing beliefs, attitudes, and experiences of nurses to assist them to overcome these barriers (Wright & Pugnaire-Gros 2010). If nurses develop an understanding of their attitudes and beliefs concerning human sexuality, biases may be reduced and communication with consumers might well be improved (Crouch 1999a; McCann 2000; Ruane & Hayter 2008).

**Boundaries and nursing**

Boundaries act to limit, constrain and to constrict, providing clear and concrete guidelines on how nurses should interact with consumers (Austin et al. 2006). Boundaries within a therapeutic relationship are the limits that allow a safe connection between nurses and consumers that are based on the consumer's health needs (Peterson 1992). Nurses are accountable and responsible to maintain boundaries in the professional relationship, to act as a consumer advocate and, when it is appropriate, to intervene, preventing or stopping boundary violations from occurring (Campbell et al. 2005; Peterson 1992).

The ANMC (2009) state that it is the responsibility of nurses to maintain professional boundaries, and to assist colleagues and consumers to maintain
boundaries. A tenet that has been well supported (Austin et al. 2006; Campbell et al. 2005; Maes 2003; Wright 2006). Nurses generally spend considerably more time with consumers than other members of the treating team and this closeness makes it more difficult for nurses than for other disciplines to maintain clear roles and boundaries in the relationships they have with consumers (Bachmann et al. 2000; Maes 2003). Nurses must maintain professional boundaries to ensure that their professional relationships are for the benefit of consumers (Campbell et al. 2005). Violating boundaries can be harmful and can result in preventing the consumer from achieving their goals, and potentially threaten a nurse’s employment position (Wright 2006).

Examining nursing boundaries Austin et al. (2006) and Campbell et al. (2005) have suggested that in the nurse consumer relationship, an unequal distribution of power exists, where nurses hold the balance of power. Nurses have access to confidential information about the consumer, provide intimate and personal care, and at times in mental health settings, force consumers to receive care (Wright 2006). The consumer, on the other hand, is vulnerable and possibly even powerless within this relationship (Wright 2006) and in a position of potential exposure to exploitation or abuse (ANMC 2009). Consumers who are most vulnerable to boundary violations are usually females, often with a diagnosis of bipolar or personality disorder with an associated history of child sexual abuse (Baca 2009). It has been suggested by Magnan et al. (2005) that by avoiding sexual concerns in nursing practice, nurses subconsciously could be protecting both the consumer and themselves from “drifting to the edge of what is considered socially acceptable” behaviours (Magnan et al. 2005 p. 287).
Boundaries and sexuality care

The inclusion of sexual concerns in care raises many “complex legal, ethical, personal and professional dilemmas” (Earle 2001 p. 433) such as boundary and gender concerns that nurses find difficult to resolve. Providing care around these issues for consumers can place nurses in a challenging situation however, this dynamic has been poorly explored. When it comes to care relating to sexual concerns a relationship exists between the preferences for a same-gender nurse (Chur-Hansen 2002; Kerssens et al. 1997). Female consumers prefer female health professionals for matters regarding sexual concerns (Brooks & Phillips 1996; Chur-Hansen 2002) and males demonstrate this trend as well (Inoue et al. 2006; Kerssens et al. 1997). In an Australian study exploring this dynamic from a male nurse perspective Inoue et al. (2006), found that providing intimate care for women was challenging, and male nurses felt they were invading the person’s personal space.

However, the provision of care addressing sexual concerns can be problematic for male nurses regardless of the consumer’s gender. Harding (2008) discusses the risk of being accused of heterosexual misconduct when male nurses provide intimate care for women, and homosexual concerns when providing this care for men. For male nurses many of the difficulties in providing this type of care arise from the stereotyped beliefs that male nurses must be gay, and that gay men are sexual predators (Harding 2008). Stereotypes are powerful forces that can influence opinion when a nurse is accused of a possible boundary indiscretion (Harding 2008).

Some nurses might fear that questions about sexual concerns will be considered inappropriate and might encourage inappropriate behaviours (Raja & Azzoni 2003) or might be misinterpreted as a sexual advance from the consumer (Bartlik et al. 2005; Kelly & Conley 2004) particularly when the
nurse and consumer are of the opposite sex (Kerssens et al. 1997). The trust and closeness that occurs within the therapeutic relationship combined with the “seductive pull of helping” consumers (Austin et al. 2006 p. 78), and the intensity of the therapeutic relationship may stimulate personal and sexual needs of both the nurse and the consumer (Austin et al. 2006). According to Campbell et al. (2005) when this occurs, most clinicians feel guilty, anxious, or confused about the attraction. Furthermore most nurses have received little education in their training to help prevent them from acting on these feelings or to help them cope with understanding the dynamic that has occurred (Campbell et al. 2005).

There has been less attention in the literature examining boundary transgressions from consumers towards nurses and the strategies for nurses to manage these situations. When this does occur male consumers are more likely to make sexual boundary transgressions towards female nurses in the form of sexualised statements and advances (Baca 2009; Bronner et al. 2003; Celik & Celik 2007). In a study by Higgins et al. (2009) where this type of sexual harassment by consumers was explored with 27 mental health nurses, an immediate response was observed where the nurses responded by putting rigid boundaries in place to curtail the behaviour. These nurses would warn others of the unwanted behaviour, transfer the care to another nurse and label the behaviour as inappropriate, and therefore providing a justification to avoid any further discussion or exploration of the behaviour with the consumer (Higgins et al. 2009) rather than effective strategies to reduce these risks (De Santis & Vasquez 2010).

**Sexual safety, abuse, exploitation, vulnerability and nursing**

As is the case with other sexual related concerns, there are identified barriers to raising sexual safety with consumers. These include: more immediate priorities; concerns regarding upsetting and distressing the consumer; gender
issues; and lack of training (Read et al. 2007). The provision of clinician training on a range of sexual health and sexual concerns including sexual rights and safe sex has been advocated as a strategy to protect the sexual rights of consumers (Ford et al. 2003). However, the sexual rights of people can only be up-held when sexuality becomes a legitimate topic within healthcare (Berer 2004). There is a need for nurses to ensure that consumers are aware of their sexual rights, as it cannot be assumed that consumers have this knowledge (McCann 2000). Access to information and resources promotes the opportunity for consumers to make informed choices about their sexuality (Sexual Health and Family Planning Australia 2006).

A balancing act does require consideration. There is the right to engage in wanted sexual relationships on one side, and the right to be free and protected from unwanted sexual activity, abuse and violence on the other side (Graupner 2010). A challenge for mental health services is deciding on:

- How to judge the consensual nature of consumer sexual activity (Graupner 2010; Pacitti & Thornicroft 2009);
- How to balance this while responsibly protecting other consumers from potential harm (Graupner 2010; Pacitti & Thornicroft 2009); and
- How to provide care for consumers who may themselves be perpetrators of sexual aggression or abuse, are regular questions that confront mental health services (Wright & Pugnaire-Gros 2010).

In a study by Cole et al. (2003) of 109 clinicians, (62% were mental health nurses), it was reported that the level of sexual vulnerability arising from exploitation was the most concerning feature of inpatient sexual activity, followed by the formation of relationships while sexually disinhibited. Sexual safety of female consumers in inpatient facilities, in particular the issue of impaired judgement resulting from illness can result in difficulties for female
consumers in their ability to protect themselves from an abuser (Judd et al. 2009). Adding to this are the concerns expressed by Earle (2001) that female consumers who experience impaired judgement and sexual disinhibition could possibly be targeted by sexual predators.

Nurses may feel blamed in some way when a consumer is sexually assaulted. In a study by Cole et al. (2003) it is reported that 16.7% of doctors and 28.2% of nurses were concerned that they would be blamed for sexual assaults occurring on inpatient units. Keel (2005) has posed that this may be a contributing reason for clinicians disbelieving consumer reports of sexual abuse and not discussing this topic and hence if they do not acknowledge it occurring, they cannot be held to account. Then there is the situation that when female consumers report sexual harassment or inappropriate sexual behaviour occurring, that their reports are not always taken seriously by clinicians (Judd et al. 2009). Due to the level of vulnerability and risk to female consumers it is advocated that environments within psychiatric hospitals be created offering safety and security for female consumers (Price 2009).

**Unsafe sex and nursing**

Consumers are sexually active, and according to Warner et al. (2004) clinicians are aware of this. In a study by Warner et al. (2004) where 27 mental health clinicians were interviewed, 26 believed sexual activity to be occurring in the inpatient unit and 13 thought it happened often. Despite this awareness much of the nursing research regarding the high STI risk for consumers discusses the belief systems of the nurses working with the consumer group that form barriers to the provision of strategies to promote safer sex (Shield et al. 2005). These include embarrassment; poor awareness; cultural difficulties; discrimination; and homophobic ideas (Ritchie 2006).
It has been demonstrated that providing factually clear information for people about STIs including information regarding prevention reduces risky sexual behaviours for those people (Crepaz et al. 2006; Ritchie 2006). Dyer and McGuinness (2008) support the development of strategies that are tailor made for consumers, providing information regarding the transmission of STIs, information regarding high risk activity and safe alternatives. In a systematic review of the literature, Higgins et al. 2006a evaluated the small number of published programmes available (No. = 14). The programmes focussed on HIV, STIs, and safe sex. The review revealed that most of the programs composed of topics similar to those suggested by Dyer and McGuinness (2008) and revealed that such programs run as groups or individually based approaches benefit consumers, and reduce high risk sexual behaviour. Further to this, Crepaz et al. (2006) in a review of programs suggest the following considerations to support successful outcomes: that the program has a focus on transmission; provides skill building such as demonstrating correct condom use; includes problem-solving skills and role-playing safer sex communication; delivered on a one-to-one basis; and in an intensive manner rather than a one off approach. For nurses, there is a need for education that informs them that consumers are sexually active and engage in behaviours that place them at high risk for acquiring and transmitting STIs. Furthermore, the experience of mental illness may further complicate the risk of infection. Clearly form the level of risk there is a strong need for nurses to consider risk reduction strategies that are tailored to the unique needs of consumers

**Sexual side effects: Nursing roles**

Non-adherence to prescribed medication has been identified as a major barrier to effective treatment for consumers (Deegan 2001; Gray & Gournay 2000; Morken et al. 2008) with reported non-adherence rates of up to 50% in
outpatient settings (Gray & Gournay 2000). Lower adherence rates also lead to higher costs for treating mental illness due to ongoing episodes of relapse and readmission (Fernandez et al. 2006). In a study following the commitment to medication of 50 consumers diagnosed with schizophrenia (Morken et al. 2008) it was reported that non-adherence results in increased relapse and the associated need for re-admission. Supporting earlier work by Valenstein et al. (2004) and that of Kent and Yellowlees (1994) who estimated that non-adherence to psychotropic medications resulted in up to 43% of psychiatric admissions (Kent & Yellowlees 1994).

A study involving 14 community mental health nurses by Jordan et al. (1999) found nurses believed informing consumers about side effects would result in consumers ceasing medication. However when consumers who are empowered to be active participants in the management of their illness, with helpful strategies that they find useful, their capacity and motivation to take and adhere to treatment needs increases (Fernandez et al. 2006; Raja & Azzoni 2003; Roberts et al. 2006; Smith & Henderson 2000).

It has been well established that the experience of sexual side effects is an important cause of non-adherence (Deegan 2001; Malic 2007; Perlman 2007; Schweitzer et al. 2009; Smith et al. 2002) however when nurses consider side effects of psychiatric medications, they tend to focus on extrapyramidal side effects, sedation, metabolic concerns, and consider these to be the most common and the most troublesome for consumers and the most likely to result in non-adherence (Basson et al. 2010; Deegan 2001; Gray & Gournay 2000; Higgins 2007). In addition Smith and Henderson (2000) report on the results of a questionnaire on medication side effects with 121 psychiatrists. They found that the information shared with consumers around medication side-effects is selective in nature with anticholinergic and extrapyramidal side effects having the greatest focus. Higgins et al. (2005) also explored this issue and found that nurses provide little importance towards the sexual side
effects of medication. As a result, many consumers are never informed about the possibility of sexual side effects from clinicians (Deegan 2001; U’cok et al. 2008). A preferred strategy would include discussing the concern with the consumer and their partners to dispel any false beliefs and to gauge their thoughts upon an agreed solution (Higgins et al. 2005; Katz 2005a; Montejo et al. 2010).

**False assumptions of nurses towards discussing sexual concerns**

Magnan et al. (2005) in a survey of 148 nurses from a variety of clinical settings in a large teaching hospital found that the majority of nurses believed that it was not expected of them to discuss sexual concerns. This avoidance by mental health nurses has been described as maintaining:

“… a veil of silence around sexual issues whilst controlling their own feelings of discomfort, thus avoiding the perceived risk of transgressing a social and professional taboo” (Higgins et al. 2008 p. 311).

There is a belief held by nurses that consumers do not want to discuss sexual concerns (McCann 2010; Waterhouse & Metcalfe 1991). This has been further supported by Saunamaki et al. (2010), in a Swedish study with 100 nurses. In this study, 90% of the nurses discussed their understanding towards the effect that treatment and illness can have upon one’s sexuality, however 80% did not discuss sexual concerns with most nurses expressing lack of confidence (Saunamaki et al. 2010).

Some nurses believe discussing sexual concerns can invade the consumer’s privacy and often report that they do not know how to advise the consumer about their concerns (Magnan et al. 2005). Therefore, they are less likely to engage with consumers regarding their sexual concerns (Higgins et al. 2005;
Magnan & Norris 2008). Crouch (1999a) and Magnan et al. (2005) suggest that while nurses are waiting for consumers to disclose their sexual concerns, the consumer might be waiting for the nurse to invite them into a discussion on this topic.

The evidence suggests consumers would prefer nurses to initiate discussions regarding their sexual concerns (French 2010; McCann 2010; Waterhouse & Metcalfe 1991). The study conducted by Waterhouse and Metcalfe (1991) found that 92% of the consumer participants thought it appropriate for nurses to have these discussions. McCann (2010) found that consumers (n=30) would welcome nurses initiating a discussion regarding their sexual concerns and would find these discussions to be supportive. However, Shell (2007) has suggested that when nurses do discuss sexual concerns, it tends to be specific to consumers they regard as being sexually active, resulting in disregard for the sexual concerns of other consumers.

**Sexuality: A legitimate area for nursing**

Revisiting Travelbee (1971), the importance of nursing care is the establishment and maintenance of the interpersonal relationship that supports the consumer where the aim is to:

“… assist an individual, family or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences” (Travelbee 1971 p. 16).

To assist consumers to cope and find meaning of their experiences, nurses need to provide care to the whole person including any sexual concerns the consumer might have. Since sexuality involves the totality of being a person (World Health Organization 2006), the inclusion of sexual concerns therefore becomes important to the promotion of health, and nurses are in an ideal
position to include consumer sexual concerns (McCann 2003; McCann 2010; Nakopoulou et al. 2009). It is not surprising however that nurses find difficulties in including sexuality when society itself has placed such a restrictive view upon discussing sexual concerns (Odey 2009). Assuming the goal within nursing is to provide holistic care, when nurses omit sexual concerns; their assessments are not complete and could lack vital information that may affect a consumer’s recovery (Warner et al. 1999).

Shuman and Bohachik (1987) in their study of nurses caring for people who have experienced myocardial infarctions reported that 82% of the nurses in their study agreed that discussing sexual concerns is a nurse’s role however over 50% did not feel comfortable to discuss these concerns. Cort et al. (2001) interviewed 122 community mental health nurses and reported that 52.5% of the nurses encountered consumer sexual concerns on an occasional basis, and 32% reported the frequency as often. A high percentage of nurses 72% in Magnan et al. (2005) study with 148 nurses, believe that giving consumers’ permission to talk about their sexual concerns is a nursing responsibility, but only one-third reported actually making time to discuss sexual concerns with consumers. Further to this was the report that nurses who were uncomfortable in discussing sexual concerns believed that those people requiring care were too ill to be interested in sexuality (Magnan et al. 2005).

The results of a file audit conducted by Singh and Beck (1997) in an acute unit demonstrate the reluctance to include sexuality as a legitimate topic in care where only 1 of the 100 files contained a detailed sexual history. A consumer’s sexual and relationship history is however an important aspect of a consumer’s social and developmental history that should form part of a consumer’s holistic nursing assessment (Cort et al. 2001; Price 2009). For this to occur nurses need to understand the significance that human sexuality represents for consumers throughout their life (Crouch 1999a; Price 2009),
where nurses legitimise sexuality as an important aspect of care for them (Katz 2005a; Krebs 2007) and recognise that consumers are sexual beings with needs and desires. By legitimizing the topic of sexuality, the nurse provides the consumer with permission to think and talk about any sexual concerns they might be experiencing (Mick et al. 2004; Odey 2009).

Nurses have a role in assessing sexual health and providing sexual information and sexual education for consumers (Katz 2002; Magnan et al. 2005). Strategies to assist nurses to improve this area of assessment have been suggested by Mick (2007). These include:

- understanding sexuality, and how sexual concerns affects one’s quality of life;
- providing information;
- addressing causes of discomfort;
- asking broad questions and consider the broader concepts of sexuality;
- avoiding making assumptions about sexuality in relation to age, gender, culture, which are not based upon fact or experience; and
- learning about sexual concerns and encourage questions.

Expanding on these strategies, authors strongly recommend the inclusion of sexual diversity issues in the training of all health professionals to increase awareness and understanding (Stein & Bonuck 2001; Tate & Longo 2004; Welch et al. 2000). In becoming familiar with sexual diversity issues, and over-coming prejudices, nurses can provide a safe environment where consumers can discuss their health care needs in an environment free from prejudice and stigma (Burrows 2011; Wright & Anthony 2002). This approach can assist the consumer to feel like a complete person (Tate & Longo 2004) and to assist them to overcome the dual stigma experienced by this group (Welch et al. 2000).
Awareness building for nurses and overcoming discomfort

Nursing has been described as a science and an art, and that one informs the other (Jasmine 2009; Montgomery-Dossey 2008; Peplau 1988). The science aspect of including sexual concerns in nursing practice requires knowledge about sexual functioning, and an understanding of the changes to one's sexual health that can occur as a result from illness; or resulting from the psychological trauma of sexual abuse; or from the side effects of medications along with knowledge about assessing and treating sexual difficulties (Krebs 2007). The art of including sexual concerns into nursing practice comes from awareness of one's beliefs, values, and comfort in talking about sexual concerns (Krebs 2007).

Bringing the science and art together into training for nurses, Krebs (2007) is of the opinion that this training is better facilitated for nurses at a post graduate level. The reason being is that the topic is too sensitive for undergraduate nurses, who are trying to master basic nursing skills (Krebs 2007). According to Cort et al. (2001) unless a specific sexual health programme is implemented which includes training and support for nurses, their potential for engaging with consumers on their sexual concerns may not be achieved. In addition, unless nurses can integrate this knowledge into practice, it is of little value (Guthrie 1999). Higgins et al. (2006a) is of the opinion that in the absence of specific training, nurses may offer care may offer care where it is not required and omit care where it is wanted.

Certain strategies and skills are required to assist nurses to engage with consumers about their sexual concerns. It has been suggested by Lewis and Bor (1994) that to assist nurses to overcome their discomfort and improve their interpersonal skills nurses may require assistance to examine their personal beliefs and to learn how and why it is important to keep personal
beliefs separate from professional values. Building upon this, Montura et al. (2001) and Skelton and Matthews (2001), stress the importance for nurses to learn to understand that they possess a unique set of personal beliefs, values and behaviours related to sexuality. This is important so nurses can work towards developing awareness into their own sexual attitudes and sexual self-awareness. When this occurs, both Cort et al. (2001) and Montura et al. (2001) have observed a noticeable improvement in the ability of nurses to be inclusive of consumer sexual concerns in their practice.

The reaction of embarrassment towards the sexual concerns of consumers or appearing shocked can result in limiting exploration (Higgins et al. 2008; Odey 2009; Peck 2001). It has been observed that consumers are less likely to express sexual concerns to nurses who display discomfort with the topic (Montura et al. 2001; Skelton & Matthews 2001) and that nurses over-look sexual concerns due to their personal discomfort (Meerabeau 1999; Skelton & Matthews 2001). Overcoming personal beliefs around consumer sexual concerns creates a foundation that is required for open communication to occur (Mick 2007; Saunamaki et al. 2010; Wright & Pugnaire-Gros 2010).

To improve the practice of nurses towards inclusiveness of consumer sexual concerns teaching strategies are necessary to assist improve nursing confidence to support the sexual concerns experienced by consumers in an informed and mature manner (Duldrt & Pokorny 1999; Montura et al. 2001). For this to occur one recommended solution is for workshops that allow nurses the opportunity to examine their attitudes and beliefs about sex, and the relationship between illness and sexual functioning (Duldrt & Pokorny 1999). Further to this, workshops need to provide nurses not only with a strong nursing knowledge and skill base, but also with appropriate attitudes that show respect for the dignity of the consumer when addressing their sexual concerns (Skelton & Matthews 2001).
Assessment tools inclusive of sexuality are considered ineffectual if nurses do not have the interpersonal skills necessary to encourage consumers to talk about their concerns (Kotronoulas et al. 2009; Sharkey 1997). Hence, the need to develop sound counselling skills to support nurses to engage on a topic that can be a sensitive and difficult subject for them (Duldt & Pokorny 1999; Higgins et al. 2006b; Montura et al. 2001).

Counselling approaches to promote the inclusion of sexual concerns

The use of general counselling approaches when talking about sexual concerns has been encouraged (Bartlik et al. 2005; Beck & Justham 2009; Higgins et al. 2006b; Krebs 2007; Warner et al. 1999):

- asking nurses to consider the use of a private environment that is non-threatening and quiet (Warner et al. 1999);
- asking the consumer permission to discuss their concerns (Higgins et al. 2006b; Warner et al. 1999); and
- with the consumer’s permission, include their partner (Krebs 2007).

In promoting consumer ease there is a need to acknowledge that consumers might be uncomfortable talking or answering questions about sexual concerns (Higgins et al. 2006a) and to assist in promoting comfort by asking consumers what changes have occurred for them and to be accepting of their responses (Bartlik et al. 2005; Mick et al. 2004). Being open, sensitive (Beck & Justham 2009) and non-judgemental about the sexual myths or sexual practices expressed by the consumer (Bartlik et al. 2005; Higgins et al. 2006a). These components are important in promoting comfort and discussion.

Nurses frequently do not know how to start a conversation regarding sexual concerns (Peck 2001). Using a simple question that nurses feel comfortable with (Warner et al. 1999) while removing the ambiguity of euphemisms such
as “Are you married?, or Do you have a partner?” (Skelton & Matthews 2001 p. 607) along with gender neutral terms to avoid the assumption that the consumer is heterosexual is encouraged (Bartlik et al. 2005). can assist consumers to see the relevance of the questions and It is also encouraged to avoid medical jargon and to speak in a straightforward, matter of fact, professional manner, with confidence and without embarrassment (Krebs 2007; Odey 2009; Peck 2001; Warner et al. 1999). Using language that the consumer and their partner understand (Higgins et al. 2006a; Meacher 1999; Peck 2001) assists I promoting a positive safe environment to discuss sexual concerns and to reduce the risk of nurses being perceived as being voyeuristic (Higgins et al. 2006b).

SECTION 3: SEXUAL INTERVENTION MODELS

Intervention models to assist nursing practice

Models provide frameworks to guide nurses in the delivery of care that is scientifically constructed and of scientific origin (Fawcett 2005; Pearson et al. 2005). Models should provide direction for nurses, helping them to better understand the reasons behind their practices (Murphy et al. 2010; Pearson et al. 2005). Models can also provide guidance to assist nurses in solving problems, and improve nursing care (Murphy et al. 2010; Pearson et al. 2005). Sexuality intervention models therefore can be used to improve nursing care by helping nurses to open the doors for consumers to discuss sexual concerns (Mosley & Jett 2007) assisting nurses to focus their assessment (Krebs 2006), and can support nurses by providing a framework to include sexual concerns with consumers (Mick et al. 2004). A number of sexual intervention models exist, and it has been reported that they can be incorporated into routine practice to improve communication and assist
nurses in gradually introducing the topic into practice (Martinez 2007). The following models are considered to be supportive frameworks to assist nurses in conducting sexual health assessments (Mick 2007). These models are:

- ALARM (Andersen 1990);
- PLEASURE (Schain 1988);
- PLISSIT (Annon 1976), Ex-PLISSIT (Taylor & Davis 2006); and
- BETTER (Mick et al. 2004).

The ALARM model

ALARM is a model of assessment and communication about sexuality and sexual activity (Andersen 1990). It was designed to assist clinicians in assessing each stage of sexual performance along with obtaining a relevant history to facilitate the diagnosis of a sexual problem (Andersen 1990). The model has a primary focus on the physical aspects of sexuality. This includes sexual activity; arousal; the quality of lubrication; the ability to reach orgasm; resolution following orgasm; and the effects of the person’s medication on their sexual functioning (Andersen 1990). The ALARM model (Andersen 1990) is closely modelled upon Helen Kaplan's triphasic model of physical sexual response that is: desire; excitement; and orgasm (Kaplan 1979).

Figure 3: ALARM model
The first stage of ALARM is *Activity*, where an assessment of the person’s sexual activity prior to the current identified problem occurs (Andersen 1990). The second stage *Libido* is where an evaluation of sexual interest and desire is assessed to ascertain whether this might be exacerbating the sexual problem (Andersen 1990). The third stage is *Arousal*, where feelings of arousal are considered, the quality and quantity of lubrication and the ability to reach orgasm are examined (Andersen 1990). *Resolution*, is the fourth stage, where an assessment of whether the person can obtain resolution following orgasm (Andersen 1990). The final stage is *Medical Information* where the attention is towards the need to provide medical and sexual health information (Andersen 1990).

**The PLEASURE model**

The PLEASURE model (Schain 1988) has a focus on psychosexual issues. The model has eight assessment domains: Partner; Lovemaking; Emotions; Attitude; Attitude; Symptoms; Understanding; Reproduction; and Energy. The PLEASURE model has been cited frequently within the literature as a model that can assist oncology nurses in the inclusion of sexual concerns in care (Audette & Waterman 2010; Kotronoulas *et al.* 2009; Mick *et al.* 2004; Mick 2007).

Figure 4: PLEASURE model
The PLISSIT model

The PLISSIT model (Annon 1976) was developed for the assessment and management of sexual health problems. The PLISSIT model is intended to represent a graded approach towards intervention (Annon 1976) and the provision of information (Katz 2005a). The premise behind the PLISSIT model is that a simple problem requires a simple approach, with more difficult problems requiring expert knowledge and intervention (Annon 1976). There are four levels to the PLISSIT Model. These levels, range from the simplest interventions to more complex interventions requiring a higher level of expertise (Annon 1976).

Figure 5: PLISSIT model

Permission is the first level. Permission is considered the fundamental of all sexual interventions where the clinician creates the appropriate environment for the person to discuss sexual concerns (Annon 1976). This is where the nurse utilises their counselling skills, finding an environment which is private and confidential (Annon 1976). The next level is Limited Information which involves the provision of general information relating to sexual concerns. The person at this stage has been given permission to discuss sexual concerns (Annon 1976). The third level is Specific Suggestions. This level requires specific suggestions about sexuality and sexual health interventions.
Clinicians are required to have post graduate experience in sexual health to intervene at this level (Annon 1976). The final level is Intensive Therapy and is where the clinician uses there advanced counselling skills and postgraduate knowledge to address specific problems faced by the person or couple (Annon 1976).

The Ex-PLISSIT Model

The Ex-PLISSIT (Taylor & Davis 2006) is an expansion of the PLISSIT model where permission giving questions are required at each level. These questions allow the clinician at each level to check-in with the person, and clarify their situation and experience providing the clinician with an opportunity to reflect on their interventions (Taylor & Davis 2006; Taylor & Davis 2007).

The BETTER model

The BETTER Model (Mick et al. 2004) was developed to assist nurses to include sexual health assessment in oncology settings. There are 6 stages to the BETTER model.

Figure 6: BETTER model

![BETTER Model Diagram]
Bring-up the topic of sexual health is the first stage of the BETTER model, where the nurse raises the issue of sexual health with the person creating the opportunity for them to discuss what sexuality means to them and to identify any concerns (Mick et al. 2004). The second stage requires nurses to Explain that for many people, sexual health is an important quality-of-life issue, and that nurses are open to discussing these issues (Mick et al. 2004). Tell is the third stage of the model and is where the nurse tells the person that there are resources available and they can assist in making them accessible. The fourth stage is Time, where nurses are encouraged to time the discussion to the person’s preference and those who aren’t ready to deal with sexual concerns can ask for information in the future (Katz 2005a; Mick et al. 2004). The fifth stage is to Educate, where nurses provide education regarding sexual side effects of treatments or medical conditions, where it is emphasised by Mick et al. (2004) that this is as important as informing people about any other adverse effect of treatments (Mick et al. 2004). The final stage of the BETTER model is to Record. Recording is where nurses record their assessment, treatment, and outcome in the person’s medical record (Mick et al. 2004).

Appraisal of these intervention models

In response to the need for oncology nurses to include sexual health in their assessments, Mick et al. (2004) encourages the use of the above cited models, as does Kotronoulas et al. (2009) who considers these models offer appropriate support for clinicians. However neither author provides guidelines for implementing these models in practice. In considering the over-all effectiveness of these models, Katz (2006b) discusses that even when nurses have an adequate understanding of these models, the inclusion of sexual concerns may continue to remain a topic that is avoided, due to barriers such as personal discomfort and fears of perhaps offending the person if they raise this topic (Katz 2005b).
The ALARM model as discussed previously has a focus on the physical aspects of sexuality (Krebs 2007) and as discussed is closely based on Kaplan’s triphasic model (1979). As such, Hordern (2008) believes that this model represents an out-dated medicalised approach to sexual health, and is concerned with penetrative sex to the exclusion of all other sexual practices and sexual concerns (Hordern 2008). Hordern (2008) discusses how the ALARM model overlooks intimacy, closeness, and self-image and as such in critiquing the model’s effectiveness, claims limitations towards gaining personal awareness into the person’s experience of their sexual concern (Hordern 2008). The ALARM model assumes that nurses have the necessary sexual health knowledge to assess and intervene (Krebs 2007).

The PLEASURE model is considered by a number of authors as a useful in improving communication for nurses around sexual concerns (Audette & Waterman 2010; de Vocht 2011; Kotronoulas et al. 2009; Mick et al. 2004; Mick 2007) however further details of how to apply the model along with the purpose of each individual stage has not been provided by these authors. According to Yarbro et al. (2011), the model has not been evaluated for over ten years. Despite numerous unsuccessful searches to find literature providing further information or to contact the author, one needs to question why the above authors continue to include a model that is effectively little more than an acronym for the word pleasure.

In evaluating the PLISSIT model, it is generally accepted that nurses would be able to intervene at the first two levels of the model (Cort et al. 2001; Hordern 2008; Katz 2005a). The provision of limited information the second level of Annon’s model is not considered adequate for nurses who are attempting to provide holistic care (Higgins et al. 2006b). A further limitation of the PLISSIT model relates to insufficient guidelines towards the interpersonal communication strategies required by mental health nurses to
engage with consumers regarding their sexual concerns (Higgins et al. 2006b). Similar shortcomings have been observed by Hordern (2008) and Katz (2005a) in other nursing settings. These authors discuss that because nurses experience difficulties in raising the topic, the PLISSIT framework may hamper further discussion rather than facilitate an exploration of the person’s concerns (Hordern 2008; Katz 2005a). The counselling strategies built in to the PLISSIT model are considered to be out-dated (Hordern 2008), however, Hordern (2008) concedes that at the time when the model was developed, the approach was effective and contemporary. In short, Krebs (2007) believes that PLISSIT and the revised Ex-PLISSIT model are beyond the scope of nursing practice, and are models best suited for sex therapists and sexual health experts (Krebs 2007).

McCandless et al. (2003) informs us that nurses who practise at level three of the PLISSIT model and make specific suggestions about sexual health and sexual activity will have specialist post-graduate sexual health qualifications. As such specialist training may present a further barrier for mental health nurses in utilising the PLISSIT model (McCandless et al. 2003).

To improve the inclusion of sexual concerns in nursing practice Katz (2005a) comments frequently regarding the use of both the PLISSIT and BETTER models to guide practice and informs us that although both models are helpful, the BETTER model in her opinion can be employed with all people (Katz 2005b). Katz (2005b) fails to define who she is referring to as all people nevertheless she infers a limitation to the usefulness of the PLISSIT model. Further preference for the use of the BETTER model is offered by Hordern (2008) in stating that the model promotes human sexuality as more than sexual function by discussing human sexuality within a quality of life context (Hordern 2008). As such the BETTER model provides a significant step in assessing and documenting the person’s experience of their sexual concerns utilising a person-centred approach (Hordern 2008).
Choosing to trial the BETTER model

The BETTER model was chosen over other models for this research for a number of reasons. The first, that nurses in other specialised nursing environments where the avoidance of discussing sexual concerns has been identified have strongly encouraged the use of sexual intervention models such as the BETTER model to support this area of practice (Audette & Waterman 2010; Gianotten et al. 2006; Hordern 2008; Katz 2005a; Katz 2005b; Kotronoulas et al. 2009 Krebs 2007; Martinez 2007; Mick et al. 2004; Mick 2007; Mosley & Jett 2007; Shell 2007; Yarbro et al. 2011). Secondly, the BETTER model has been reported as one model that can provide a useful framework to assist nurses in improving this area of care (Katz 2005a; Mick et al. 2004). Thirdly, the BETTER model has been described as having a person centred approach (Hordern 2008), and a model that can be used by nurses in various clinical settings (Katz 2005b), even though references to using the BETTER model are mostly limited to oncology settings (Katz 2005a; Katz 2005b; Kotronoulas et al. 2009; Yarbro et al. 2011). However, this model has not been evaluated in a mental health setting or with mental health nurses, and may well be an effective model to support mental health nurses to include the sexual concerns of mental health consumers in their practice.

The BETTER model: A closer look

Examining the BETTER model more closely, the first stage Bring up is one where nurses are opening the door to a discussion on current or potential alterations in sexual health (Krebs 2007). By raising the topic even if the person chooses not to respond, nurses are informing the person that they are open and willing to discuss these issues if the person wishes to do so at a later time (Katz 2005a; Mick et al. 2004). According to Mick et al. (2004),
unless nurses are willing to introduce the topic, they will be unable to assess the person’s sexual concerns. Explaining that this question is part of standard nursing practice and one that is asked of all people can increase comfort in discussing these matters with the nurse at any time (Mick et al. 2004). As such, if the person does not wish to pursue this line of enquiry then this has to be respected and with the nurse remaining available for discussion when the person is ready (Krebs 2007; Mick et al. 2004).

The second stage of the BETTER model (Mick et al. 2004) is where nurses explain that sexual health is a quality-of-life issue for all people, and that the person is made aware that they can talk about this with nurses (Cook 2000; Raja & Azzoni 2003; Shell 2007). Explaining that sex is a vital part of life can help to normalise the discussion and may help the person to feel less embarrassed or alone (Mick et al. 2004). It is the stage where the nurse explains that they are concerned with all aspects of the person’s life including their sexual health (Katz 2005a; Mick et al. 2004). Discussing sexual concerns indicates to the person that it is a legitimate topic and places it on par with other health care concerns (Mick et al. 2004).

The following stage tell is concerned with the provision of information which is considered an important component to the approach of including sexuality in practice (Krebs 2007; Shell 2007). There is the need to determine the severity of any sexual concern the person might be experiencing along with the person’s ability in managing this concern (Katz 2005a; Mick et al. 2004). At this stage Mick et al. (2004) discusses the importance of reassuring the person, and in the event that the scope of the concern raised by the person or their partner are beyond the capability of the nurse or that of the treating team, a referral to an appropriate clinician or service should be provided which are practices supported by Gianotten et al. (2006) and Krebs (2007).
Timing of the assessment (the fourth stage), is an essential and important factor (Mick et al. 2004), and is where the nurse reassures the person that the sexual concern can be discussed any time that they have a question or want to clarify information (Mick et al. 2004). The assessment should comfortably lead from one question to the next or area for discussion and terminology used should be understandable and comfortable for the person (Krebs 2007). Timing has also been identified by Higgins et al. (2006a) as important to the development of the therapeutic relationship establishing rapport and gaining trust with the person before raising sexual concerns.

The fifth stage is to educate, there is the need to determine the person’s knowledge of symptoms and symptom management related to their sexual concerns, their understanding of what is happening and why, and what to anticipate (Katz 2005a; Mick et al. 2004). The final stage of the model, is where both Mick et al. (2004) and Katz (2005a) advise that by recording what has occurred in the medical record, integrates this information about sexual health into clinical practice which can validate the person’s experiences and enhance their quality of life. This stage may well have a further impact upon the practice of other nurses by legitimising the topic and serving as a reminder for others to include sexual concerns in their practice (Katz 2005a).

Summary

This chapter has discussed the available literature as it relates to the research aims and question. Throughout this review, the literature highlights that consumers experience a range of sexual concerns that are not well supported by nurses who tend to avoid the topic. The importance of the therapeutic relationship between nurses and consumers has been discussed in the context of providing holistic nursing. Sexuality is presented as an important component of the individual’s self-concept and as such, holistic care cannot occur by ignoring the importance of one’s sexuality. I have
presented the literature discussing the concerns nurses have around boundary issues in relation to the inclusion of human sexuality in care. The skills nurses require to assist them to build confidence and competence in discussing sexual concerns with consumers is presented, and in doing so I have put forward an argument supporting the legitimacy of this topic for nursing practice. I then set out in presenting literature discussing sexual intervention models that have been utilised by nurses to assist in the inclusion of sexual concerns in care are discussed and the reasons for deciding to trial the BETTER model for this research. The next chapter introduces the methodology I have utilised in this research.
CHAPTER THREE:  
METHODOLOGY

“… exploration will always be the home for the intellectual adventurer, the academic Columbus of the day, who suspect the existence of something outside conventional wisdom and thought that is worthy of systemic examinations.”

(Stebbins 2001 p. 61).
Introduction

The purpose of this research was to explore the practice of mental health nurses, to determine whether and how these nurses include the sexual concerns of consumers in their practice. If it were found that mental health nurses avoided the sexual concerns of consumers, a second aim was to explore whether the BETTER model would provide an appropriate framework to improve this area of their practice. The following sections of this chapter provide a description of the processes taken to address the research question. Topics discussed in this chapter include a description of the research design, ethical considerations, the setting and sample used in the research, data collection procedures and procedures for data analyses. The chapter concludes by describing the procedures utilised for establishing trustworthiness of the research.

Philosophical assumptions

A naturalistic paradigm is the general perspective for this research where the ontological assumption is that reality is a construction belonging to those who are participating in the research, and as such the reality exists in the context of these participants and many constructions are possible (Polit & Beck 2010; Ritchie & Lewis 2007). Working within this paradigm, the ontological assumption is that social reality has been subjectively shaped by the multiple experiences of multiple participants, and that this reality is diverse and multifaceted (Denzin & Lincoln 1998). It is this diversity that assisted me to understand the richness of the participant’s experience to assist me to better understand how the research participants practice as mental health nurses in relation to the sexual concerns of consumers.
Epistemology allowed me to gain a more thorough understanding of the meanings of the research within this paradigm. For this study, my interaction with the research participants occurred during a series of interviews allowing their voices to be heard and the findings presented in this thesis result are the interpretation and understandings of their experiences (Polit & Beck 2010). A key feature of my epistemological approach was to strive to be as neutral and objective as possible in the collection of data, my interpretation of the data and the reporting of this data. I acknowledge though that this aspiration of being neutral and objective is subject to my interpretations of the data. In acknowledging this, the importance of reflecting on the way personal bias might occur towards the data and being open in the disclosure of any such bias in the reporting of data.

Design

This research was conducted utilising an exploratory qualitative research approach (Stebbins 2001). Research begins with a curiosity, and involves a great deal of “guesswork ... filling in empty spaces ... figuring out ways to usefully categorise and explain what it is that one has learned” (Stebbins 2001 p. v). Research can be used to identify problems with clinical practice (Polit & Beck 2010) along with the possible discovery of new knowledge (Happell 2007; Polit & Beck 2010). Qualitative approaches offer both flexibility and robustness, and are “multi-method in focus, involving an interpretive, naturalistic approach to its subject matter” (Denzin & Lincoln 1998 p. 3). This means that qualitative researchers explore participants’ subjective experiences (Devers & Frankel 2000; Polit & Beck 2010; Liamputtong 2010). Illuminating the meaning of the phenomena (Ritchie & Lewis 2007) and attempts to understand and interpret the phenomena in terms of the meanings the participant’s bring to them (Stebbins 2001) by
engaging in an in-depth dialogue with participants (LoBiondo-Wood & Haber 1994).

Due to the limited literature in this field (Polit & Beck 2010; Stebbins 2001) a qualitative exploratory approach was considered appropriate. Utilising this approach is considered useful when the researcher does not have a clear understanding of the phenomenon (Polit & Beck 2010; Stebbins 2001) and wants to develop improved understandings of a phenomenon that we know little about (Stebbins 2001). This method provides the opportunity for participants to describe in detail their experiences, beliefs and opinions regarding the topic of investigation (Polit & Beck 2010; Stebbins 2001); in this instance the participants’ experiences of including the sexual concerns of consumers in their nursing practice.

The essential purpose of exploratory qualitative research is to:

- describe and explore the participants’ understanding and interpretations of the phenomena (Ritchie & Lewis 2007 p. 28);
- explore the phenomenon to satisfy the curiosity the researcher has by listening and building understandings upon what participants are willing to share (Stebbins 2001); and
- explore the manner in which the phenomenon shows itself, and any other factors relating to it (Polit & Beck 2010), by unpacking meanings within the data, to develop explanations or to generate ideas from the data (Ritchie & Lewis 2007).

Setting

The research was conducted on the Gold Coast, which is the sixth largest city in Australia and one of the fastest growing regions in Australia with a population of 536,480 at the 30th June 2011 (Queensland Treasury and Trade 2012). The Gold Coast covers an area of 1400 square kilometres, the
The Gold Coast Hospital and Health Service, Mental Health and Alcohol Tobacco and Other Drugs Service (ATODS 2012), the site of the research, has the stated aims to provide a continuing, cohesive and responsive service to consumers requiring assessment, support, treatment and management of their mental health presentations. There are various streams which operate within the service with close liaison, networking and overlapping occurring between the streams to facilitate enhanced care for consumers (Division of Mental Health and ATOD Services 2009). The care streams which operate within the Gold Coast Mental Health and ATODS Service are:

- Alcohol Tobacco and Other Drugs Service;
- The Acute Care Stream;
- The Continuing Care Stream; and
- Child and Youth Mental Health Service.
Recruitment

Recruitment involves identifying potential participants, and inviting them to participate in the research (Polit & Beck 2010). However, an important consideration is to select participants who will be able to provide in-depth accounts of their experiences (Liampittong 2010; Polit & Beck 2010; Ritchie & Lewis 2007) which assists the researcher in gaining insight into how the participants view this area of research (Minichiello et al. 2008). It has been identified in the literature that brief admissions result in reduced time to discuss consumer sexual concerns (Herson et al. 1999). In consideration of this it was decided during supervision, that nurses employed in Continuing Care Stream teams from the community and inpatient settings, would have an opportunity to form strong therapeutic relationships that might assist them in engaging with adult consumers around their sexual concerns and as such would be suitable participants.

Gaining access to potential participants firstly involved ethics approval and secondly, obtaining the approval of the gatekeepers (Clark 2010; Minichiello et al. 2008; Polit & Beck 2010; Ritchie & Lewis 2007). In this case the gatekeepers were the managers of the teams I approached for enlisting prospective nurses as participants. These managers were contacted in person and I discussed the planned research and my interest in interviewing nurses from their teams. The managers allowed me to address nurses at team meetings, where I provided an overview of my planned study. My contact details were provided and a face to face meeting with me was arranged with those nurses who contacted me with their interest to participate. As such, participants were selected according to ease of access (Liampittong 2010; Polit & Beck 2010; Ritchie & Lewis 2007), where the participants were available to me and volunteered to participate. This process
is referred to as convenience sampling (Liamputtong 2010; Polit & Beck 2010).

Participants

Sample size depends on the purpose of the research, the quality of the participants, and the sampling strategy utilised (Polit & Beck 2010). With exploratory qualitative research, sample size is typically small (Stebbins 2001). Initially 17 nurses approached me with interest in participating in the research. The sample size was determined by theoretical saturation which is the point in data collection when new data no longer brings additional awareness to the research questions (Polit & Beck 2010), or the information gained becomes repetitive (LoBiondo-Wood & Haber 1994). Morse (1991) considered theoretical saturation to be a myth, and argued that at another time, or with other participants that data may differ. Therefore theoretical saturation can only occur with a particular group of participants and only during specific times.

Theoretical saturation occurred after interviews with 14 participants when clear themes were becoming evident within the data (Stebbins 2001). This was discussed with my research supervisors who confirmed my point of view that data saturation had occurred, and as a result, further participants were not required. I contacted the three nurses who were not required as part of my sample and thanked them for their interest.

The fourteen mental health nurses who participated in this study were from three sites within the Gold Coast Mental Health and ATODS Service. The participants included eight females, and six males (see Table 1). Their age ranged from 24 years to 60 years with a mean of 44.4 years. One participant was a clinical nurse consultant (a nurse with advanced clinical skills), there were 7 clinical nurses (minimum of 2 years postgraduate experience), and 6
registered nurses. Their level of experience ranged from 2 to 39 years, with the mean at 14.9 years. Length of time in their current position ranged from 4 months to 9 years with a mean of 3 years.

**Table 1: Participant demographics Stage 1**

<table>
<thead>
<tr>
<th>Participant (pseudonym)</th>
<th>Sex</th>
<th>Age</th>
<th>Years in current position</th>
<th>Years as Mental Health Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris</td>
<td>M</td>
<td>41</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Ethan</td>
<td>M</td>
<td>56</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>Frank</td>
<td>M</td>
<td>37</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Jean</td>
<td>F</td>
<td>60</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Jenny</td>
<td>F</td>
<td>44</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Joan</td>
<td>F</td>
<td>48</td>
<td>4 months</td>
<td>8</td>
</tr>
<tr>
<td>Joanne</td>
<td>F</td>
<td>46</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Lance</td>
<td>M</td>
<td>49</td>
<td>1.5</td>
<td>10</td>
</tr>
<tr>
<td>Lisa</td>
<td>F</td>
<td>49</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>Louise</td>
<td>F</td>
<td>34</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Mick</td>
<td>M</td>
<td>52</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Olivia</td>
<td>F</td>
<td>34</td>
<td>8 months</td>
<td>4</td>
</tr>
<tr>
<td>Rhys</td>
<td>M</td>
<td>24</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Shannelle</td>
<td>F</td>
<td>48</td>
<td>2</td>
<td>27</td>
</tr>
</tbody>
</table>

Nurses who work in the continuing care streams have a role in assessment, management and treatment as either case managers or as primary nurses. Nurses are employed at an entry level 2 (Clinical Nurse) in the community and for the two hospital based Teams, nurses enter at level 1 (Registered
Nurse). Nurses are expected to be responsible for managing their case load; manage their time; and their professional development.

The participant demographics in Table 1 were collected at Stage 1 of the research. I initially utilised alphanumeric coding to identify participants, however I found this approach de-personalised the participant’s voice in the data. As a result I replaced the alphanumeric coding with pseudonym to assist me to retain a personality for each participant. For example, participant A became participant Chris.

The following, provides a brief introduction to the participants:

Chris: a 41 year old male mental health nurse who for the past three years since completing his graduate transition to mental health nursing has been employed in the extended treatment unit as a registered nurse.

Ethan: a 56 year old mental health nurse who first registered as a nurse 39 years ago. He has had clinical roles in a variety of settings including inpatient and community. He is employed as a registered nurse in the inpatient rehabilitation unit, a position he has held for five years.

Frank: a registered nurse who is employed at the extended rehabilitation unit. He is 37 years old and has been working in mental health for the past 15 years, and has been in his current position for the past four years. Frank qualified as a mental health nurse in the United Kingdom.

Jean: at the age of 60, completed her undergraduate nurse training in New Zealand three years ago, and since qualifying, she completed a
transition to mental health nursing and since has held a position in the extended rehabilitation unit as a registered nurse.

Jenny: a 44 year old female, who qualified as a mental health nurse 20 years ago. She has held clinical and teaching positions and for the past five years she has been employed as a registered nurse in the extended treatment unit.

Joan: a 48 year old female, employed as a clinical nurse at the inpatient rehabilitation unit and like Ethan, she has worked in a variety of adult clinical settings booth inpatient and community. Joan trained to become a mental health nurse 27 years ago. She has been in her current position for the past two years.

Joanne: a 46 year old female, who has 26 years of experience as a mental health nurse, in a variety of clinical settings including private practice. Joanne completed her pre-registration program of study in the United Kingdom, she is employed as a clinical nurse consultant in the community case management team, a position she has held for the past two years.

Lance: a 49 year old male who has been working as a mental health nurse for the past ten years. He trained in New Zealand, and has been working as a clinical nurse for 18 months with the community case management team.

Lisa: a clinical nurse in the inpatient rehabilitation unit, a position she has held for the past nine years. Lisa is 49 years old, and has 27 years of experience as a mental health nurse, with extensive inpatient and community experience.
**Louise:** a 34 year old female, with 16 years of experience as a mental health nurse. She has been in her current position as a clinical nurse with the community case management team for the past six years.

**Mick:** a 52 year old nurse, who has been working in nursing for over 20 years, in a variety of clinical settings, including a sexual health clinic and as an accident and emergency nurse, before training as a mental health nurse eight years ago. He is working in the extended treatment unit as a clinical nurse. A position he has held for the past two years.

**Olivia:** a 34 year old female, who completed her mental health nurse training in New Zealand four years ago. She is employed as a clinical nurse in the community case management team. A position she had held for eight months.

**Rhys:** is 24 years old. He completed his nurse training in New Zealand two years ago before completing his transition to mental health nursing post graduate program. He has been in his current position as a registered nurse at the extended treatment unit for the past year.

**Shannelle:** is a 48 year old female mental health nurse. She completed a graduate diploma in mental health nursing eight years ago, and has held her position with the community case management team for the past four months. Prior to working in mental health, Shannelle had been working as a registered nurse in aged care.
Procedure

Data collection

Data were collected through individual in-depth interviews conducted at venues chosen by participants. Participants were encouraged to choose a comfortable environment that was quiet and away from the immediate work environment to ensure privacy, and avoid interruptions (Ritchie & Lewis 2007). For interviews occurring at the same site, these were staggered in time and date to assist in ensuring the confidentiality of participants.

The aim of the in-depth interviews were to obtain as much of the participants’ perspective as possible (Ritchie & Lewis 2007). The interview style sought to establish empathy without leading the conversation in a particularly direction (Ritchie & Lewis 2007). Conducting in-depth interviews are similar to conversations however; they have a specific purpose with a detailed exploration of the participants’ experiences and perceptions as described in their own words (Giacomini & Cook 2000; Minichiello et al. 2008; Ritchie & Lewis 2007).

I was aware of the need to be creative in my exploration into the private thoughts of the participants (Minichiello et al. 2008; Price 2002). The depth of interviews was enhanced by seeking to clarify the participant’s views; exploring the language of participants; challenging any inconsistencies reported; and putting aside my personal knowledge to better understand the narratives of participants as they were presented (Ritchie & Lewis 2007). At the commencement of each interview, participants were asked to discuss their opinions and experiences and were also encouraged to share any additional information they considered relevant to the topic. The interviews were interactive and participants were encouraged to share their stories, experiences and knowledge around the topic (Polit & Beck 2010). Following
each interview, I would check-in with my supervisors, to discuss progress and to allow me to clarify progress and concerns.

The research was conducted in three stages over a two year period. An overview of each stage is now provided.

**Stage 1:**
The purpose of the first interviews was to ascertain whether the participants talk about sexual concerns with consumers, and to explore their current practices as they relate to these concerns in more detail. Participants were asked firstly to reflect on the care they provide to consumers regarding the sexual concerns of consumers by posing the following question: “When you’re talking to consumers, do you ask about any sexual concerns they might be experiencing?”

This question was widely framed, to assist in facilitating discussion. When participants reported that they did not talk to consumers about sexual health concerns, clarifying and probing questions were used to explore the reasons why. For participants who did discuss these concerns, participant responses were explored to reveal what approaches they use and what topics they explore in their practice. This refining process where participants were assisted in narrowing their focus to specific issues has been referred to as ground mapping questions such as; “And then what happened?” and perspective widening questions such as; “Are there any other factors that would have contributed to this?” (Ritchie & Lewis 2007). This approach encourages spontaneous responses from the participants where they are encouraged to share issues that have the greatest importance to them and to assist the researcher to further understand the participant’s perspective (Ritchie & Lewis 2007).
At the end of the interview participants were asked if they had anything further to add before providing an individual education session. Each education session focussed on reported evidence regarding sexual concerns commonly experienced by consumers such as: sexual safety; abuse, exploitation; vulnerability; and sexual function problems associated with the side effects from psychotropic medications (Appendix 3). The education sessions were intended to increase awareness using evidence gained from the literature. These sessions were interactive in nature, I encouraged participants to ask questions and share their experiences. The sessions also provided an opportunity to gain improved understandings into the knowledge base of participants along with an opportunity for me to present evidence that might dispel myths or misinformation of participants. These sessions also included a discussion of the BETTER model (Mick et al. 2004) as a framework that might assist them to engage with consumers on the topic. Each stage of the BETTER model was described to participants and they were encouraged to ask questions to clarify their understanding of the model and its component parts. This approach assisted in gaining personal insights from participants (Horsfall et al. 2007). Each participant was also provided with an outline of the BETTER model at this session (Appendix 5) along with a BETTER card (Appendix 6).

The BETTER card provided an easy reference for participants to refer to in their work place to each stage of the model, and was designed so it could attach to their hospital identification tag. Contact details for myself were provided to each participant in the event that they might require any further support or assistance. However, between the stages of the research I had no contact with any participant. Each education session took approximately 40 minutes to complete for each participant, and signified the end of their initial interview at which time they were asked to trial the BETTER model with consumers over the following four weeks.
Stage 2:
The purpose of this second round of interviews was to gain insights into whether participants found the BETTER model useful in assisting them to engage with consumers about their sexual concerns. These interviews occurred four weeks following the initial interviews. More specifically they were asked to discuss whether the model had assisted them to discuss sexual concerns with consumers, how they approached the topic, and how the discussion of sexual concerns was received by the consumers. Participants were asked to reflect on each stage of the BETTER model to specifically identify strengths and weaknesses of the model for their practice and to gather data to show whether the model is useful for mental health nurses.

Stage 3:
The third stage occurred two years following the initial interviews. This third stage was not initially planned, however during supervision and revision of findings, there was an identified need to establish whether changes in practice for the participants had been sustained over time, and if so, what the participants felt contributed to this? Participants were asked whether in their practice they continue to include consumer sexual concerns in their assessments, and if so why this change had occurred. They were asked to reflect on whether there had been any changes in their practice regarding the sexual concerns of consumers, what they believe contributed to this change, and whether they would share with me their approach to engaging with consumers on the topic.

Ethical considerations and Ethics applications

The foundations of ethical research are based upon the principles of justice, beneficence and respect for human beings (Aita & Richer 2005; Horsfall et al. 2007; Polit & Beck 2010). In qualitative research, ethical considerations are
of great importance due to the close intimate nature of the relationship the researcher has with the research participants (Liamputtong 2010; Polit & Beck 2010). As such, these principles ensure participants are not placed in a position of harm (Liamputtong 2010) and their human rights are protected (Polit & Beck 2010).

A National Ethics Application Form (NEAF) was completed and submitted for approval to the Gold Coast Health Service District Human Research Committee, National Ethics Application Form Version 1.1 Research Proposal 200878 (Appendix 7) where ethics approval was obtained. This application was subsequently submitted to Central Queensland University, Human Research Ethics Committee, Project reference number H09/04-028. Expiry date of Human Research Ethics Committee (HREC) approval was 31/12/2009 (Appendix 8). Requested extension for 2 years to the 31/12/2011 was requested and granted to allow for further investigation and clarification of findings. Approval to name the research site was obtained by the Gold Coast Mental Health and ATODS Service.

**Informed Consent**

Informed consent is essential when conducting research with human participants (Aita & Richer 2005; Asmundson *et al.* 2002; Bowling 1997; Polit & Beck 2010) so participants can make a decision to participate or to decline participation. Participants were provided with a verbal and written explanation of the research (Appendix 3) and were advised that participation was of a voluntary nature and that they had the right to withdraw their consent at any time during the study. Participants were fully informed that data would be used for the purposes of research and that interviews would be digitally recorded. They were informed that these recordings would only be listened to by me as the principal researcher and by my supervisors and would not be
used for any other purpose. No incentives were offered to participants and they were not reimbursed for their involvement in the research.

Contact details for the research team were provided to allow participants the opportunity to further clarify any concerns they might have. Contact details for the Chair of the local Research Committee where the research was conducted was provided for participants in the event that they had any ethical concerns regarding the research. Participants were asked to sign a consent form (Appendix 4), that outlined the issues of participation. To assist in maintaining confidentiality, pseudonyms replaced participant names and identifying information has been removed from all reported material. A further protection to the identity of participants occurred by ensuring that all data has been securely stored. The data has been stored on an external hard drive that has been securely password protected.

**Process consent**

As this research occurred in three stages over a two year period, a once-off approach to gaining consent from participants would have been insufficient (Houghton *et al.* 2010; Usher & Arthur 1998). Informed consent is not absolute and so, consent regarding ongoing participation was re-negotiated with participants at all stages of the research (Ritchie & Lewis 2007). This is referred to as process consent (Polit & Beck 2010; Usher & Arthur 1998). Process consent allows the participants to have a more collaborative role in deciding on their contribution and ongoing participation in the research (Houghton *et al.* 2010; Polit & Beck 2010), and being kept informed as the research progressed through the three stages (Usher & Arthur 1998). As discussed above initial consent was sought prior to the first stage of the research. Ongoing consent occurred in a verbal manner allowing me to check with each participant whether they remained fully informed about the
nature of the research and their role to continue to participate in the research process.

Data analysis

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Beck 2010). With this research, all interviews were digitally recorded. An advantage of recording interviews is that rapport between interviewer and participants is more natural and allows the focus of attention on the participants, when compared to other recording processes such as taking field notes (Minichiello et al. 2008). I transcribed each interview verbatim, with the aim of immersing myself in the data (Polit and Beck 2010). This process greatly assisted subsequent data analysis. As I would read transcripts, it was like having the participants once again speaking with me.

All data collected at each stage of the research was examined using the process of thematic analysis, which is a method of identifying, analysing and reporting themes within data (Braun & Clarke 2006). The advantages of this approach is that it offers flexibility; it is a relatively simple method to learn and use; it is a useful method to assist the researcher in summarising and sorting large amounts of data; and it can help in identifying unanticipated insights into data (Taylor & Bogdan 1984; Polit & Beck 2010; Braun & Clarke 2006). The five-step framework developed by Ritchie and Spencer (1994) guided the thematic analysis. That is:

- familiarization;
- identifying a thematic framework;
- indexing;
- charting; and
- mapping and interpretation (Ritchie & Spencer 1994).
Familiarization:
Familiarization refers to the process where the researcher becomes aware and at ease with the transcripts of the interview and gains an overview of the data (Ritchie & Spencer 1994). It is crucial at this initial structural stage to ensure a strong foundation with the data for further interpretation (Ritchie & Lewis 2007). I became familiar with the data by listening to the digital audio recordings on a number of occasions, transcribing the interviews, reading and re-reading the transcripts and checking them against the audio recordings, increasing my familiarity and sensitivity to the narrative data (Polit & Beck 2010). Throughout this process awareness of themes and ideas began to emerge for me, which I noted down for discussion and validation during supervision. The interviews were conducted concurrently with analysis of the data, an approach advocated by Ritchie and Spencer (1994), whereby the researcher continuously takes large amounts of verbatim text and notes and place them into groups as interviews progress.

Identifying a thematic framework:
The second stage of the framework commences once the researcher has become familiar with the data and there is recognition of emerging themes within the data (Ritchie & Spencer 1994). The aim at this stage is to identify words and phrases carrying meaning and importance of the phenomenon of interest (Braun & Clarke 2006; Polit & Beck 2010). This stage is concerned with classifying and organising data according to key issues and themes that have been expressed by the participants (Ritchie & Lewis 2007) forming the basis of a thematic framework that can be used to further filter and classify the data (Ritchie & Spencer 1994). Deciding on a theme is largely dependent on the judgement of the researcher, in deciding whether it is a theme, and that the theme has relevance and importance to the research question (Braun & Clarke 2006). The end result of this stage is a detailed index of the data, labelling the data into manageable blocks of information to assist in
easy retrieval and for the purpose of further exploration (Ritchie & Spencer 1994).

In identifying a thematic framework, I read and re-read the transcripts to identify common themes, noting down initial ideas and grouping common responses. A series of transcript documents evolved along with initial emerging themes that were reviewed and re-reviewed allowing the data to inform me of emergent ideas and concepts. This ensured that data was not forced to fit preconceived categories (Ritchie & Spencer 1994). These themes were further reviewed during supervision sessions, providing an initial conceptual structure for organising the data (Ritchie & Spencer 1994). This approach to data analysis facilitated progression from a broad understanding of the interview data to the identification of specific themes. This interpretation of data, I continued to refine on an ongoing basis and would confirm my interpretations with my supervisors.

**Indexing:**

Indexing is where the researcher provides a conceptual structure to assist in the organisation of the data (Ritchie & Spencer 1994). At this stage of the procedure portions of data are aligned with a particular theme. The process of indexing is to tag, number, or to label the original transcripts to identify the theme to which it relates to (Ritchie & Lewis 2007) for all transcribed data. This process Ritchie and Spencer (1994) refer to as indexing rather than coding because indexing more accurately portrays the status of the categories and the way in which they fit the data. Of key importance with indexing is the need to read and re-read responses provided by participants, deciding what the response is about, in order to decide what index applies to it (Ritchie & Lewis 2007). Applying an index shows which theme or concept is being mentioned or referred to within a particular section of the data, in much the same way that a subject index operates at the back of a book (Ritchie & Spencer 1994).
Initially I made attempts to tag data using numbers; however I found this process over complicated and problematic. I soon replaced this system with labels that naturally appeared to me in the responses of the participants. As I would read over transcripts, making sense of the data, I would make brief one to two word labels in the margins of each interview’s transcript (see Table 2) and look to match and find similarities in subsequent responses from the interviews of other participants.

Table 2: 1st Stage Interview Transcript example

| Don’t bring it up | Q: When you’re doing assessments or when talking to consumers do you talk about their sexual concerns?  
H: No I don’t, I don’t bring it up. I wait for them to talk about it in conversation, or um if they ask me something I’m happy to answer. But as a rule I don’t ever bring the subject up. I’ve only been a nurse for 3 years and this is a topic that’s not ever touched ... I don’t bring it up. I wait for them to talk about it in conversation, or um if they ask me something I’m happy to answer. But as a rule I don’t ever bring the subject up. |

Charting:

Charting is where the specific pieces of data that were indexed in the previous stage are now arranged in charts of the themes (Ritchie & Spencer 1994). I would cut quotes from the original transcripts and paste them in to charts that consist of the headings and subheadings that became evident during indexing (Ritchie & Spencer 1994). This helped to organise data so I could locate information and to keep that information in context (Devers & Frankel 2000). This way I didn’t have to return to the original transcripts, and could ensure the original context and language expressed by participants was retained (Ritchie & Lewis 2007). The aim of this process is to retain meaning without losing the voice of the participants (Ritchie & Spencer 1994). It is about creating a balance, and getting the balance correct (Ritchie
The labelling of transcripts during the indexing stage showed a number of obvious similarities between reports which were grouped and charted together (see Table 3). At this stage, the charts that were created completely contained full participant quotes that were unedited to retain the participant voice.

**Table 3: Charting example**

| Don’t bring up or avoiding the sexual concerns of consumers | Participant J: “It is probably something least discussed something you don’t really discuss. I’d want to build a rapport with them or something first. If they brought a question up initially I would discuss it with them.”  
Participant H: No I don’t, I don’t bring it up. I wait for them to talk about it in conversation, or um if they ask me something I’m happy to answer. **But as a rule I don’t ever bring the subject up.** I’ve only been a nurse for 3 years and this is a topic that’s not ever touched... I don’t bring it up. I wait for them to talk about it in conversation, or um if they ask me something I’m happy to answer. **But as a rule I don’t ever bring the subject up.**  
Participant K: “I don’t, it’s probably not something that will be mentioned as part of a care plan unless I receive a hint of some sort from the client when I am speaking to them, you know like if they are mentioning or they are having erection problems … I will ask in an interview if they have a partner but that is all they will get and if they say no, you will stop there, you won’t actually go any further. |

**Mapping and interpretation:**

The final stage mapping, involves the analysis of the key characteristics from the charts (Ritchie & Spencer 1994). From this analysis a schematic diagram of the phenomenon occurs and guides the researcher in their interpretation of the data. The researcher is conscious of the objectives of qualitative analysis, which are: “defining concepts, mapping range and nature of phenomena, creating typologies, finding associations, providing explanations, and
developing strategies” (Ritchie & Spencer 1994 p. 186). It is essential that strategies and recommendations made by the researcher are representative of the true attitudes, beliefs, and values of the participants (Ritchie & Spencer 1994).

In qualitative research making sense of large volumes of verbal or written information is a challenge (Polit & Beck 2010; Ritchie & Spencer 1994). Detailed data require careful, thoughtful, and insightful analysis to produce results that add to clinical knowledge (Horsfall et al. 2007). During this final stage of Ritchie and Spencer’s (1994) five step framework, I remained conscious of the need to ensure the truth in the participant’s reports remained. I retained quotes as they occurred in the charting phase key phrases, terms and expressions. I had become so familiar with the data that I could hear each participant’s voice when reading each quote. Quotes were linked with my interpretation of their reports, so that the mapping stage could read more like a story (see Table 4). For me this stage was my way of bringing the participants into the one room, as if I had interviewed them as a group.

**Table 4: Mapping and interpretation example**

<table>
<thead>
<tr>
<th>The majority of participants stated that they don’t discuss sexual concerns with consumers. They stated that their practice was one where they would wait for the consumer to approach them about their sexual concerns, and when approached they would then offer assistance:</th>
</tr>
</thead>
</table>
| **Chris:** “No unless it directly affects their health, generally as a rule no I don’t.”  
**Jean:** “I don’t bring it up … But as a rule I don’t ever bring the subject up.”  
**Frank:** “… it’s probably not something that will be mentioned”.  
Although there was avoidance towards bringing up the topic, all expressed a willingness to engage if brought up by the consumer, and despite this lack of confidence with this topic, these participants agreed that if a consumer was to bring it up, they would make time to discuss the issue, that they were ready:  
**Louise:** “If someone brings it up, as an issue that is really affecting them, then you know, I’d make time to sit down and listen to what they have to say”.
|
Ensuring rigor

For research to be considered trustworthy it must be conducted in an honest and ethical manner and represent the participant’s experience (Liamputtong 2010). Furthermore, the aim of establishing trustworthiness is to support the research findings, ensuring that the results of the research are “worth paying attention to” (Lincoln & Guba 1985 p. 290). Trustworthiness can be achieved by showing all data collected, the processes used to collect the data, and making these steps available for external perusal (Liamputtong 2010). This is an essential step, as qualitative research cannot be exactly replicated. For this research, measures to enhance trustworthiness have been based on Guba and Lincoln’s (1989) criteria of credibility, transferability, dependability and confirmability.

Credibility:
Credibility is a process to evaluate whether the findings of the research represent a credible conceptual interpretation of the data that has been described from the participant’s original data (Lincoln & Guba 1985). In establishing credibility, Guba and Lincoln (1989) maintain that the researcher must carry out the research in a way that enhances the believability of the findings, that is, the participants or others will pass a judgement on the truthfulness of the findings (LoBiondo-Wood & Haber 1994). Credibility refers to the confidence in the truth of the data and the interpretation of the data (Polit & Beck 2010) or as Guba and Lincoln (1989) simply state that credibility is the degree to which findings make sense.

Lincoln and Guba (1985) discuss a number of methods for demonstrating credibility including prolonged engagement and member checking. Prolonged engagement can be achieved by spending sufficient time in the field to learn about and understand the culture and setting of the participants along with the development of relationships and rapport with members of the culture.
(Lincoln & Guba 1985). The prolonged engagement that occurred during the recruitment process and during interviews enhanced a conversational approach with participants. Fostering open communication, promoting rapport and trust with the participants. This allowed them to feel safe in their disclosure of their experiences to me (Horsfall et al. 2007; Lincoln & Guba 1985). Credibility was further by the length of each interview and that participants were interviewed on three occasions.

Member checking occurs when data, and the interpretations and conclusions are tested with the participants from whom the data were originally obtained (Lincoln & Guba 1985). As such, it is a method for establishing validity of the findings (Lincoln & Guba 1985). For this research member checking occurred during interviews with participants where I would take advantage of opportunities during interviews to check with participants whether my interpretations of their reports were correct. Checking with the participants provided them with an opportunity to offer further points of view, enriching the data and provided them with an opportunity to confirm my interpretation of the data.

Credibility was further enhanced through the use of participant quotes to provide a voice to the participant’s views. Using quotes ensures the explanation fits the description and that the description is credible (Tobin & Begley 2004). A further demonstration of credibility occurred through the supervision process of the research. The research supervisors, provided a level of peer review to facilitate the integrity of the interpretation of the findings (Polit & Beck 2010) and ensured that my interpretation of the data was a credible, genuine, and a reliable interpretation of the data (Liamputtong 2010; Polit & Beck 2010), thus ensuring credibility.
Transferability:
Transferability refers to the relevance and usefulness of the findings, or the applicability the findings have to other settings (Guba & Lincoln 1989) that is the degree to which the findings can be applied to other contexts and settings or with other groups, thus determining the applicability of the findings to a different or larger population (Liamputtong 2010; Polit & Beck 2010) and is similar to that of external validity (Tobin & Begley 2004). Transferability has been achieved by providing thick descriptive data and detailed information about the participants to facilitate any comparisons to other mental health nursing groups (Polit & Beck 2010). Furthermore, I provided sufficient detail about the research process and data analysis so others can evaluate the extent to which the conclusions drawn can be transferable to other times, settings, situations, and people (Lincoln & Guba 1985).

Dependability:
The next criterion in establishing trustworthiness is dependability, an assessment of the quality of the processes of data collection, the analysis of the data and the development of theory (Lincoln & Guba 1985). Dependability has been described as the consistency of the findings (Polit & Beck 2010), that the process of the research makes logical sense, can be followed, and is well documented (Liamputtong 2010). This can be demonstrated by an audit trail, where others can examine the researcher’s documentation of the data, and the methods and decisions resulting (Polit & Beck 2010; Tobin & Begley 2004). For this research, the processes of each stage of the research have been clearly documented. Transcripts and the thematic analysis have been openly discussed. I kept a research journal that contains details describing decisions I made, along with personal reflections and questions I would pose to myself, creating a running record of my research journey. I also kept a record of decisions and processes discussed during supervision along with a running record of email communication between myself and my supervisors. My audit trail provides a clear
description of all steps of the research design, data collection processes and how I have reported the findings.

**Confirmability:**

The final stage of trustworthiness is confirmability. Confirmability is a measure of how well the research findings are supported by the data that has been collected (Lincoln & Guba 1985). Confirmability is concerned with establishing that the interpretation of the findings by the researcher clearly comes from the data (Liamputtong 2010; Tobin & Begley 2004) and are not “figments of the imagination” of the researcher (Guba & Lincoln 1989 p. 243). As such, in considering confirmability, is there the potential for two or more independent people to come to similar agreement on the data’s accuracy, relevance or meaning (Polit & Beck 2010).

Strategies that enhanced confirmability included ensuring findings presented were from the experiences and ideas of the participants, and did not result from interfering ideas coming from myself or from the influence of my supervisors during supervision. The use of participant quotes and ensuring my interpretation of the data was confirmed by that of my supervisors occurred to reduce the risk of researcher bias (Polit & Beck 2010). I paid particular attention to the management of all data. Audio recordings have been digitally downloaded into secure computer files, with corresponding transcripts. The audio recordings of interviews enabled an accurate account of each interview to be produced (Graneheim & Lundman 2004). The analysis and the synthesis of these interviews following the Ritchie and Spencer (1994) framework for thematic analysis has been clearly documented and independent analyses of the thematic analysis was conducted by my supervisors during supervision to establish the consistency of data analysis.
Reflexivity is a further method to assist in establishing confirmability. Lincoln and Guba (1985) encourage researchers to keep a reflexive research journal, which can provide valuable scrutiny and insights into the research processes (Liamputtong 2010). I kept a research journal into which I made regular entries, recording ideas and reflections on all aspects of the research. At times when I would feel stumped, I would read back through the journal which would assist me in finding my way once again. I used my personal reflections to assist and guide me in writing the findings of the research.

The audit trail that was established to show dependability can also be used to establish confirmability. The purpose of an audit trail is to enable an auditor to determine if the conclusions, interpretations, and recommendations can be traced to their sources and if they are supported by the inquiry. My audit trail provides a clear description of all steps of the research design, data collection processes and how I have reported the findings. The audit trail clearly shows the steps that were taken to ensure that the process of the research was logical, clearly documented, and observable, therefore increasing the confirmability of the research (Polit & Beck 2010).

**Summary**

In this chapter I have provided a description of the methodological considerations I have employed for this research. The methodological design and the reasons for choosing an exploratory qualitative design are put forward along with the ethical considerations underpinning the research. The site and the methods used to access and recruit participants are discussed. Ethical considerations for conducting this research are presented. Following this, the procedures used to gather data and issues related to consent and recruitment are put forward. I then have provided the procedure for data collection, followed by the method used to analyse the data. Finally the methods employed to demonstrate rigor have been described. The following
chapter presents the findings of the research that are presented in the publications arising from the research.
CHAPTER FOUR:
FINDINGS

“It’s really important (to talk about sexual concerns). It’s a really essential part of people’s identity, their recovery, and their wholeness as human beings…”

(Participant Shannelle)
Introduction

The findings from the research are presented in this chapter. The primary purpose of this exploratory qualitative research was to explore whether mental health nurses avoid the sexual concerns of consumers in their care, and if so, to better understand the factors involved and to develop strategies to assist in improving this area of their practice. The findings are discussed in three sections: avoidance; applying; and acknowledgement, representing the three stages of the research. As a Doctorate thesis by publication the published manuscripts comprise most of the findings. These will be presented sequentially with a brief introduction to each so their relevance both individually and in totality is clear.

The findings reveal a journey for the participants from avoidance of consumer sexual concerns through to acknowledging the importance of including these concerns as an essential component of holistic nursing. Themes of avoidance were evident at Stage 1 and included: talking about or avoiding sexual concerns; that this topic is not an important priority; that if a consumer was to raise the topic that they would refer to others; and their colleagues also tend to avoid the topic. Further avoidance themes are discussed in relation to gender and boundary issues where personal concerns and beliefs form avoidant barriers. Finally, medication related issues are discussed where concerns that non-adherence to psychotropics might occur if they were to discuss sexual side effects, and as such, avoiding these discussions justifying the participants’ avoidant stance.

At Stage 2, participants reported their initial experiences of discussing consumer sexual concerns. The themes arising from the data at Stage 2 include: their experience in applying the BETTER model; the response of consumers to their enquiries; medication and sexual concerns; sexual safety and identity concerns; their greater awareness of sexual concerns; and a
sense that discussing sexual concerns was becoming part of their routine practice. The final Stage of the research discuss the themes concerning commitment by participants towards the inclusion of consumer sexual concerns as an important component in the provision of holistic care, and acknowledgement by these participants that the inclusion of consumer sexual concerns is a normal component of their role as mental health nurses. Further to this, the findings informed the development 5 A’s framework for including sexual concerns in mental health nursing practice, which is presented in the discussion chapter.

Avoidance

Three main themes all highlighting the participants’ avoidance of the sexual concerns of consumers were identified during stage 1. These included: avoidance; gender issues; and medication issues. These three themes and their associated sub-themes are represented in Table 5.

Table 5: Findings Themes Stage 1

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Avoidance:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Talking about or avoiding sexual health concerns;</td>
</tr>
<tr>
<td></td>
<td>Not an important priority;</td>
</tr>
<tr>
<td></td>
<td>Refer to others / not my job; and</td>
</tr>
<tr>
<td></td>
<td>Poorly addressed by others.</td>
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<tr>
<td>Gender issues:</td>
<td></td>
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<td></td>
<td>The impact of gender;</td>
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<td></td>
<td>Young males;</td>
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<tr>
<td></td>
<td>Vulnerability of female consumers; and</td>
</tr>
<tr>
<td></td>
<td>Boundary issues.</td>
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<tr>
<td>Medication issues:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment;</td>
</tr>
<tr>
<td></td>
<td>Sexual side effects;</td>
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<tr>
<td></td>
<td>Consumer embarrassment; and</td>
</tr>
<tr>
<td></td>
<td>The pros and cons of information.</td>
</tr>
</tbody>
</table>
The following three publications present the findings of Stage 1 of the research and provide the discourse concerning the themes presented in Table 5. These publications are:

- *Talking or avoiding? Mental health nurses’ views about discussing sexual health with consumers*;
- *Sexuality and consumers of mental health services: the impact of gender and boundary issues*; and
- *Opportunity lost? Psychiatric medications and problems with sexual function: a role for nurses in mental health*.

The first of these publications: *Talking or avoiding? Mental health nurses’ views about discussing sexual health with consumers*, investigates whether the mental health nurse participants in this research include or avoid consumer sexual concerns. Investigating this issue, four subthemes are discussed:

- Talking about or avoiding sexual concerns with consumers;
- Sexuality is not an important priority;
- Refer to others, as talking about sexuality is not ‘my’ job; and that,
- Sexuality is poorly addressed by others.
Feature Article

Talking or avoiding? Mental health nurses’ views about discussing sexual health with consumers

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ABSTRACT: Mental health consumers are sexual beings; however, their sexual desire, capacity, and ability to maintain previous sexual patterns can be altered by their illness or by the effects and side-effects of medications. The sexuality of consumers has been poorly addressed, and the limited evidence suggests that mental health nurses remain ambivalent to including sexuality in their care. This paper presents the findings of a research project investigating the practices of mental health nurses in assessing and supporting the sexuality of consumers. A qualitative, exploratory approach underpinned individual interviews with 14 mental health nurses from inpatient and community settings. The participants acknowledged the importance of sexuality; however, most were reluctant to enquire about consumer concerns and tended to either ignore the issue or refer it to another clinician. Four themes were identified: talking about or avoiding sexuality concerns with consumers; sexuality is not an important priority; refer to others, as talking about sexuality is not ‘my’ job; and sexuality is poorly addressed by others. It is important that barriers to the assessment and discussion of sexuality are identified, and measures are taken to overcome them.

KEY WORDS: consumer, mental health, nurse, sexuality.

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INTRODUCTION

Throughout life, sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction (World Health Organization 2001).

The sexuality of consumers of mental health services, their capacity to engage in sexual activity, and their ability to maintain previous sexual patterns can be altered by illness or by the effects and side-effects of medications. Regardless of this, these effects cannot alter the fact that consumers remain sexual beings (Krebs 2007; McInnes 2003).

The responsible exercise of human rights requires that all persons respect the rights of others (World Health Organization 2001); this includes the sexual rights of all people to the highest attainable standard of sexuality, including access to sexual and reproductive health-care services, receiving information related to sexuality, and sexuality education (World Health Organization 2001). In discussing disability theories, Earle (2001) informs us that there are physical and social barriers that prevent people with disabilities from fully participating in the social world; it is the role of nurses to be aware of these barriers and to remove them, and to ensure that information and services are available to all.

The area of sexuality for consumers has been poorly addressed by mental health service providers (Deegan 2001; Earle 2001; Guthrie 1999; Higgins et al. 2006a; Katz 2002; McCann 2003; Shield et al. 2005; Waterhouse & Metcalfe 1991; Woolf & Jackson 1996). Published research exploring the way mental health nurses engage with consumers about their sexuality concerns is scarce (McCann 2003; Quinn & Browne 2009; Volman & Landeen 2007). Despite broad acceptance of sexuality as a legitimate focus of nursing (Guthrie 1999; Higgins et al. 2006b; McCann 2000; Shattell et al. 2007), nurses remain ambivalent about discussing sexual issues, which can lead to consumer needs not being addressed (Earle 2001; Katz 2002; McCann 2003; Shield et al. 2005; Woolf & Jackson 1996).

Kautz et al. (1990) identified a number of factors describing why nurses do not discuss consumer’s sexual concerns and problems, and categorized them into four groups as follows:

1. Sexual knowledge: where there is a de-emphasis in nurse education.
2. Opinions about professional roles and tasks: other nurses do not discuss sex, sexuality is not seen as an issue for nurses to address, there is a lack of management support, an unwillingness to chart, insufficient time, nurse values are different from consumer’s values, and it is not part of the nursing role.
3. Attitudes towards sexuality: nurses believe consumers are too ill to discuss sex, and discussing sexuality causes the consumer anxiety.
4. Comfort with sexuality: it is hard to discuss sex; it causes nurses anxiety, and there is discomfort asking for peer help.

Most of the limited research in this area relates to comfort with sexuality. For example, Crouch (1999) suggests that nurses tend to wait for consumers to initiate discussions about sexuality if they choose to, and surmised that they are
probably too anxious or shy to do so (Gianotten et al. 2006). Similarly, the nurse participants, in a study by Woolf and Jackson (1996), said they would discuss sex only if the consumer brought it up, and 10% of the nurses had never discussed sex with a consumer. However, in contrast, Shuman and Bohachick (1987) found that 82% of nurse participants in their study believed sexual counselling should be included in the nurse’s role.

Sharkey’s research (1997) found that consumers appreciate the opportunity to talk to nurses about sexual issues, and were not concerned by the assessment content. In a study examining the attitudes of 88 consumers, (Waterhouse & Metcalfe 1991) the consumers indicated that sexual counselling by nurses is appropriate, that consumers would prefer nurses to initiate discussions regarding their sexual concerns, and that nurses should stop assuming that consumers do not want to discuss these topics. Attitudes held by nurses are considered major barriers preventing open discussion on the topic (Cort et al. 2001; Kautz et al. 1990; Skelton & Matthews 2001).

To fully respect consumers, holistic nursing, incorporating acknowledgement that sexuality is a vital component of being human is required (McCann 2000). There needs to be a constant drive towards facilitating communication about sexuality, correcting myths and misinformation, providing education, and encouraging exploration of the consumer’s feelings and resources (McCann 2003; Sharkey 1997; Waterhouse & Metcalfe 1991). Nurses have a responsibility to engage with consumers on sexuality concerns in an informed and sensitive manner, which would help to legitimize the topic (Higgins et al. 2006a). Katz (2005b, p. 240) describes this avoidance as creating a ‘deafening silence’.

In light of the limited research in this field and the importance of sexuality issues for consumers of mental health services, a research project was undertaken to investigate the practices of mental health nurses in relation to consumer sexuality. This paper presents findings from this study.

**METHODOLOGY**

**Design**

An exploratory, qualitative design was the chosen methodology used to investigate participants’ experiences of addressing the sexual concerns of consumers in their mental health nursing care. The emphasis with exploratory, qualitative research is on exploring the phenomenon, the manner in which it shows itself, and any other factors relating to it (Polit & Beck 2004), which is a useful approach when little is known about the phenomenon under investigation. Polit and Beck (2004) inform us that exploratory, qualitative research is in-depth and subjective, and is intended to increase the knowledge of the field of study. The goal of the present study was to develop a rich understanding of whether mental health nurses talk about consumer sexuality or avoid such issues in the ‘real world and as it is constructed by individuals in the context of that world’ (Polit & Beck 2004, p. 247), with the intent to describe and explain this phenomenon.

**Setting**

Fourteen mental health nurses were recruited from three sites within a Queensland mental health service. The sites included a community mental health continuing care team, an inpatient
extended treatment unit, and an inpatient rehabilitation unit.

Participants

Following ethics approval, an overview of the project was delivered to mental health nurses in three settings. An overview of the proposed research was presented, and the participants were asked to contact the researcher if they were interested in participating. Following the presentation, five participants from a community continuing care case management team, five from an inpatient extended rehabilitation team, and four participants from an inpatient extended treatment unit agreed to participate in the research.

The participants included eight females and six males. Their ages ranged from 24 to 60 years, with a mean of 44.4 years. One participant was a clinical nurse consultant (a nurse with advanced clinical skills); there were seven clinical nurses (minimum of 2 years’ postgraduate experience) and six registered nurses (postgraduate entry level). Their level of experience varied from 2 to 39 years, with a mean of 14.9 years. The length of time in their current position ranged from 4 months to 9 years, with a mean of 3 years.

Procedure

Individual, semi-structured interviews were conducted to ascertain whether the participants talked about sexuality with consumers, and second, to explore their current practices and comfort levels as they related to sexuality issues. During the individual interviews, participants were asked to reflect upon the care they provide to adult mental health consumers regarding their sexual concerns. An initial question was asked of all participants: ‘When you’re talking with consumers or during an assessment, do you ask whether they are experiencing or have any sexual concerns?’

The guiding principle with the interview process was to encourage the participants to speak at length about their experiences, and to gain an insight into their attitudes, behaviours, concerns, and practices (Horsfall et al. 2007). The principal researcher was a mental health nurse with considerable interview experience. Responses from the initial question were fully explored with the use of actively listening to responses, being non-judgmental of responses and behaviour, paraphrasing, reflecting back, and clarifying and questioning responses. Interviews occurred at an agreed time and venue, away from the participant’s immediate work environment, in a private and confidential room.

Ethical issues

Ethics approval was obtained from the mental health service where the study was undertaken, and from the relevant university. Participants were provided with a verbal and written explanation of the study and were asked to sign a consent form. They were advised that participation was voluntary and they had the right to withdraw their consent at any time during the study. Participants were assigned a pseudonym to preserve their confidentiality, and all data were securely stored under lock and key.

Data analysis

All interviews were digitally recorded and transcribed verbatim by the first author. The Ritchie and Spencer (1994) framework method was used to guide the data analysis process. This five-step approach includes: familiarization, identifying a thematic framework, indexing,
charting, and mapping and interpretation. The familiarization phase began with the manual transcription of interview data. This increased familiarity and sensitivity to the narratives. The phase of identifying a thematic framework involved the examination of data to identify the emergent themes and subthemes (Braun & Clarke 2006; Polit & Beck 2004). During the charting phase, the interview transcripts were annotated with the relevant theme or subtheme, and a summary of the findings relevant to each theme were recorded on a chart. During the mapping and interpreting stage, the participants’ responses for each theme were compared and contrasted in order to identify patterns and explanations for the findings.

The process of reading and rereading the transcripts to identify common themes occurred, with the principal researcher noting down initial ideas and grouping common responses. This process is referred to as familiarizing yourself with the data (Polit & Beck 2004). The aim was to find words and phrases carrying meaning and importance to the phenomenon of interest (Braun & Clarke 2006; Polit & Beck 2004). Initial codes were generated, leading to the emergence of initial themes and the gathering of all data relevant to each theme. These themes were reviewed for their relevance and importance, ensuring that bias of interpretation of the data had not occurred, and named by the research team during supervision sessions.

**FINDINGS**

The four main themes identified will be briefly discussed and illustrated with the use of quotes from the participants. Pseudonyms are used to protect the identity of participants.

**Talking about or avoiding sexuality concerns with consumers**

All 14 participants acknowledged that broaching the issue of sexuality generally depended on whether the consumer provided them with some indication that they were experiencing a sexual problem. Ten of the participants indicated that they had never initiated this type of enquiry with a consumer; however, four participants reported that they had initiated the topic of sexuality during assessments. These four viewed this area of care as an important component of standard mental health nursing practice. They were unsure whether they had always practiced in this manner; their responses suggesting that perhaps their age, training, and level of experience contributed to their ease and confidence in bringing up the topic with consumers; for example:

I think it’s just experience; I think I wouldn’t have been able to do that 25 years ago, maybe (Lisa).

Another participant commented that they did not tend to raise the issue initially, but rather, at a later stage when they sensed that rapport had been developed, and that such questions would not feel out of place because of their well-developed therapeutic relationship:

Yes, I do (bring it up), but not always on the first contact. Usually I have some degree of rapport with them (consumers) first (Shannelle).

Most participants described avoiding the topic with consumers. There was an understanding by the participants that consumer sexuality is important, and can be affected by illness and treatments, and therefore, is a focus for nursing care requiring attention. However, for the
majority of participants, there was hesitancy or avoidance in intervening, as the following quotes demonstrate:

On the whole, I don’t think I would approach any consumers about it (Chris).
This is a topic that’s not ever touched (on) (Jean).
I think from a nursing point of view, it is still a taboo subject (Frank).

The majority of participants described their practice as one where they wait for the consumer to approach them about their sexual concerns, and offer assistance to the consumer when approached. These participants agreed that if a consumer brought the issue up, they would make time to discuss the issue; that they were ready:

If someone brings it up as an issue that is really affecting them, then you know, I’d make time to sit down and listen to what they have to say (Louise).

One participant acknowledged the importance of mental health nurses discussing a consumer’s sexual concerns:

I think we’re looking more at their mental state at the time than their sexual stuff, but it’s something that has to be discussed with them, especially young females and young males. It’s like we don’t do enough stuff like that, because we just don’t have enough time or we are just getting too many acute patients because they want beds filled (Mick).

Sexuality is not an important priority

Participants spoke of the many demands of the job, the amount of paperwork, such as routine outcome measures, and the assessments requiring completion. These tasks were viewed as a priority, and in comparison, enquiries about the sexual concerns of consumers were considered a lesser priority:

I guess it goes back to . . . (the) other issue(s) at hand that need addressing, and that (sexual assessment) gets pushed down to the bottom . . . . It’s not as important as their experience (of) side-effects and symptoms of their mental illness. I guess I consider that I have greater expertise in helping them with symptoms of their mental illness, rather than talking about and assisting them with their sexual issues (Louise).

You find there are just so many things to talk about (Jenny).

One participant joked about sexuality as not being an important concern:

Yeah, well, I never went away from an interview and thought: ‘Oh my God, I didn’t talk to them about their sexual function.’ No, I’ve never done that (Joan).

Participants noted that the discussion of sexuality did not appear to be a priority for mental health services, and they were not encouraged to address consumer sexuality in their care or assessments:

The funny thing is when doing assessments, nowhere on the assessment sheet does it say anything about sexuality. There are no questions; there is nothing (asking) ‘Are you sexually active?’ Nothing. It avoids it too (laughs); we avoid it like the plague (laughs) (Jean).

Refer to others, as talking about sexuality is not ‘my’ job

Avoidance of sexuality issues by some participants was articulated. A sense that this is not ‘my job’, combined with a lack of confidence with this topic, resulted in a referral often being made to another clinician when issues of sexuality were raised; the topic of consumer
sexuality being out of the participants’ area of expertise and their comfort zone:

To start with, I just see what they’ve got to say and basically refer it onto the doctors. I don’t really . . . delve into it (Chris).

Some participants tended to refer consumers to another clinician. Due to their personal discomfort in discussing sexuality, the referral is made in the hope that the other clinician will feel more comfortable or have better-developed skills in this area, and will meet the needs of the consumer in a more appropriate manner:

I don’t see myself as an expert in that department. It’s often the case that I’ll say we’ll talk about it later, at your next doctor’s appointment . . . he’s the one who often answers these kind of questions (Louise).

The consumer’s treating psychiatrist was the clinician most often referred to. There was a shared belief that the psychiatrist might have a better knowledge of the problem, or that the problem or concern might be due to the consumer’s medication, which would require the psychiatrist’s review.

**Sexuality is poorly addressed by others**

Upon reflection of consumer sexuality as a legitimate care concern, there was a sense that the sexual issues experienced by consumers were poorly addressed by other mental health clinicians, and that this issue should be discussed far more frequently than it is within current practice. Participants recognized that talking about sexuality can be difficult for the consumer and for clinicians. While the consumer might be experiencing some problems in discussing such issues, so might the clinician, due to their own sexual education, sexual identity, and their personal belief system surrounding sexuality and sexual practices:

We shouldn’t have to be reminded, and I guess some people find it really difficult because some people have their own issues, so they don’t feel okay about talking to clients about it. I’ve always been quite open in that area and I have an interest in that area. . . . I’ve sat in on many doctor’s appointments, and not once have I heard them ask, unless you initiate it (Lisa).

One participant took the issue of discomfort a little further, suggesting that clinicians might avoid dealing with the issue because they desexualize consumers:

When you talk about sexuality, a large number of staff tend to be very uncomfortable with the idea; they believe that our patients should be asexual, they don’t have a right to sexuality, and they feel very uncomfortable that these people should have a sexual life. . . . It is as if people with a mental illness have no right to sexuality (Ethan).

Another participant joked that she observed that within mental health hospitals, consumers are desexualized, and that the consumer’s sexuality was disregarded:

It doesn’t exist (laughs). Once you’ve got a mental illness, it all goes away (Lisa).

**DISCUSSION**

From the findings of this study, it is evident that most of the participants do not raise the topic of consumer sexuality during their assessments. This was despite acknowledging that consumers’ sexuality can be affected by illness and treatments, supporting the available evidence that the majority of mental health nurses do not support the sexuality needs of consumers.
Participants generally indicated that they would wait for the consumer to approach them about any sexual concern they might be experiencing, which supports the findings of Crouch (1999) and Woolf and Jackson (1996) that nurses tend to wait for consumers to broach the subject. Most of the participants chose to refer the consumer to the treating psychiatrist when the issue of sexuality was raised. However, U’cok et al. (2008) report that over 70% of consumers experiencing sexual dysfunction had never been asked about their sexual functioning during a consultation with their psychiatrist. This is despite the evidence that consumers welcome the opportunity to discuss sexuality and would not be deterred if this were raised during an assessment (Sharkey 1997; Waterhouse & Metcalfe 1991).

While participants acknowledged that consumers can experience a variety of sexual concerns, the demands of clinical work for mental health nurses would see these issues as a low priority for the participants. There was recognition that talking about sexuality can be difficult for clinicians and consumers for shared reasons, such as feeling comfortable with one’s sexuality identity or the sexual identity of another, and their personal belief system surrounding sexuality and sexual practices. Attitudes about consumers’ sexuality are often dominated by personal, rather than professional, values about the nature of consumers, their behaviours, and their sexual rights (Ruane & Hayter 2008). Although some of the reasons given by the nurses, such as heavy workloads and lack of privacy, as reasons for avoiding the topic have been reported elsewhere (Herson et al. 1999; Kautz et al. 1990), they might also be used by the participants as justification for avoiding sexual conversations, by steering conversations towards topics they feel safer with.

Four of the participants stated that they do bring up the topic. This did not always occur at initial assessments; often, they would raise the topic at a later time when they sense that rapport and a therapeutic alliance had been developed. This is understandable given the greater ease of discussing sexuality once rapport has been established (Katz 2005a). It was unclear why these four participants practiced in this manner. Krebs (2007) found that nurses who have the ability to include sexuality in their practice do so because of their own awareness of their beliefs, values, and comfort in talking about sexuality. Given participants were not specifically asked about their level of comfort in discussing sexuality, this view cannot be confirmed.

These four participants spoke of a method of introducing the topic of consumer sexuality by talking about medication issues, such as side-effects, then using a more specific question related to sexual dysfunction. Higgins et al. (2006a) report that the most effective treatment of sexual dysfunction begins in asking the consumer whether they are experiencing any problems. This is of particular importance, as consumers are generally more concerned about the sexual side-effects of medication than any other side-effects, yet mental health professionals do not routinely enquire about sexual problems (Deegan 2001). Despite this, most participants indicated that they are likely either to wait for the
consumer to initiate the discussion or to ignore the issue of sexuality completely. This could result in sexual problems not being recognized or addressed, as identified in the literature (Katz 2005a). Volman and Landeen (2007) suggest that as nurses we need to open the door to consumers to discuss their sexual issues. It has been suggested that the provision of holistic, consumer-focused care would be enhanced by including consumer sexuality as a component of consumer assessment (McCann 2003; Peck 2001; Tomlinson 1998).

Waiting for the consumer to raise the topic or ignoring consumer sexuality might well be the easiest, and therefore, commonest way of handling this situation (Medley & Douglas 1988). Higgins et al. (2008, p. 311) describe this ignorance by mental health nurses as maintaining ‘a veil of silence around sexual issues whilst controlling their own feelings of discomfort, thus avoiding the perceived risk of transgressing a social and professional taboo’. This seems to ignore our professional obligation to inform consumers of the indications and contraindications of treatments prescribed. Nurses need to recognize that they have a role in educating consumers in areas such as relationships, courtship, and safe sexual practices, along with the need to create opportunities for discussion on the topic (Higgins et al. 2006a). Consumers want to know about what side-effects to expect from various medications before they personally experience them and before they see them in other people (Happell et al. 2004). It has been established that when consumers are educated about potential side effects, adherence improves, and the refusal of treatment is reduced (Smith & Henderson 2000).

Woolf and Jackson (1996) consider it appropriate for nurses to raise and discuss issues. The participants in this study recognized that sexuality for consumers is an important area of care; however, their level of confidence in addressing these concerns was at times poor and they referred the consumer to another clinician or service. This again supports the importance of educational preparation to assist nurses not only in acknowledging sexuality as a clinical issue, but to also feel confident in addressing it (Warner et al. 1999). It has been suggested that contemporary nurse education does not prepare nurses to deal with consumer sexuality in an effective manner (Crouch 1999), and that nursing education needs to include human sexuality addressing the importance of sexual history taking and sexual counselling (Montura et al. 2001; Volman & Landeen 2007).

The findings have highlighted the participants’ view of sexuality as a relatively low priority in the day-to-day care of consumers, and their opinion that mental health services also do not consider this area of care as important. There was a lack of confidence in dealing with consumer sexuality, and that sexuality issues for consumers are best dealt with by another clinician, with the practice of referring the consumer on, despite recognition that these issues are poorly addressed by others (Crouch 1999; Higgins et al. 2006a; McCann 2003; Woolf & Jackson 1996). Unlike other research investigating the practice of mental health nurses, the responses from participants in this current study revealed that there was awareness that this personal and private
topic can be a difficult subject for both mental health nurses and consumers alike.

This study used a qualitative approach with 14 mental health nurse participants. Due to the study design and the number of participants, the findings might not be representative. Because of the qualitative approach used in this study, it is not possible to generalize these findings to a broader population. Furthermore, the mental health nurses who participated in this study were from the same service within Queensland and might not represent the practices and views of mental health nurses elsewhere.

Further research is needed to investigate this important issue. There is also a need to ensure that sexuality is recognized as a need for education and training, and is included in undergraduate curricula to assist nurses to understand the importance of sexuality and to feel a greater degree of comfort and confidence in supporting the sexuality concerns of consumers.

CONCLUSION

The findings from this research suggest that while the mental health nurse participants acknowledged the importance of sexuality in their practice, most were reluctant to address these issues actively with consumers, and tended to either ignore issues or refer them to another clinician. If mental health nurses are to provide holistic care for consumers, it is important that barriers to the assessment and discussion of sexuality are identified and measures are taken to overcome them. An aim of this research was to encourage mental health nurses to reflect upon their attitudes and current practices regarding the sexuality of consumers of mental health services and highlight the need for mental health nurses to include consumer sexuality in their care.

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The findings from this initial publication emphasises that mental health nurses are aware that consumers can experience a variety of sexual concerns however, most were reluctant to actively address sexual concerns with consumers. The most common response by participants reflected avoidance responses. Participants tended to minimise sexual concerns as a low care priority; ignore sexual concerns; or refer the consumer to another clinician.

The second publication from Stage 1: *Sexuality and consumers of mental health services: the impact of gender and boundary issues*, discusses two main themes found to influence nurses’ tendency to avoid the topic of sexual concerns. These are:

- The impact of gender; and
- Professional boundary issues

In this publication, gender issues are presented. The participants discuss the impact of medication side effects on sexual functioning. Their responses had a particular focus on young adult male consumers, to the exclusion of women and older males. Discussions regarding female consumers tend to reflect the view that they are sexually vulnerable, and warrant protective care strategies. Gender concerns are presented revealing the participants’ concerns that discussing sexual concerns with consumers warrants caution because of the possibility of being misinterpreted by consumers and exposing them to being questioned by colleagues about their professionalism.
Sexuality and Consumers of Mental Health Services: The Impact of Gender and Boundary Issues

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The importance of sexuality to humanity is clearly acknowledged. However, for consumers of mental health services, it tends to be a neglected topic. Although nurses are at the forefront of mental health service delivery, evidence suggests they are reluctant to include sexuality as part of their care. This article describes the findings from a qualitative exploratory research project that examined mental health nurses’ attitudes to discussing sexuality with consumers. Fourteen mental health nurses from a service in Queensland participated in this study. Data analysis revealed two main themes: the impact of gender, and professional boundary issues. In terms of gender, participants referred to the impact of sexual dysfunction experienced by young adult male consumers. For female consumers the discussion centred on vulnerability to sexual exploitation and the need to exercise protective measures to ensure safety. Participants indicated concerns about being professionally compromised when discussing sexuality with consumers of the opposite sex. These findings highlight the need for further exploration of mental health nurses’ attitudes towards discussing sexuality with consumers as part of their practice.

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Sexuality is an important part of how we view ourselves, and is fundamental to our health, our quality of life, and our general well-being (World Health Organisation, 2001). The way sexuality is understood and defined is closely associated with the cultural and social values that prevail at the time (Price, 2009). A strong influence on sexuality is the attitudes held by others, especially those attitudes that define behavior as either acceptable or unacceptable (DeLamater & Friedrich, 2002). Attitudes held by nurses about sexuality, toward those who receive mental health services, often impact negatively on the nurse-consumer relationship (Shattell et al., 2006).

Sexual dysfunction is common in the general population, where it has been estimated to affect that up to 43% of women, and 31% of men (Perlman et al., 2007). However sexual dysfunction is reported at much higher rates for consumers of mental health services, where rates have been estimated at approximately twice that of the general population, particularly when these individuals are being treated with psychotropic medications (Kodesh et al., 2003; Perlman et al., 2007; Sullivan & Lukoff, 1990; U’cok et al., 2008). Sexual dysfunction includes erectile and ejaculation problems for male consumers, reduced libido and arousal problems for both males and females and dysfunctions of the menstrual cycle for female consumers (Balon, 2006; Higgins et al., 2005; Smith, 2007).

Consumers’ sexuality can be potentially compromised by their vulnerability to sexual exploitation and their increased susceptibility to coerced sex, as consumers may lack the assertiveness needed to negotiate safer sexual relationships (Chernomas, Clarke, & Chisolm, 2000). It has been reported that up to 44% of consumers with a diagnosis of schizophrenia, in a variety of clinical settings including inpatient and community, are engaging in high risk sexual activity (Ford, Rosenberg, Holsten, & Boureaux, 2003). They are also more likely to have coexisting drug and alcohol problems, often associated with sexual risk taking and increased risk of HIV, hepatitis B, and hepatitis C (Higgins et al., 2005; King et al., 2008; Rosenberg et al., 2005). It has been suggested by Earle (2001) that potential perpetrators perceive mental health consumers as easy prey, and that consumers may find it difficult to articulate their abuse, may be less likely to be believed, and may lack the knowledge required to understand when abuse has taken place. Unfortunately, consumers’ sexuality is often ignored by mental health professionals and researchers, creating a situation where consumer concerns and needs are overlooked (Earle, 2001; Fortier et al., 2003; Katz, 2002; McCann, 2010; Quinn & Brown, 2009; Shield, Fairbrother, & Obmann, 2005; Wong & Mak, 2008; Woolf & Jackson, 1996).

Gender has emerged as an important theme in considering sexuality issues and care of consumers. While studies such as Fortier et al. (2003) discuss the early onset of mental illness, poorly developed socio-sexual skills, and the resulting difficulties for consumers in finding a partner, other research by Dickerson et al. (2004) discuss issues specific to female consumers such as having more partners than male consumers and more partners than females in the control group. A study examining the sexuality concerns of women with bipolar disorder (McCandless & Sladen, 2003) found that sexual impulsivity can have a negative effect on
consumer’s self-esteem and self-image as they recover and reflect upon their behaviour. Sexual impulsivity and associated behaviours may conflict with a consumer’s cultural or religious background, or could be inconsistent with usual standards of personal sexual behaviour. These consequences can add to the stress already experienced by vulnerable consumers. When staff become aware that a consumer is sexually active, Pacitti and Thornicroft (2009) observed that staff were unsure of how to balance the consumers’ right to express themselves sexually, with the need to protect the consumer who might be vulnerable. Complicating this balancing act, are concerns that nurses have around boundaries.

Professional boundaries contribute to identifying the scope and limits of practice (Maes, 2003). In the nurse-consumer relationship, an unequal distribution of power occurs, with the nurse in the dominant role and having more power than the consumer (Campell, Yonge, & Austin, 2005). Nurses have access to confidential information about the consumer, provide intimate and personal care, and at times provide care and treatment against the will of consumers (Wright, 2006). The power of the consumer is diminished within this relationship (Wright, 2006), creating a situation where the consumer is placed in a position of potential exposure to exploitation or abuse (Australian Nursing and Midwifery Council, 2009). Violating boundaries can be harmful, result in preventing consumers from achieving their goals, and threaten the nurse’s professional status (Wright, 2006).

Professional boundaries are not always easily identifiable. The closeness of the care provided by nurses to consumers, their families, and carers—often in residential style settings or the consumer’s home—can result in blurred boundaries within the nurse-consumer relationship where professional boundaries can be threatened (Jacobson, 2002). Nurses must maintain professional boundaries to ensure that their professional relationships are for the benefit of consumers (Campell et al., 2005).

Consequently, some nurses might fear that questions about sexuality will be considered inappropriate, particularly when the nurse and consumer are of opposite genders. Research has found that a relationship exists between the preference for a same-gender nurse when private thoughts and emotions require discussion (Kerssens, Bensing, & Andela, 1997), or when care is of an intimate nature (Chur-Hansen, 2002). Females have been found to prefer female health professionals for matters regarding sexuality, and especially for consultations regarding intimate or psychosocial issues (Brooks & Phillips, 1996; Chur-Hansen, 2002); males demonstrate this trend for “same-gender professionals” as well (Inoue, Chapman, & Wynaden, 2006; Kerssens et al., 1997). The review by Chur-Hansen (2002), examining the nurse gender preferences of consumers, asserts that when issues such as sexuality are no longer a clinical issue, gender preference for care is no longer a concern.

If nurses are to fulfil an important aspect of their role and discuss sexuality concerns with consumers, it is important to explore the barriers that are likely to prevent them from doing so. The aim of this article is to explore two important themes that emerged from this study, that is, how gender and the perceptions of professional boundaries are perceived by mental health nurses with in the context of discussing sexuality issues with
consumers. The importance of understanding preventative barriers to the discussion of sexuality with consumers will provide valuable insights for the development of strategies to assist mental health nurses to be inclusive of sexuality issues in consumer care.

METHODS

Approach

Qualitative exploratory methodology was utilised to conduct this research. This approach allows the detailed exploration of the participants’ beliefs, opinions, and experiences in relation to the area of interest (Polit & Beck, 2004; Stebbins, 2001).

Sample and Setting

The sample for this research was mental health nurses drawn from a community mental health continuing care team, an inpatient extended treatment unit, and an inpatient rehabilitation unit from a mental health service located in Queensland, Australia. An explanation of the study was provided to nurses working in these three areas. Fourteen nurses agreed to participate in the research, including eight females and six males, ranging in age from 24 to 60 years. The participants had between 2 and 39 years of experience in mental health nursing, and had been in their current position for between four months and nine years. After the 14 interviews were completed it became apparent that data saturation had occurred (Stebbins, 2001).

Procedure

The research was conducted with the use of individual indepth semi-structured interviews, to ensure that the research question was adequately addressed, and to allow the participants to speak freely of their experiences (Polit & Beck, 2004). Participants were asked to discuss their practice in relation to the sexuality concerns of mental health consumers. Subsequent questions probed their opinions of and attitudes to the topic, and how these underpinned or influenced their practice. An open style of questioning was adopted to encourage participants to articulate their opinions and experiences in detail (Horsfall, Cleary, Walter, & Hunt, 2007).

Ethical Issues

Ethics approval was obtained from the auspice university and the mental health service where the study was conducted. An explanation of the study was provided to potential participants in an open forum, and they were asked to contact the researcher directly if they were interested in being involved. A copy of the plain language statement and consent form was provided to interested participants. Prior to signing the consent form potential participants were advised of the voluntary nature of their participation and assured they had the right to withdraw from the research at any stage. A pseudonym was assigned to each participant to maintain confidentiality. All research data remain securely stored and only made available to members of the research team.

Data Analysis

The interviews were digitally recorded with the permission of the participants. The interviews were transcribed verbatim by the principal investigator, to assist with developing familiarity with and sensitivity to the content of the interviews. The Ritchie and Spencer (1994) method was used to guide the data analysis process. This five-step approach includes: familiarisation with the data, identifying a thematic framework, indexing, charting and mapping, and interpretation. The
interviews progressed simultaneously with analysis of the data, an approach advocated by (Ritchie & Spencer, 1994), whereby you continuously take large amounts of verbatim text and notes and place them in groups.

The transcripts were continuously reviewed by the research team to enable identification of the main themes (Braun & Clarke, 2006; Polit & Beck, 2004). The aim was to find words and phrases carrying meaning and importance to the phenomena of interest (Braun & Clarke, 2006; Polit & Beck, 2004). Initial themes emerged, which were reviewed by the research team during supervision sessions.

To ensure the trustworthiness of the data, the members of the research team independently analysed and interpreted the data. The identified themes were then discussed until consensus was reached.

FINDINGS

Two main themes to emerge from this research were: the impact of gender and professional boundaries. These themes are described and illustrated with quotes from the participants.

The Impact of Gender

Responses from participants demonstrated that both age and gender influenced their attitudes towards consumer sexuality. In particular, they referred to young men and the vulnerability of females.

Young Men

Participants described a much greater degree of empathy for young adult men than any other consumer group. Young adult males tended to be viewed by participants as sexual beings, who are considered to be greatly impacted upon by medication related sexual dysfunction:

I’m sure with some of the guys here becoming impotent, at their age ... must be horrifying and something they can’t get out of their mind, it eats at them, we wonder why they’re depressed. It’s a whole body thing, isn’t it? (Jean)

and:

But the younger people, they will be more vocal about it. They will actually say “Look I’m having a problem.” ... There is a young guy, I was speaking to him, and he said, “Yeah I can’t take this medication, I just can’t get an erection or I can’t ejaculate or I can’t have a girlfriend,” then it is obviously a problem. (Lance)

The impact of erectile dysfunction on young adult males was identified as a common reason for discontinuing medication, as the following quotes demonstrate:

Sexual abilities, especially for young persons is a really big issue, it’s one of the reasons they go off their medication, because they recognise the connection between their medication and their sexual abilities. So that’s a very common problem. (Ethan)

and:

But, one of the major concerns, especially with the young males, is one of the reasons they stop taking it ... I don’t want to take it cause I can’t get an erection ... if you’re talking about young guys who are 23 or 24, they’re looking for females, looking for sex, so they have real problems with not being able to get an erection. (Mick)

Vulnerability of Female Consumers

When it came to discussing female consumers, participants tended to voice concerns for their safety, viewing them as being vulnerable to exploitation, and requiring protection from sexual predators, unwanted sexual encounters, unplanned pregnancy, or sexually transmitted infections. They also expressed the view that female consumers may put themselves at risk due to the way they might be dressed or by their behaviour, which might expose them to a dangerous sexual situation:
We have one little girl here ... I tried to talk to her about walking around at night at the railway station with her short shorts on and a singlet. She wanted to go to the railway station and I said, “I’m sorry you can’t, it’s dark and you can’t go like that actually.” She was like, “I’m all right, I’m all right.” But because she is so elevated, she couldn’t see that she was asking for trouble, and I’m saying no woman asks for trouble but when she’s ill like that, if anyone approached her she’d probably go with them anyway. (Jean)

Participants described discussing health and safety issues associated with the risky sexual behaviour of female consumers and the actions they took in response, for example:

Often if they’ve been promiscuous in some way ... they may have some sexually transmitted disease...and they might need some further follow-up and so we might talk to the doctor ... sometimes they might need to go to some community clinic, and we can organize that, or even go with them if need be. (Jenny)

However, one participant discussed the negative reaction of nurses towards female consumers who display sexually disinhibited behaviours and expressed the strong view that nurses should be supporting and protecting female consumers:

A good example is the female patients, their sexuality is often a big focus for staff, they will label them, they will denigrate them, they will castigate them but they don’t see that this is part of their pathology but also that it’s our role to not only address it but not to react to it ... The women tend to be more victims of sex, they tend to be more vulnerable and sexually exploited. (Ethan)

Boundary Issues
Several participants indicated the importance of maintaining professional boundaries and acknowledged a greater sense of security and safety in their practice when talking with consumers of the same sex. Some were concerned that speaking with a consumer of the opposite sex could lead to possible allegations of sexual misconduct and that their actions may be misinterpreted by others as possible boundary violations. If their behaviour was misinterpreted in this manner, it might be damaging to their professional reputation. Resulting from these concerns is the practice of referring the issue to a same-sex nurse:

I tend to talk about it more with females rather than men. I feel more comfortable bringing it up with women rather than men. If they tend to bring it up with me, then that’s fine but I don’t tend to broach the subject with them ... probably a sex difference, I feel more comfortable probably with females. (Olivia)

and:

I suppose with a guy, like, if I was on my own it would feel a bit strange, I guess. I wouldn’t want to bring it up [with a male] as an issue unless I thought there was a problem. You know I wouldn’t go straight in there and say, “Are you having problems with your sex life?” with a guy as he may intertemperate that as, you know, making suggestions to him. (Joanne)

The male participants expressed similar concerns:

My case load is predominantly men because of boundary issues. I’m probably a bit more discerning when it comes to talking to females, it depends on what the topic subject is with how far I’d go and how deep I’d discuss it. Basically, I don’t want any professional comeback from any consumers that I work with, I don’t want to go over any sexual boundaries as I’m very aware when working with female clients about not going too in-depth unless I’m with a female colleague. [I don’t want things to be] misconstrued and used against me. (Lance)

similarly:

I don’t feel comfortable to raise it [with females], I’m sure if I’m actually given a female client and she’s talking to me about it, of course, I would pass it on, but for me to go to her and actually say, “Is there any problem?” One, because I don’t know much about what sort of problems ... the female patients have, well, apart from the obvious, are they actually having regular sex or whether they have a boyfriend then we will most probably talk about it. But whether
I will actually raise [sexuality], I don’t think I would, no. (Frank)

Although female participants stated that their comfort zone is in talking about sexual concerns with female consumers, they were much more likely to provide examples of sexuality concerns faced by male consumers, as the following quote demonstrates:

With young men, especially, because it’s an important thing in their life, so I probably need to broach that more, but I don’t tend to do that very much. (Olivia)

When female consumers are discussed, it is again generally in the context of them being vulnerable and in need of protection.

One participant who had worked in a variety of clinical areas, including nursing roles in emergency settings, surgical wards, and in a sexual health clinic, reported that in these settings it is common practice for him to ask consumers about their sexuality, stating that this was done with female and male consumers without any concern that this practice might warrant some caution. However in mental health settings, there is a great deal concern and caution exercised by this participant:

With females, it’s probably much better to have one of the female nurses to do it. It’s something you need to be aware of, careful of discussing sexual problems ... with females you’re better talking with a female nurse because they’re going to be more open than with a male. Especially within mental health, given that you can be seen as taking advantage of them or something like that. (Mick)

It was not only boundary issues that influenced the practice of referring to a same sex nurse, this was also seen as a way to make the consumer feel more at ease, for example:

I think it’s more for the fellas that they might feel more comfortable in talking to a bloke, and they might be able to talk about issues more comfortably, that’s just my perception ... I think it’s broaching the topic with fellas, with guys, and having a suitable environment. Often the environment is, perhaps, a problem. I think the fellas would prefer a male nurse. (Jenny)

Having a nurse of the same gender to discuss these issues was also considered important in relation to the consumer’s clinical history, particularly in light of the way that sexual abuse, religious beliefs, and cultural background can impact upon a person’s sexuality, and the response consumers may have towards questions examining their sexuality, as Ethan explains:

Sometimes I’ll refer a female client to a female staff member if that’s more appropriate ... There might be a history of sexual abuse, or other things where it might be inappropriate for me. So, I might inform the doctor so they can discuss it with them, or refer to a female nurse to discuss it. (Ethan)

One female participant (Lisa) expressed that she was comfortable in discussing sexuality issues with male consumers, and felt that this had something to do with her age (49 years), however she went on to state that if she felt that the male consumer would feel more at ease with a male clinician, that she would facilitate this process, that this might prevent the male patient from closing-up in talking about something with embarrassing content.

Another male participant felt that as long as one conducts themselves in a professional manner, that there is little need for concern of boundary issues:

As long as you conduct yourself professionally, everyone, well I can only speak for myself, you try to do your best. There are boundary issues I’d say some of which I haven’t given a huge amount of thought to. (Chris)

**DISCUSSION**

In exploring mental health nurses’ attitudes in discussing sexuality with consumers, this article explores how gender and the perceptions of professional boundaries impact on the assessment
and discussion of the sexuality issues of consumers. The literature and findings from this study indicate that sexuality is both an important and neglected issue in the delivery of mental health care. Participants acknowledged that consumers can find difficulties in maintaining sexual relationships and that the effects of mental illness and treatment can impact on the sexuality of consumers, regardless of whether they are in a relationship. The literature (Kodesh et al., 2003; U’cok et al., 2008, Volman & Landeen, 2007) and the participants identified a loss of sexual responsiveness as an issue for both male and female consumers. Specifically erection and ejaculation problems in men and arousal difficulties for women were identified by the literature (Perlman et al., 2007, Schlachetzki & Langosch, 2008). The participants also identified different issues and concerns for the genders.

Both male and female nurse participants expressed empathy for the distress that sexual dysfunction has on young adult male consumers. Shell (2007) points out that when sexuality is discussed with consumers, the discussion is limited to those consumers nurses regard as being sexually active. It is possible that the nurses did not view older men or female consumers as being sexually active or see that sexuality was important to them. This is consistent with the view expressed by Atwood and Klucinec (2007) that sexuality has been frequently studied defined and viewed from a masculine point of view, and that male sexuality is concerned with genitals and sexual activity (McCarthy & Bodnar, 2005), while female sexuality is more complex, and is more concerned with desire, pleasure, and satisfaction (McCarthy & Bodnar, 2005). Of interest here is that although female nurse participants stated that they address female consumer’s sexuality most of their discussion was around male consumers. This suggests the need for a broader discussion about sexual issues for all consumers.

Female consumers were more often discussed in terms of their vulnerability to exploitation, with the role of nurses being to provide guidance and offer moral policing of sexualized behaviours and protective measures to ensure safety. Women are mostly mentioned in regard to promiscuous behaviour that puts them at risk. A practice was revealed where, at times, nurses put down and negatively label the consumer because of behaviour, echoing the work of Shattell et al. (2006) who suggest that this practice also might be used by nurses as excuses to avoid sexual conversations, possibly creating a cycle of avoidance where nurses avoid the topic of sexuality by referring to others, knowing full well that others avoid the topic as well (Quinn, Happell, & Browne, in press).

These findings support the work of Phillips (2009), who reports that sexuality issues for female consumers do not appear to be explored, and that women’s sexuality is often viewed as the exhibition of an uncontrollable “eagerness for sex” (Phillips, 2009, p. 24), which leads to the practice of nurses offering protection and putting safe guard measures in place. There was little mention by the participants of women’s libido, their sexual functioning, or their physiological responses.

All participants discussed gender issues, acknowledging that they felt more secure when discussing sexual issues with consumers of their same sex. There was concern that discussing sexuality issues with a consumer of the opposite sex might be questioned by their colleagues or
misinterpreted by consumers, leading to possible allegations regarding boundary violations.

It is recognised that boundary violations can threaten a nurse’s position (Wright, 2006) and possibly result disciplinary action by employers and professional bodies. In particular, sexualising the nurse-consumer relationship is prohibited (Campell et al., 2005). The possibility of having their actions misinterpreted by fellow nurses and the ethics of discussing sexuality with consumers has not been well explored (Albaugh & Kellog Spadt, 2003).

It has been suggested (Magnan, Reynolds, & Galvin, 2005; McCann, 2003; Quinn et al., in press) that nurses avoid sexuality topics with consumers for reasons of personal embarrassment, that the topic is not important, or is someone else’s responsibility. The evidence here suggests that avoidance may reflect the fear that talking about sexuality might be viewed by fellow nurses as a boundary violation. It is not clear whether these findings are representative of nursing, or whether this is used as an excuse to avoid sexuality because the topic can be professionally difficult and confronting (Quinn et al., in press).

LIMITATIONS OF THIS STUDY

Because this study utilised a qualitative approach with 14 participants from the one mental health service, these findings cannot be readily generalised to the broader population of mental health nurses. It is important to emphasise that the aim of this study was to explore this important topic rather than to seek representative opinion.

CONCLUSION AND RECOMMENDATIONS

The findings from this research suggest there is a reluctance to discuss sexuality with consumers of mental health services, and that there is a need for further discussion on the topic. Sexuality is one of the clinical areas for nurses to consider in providing holistic nursing care to consumers, but there are significant barriers to nurses discussing this topic with consumers. Clearly our profession needs to discuss and debate how we can address nurses’ neglect of addressing the sexual concerns of consumers.

There is a need to develop teaching strategies to assist mental health nurses raise sexual concerns with consumers (Duldt & Polkorny, 1999; Skelton & Matthews, 2001; Volman & Landeen, 2007). Nursing programmes and curriculum need to include human sexuality and the issues of sexuality that impact upon mental health consumers (Montura et al., 2001; Volman & Landeen, 2007; Warner, 1999). Further research on this important topic would open up dialogue on this topic. Research and public discussion could also seek to clarify issues of comfort and confidence in discussing sexuality with nurses from a consumer perspective, which might well assist in clarifying existing beliefs around professional boundary practices.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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Katz, A. (2002). Where I come from, we don’t talk about that: Exploring sexuality and culture among blacks, Asians and Hispanics. *AWHONN Lifelines, 6*(6), 533–536.


The findings from this publication emphasise avoidance by participants to engage with consumers of the opposite sex about the consumers’ possible sexual concerns. These findings provide a further layer of avoidance by nurses in relation to the inclusion of consumer sexual concerns in their practice to those discussed in the first publication *Talking or avoiding? Mental health nurses’ views about discussing sexual health with consumers*.

There was expressed fear by the participants that if they were to discuss sexual concerns that this might result in having their professionalism questioned, either from the consumer misunderstanding the reason behind the discussion and the possible accusation of a professional boundary transgression by the nurse towards the consumer, or from their colleagues who might question the ethical legitimacy of discussing sexual concerns with consumers.

The third publication arising from Stage 1 is: *Opportunity lost? Psychiatric medications and problems with sexual function: a role for nurses in mental health*. As with the two previous publications, this publication presents further findings illustrating the baseline avoidance by these participants in discussing sexual concerns with consumers. This publication provides four subthemes under the main theme of *medication issues*. These are:

- Assessment;
- Sexual side effects;
- Consumer embarrassment; and,
- The pros and cons of providing information.
Opportunity lost? Psychiatric medications and problems with sexual function: a role for nurses in mental health

Chris Quinn, Brenda Happell and Graeme Browne

Aim. To explore patients’ non-adherence to psychiatric medication with mental health nurses.

Background. The ability of consumers to maintain normal sexual behaviours is complicated by abnormally high incidence of sexual problems arising from the medications they are prescribed. Sexual side effects of psychiatric medications are identified as a major reason for non-adherence to psychiatric medication regimes yet it remains an issue mental health nurses tend to avoid in their practice with consumers.

Design. An exploratory, descriptive qualitative approach.

Method. Individual interviews were conducted with 14 nurses currently working with adult consumers of mental health services. Data analysis followed the framework approach developed by Ritchie and Spencer as the process for identification of the main themes.

Results. Problems with sexual function in relation to psychiatric medication issues was one major theme to emerge from this research. More specifically the participants referred to: assessment of sexual function, the side effects of psychiatric medication, consumer embarrassment, and, the pros and cons of information. Participants recognised that sexual side effects were likely to have an impact on adherence to medication and that this was an important consideration but most did not discuss this issue with consumers. Consumer embarrassment and the belief that knowledge itself might cause non-adherence were the two main reasons for not discussing this topic.

Conclusions. Problems with sexual function of consumers presents an important practice consideration for nurses working in mental health settings. There is an urgent need for strategies to enhance awareness and confidence among nurses in exploring this topic with consumers.

Relevance to clinical practice. Mental health nurses can adopt a leadership role in recognising the relevance of sexuality in care and treatment for consumers of mental health services. Strategies to assist in developing skill and confidence in this domain are required as a matter of priority.

Key words consumers, medication, mental health, nurses, nursing, sexuality, side effects

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Introduction

Problems with sexual function have been identified as a primary, if not the primary, reason for non-adherence to psychotropic medication (Deegan
The ability to engage in sexual activity is linked to the ability to maintain self-esteem and consumers may well choose to cease medication to regain their ability to maintain their usual sexual activities (Baggaley 2008).

Despite commonly documented problems with medication adherence (Mahone 2008, McCann et al. 2008, Patel et al. 2010, Anderson et al. 2010), up to 73.5% of mental health consumers, have never been asked about their sexual functioning during a psychiatric consultation (U’cok et al. 2008). Problems of sexual functioning may be a major contributor to consumers ceasing their medication regimes (Gray et al. 2010). Indeed it has been reported that 41.7% of male consumers and 15.4% of female consumers will cease their medication at some point in time due to sexual problems (Rosenberg 2003).

The consequence of ceasing psychiatric medication, risking relapse and further hospital admissions has been described as a ‘major public health crisis’ (Gray et al. 2010, p. 37) leading to higher costs for treating mental illness due to ongoing episodes of relapse (Fernandez et al. 2006). Furthermore, sexual problems can result in negative attitudes towards psychiatric medication and lead to non-adherence (Lambert et al. 2004) and the level of distress experienced by consumers due to sexual dysfunction, may well exacerbate psychiatric symptoms (Kelly & Conley 2004).

Problems with sexual function refer to the inability to express ones sexuality consistently with personal needs and preferences (Volpe & Wertheimer 2004). These problems are often multi-faceted and include a variety of physical, psychological and sociocultural factors. These problems are common in the general population, where the prevalence has been estimated at 31% of men and 43% of women (Perlman et al. 2007). There is no consensus regarding the rates of problems of sexual function for consumers of mental health services but they are estimated to be considerably higher than those rates reported in the general population, with approximately 60% in men and as high as 93% in women treated with antipsychotic medication, with higher rates observed for men being treated for depression (Perlman et al. 2007, Smith et al. 2002, U’cok et al. 2008).

Being diagnosed with a mental illness does not mean the person is no longer a sexual being (Volman & Landeen 2007). Problems of sexual functioning can impact profoundly on self-esteem and have negative consequences for relationships (Berner et al. 2007). Research into problems of sexual function in consumers treated with antipsychotic medication found that male consumers experienced normal levels of libido, but high incidence of erectile and ejaculatory problems (Smith et al. 2002, Perlman et al. 2007, U’cok et al. 2008) and are concerned with the impact that these effects had on their personal beliefs around their masculinity (Volman & Landeen 2007). In addition hyperprolactinaemia as a result of treatment with certain antipsychotic medications can result in increased incidence of erectile dysfunction and quality of orgasm in males (Smith et al. 2002). Sexual function is therefore an important area that requires monitoring and where necessary open discussion about these issues (McCann 2000, Higgins et al. 2005). Consumers deserve the opportunity to have their sexual problems appropriately and thoughtfully identified and addressed (Krebs 2007).

When nurses assess for side effects of antipsychotic medications, the extra-pyramidal side effects are considered to be the most common, the most troublesome for consumers and the most likely to result in non-adherence (Gray & Gournay 2000, Smith & Henderson 2000, Deegan 2001). By way of comparison side effects that impact on sexuality have remained a low priority over the past three decades (Medley 1988, Higgins et al. 2005.).

It has been reported that nurses believe that informing consumers about side effects, leads to non-
adherence (Jordan et al. 1999, Cort et al. 2001), as a consequence of consumer anxiety (Magnan et al. 2005, Shell 2007). The most frequently cited concern is the fear that the consumers responses and concerns might be overwhelming for the nurse or for the consumer (Krebs 2007) and the fear of embarrassing or causing distress to the consumer if sexual issues are discussed has also been reported (Higgins et al. 2005).

This practice of avoiding discussions about the sexual side effects of medication has also been described as mental health nurses maintaining ‘a veil of silence around sexual issues whilst controlling their own feelings of discomfort, thus avoiding the perceived risk of transgressing a social and professional taboo’ Higgins (2008, p. 311). Magnan et al. (2005) found that most nurses (72.3%) in this study believed giving consumers permission to talk about sexual concerns was a nursing responsibility, but only one-third reported actually making time to discuss sexual matters with their consumers. This reported avoidance of sexuality in nursing is not restricted to mental health nursing (Mick 2007, Quinn et al. 2011). It has been reported that nurses have an opportunity to address sexuality with consumers across a broad range of specialty areas (Albaugh & Kellog-Spadt 2003, Volman & Landeen 2007).

Consumers who are empowered with relevant knowledge and information are more likely to be active participants in the management of their illness, which should increase their capacity and motivation to adhere to treatment (Fernandez et al. 2006). There is some evidence to suggest that when consumers are educated about potential side effects that adherence is improved and the refusal of treatment is reduced (Smith & Henderson 2000). Indeed the most effective response to sexual problems begins with simply asking whether the consumer is experiencing any sexual concern so the problem can be identified as a starting point (Higgins 2007).

Not only do problems of sexual function impact on the consumer’s quality of life, they pose significant barriers to effective treatment outcomes. Nurses, by virtue of their numbers and their close relationship with consumers of mental health services are well placed to play a support role in the recognition and support of these problems (Earle 2001, Jolley 2002, Krebs 2007).

Aim
The aim of this article is to present a major theme from a broader study of mental health nurses and their practice in relation to sexuality issues for consumers of mental health services. This article presents the findings that relate specifically to the participants’ views about psychiatric medication and sexual side effects.

Methods
Design
This research was conducted utilising an exploratory qualitative research approach. This method provides the opportunity for participants to describe in detail their experiences, beliefs and opinions regarding the topic of investigation, in this instance the participants’ experiences of addressing the sexuality concerns of consumers in their mental health nursing care (Stebbins 2001, Polit & Beck 2004). This type of research approach is in-depth, in that the study explored the practice of the participants as they occur in their natural setting (Liamputtong 2010), gaining insights into their subjective experiences (Polit & Beck 2008, Liamputtong 2010) and is intended to increase the knowledge of the field of study, particularly where there is a limited understanding of the topic of interest (Polit & Beck 2008). It is a method that has been widely used in nursing research as a means to collect detailed information about an issue of interest (Manias et al. 2005, Beaver et al. 2007, Hayter & Harrison 2008, Chen 2010).

Setting
This research was conducted in a mental health service in Queensland, Australia. The specific sites for the study were a community mental health continuing care team, an inpatient extended treatment unit and an inpatient rehabilitation unit.

Participants

The 14 participants were recruited using convenience sampling (Polit & Beck 2008, Liamputtong 2010), with nurses from one mental health service in Queensland. An outline of the study was presented to mental health nurses working in each of the three adult mental health settings and they were asked to indicate to the researcher if they were interested in participating.

Eight participants were female and six were male. They were aged between 24–60 years (mean age = 44.64 years). Seven participants were clinical nurses (at least two years post-registration experience), six registered nurses with postgraduate qualifications and one clinical nurse consultant (nurse possessing advanced clinical skills). Their years of experience as mental health nurses ranged from 2–39 years (mean = 14.9 years). The duration of their current position, ranged from four months to nine years with a mean of three years. At the time of interviews five participants were working in a community-based continuing care team, five in an inpatient extended rehabilitation and four from an inpatient extended treatment unit.

An overview of the demographic and employment characteristics is presented in Table 1

<table>
<thead>
<tr>
<th>Participant (pseudonym)</th>
<th>Sex</th>
<th>Age</th>
<th>Years in current position</th>
<th>Years as Mental Health Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olivia</td>
<td>F</td>
<td>34</td>
<td>8 months</td>
<td>4</td>
</tr>
<tr>
<td>Lisa</td>
<td>F</td>
<td>49</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>Ethan</td>
<td>M</td>
<td>56</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>Joan</td>
<td>F</td>
<td>48</td>
<td>4 months</td>
<td>8</td>
</tr>
<tr>
<td>Joanne</td>
<td>F</td>
<td>46</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Shanelle</td>
<td>F</td>
<td>48</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td>Jenny</td>
<td>F</td>
<td>44</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Chris</td>
<td>M</td>
<td>41</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Jean</td>
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<td>3</td>
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<tr>
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<td>M</td>
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<td>10</td>
</tr>
<tr>
<td>Frank</td>
<td>M</td>
<td>37</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Rhys</td>
<td>M</td>
<td>24</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Louise</td>
<td>F</td>
<td>34</td>
<td>6</td>
<td>16</td>
</tr>
</tbody>
</table>

| Table 1 Participant characteristics |

Procedure

Data was collected through individual in-depth interviews. The interviews were held in a private location away from the immediate work environment to ensure privacy and avoid interruptions. At the start of each interview, participants were asked to discuss their opinions about and experiences of, discussing sexuality with consumers in a mental health service setting and whether sexual issues are raised as part of the assessment process or through their interactions with consumers. The interview was primarily directed by the responses of the participants. The guiding principle was to encourage the participants to speak at length about their experiences and to gain an insight into their attitudes, behaviours, concerns and practice (Horsfall et al. 2007). An informal, conversational approach was therefore utilised to allow participants the opportunity to speak freely and openly (Horsfall et al. 2007). The principal researcher sought clarification of responses and encouraged participants to elaborate if relevant. The interview times were between 45 and 90 minutes. Following each
interview, the principal researcher would check-in with the research team, to discuss progress and to allow for the discussion of any concerns. At the completion of the fourteenth interview it was agreed by the research team that theoretical saturation had been achieved, as no new themes had emerged from the previous four interviews (Liamputtong 2010) and clear themes were now evident in the data (Stebbins 2001).

Ethical issues
The research received ethics approval from the research site and the relevant university. Potential participants were informed that they were at liberty to decline involvement in the study and were able to withdraw from their involvement at any stage. Those who indicated their interest were provided with a copy of the plain language statement and given the opportunity to ask questions. They were required to sign the consent form before the interview commenced. Each participant was assigned a pseudonym to protect their identity becoming known. All data was securely stored according to the Ethics Committee guidelines.

Data analysis
The interviews were audio recorded and transcribed verbatim by the first author. This enabled him to become immersed in the data from the outset. Data analysis was undertaken using the framework approach developed by Ritchie and Spencer (1994). There are five stages to this process including familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation. Familiarisation commences with the transcribing of the data where the researcher increases the familiarity with and understanding of the data. The transcripts were then carefully read and re-read to identify the themes and sub-themes (Polit & Beck 2004, Braun & Clarke 2006).

Indexing describes the organisation of data according to the thematic framework. Charting involves annotating the transcripts and constructing a chart of the summary of findings for each theme. At this stage it is important to achieve a balance between summarising and paraphrasing the data and using sufficient quotes to enable the voice of the participants to be apparent. The mapping and interpreting phase involves comparing and contrasting participant responses for each theme to observe patterns and consider explanations for the findings. This is imperative to make sense of large volumes of data (Ritchie & Spencer 1994, Polit & Beck 2004).

Medication and problems of sexual functioning was one of the themes identified from this research project and the findings from this theme are the focus of this article.

Trustworthiness
Measures to ensure the trustworthiness of the research findings were based on Guba and Lincoln’s (1989) criteria of credibility, transferability and dependability. Credibility was achieved through prolonged engagement during the interview process enhancing a conversational approach to foster open communication about the topic (Horsfall et al. 2007). In addition the researcher kept a journal to avoid own experience and opinions from influencing the interviews or interpretation of data (Guba & Lincoln 1989). Transcripts for each interview were offered to participants for them to check for accuracy, however, they all indicated this was not necessary as the interviews had been recorded and transcribed verbatim.

Transferability refers to the applicability of the findings to other settings (Guba & Lincoln 1989). This has been achieved by providing thick descriptive data and detailed information about the participants to facilitate comparisons. Dependability involves providing sufficient detail about the research process and data analysis to determine whether similar results would be obtained in a similar context (Guba & Lincoln 1989). This was achieved by carefully following the Ritchie and Spencer framework (1994). The audio recordings of interviews enabled an
accurate account of each interview to be produced (Graneheim & Lundman 2004). And independent analyses were conducted by the research team to establish the consistency of data analysis.

Findings
There were four main points or sub-themes identified under the broad theme of medication issues: assessment, sexual side effects, consumer embarrassment, and, the pros and cons of information.

Assessment
Only four of the participants stated that they broach the topic of sexuality with their consumers. An approach common to two of these participants was to bring up the topic of side effects which have an impact on sexuality while discussing the side effects of medications in a general manner, for example:
Again I’d look at side effects in general and ask whether they’ve been having any problems with their medication and then ask them how they are going sexually in terms of sexual functioning. (Ethan)
This non-direct approach was a comfortable method of raising the issue for these participants. There was concern for the need to avoid a communication style that consumers might perceive as being confrontational, as one stated:
If you bring it up [sexual function] in that context, then it’s much easier and (consumers) are able to discuss it rather than bring it up with you... Because it’s not something most people bring up in the normal conversation. (Mick)

Sexual side effects
The participants described an understanding that problems with sexuality for consumers can be attributed to the side effects of certain psychiatric medications. However it was very interesting that most discussion about sexual problems were discussed in the context of the impact on young men:
It’s mainly males who bring up erection problems and they obviously relate that to their medication and so they have questions about the side effects of their medication and how that can affect their sex drive. (Louise)

Consumer embarrassment
Some participants indicated their concern that discussing sexuality may cause embarrassment for consumers, who may prefer not to discuss their sexual problems, for example:
Particularly male clients who are around the same age as me, or younger in their 20’s or 30’s ... With male clients around the same age group they feel a tad embarrassed ... uneasy at times, or uncomfortable in bringing-up that topic in front of me. (Louise)
Embarrassment was seen as a particular issue for consumers of mental health services because of specific characteristics that may impede their ability to talk openly about sexuality as one participant explains:
the (consumers) are reluctant to discuss it, these people are extremely vulnerable ... disempowered and they’re not given the opportunity. (Ethan)
Consumers were considered more likely to be embarrassed with nurses of the opposite gender, as one participant described:
I would also feel an empathy for the guy also not being comfortable talking to a woman about men’s issues. I would kind of think (men) would be uncomfortable as well (in talking to women). (Joanne)

The pros and cons of information
The participants acknowledged the importance of providing information about sexual side effects. However, written information to assist with this process was not readily available, for example:
There’s no information here for them. I often do a print out from MIMS [MIMS Australia is a supplier of quality, independent medical information for Australian healthcare professionals] I do that with all my patients, I give them all the information. Let them read it and see whether they can identify with any of the symptoms. I give them a printout. You get one when you go to the chemist, don’t you. (Ethan)
On the reverse side of the desire to provide information was concern that educating consumers about this potential may encourage consumers to cease their psychiatric
medications to enhance their sexual function, as Joanne describes:

... you have to educate the consumers so if they’re going to be put on (medication) or something that you might say to them they’re going to get some dysfunction whilst you’re on this and that kind of opens up the door for them to come and tell you if it has. But then it may make them think, I’m not taking it, you might be making it more kind of difficult. (Joanne)

Discussion

Only four of the participants in this study reported discussing sexual side effects with consumers. Discussing side effects of medication was one approach they used to introducing the sensitive topic of sex. As an integral part of holistic care, nurses should include sexual issues as part of the assessment process. Furthermore, they should provide information and education for consumers (Katz 2002). The findings from the current research support the view that nurses do not routinely discuss problems of a sexual nature with consumers of mental health services (Earle 2001, Katz 2002, McCann 2003, Shield et al. 2005, Quinn & Brown 2009).

The nurse participants did identify that sexual problems frequently resulted as a side effect of psychiatric medication. This was an interesting finding given that less than half actually discussed sexual issues with consumers. It has been argued that consumers deserve the opportunity to have their sexual problems appropriately and thoughtfully identified and addressed (Krebs 2007) yet there is no evidence that this is part of routine nursing practice or the practice of other mental health professional such as psychiatrists (U’Cok 2008).

Adherence to psychiatric medication is identified as a major treatment issue for people with mental illness and side effects that impact on sexual functioning substantially decrease the likelihood of consumers being adherent (Mahone 2008, McCann et al. 2008, U’Cok et al. 2008, Gray et al. 2010, Anderson et al. 2010, Patel et al. 2010). These findings reinforce the important role nurses can play in openly discussing sexuality issues with consumers to improve their adherence to treatment (Salvon et al. 2007).

When participants discussed the sexual side effects experienced by consumers they almost invariably referred to or gave examples pertaining to young men. Women and older men were not mentioned. This appears to reflect a broader trend to empathise with the needs of younger men (Shell 2007, Phillips 2009). Sex education and the opportunity to discuss concerns of a sexual nature need to be offered to all consumers, particularly around issues of medication and possible side-effects that impact on sexual function (McCann 2000).

Participants felt that consumers would be too embarrassed to talk about sexual problems with staff. This has been identified as an excuse nurses use to avoid the topic due to their own embarrassment and lack of confidence (Shattell et al. 2007). Training can be used as an approach to help nurses overcome embarrassment and are better educated regarding sexuality issues (Lewis & Bor 1994).

The participants referred to a lack of information available to consumers about the sexual side effects of medication. Providing this information is considered an important nursing role (Happell et al. 2002, Savlon 2007). Nurses have ‘viewed themselves as primary educators, who provided information about adverse effects and gave advice about how medications could fit into a patient’s lifestyle’ (Happell et al. 2002, p. 254). Fundamental to this educational role, is the need to develop an understanding of adverse effects of medication. Consumer participants indicated that being better informed about side-effects allowed them to be better prepared and that consumers want to
know about what side-effects to expect from various medications before they had personally experienced them and before they had seen them in other people (Happell et al. 2004).

There was some concern amongst participants that if consumers becoming knowledgeable about the side effects they could experience, they may be deterred from taking medication at all (Jordan et al. 1999, Cort et al. 2001, Magnan et al. 2005, Krebs 2007, Shell 2007). Conversely it has been suggested that knowledge about side effects improved rates of adherence (Smith & Henderson 2000, Fernandez et al. 2006, Mitchell & Selmes 2007, Gray et al. 2010).

Limitations

The use of an exploratory qualitative approach with 14 participants from the one mental health service in Queensland, Australia limits the extent to which these findings may be considered transferable to other populations and settings. Furthermore, as an exploratory study, the findings are descriptive in nature. Theoretical explanations for the participant responses can only be tentative. It is important to emphasise that the aim of this study was to explore this important topic rather than to seek representative opinion.

Conclusions

The findings from this research suggests mental health nurses are reluctant to discuss sexuality as part of consumer care, even when they are aware of the implications these problems can have for their ongoing care and treatment. Sexual side effects of medication have been identified as a major contributor to non-adherence to medication, signalling a clear need for nurses to understand the importance of sexual functioning for consumers. It is, therefore, essential to address these issues and indeed to consider these discussions to be an important part of routine nursing care.

Relevance to clinical practice

The importance of sexuality in mental health care needs to be embedded into practice at assessment and throughout treatment trajectory. Strategies to address misconceptions and increase nurses’ comfort and confidence in discussing sexuality is an urgent priority. Further research is needed to investigate strategies and approaches that might assist mental health nurses with the skills and confidence to discuss sexual function with consumers. An opportunity exists for mental health nurses to engage and support consumers with their sexual concerns and perhaps this will reduce the risk to this group of dropping out of treatment as a result of sexual function problems arising from the side effects of the medications prescribed to them. Consumers are open to discussing their sexual concerns with nurses and nurses are in an ideal position to provide this care. Failure to address the sexual concerns of consumers limits the ability of mental health nurses to deliver holistic care.

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Contributions

Study design: CQ, BH, GB; data collection and analysis: CQ, BH, GB and manuscript preparation: CQ, BH, GB.

Conflict of interest

None.

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The findings from this publication provide a further dimension of avoidance by participants in discussing sexual concerns with consumers. The participants describe that despite their awareness that psychotropic medications can commonly cause sexual side-effects, they remained reluctant to engage with consumers on the topic. Participants also discuss their belief that if consumers were informed about possible sexual side effects from psychotropic medications they might cease their medication, providing additional justification for the avoidance of this topic by the participants. A further reason for avoiding discussing sexual concerns is illustrated in the beliefs held by participants that consumers would be too embarrassed to discuss such concerns.

All three publications arising from Stage 1 highlight that participants’ possess a level of understanding about the sexual concerns experienced by consumers. Despite this understanding, participants tended to avoid engaging with consumers regarding these concerns.

At the completion of Stage 1 interviews participants were provided with an overview of common sexual concerns experienced by consumers. Further to this, the participants were introduced to the BETTER model (discussed in greater detail in Chapter 3) as a framework that might assist them to engage with consumers. The participants were asked to trial the model to assist them to engage with consumers.

**Applying**

The interviews at Stage 2 occurred 4 weeks following the initial interviews. The aim of these interviews was to explore whether participants found the BETTER model to be a useful framework to promote the inclusion of consumer sexual concerns in their practice, and whether the participants
could identify any changes to their practice that were revealed in the findings at Stage 1.

At Stage 2, participants reported increased awareness about the impact sexual concerns can have on the lives of consumers, and subsequently they had commenced incorporating consumer sexual concerns into their practice. The findings from stage 2 are presented in the following publications: *Talking about sexuality with consumers of Mental Health Services*; and *Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care*.

This first publication: *Talking about sexuality with consumers of Mental Health Services* represents the first findings from Stage 2. Six themes are discussed from this publication these are:

- Using the BETTER model;
- Consumer responses;
  - Relief;
  - Gender;
  - Avoidance;
- Medication and sexuality;
- Sexual safety and identity;
Talking About Sexuality With Consumers of Mental Health Services

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Search terms: BETTER model, consumer, mental health nursing, sexuality

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PURPOSE: To explore nurses’ perceptions of how consumers of mental health services have responded to mental health nurses discussing sexuality with them. DESIGN AND METHODS: Qualitative exploratory design including in-depth individual interviews with 14 mental health nurses in Australia on two occasions. Nurse participants were taught the BETTER model in the first interview and were asked to use this in their practice.

FINDINGS: In the second interview nurse participants described the model as useful and consumer responses as very positive.

PRACTICE IMPLICATIONS: The findings suggest the BETTER model is a simple and effective intervention that can assist mental health nurses to include sexuality as part of nursing care.
Throughout history, civilizations have attempted to contain and control sexual behaviors in the effort to define what is considered normal sexuality for their society (Goodwach, 2005). At times containment and control of sexuality resulted from religious beliefs where right from wrong has been defined within a religious context (Foucault, 1998).

During the nineteenth century, normal sexuality, the act of having sex to create a family, was considered a right belonging to married couples (Goodwach, 2005). Sexual activity other than that of intercourse between married couples was considered unnatural and deviant (Leiblum & Rosen, 2000), and as a demonic force that could destroy families and society (Francoeur & Hendrixson, 1999). Around this time sexuality moved from the control of the church and came under the scrutiny of medicine, where medical treatments have been prescribed for what is regarded as normal and abnormal sexuality (Foucault, 1998).

Masturbation was understood as a primary cause of mental illness (Price, 2009), and loss of semen was thought to be debilitating with potential for madness or death (Price, 2009). Mental illness in women was attributed to a disease of their womb, and they were labelled as having “hysteria” (Keel, 2005). The surgical sterilization of women was viewed as a potential cure. In the early twentieth century sexual promiscuity was identified as a cause of insanity (Francoeur & Hendrixson, 1999; Kelly & Conley, 2004).

By the 1970s, there was a belief in psychiatry that sexual activity could contribute to the development of schizophrenia and therefore discussing sexuality concerns with consumers was considered inappropriate (Kelly & Conley, 2004). It was not until 1974 that homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders as a result of the powerful influence society had upon the medical profession because of the changing values and beliefs of Western society (Goodwach, 2005); homosexuality was no longer considered as an emotional or social problem (Deegan, 2001; Tate & Longo, 2004).

Today, society generally remains uncomfortable and ambivalent about the idea that people with disabilities might want or actually have sex (McInnes, 2003), and the notion that these people might seek intimate relationships has been met with disapproval (Earle, 2001; McInnes, 2003). The sexual and relationship needs of consumers can be negatively influenced by the prejudicial and discriminatory attitudes of others (McCann, 2003). The labelling of consumers as asexual is one way they are denied their rights as full adult members of society (Earle, 2001). Further, clinicians often assume that because of chronic illness, a discussion about sex is irrelevant because consumers are unlikely to form a relationship (Ford, Rosenberg, Holsten, & Boudreaux, 2003).

Being diagnosed with a mental illness does not mean the person is no longer a sexual being (Volman & Landeen, 2007). Problems of sexual functioning can impact profoundly on self-esteem and have negative consequences for relationships (Berner, Hagen, & Kriston, 2007). Furthermore, difficulties with sexual function have been identified as a major reason for nonadherence to psychiatric medications (Deegan, 2001; Roose, 2003; Rosenberg, Bleiberg, Koscis, & Gross, 2003), yet little attention has been given to this issue by mental health service providers (McCann, 2003; Quinn & Browne, 2009; Shield, Fairbrother, & Obmann, 2005; Wong & Mak, 2008). Major barriers to nurses discussing sexuality with consumers have been identified as lack of
education (Shell, 2007), low priority, and deferred responsibility. Also, the conversation might be distressing and embarrassing (Higgins, Barker, & Begley, 2005; Krebs, 2007). These barriers may in fact be excuses to avoid the topic (Krebs, 2007; McCann, 2010). From a consumer perspective, a recent study (McCann, 2010) has identified the major barrier for consumers in discussing sexual issues as failure of health professionals to address this topic. Consumers have the right to have their sexual concerns addressed in care (Krebs, 2007). Consumers may feel embarrassed and anxious (Cook, 2000; Quinn, Happell, & Browne, 2011) or have fear of being labeled or ridiculed by staff for their interest in sex (McCann, 2010). In fact, consumers report being eager and receptive to discuss these issues (Kelly & Conley, 2004), and welcome the opportunity to discuss their sexual health concerns (McCann, 2000) when nurses are willing to raise the topic (Kelly & Conley, 2004). So for consumers, the issue is less their inability to discuss their sexual concerns but more about nurses not creating opportunities (Wright & Pugnaire-Gros, 2010) or providing permission to discuss the topic (McCann, 2010).

Nurses, because of their close working relationship with consumers, are in an ideal position to support consumers in discussing sexuality, as well as providing information and education for consumers (Katz, 2002; Magnan, Reynolds, & Galvin, 2005; Mick, Hughes, & Cohen, 2004). Standardized forms have been criticized for limiting discussion and exploration of the consumer’s experience (Meacher, 1999; Skelton & Matthews, 2001). Specific models can be used to assist nurses in discussing sexual issues with consumers (Mosley & Jett, 2007), particularly as discussing sexuality can be embarrassing for nurses (Herson, Hart, Gordon, & Rintala, 1999; Higgins et al., 2005; Magnan et al., 2005; Shell, 2007). Models have been developed to provide a framework to assist nurses in addressing sexuality in a systematic way (Mick et al., 2004).

The BETTER model was developed to support nurses in oncology settings by providing a guide to assist them to discuss sexuality issues with people affected by cancer. In this study the BETTER model was used by psychiatric nurses as they discussed sexuality with their clients.

The BETTER model (Mick et al., 2004) includes six stages:

B = Bring up the topic, creating an opportunity for consumers to discuss what it means to them and identify any concerns (Mick et al., 2004), use of a private environment that is nonthreatening (Higgins, Barker, & Begley, 2006; Warner et al., 2004). Explaining that this is usual practice can increase the consumer’s comfort in discussing these matters with the nurse at any time, even if the consumer does not want to talk about them during the present assessment (Mick et al., 2004; Shell, 2007).

E = Explain that sexuality is a quality-of-life issue and that you are concerned with all aspects of the consumer’s life including his or her sexuality (Mick et al., 2004), and being open to discussing these issues can assist to normalize the discussion (Katz, 2005). Sexuality is a quality-of-life issue for all people, and consumers are no exception (Cook, 2000).

T = Tell consumers that even if an immediate solution is unavailable, resources to assist them will be made available or that referral to a specialist service will occur (Mick et al., 2004).

T = Time the discussion to an appropriate time for the consumer (Mick et al., 2004), and for consumers...
who are not ready to deal with sexual issues, indicate that you are willing to talk about sexuality issues and questions at a suitable time (Katz, 2005; Shell, 2007).

E = Educate the consumer about the side effects of their medications (Mick et al., 2004). Informing consumers about sexual side effects is as important as informing consumers about any other adverse effects (Mick et al., 2004), along with the need to provide consumers with written materials along with verbal explanations regarding how their treatment will affect their sexual function (Shell, 2007).

R = Record your assessments and interventions (Mick et al., 2004). Recording information about sexuality into clinical practice can validate the consumers’ experiences (Katz, 2005; Mick et al., 2004) and may well have a further impact upon the practice of other nurses by legitimizing the topic and serving as a reminder for others to include sexuality in their practice (Katz, 2005).

The BETTER model (Mick et al., 2004) is having an increasing impact within the field of oncology nursing (Katz, 2005; Shell, 2007; Southard & Keller, 2009), providing a framework to assist nurses in assessing and documenting the consumer’s experience (Hordern, 2008) and providing a person-centered approach to the inclusion of sexuality in care (Katz, 2005). An advantage of the BETTER model is that nurses are not required to hold specialist or advanced practice education in family planning, genitourinary medicine, or HIV/AIDS to use it. It is usable as an educational and discussion tool by generalist prepared nurses. The model’s growing popularity within oncology appears to be on the strength of the authors who have advocated its usefulness, rather than from research examining the effectiveness of the model.

The BETTER model’s applicability to mental health settings has not been researched. This article presents findings from a larger study exploring mental health nurses’ attitudes around discussing sexuality with consumers and the effectiveness of the BETTER model in assisting them to do this. The research question addressed in this article has the specific focus of examining nurses’ perceptions of how consumers of mental health services have responded when the nurse participants have discussed sexuality with them.

Method
Design
Because of the limited literature in this field, a qualitative exploratory design was utilized to explore nurse participants’ experience of using the BETTER model (Stebbins, 2001). Qualitative exploratory research facilitates an in-depth exploration of the opinions and experiences of nurses in relation to the topic of interest and is particularly relevant in areas where limited or no research is available.

Setting and Participants
Study participants were nurses providing care who were recruited from the continuing care stream of the adult mental health service in Queensland, Australia. This included an extended treatment inpatient and rehabilitation unit, and a community-based case management team. The principal researcher introduced the project to nurses at staff meetings and sought volunteers to participate in the study. Fourteen nurses agreed to participate. All participants had specialist qualifications in mental health nursing. There were eight females and six males, with an age range from 24 to 60 years with a mean of 44.4 years. One was a clinical nurse consultant (a nurse with advanced clinical skills), seven were clinical nurses (minimum of 2 years postgraduate experience),
and six were registered nurses (postgraduate entry level). Their level of experience varied from 2 to 39 years, with the mean at 14.9 years. Length of time in their current position ranged from 4 months to 9 years with a mean of 3 years. Nurse participants have been assigned a pseudonym to preserve their confidentiality.

**Procedure**

This research project occurred in two stages. During the initial stage the nurse participants were interviewed individually to discuss their current practices toward addressing the sexuality concerns of mental health consumers. They were provided an overview of the sexuality issues experienced by consumers to increase their knowledge base and awareness toward the sensitivities required by a nurse when exploring sexuality issues with consumers. Toward the end of the interview the nurse participants were introduced to the BETTER model and educated about its use in practice (Mick et al., 2004). This took approximately 20 min per participant. They were then asked to use the model to facilitate discussing sexuality with consumers over a 4-week period.

In the second stage, after the initial 4-week period, the in-depth interviews focused specifically on their utilization of the BETTER model, whether they found it useful in discussing sexuality with consumers, and to gain an understanding of how consumers responded toward them bringing up the topic of sexuality in care. The findings presented in this article are all derived from the second interview.

**Ethical Issues**

Ethics approval was obtained from the relevant mental health service and university ethics committees. Nurse participants were reassured that participation was voluntary and that they were free to withdraw from the study at any stage without penalty. Nurse participants received information pertaining to the study, with contact details for the research team, and were asked to sign a copy of the consent form. All participant details were kept confidential and pseudonyms were assigned to maintain privacy. To ensure consumer safety, the need for sensitivity when discussing sexuality with consumers was reinforced and nurse participants agreed not to disclose the identity of any consumer when discussing their clinical experiences.

**Data Analysis**

Interviews were digitally recorded and transcribed verbatim by the principal researcher with the aim of becoming immersed in the data. The five-step framework developed by Ritchie and Spencer (1994) guided the analysis. This process includes familiarization; identifying a thematic framework; indexing, charting, and mapping; and interpretation. This approach to data analysis facilitated progression from a broad understanding of the interview data to the identification of specific themes. The interpretation of data was refined on an ongoing basis by all members of the research team. During data analysis the team was satisfied that saturation had occurred as no new themes were emerging (Stebbins, 2001).

Consumer responses to the discussion of sexuality were a major theme to emerge from the second stage of this work, and a presentation of this theme is the primary focus of this article.

**Findings**

**Using the BETTER Model**

Participants identified barriers to including the discussion of sexuality as part of practice, including whether it should be part of their role. They expressed doubt over their clinical skills to engage with consumers on the topic. When they did broach the topic, after being introduced to the BETTER model, they were surprised at the reactions of consumers; for example:
Speaking to someone initially was a little bit daunting and it’s a bit hard to bring that sort of thing up but sometimes it’s almost like they’re waiting for you to say something and then they just explode, with all this information, it’s been good.

And:

They’ve just been open about it. I was surprised about this, I thought they might have thought it was strange and unusual for a nurse to talk about this but they were okay with it. They were happy to discuss any issues that they might be experiencing.

Most nurse participants stated that they found the BETTER model helpful. It was easy to understand, and having a guide provided them with permission to include the topic of sexuality in their practice:

It helped to show me that it was safe, it’s okay to use to actually ask questions about it, it actually gave me a little bit more confidence to raise the subject without thinking ok oh there might be a negative outcome to it.

And:

It’s good, it’s pretty straightforward (the model). I was really nervous about it, it was a bit like when first had to ask someone whether they were feeling like hurting themselves, you know like I wasn’t sure how they might react or respond to me.

Consumer Responses: Relief

Nurse participants described many examples of consumers responding positively when the topic of sexuality was included in their care. Many consumers expressed relief that the topic had been raised. They described being surprised with the relief the consumers expressed and their willingness and openness in discussing sexual issues, as stated:

[They were] pretty open about it. They were happy I think that firstly, I had asked them and secondly I think they were in a way relieved that they could now talk about their problems. It was like I’d opened the door for them, you know, given them permission to talk about their stuff.

And:

They . . . seemed relieved that I’d brought it up with [them] they all talked about having problems. One guy didn’t go into it much but the other guys talked about having problems getting it up and one guy couldn’t cum. He was so [angered] and confused. He was too frightened to tell anyone.

Consumer Responses: Gender

Nurse participants described both male and female consumers being open to discussing the topic; as this female nurse participant stated:

I find both males and females are happy to discuss it. . . . I’ve never really had anyone be embarrassed when I’ve initiated it, sometimes there’s a sense of relief, I think, for a lot of them.

This contributed to the acknowledgment that sexual functioning can also be affected for female consumers:

She said she hadn’t been sexually active for eight years, and why did I want to know. I had to put her at ease . . . I thought that by talking to a woman she might feel more comfortable . . . so I just reassured her that she can come and talk if she needs to . . . I don’t think she’d spoken to anyone about this.

Consumer Responses: Avoidance

While most consumers demonstrated openness to discussing sexuality issues with them, some chose not to discuss this topic. The nurse participants felt that these consumers may not have discussed this very private part of themselves with anyone and that the topic for these consumers resulted in consumer embarrassment:

. . . There are others (where it is) just a no go zone. In some ways I think they may not have shared that with anyone else.

And:
Some people haven’t said anything, others have gone red. . . . Yeah I think they might have been a little embarrassed, I mean they probably just weren’t use to having someone ask them about it.

**Medication and Sexuality**

Consumers discussed sexual issues related to their mental health treatment such as nonadherence to psychiatric medications frequently arose as a consequence of sexual side effects. The need to provide advocacy for the consumer with the treating team to address the problem was seen by some as an important role for nurses. Consumers are unlikely to initiate a discussion around sexuality, and avoidance of the issue might lead to further adherence problems; for example:

There was one client who was [prescribed psychiatric medications] we started talking . . . and he said he can get it up but not for long periods of time and he can’t come when having sex so he doesn’t try it with a woman and that kind of thing . . . . I did express concerns to his treatment team that it was a problem for him, prior to this he hadn’t spoken to anyone so it was quite good [for] him because he had to get something done about it but previous to that I don’t think his sexual health was considered.

And:

Most talk about problems in getting erections or in cumming, yeah I think “get it up” and cumming.

**Sexual Safety and Identity**

It also provided the opportunity for the discussion of issues related to sexual health and sexual safety as the following quote demonstrates:

One particular client . . . comes in for his depot and is HepC positive so I talked to him about protecting his girlfriend and stuff like that and of getting to the HepC group at ATODS (the alcohol and drug service) and he was open to talking about that.

The nurse participants described being open to discussing any sexuality issue raised by consumers, including, in one instance, discussing prostitution as a means of financial survival and the sexual exploitation that can result from prostitution:

She’s spoken to me about sexual things like should she still go out and do sexual work for money? But she doesn’t do it just for money, for cigarettes or if she’s low on rent . . . I had a good chat to her . . . she’s an adult and that’s her decision to make but you always have to be careful and mindful of situations and diseases and to make sure she has check-ups, uses protection and all those sort of things.

A further story was revealed where a consumer believed that her loss of libido over a 3-year period had resulted from her previous involvement in prostitution; she had not discussed her concerns previously with a health professional and as a result had received no investigation into losing her sexual drive:

She believes that it is the outcome of her lifestyle and that she did not have sex for three years. Her previous lifestyle did include being a prostitute, a lot of drug use . . . . I left her with the information, but I suspect she won’t come to me, and I will have to come to her, and I will have to continue this.

Nurse participants also described the struggle faced by many people in coming to an acceptance of one’s sexual identity, highlighting their acceptance toward discussing issues of sexual diversity as part of their care; for example:

I have a male client who (I’ve) approached a number of times about sexual issues and stuff like that and I’ve spoken to him also in regard to medications and he said he’s having no problems with that but again after questioning him about his . . . sexual identity, he always flips the coin back
half an hour later and changes his mind . . . so I’ve had many chats with him about things.

Discussion
The findings from this research suggest that the BETTER model is relevant in a mental health setting. For most nurse participants sexuality was a new topic to include in their clinical discussions with consumers. There was initial hesitancy. After a brief educational intervention using the BETTER model, all nurse participants were willing to engage with consumers around sexuality issues.

These findings support the views that the BETTER model is applicable across nursing fields (Katz, 2005). This is particularly important given the common discriminatory attitudes to sexuality for consumers of mental health services (Earle, 2001; Ford et al., 2003; McInnes, 2003; Warner et al., 2004) and the negative impact on consumers when sexual issues are not addressed as part of care (Warner et al., 2004). The nurse participants described being surprised by the positive responses by consumers; the embarrassment they expected occurred rarely. On the contrary, consumers often appeared relieved by the opportunity to discuss their concerns. The existing literature emphasizes consumers’ appreciation of the opportunity to talk to nurses about sexuality issues, which is supported by the experience of the nurse participants in the current research. This reinforces the value of having nurses initiate these conversations about sexual issues with consumers (Volman & Landeen, 2007).

The nurses in this study demonstrated an ability to support consumers on a range of sexuality-related issues, including discussing sexual health, sexual safety, and sexual diversity. After training in the BETTER model, their self-described comfort and confidence developed within a relatively short period of time of 4 weeks. They moved from a position of avoidance and anxiety around the topic to a position where they were open to discussing sexuality (Quinn et al., 2011a) issues with both male and female consumers. Concerns about boundary issues, particularly in relation to female consumers, were previously identified by the participants as a barrier to talking about sexuality (Quinn, Happell, & Browne, 2011). The nurse participants were able to demonstrate support for consumers struggling with sexual identity issues, and were accepting of consumer sexual choices, offering support toward them, and taking advantage of this situation to provide education regarding sexual safety and the importance of receiving sexual health checks. These issues are important to consumers of mental health services, and the opportunity to address them is expected to enhance the outcomes of care and treatment (King et al., 2008; Shield et al., 2005).

The nurse participants noted sexual side effects from psychiatric medications as a topic raised by consumers when discussing sexuality. Medication adherence is a significant clinical concern (Anderson et al., 2010; Patel, Ni, Clayton, Lam, & Parks, 2010); sexual side effects from psychiatric medications have been recognized as a major contributor to nonadherence, but this does not appear to have influenced clinical practice to any significant degree (Cort, Attenborough, & Watson, 2001; McCann, 2010). Nurse participants described examples of advocating the consumer’s concerns to the treating psychiatrists contributing to a treatment decision that might lead toward the resolution of the consumer’s sexual concerns. This represents a considerable clinical progress to the barriers highlighted (Cort et al., 2001), where it has been discussed that engaging with consumers on sexual side effects of medications would lead to
issues of nonadherence and that the attitudes held by the nurses formed barriers that restricted conversations on the topic.

The BETTER model provided a useful tool to assist the nurse participants, who found the model easy to understand. It took approximately 15 min to learn enough about the model to be able to use it in practice. The heavy workloads for nurses in mental health settings have been acknowledged (Happell, 2008; White & Roche, 2006). This pressure leaves little time for staff development and ongoing education in a formal sense (Happell, 2008). It is therefore imperative that educational interventions can be delivered, understood, and adopted without the need for lengthy training programs. This is clearly a strength of the BETTER model.

The implications of these findings for mental health nursing practice are significant. For more than two decades nurse researchers have advocated for nurses to attend to the sexual concerns of consumers (Lewis & Bor, 1994; McCann, 2000; Volman & Landeen, 2007; Waterhouse & Metcalfe, 1991). Despite this, reluctance to engage with consumers on the topic remains common (Magnan et al., 2005; Shell, 2007). Mental health nursing is no exception. On the strength of this preliminary work, further research into the usefulness of the BETTER model for nursing practice and consumer outcomes appears warranted.

Limitations
This sample size of 14 nurse participants, from the same mental health service within Queensland, Australia, signifies the need for caution in considering the degree to which these findings can be generalized to mental health nurses in other settings and locations.

Conclusion
Sexuality is inherently a human need, and people diagnosed with mental illness are no exception. The sexual concerns of consumers of mental health services should therefore be an important component of nursing care. Given the reluctance of nurses to address these concerns, educational programs are needed to assist nurses to develop both comfort and confidence in talking about issues of sexuality with consumers. The findings from this study suggest that the BETTER model is a simple and effective intervention to guide nurses in discussing sexuality with consumers.

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References


The findings presented here suggest all participants were willing to trial the BETTER model in their practice with consumers. They described the BETTER model as simple to understand and a useful framework to assist them in bringing-up the topic. They reported that consumers responded positively to these conversations, providing positive reinforcement for the participants to continue to include sexual concerns in their practice. It was particularly interesting to note the level of comfort and confidence the participants achieved in a relatively short period of time from avoidance to inclusion. Four weeks following the education session they had moved from avoiding the topic and feeling considerable discomfort to one where they were able to engage with and support consumers on a range of sexual concerns. The participants also discussed feeling less concerned with the gender and boundary issues that had been identified just four weeks prior to these second stage interviews.

The following publication: *Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care*, presents further findings from Stage 2. Two themes in relation to the change in the practice of participants to the inclusion of consumer sexual concerns are discussed in this publication. These are:

- Greater awareness; and
- Becoming part of practice.
Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care

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ABSTRACT: Discussing sexual issues with consumers is considered a nursing role, yet it is commonly avoided. Research suggests that sexual issues and difficulties are particularly evident in mental health settings, and failure to address these issues represents a significant gap in care and treatment. Specific models for raising sexual issues have been used in oncology and cardiac care settings to assist clinicians. A descriptive, exploratory study was conducted with mental health nurses from Queensland, Australia. The aim of this research was to explore whether a specific model, the BETTER model (bring up, explain, tell, time, educate, record) was useful in assisting mental health nurses in raising the topic of sexuality with consumers. In-depth interviews explored participants’ attitudes and experiences of discussing sexuality. Participants were introduced to the BETTER model, and were asked to trial the approach with consumers. They were then interviewed a second time. Two main themes emerged: greater awareness and becoming part of practice. Participants described a transformation of their practice from one of avoiding issues of sexuality with consumers, to a position of inclusion, which became embedded within practice. Participants did not tend to use the model in a structured way, and it appears that knowledge and awareness were more useful than the model itself.

KEY WORDS: bring up, explain, tell, time, educate, record, mental health, nurse, sexuality.

INTRODUCTION

Approximately 20% of the adult population aged between 16 and 85 years report having a long-term mental or a behavioural problem (Australian Bureau of Statistics 2007; New Zealand Ministry of Health 2005; Singleton et al. 2000; Substance Abuse and Mental Health Services Administration 2011). Within this population group, consumers diagnosed with a long-term mental illness can experience difficulties in
forming sexual relationships, and there are high rates of relationship breakdown (Berner et al. 2007; Fortier et al. 2003). These difficulties can be further compounded by social stigma associated with a diagnosis of mental illness, and the impact this can have upon a person’s self-image and confidence (Davison & Huntington 2010; Volman & Landeen 2007).

High-risk sexual behaviours are common within the general population (Anderson et al. 2006; Calsyn et al. 2010; National Centre in HIV Epidemiology and Clinical Research 2010). It is difficult to determine from research findings the extent to which these risks are exacerbated for people diagnosed with a serious mental illness. There is some evidence to suggest that consumers are more likely to acquire a sexually-transmitted illness (Cook 2000; Dyer & McGuiness 2008; Rosenberg et al. 2005). Sexual impulsivity seen in bipolar disorder (McCandless and Sladen 2003) can result in increased risk of acquiring a sexually-transmitted infection (Rosenberg et al. 2005), and risks possible conflict in their relationships through sexual indiscretions resulting from impulsivity (McCandless and Sladen 2003). Consumers are considered vulnerable to sexual exploitation (Higgins et al. 2006) and coerced sex (King et al. 2008). Sexual abuse rates for consumers are estimated at 68% for women and 40% for men (Goodman et al. 2001), compared to 22% for women and 3.8% in men in the general population (Elliott et al. 2004).

Psychiatric medications pose an additional problem contributing to high levels of sexual function problems (Khawaja 2005; U’cok et al. 2007). These side-effects frequently contribute to consumers stopping their medication (Deegan 2001). The non-adherence to psychiatric medications, as a result of sexual side-effects, has been described as a crisis within mental health (Gray et al. 2010).

Mental health nurses are aware of the sexual problems experienced by consumers, and despite this, avoiding discussions of sexual issues in care is widespread within nursing (Katz 2005b; Krebs 2006; Shell 2007) and mental health settings (Fortier et al. 2003; McCann 2003; Quinn & Browne 2009; Shield et al. 2005; Wong & Mak 2008). This persists, even though there is evidence that consumers of mental health services welcome nurses initiating these conversations (Phillips & McCann 2007). This avoidance, therefore, appears not to reflect consumers’ inability to discuss their sexual concerns, so much as nurses not creating opportunities (Wright & Pugnaire Gros 2010) or providing permission (McCann 2010) to discuss the topic.

Educational programmes have been implemented to assist nurses to discuss sexuality with consumers in other health-care settings, such as oncology and cardiology, and improved confidence in practice was observed (Katz 2005b; Krebs 2006; Martinez 2007; Mick et al. 2004). Training has an important potential to improve practice (Gianotten et al. 2006; Katz 2005b; Mick 2007), and its absence contributes to a cycle of avoidance, where consumers do not receive the support they require because of the lack in skill and level of discomfort nurses have around issues of sexuality (McCann 2010).

The BETTER model (Mick et al. 2004) was introduced as a structured approach to addressing
sexual issues with consumers in an oncology setting. The model comprises of six individual stages:

**B** = bring up, where the nurse simply raises the issue of sexuality with consumers. By raising the issue, even if the consumer chooses not to respond, nurses are informing the consumer that they are open and willing to discuss these issues if the consumer wishes to do so at a later date (Mick et al. 2004).

**E** = explain, requires nurses to explain that for many, sexuality is an important quality-of-life issue, and that you are open to discussing these issues (Mick et al. 2004). This assists in normalizing the discussion and might help the consumer to feel less embarrassed or alone (Mick et al. 2004).

**T** = tell, is where the nurse tells the consumer that even if an immediate solution to their concern is unavailable at this time, a referral will be made to a specialist service to assist (Mick et al. 2004).

**T** = time, where the nurse times the discussion to the consumer’s preference. Consumers who are not ready to deal with sexual issues can ask for information in the future (Mick et al. 2004).

**E** = educate, there is the need to educate consumers regarding sexual side-effects of treatments. Informing consumers about sexual side-effects is as important as informing consumers about any other adverse effects (Mick et al. 2004).

**R** = record, the assessment, treatment, and outcome in the consumer’s medical record. Integrating this information can validate the consumers’ experiences and enhance their quality of life (Mick et al. 2004).

Sexuality intervention models can be used to open channels of communication for consumers to discuss sexual issues (Mosley & Jett 2007), and can support nurses by providing a guide for appropriate steps to address sexuality with consumers (Mick et al. 2004). Three models are commonly identified within the literature. The ALARM (activity, libido, arousal, resolution, medical information) model (Andersen 1990) has a medical focus towards the assessment of physical problems. The PLISSIT (permission, limited information, specific suggestions, intensive therapy) (Annon 1976), and BETTER (Mick et al. 2004) models are the most commonly described within recent literature (Cort et al. 2001; Hordern 2008; Martinez 2007; McInnes 2003).

There are four levels to the PLISSIT model, and they range from the simplest interventions to more complex interventions requiring a higher level of expertise (McInnes 2003). The PLISSIT model has been described as an outdated counselling approach (Hordern 2008), and due to the need to have expertise in the area of sexual health care, nurses would be limited to intervene at the first two levels of the PLISSIT model (Cort et al. 2001), requiring postgraduate qualifications to intervene at the higher levels (Annon 1976).

The BETTER model has been recommended for use in supporting nurses in discussing sexuality (Katz 2005b), and more specifically, with those persons with a chronic illness (Krebs 2007), in oncology settings (Krebs 2006), and with women during the postpartum period.
(Convery & Spatz 2009), Martinez (2007) advocates that the model can be beneficial in supporting clinicians to overcome barriers, and provides them with a framework to promote discussions around sexuality issues arising from medical conditions, such as diabetes or cardiovascular disease, illustrating the usefulness of the model across a variety of specialty health-care settings.

The BETTER model was also selected because of its simplicity and specific focus on improving communication and assisting nurses to introduce the topic of sexuality (Martinez 2007), facilitating what has been described as a ‘person-centred approach’ (Hordern 2008). Placing the consumer at the centre of care is a philosophy familiar to mental health nursing, which suggests that the BETTER model might assist mental health nurses in discussing sexuality issues with consumers.

Despite the attention it has received in the literature, there is no evidence that the BETTER model has resulted in changes to practice in any clinical settings, including mental health. The aim of the current study was to explore the experiences of nurses’ use of the BETTER model in working with people diagnosed with a mental illness.

**METHODOLOGY**

**Design**

Exploratory research is a widely utilized methodology within nursing, emphasizing the participant’s individual experience (Polit & Beck 2004), and attempting to capture the entire experience for the participants (Polit & Beck 2004) in their natural setting, with the aim of understanding the participant’s subjective experience, and explaining their experience as they see it. This research approach is in-depth and subjective, and is intended to increase the knowledge of the field of study (Polit & Beck 2004). An exploratory qualitative design was the chosen methodology to investigate whether the BETTER model is found to be useful by nurses in discussing issues of sexuality with consumers. This involved exploring nurses’ perceptions over two time points.

**Setting**

The mental health nurse participants were recruited from three continuing care sites within a Queensland mental health service. These sites included a community mental health continuing care team, an inpatient extended treatment unit, and an inpatient rehabilitation unit.

**Ethical issues**

Ethics approval was obtained from both the mental health service where the study was undertaken, and from the relevant university. The ethical research principles of the right to self-determination, confidentiality anonymity, and the right to privacy were observed (Polit & Beck 2004). The objectives of the research were fully explained, and informed consent was obtained from the participants, along with informing them of their right to withdraw their consent at any time. The research data were only made available to the research team, and have been securely stored. All participants were provided a pseudonym to ensure their confidentiality.

**Participants**

Following ethics approval, the principal researcher met with the managers of each site prior to approaching nurses at the sites, where they were invited to participate in the research. A
convenience sample of 14 nurse participants were provided with an individual education session with the aim to expand their knowledge base to sexual issues faced by consumers. The participants included eight females, and six males. All participants were registered nurses, their age ranged from 24 years to 60 years, and their level of experience varied from two to 39 years. For the purpose of confidentiality, pseudonyms have been assigned to participant responses.

**Procedure**

Data were collected through individual in-depth interviews. The interviews were held in a private location away from the immediate work environment to ensure privacy, avoid interruptions, and to assist in protecting their privacy. At the commencement of each interview, participants were asked to discuss their opinions and experiences of discussing sexuality and whether sexual issues are raised during their interactions with consumers. Participants were also encouraged to share any additional information they considered relevant to the topic. The interviews were primarily directed by the responses of the participants. The guiding principle of the interviews was to encourage the participants to speak at length about their experiences to gain insights into their attitudes, behaviours, concerns, and practice (Horsfall et al. 2007). A conversational approach was utilized to allow participants the opportunity to speak freely and openly about their experiences and practices (Horsfall et al. 2007). The principal researcher sought clarification of responses, and encouraged participants to elaborate if relevant. The interviews were interactive, and participants were encouraged to share their stories, experiences, and knowledge around the topic (Polit & Beck 2004).

When the principal researcher was satisfied that the participant’s experience had been fully explored, a brief individual education session was provided. These education sessions focused on sexuality issues experienced by mental health consumers, sexual safety, sexual abuse and exploitation, sexual vulnerability, and sexual function problems associated with medication. The education session included a discussion of the BETTER model (Mick et al. 2004). Each stage of the model was described to participants, and they were encouraged to ask questions and clarify their understanding of each stage and the model as a whole to gain personal insights from the participants (Horsfall et al. 2007). The education session took approximately 40 min to complete for each participant, and signified the end of their initial interview. The participants were then asked to trial the use of the model with consumers over a 4-week period. A follow-up individual in-depth interview was subsequently conducted to explore their experience of using the model.

**Data analysis**

The Ritchie and Spencer (1994) five-step approach of familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation, was used to analyse the data. The familiarization phase commenced with the manual transcription of the digital recordings by the principal researcher. The process is described as immersing oneself in the data (Polit & Beck 2004), gaining a rich understanding of the data. The identification of a
thematic framework involved the examination of data to identify the emergent themes and subthemes (Polit & Beck 2004) and looking at the data that corresponds with the themes, referred to as indexing. The charting phase involved creating a summary of the findings relevant to each theme, and during the mapping and interpreting stage, the participants’ responses for each theme were compared and contrasted in order to identify patterns and explanations for the findings (Polit & Beck 2004).

**Trustworthiness**

The trustworthiness of the data was achieved by addressing credibility, confirmability, transferability, and dependability (Lincoln & Guba 1985). Credibility refers to confidence in the truth of the data, and the interpretation of the data (Polit & Beck 2004) was ensured through the use of participant quotes to provide voice to the participant’s views. A further demonstration of credibility occurred through the supervision process of the principal researcher by the research team, who provided peer review to facilitate the integrity of the interpretation of the findings (Polit & Beck 2004), and ensured that the principal researcher’s interpretation of the data was a credible, genuine, and reliable interpretation of the data (Polit & Beck 2004), thus ensuring confirmability. Transferability was established by the development of a thick description of the research (Polit & Beck 2004) and in maintaining an audit trail, ensuring that the process of the research is logical, clearly documented, and observable, therefore increasing the dependability of the study.

**FINDINGS**

Two important themes are discussed, where participants share their experience of gaining a greater awareness on the topic, and that the inclusion of the topic in care had become part of their practice.

**Theme 1: Greater awareness**

Participants discussed the effects that psychiatric medication and illness can have on sexual function, and the impact of social stigma associated with being diagnosed with a mental illness. They described the possible consequences on consumers’ confidence in finding a partner or in managing a fulfilling relationship. Participants talked about consumers having sexual health risk factors, such as the reported high-risk sexual behaviours, including multiple sexual partners, little attention to safe sexual practices, and frequent engagement in sex with other high-risk groups, such as people with substance use problems. Sexual vulnerability was frequently raised, along with the alarmingly high rates of sexual abuse.

According to participants, the education session raised awareness of the importance of sexuality and intimacy for consumers, as the following statement illustrates:

> It’s really important (to talk about sexuality). It’s a really essential part of people’s identity, their recovery, and their wholeness as human beings, to have the ability to love, be loved, and to express that intimacy with someone else, and to value themselves. So I think it’s very important that we discuss this. (Shannelle)

Participants referred to the opportunity and responsibility nurses have to address all side-effects of psychiatric medications, including
sexuality, given the implications non-adherence to treatment might have for care and treatment:

If the medications are reported to have side-effects of sexual dysfunctions in any way, then it is our duty to say: ‘Look, just like I need to ask whether you are having any physical side-effects, I need to ask you whether you are having any (sexual) side-effects. (Frank)

The BETTER model was perceived as valuable by some in supporting them in discussing sexuality issues with consumers; however, others were more inclined to see the value in terms of raising their awareness about the issues of sexuality and the potentially severe impact on consumers of mental health services, as one participant described:

I’m not sure whether the model was that helpful or whether me just gathering some courage and having a go. I definitely feel that following our talk, that it was made clear to me what a big problem sexual dysfunction can have for the (consumers), and that I should talk about it and see if it is a worry, and perhaps do something about it. (Louise)

While the participants described enthusiasm about engaging with consumers, and trying the BETTER model, they acknowledged that this would not be effective without a strong relationship with the consumer, based on rapport and trust before engaging on the topic, waiting for the appropriate time for them and for the consumer:

Yeah, I think I’ll just include it. Not straight up; I’ll probably wait until the right time. I don’t think this is the type of thing to talk about straight up, but perhaps a few days into the admission. I mean, if the guy is really psychotic, I wouldn’t bring it up, so I guess you need to pick the right time; once he’s well enough and the time is right. (Rhys)

Most of the participants referred to the topic of sexuality as a legitimate one. As a result of the education session and the introduction to the BETTER model, the participants believed that they were now more likely to view sexuality as an important area that they should include when considering consumer care needs, and would more likely to open the door for consumers to discuss the topic if they choose to:

It’s useful for the (consumers) to know that they can come and speak to us, approach us . . . we don’t know whether they are masking any signs or symptoms or anything in the area of sex or sexual dysfunction, or whether we are contributing to anything. At least they know they have the opportunity to talk about it, or that they can come and see us if they need to. (Joan)

Some participants described their views that using the BETTER model had armed them with a better understanding of sexual issues for consumers, and provided a framework to safely discuss the topic with consumers. This resulted in a change in practice from avoidance of the topic to one of inclusion:

It’s something we had never discussed before . . . and it was something I had never thought of, and it is part of that person, and sometimes a very big part, so it was a useful thing to do. . . . If the doctor had leant over to me and said: ‘Do you think she is going out and meeting boys and having sex with boys?’ I would have had to say: ‘I don’t know’. Now I do. (Jean)

For some participants, the model provided a very tangible and structured approach to raising the topic, which helped to dispel the fear of broaching a taboo subject by breaking it into steps:
It was very useful. It just gave me the confidence; it is important to ask. We do have the evidence to say we should ask; it is essential, and probably how to go about it. That was very important to me, because I didn’t know how to do it . . . with this model, we approach, we raise the topic, and we wait. We don’t need to have the answer. (Frank)

Another participant expressed the view that the model reflected his approach to bringing up topics of care that the consumer might find difficult. However, he stated that that not all steps of the model were useful; for example, he did not record his conversations around sexuality, out of concern that his conversations with consumers might be taken out of context by his colleagues, and responded to the perceived needs of individual consumers in deciding what information to share and at what point. His approach was one where he would raise sexuality as a care issue, but still exercised a censorship over information that he felt might have an adverse impact for consumers.

**Theme 2: Becoming part of practice**

Through using the BETTER model, participants perceived that bringing up the topic of sexuality progressively became easier, and they had become more confident in discussing issues relating to sexuality:

- It’s like (any new skill); if you practice it . . . and reflect upon different responses, it teaches you ways of doing things better. . . . Getting a clinical comfort around the topic is important . . . and the more you practice it, the more comfortable you get at it. (Olivia)
- It wasn’t that I was nervous or apprehensive, it’s that I had to think of what I should be saying; it didn’t come naturally. . . . Then once you’ve done it with one (consumer), you gain a little more confidence and it gets easier. (Frank)

The BETTER model was described by most participants as easy to understand, the structure was not complicated, and this assisted them to include the approach in their practice. Because of its simplicity, participants described the approach as steadily becoming part of their practice:

- It’s like the stock standard now (including sexuality), and I’ve put it into my practice. I don’t get so red now myself talking about it . . . . I’ve found that by asking about possible sexual side-effects is a good way to get the conversation going. . . . it’s opened the door to the conversation. (Olivia)

There was no discussion to the use of stage 2 of the model ‘explain’, and no discussion of the importance of timing the discussion, stage 4 of the model:

- As for explaining the quality of life thing, no didn’t go there, but I did bring it up (sexuality) with quite a few clients. (Louise)

Most participants did not use the model exactly as presented, but rather tended to adapt it to suit their own style, to find a way to introduce the topic in a way that felt natural for them:

- Well, I wouldn’t say I stuck strictly to the model. I was happy to raise it. I think it provided a better awareness to help approach people, reminding me that it was something I needed to have in my mind with each (consumer). I just couldn’t remember all the steps. (Jenny)

**DISCUSSION**

The findings from this research demonstrate that for most participants, discussing sexual issues with consumers was new ground. It has been extensively documented that nurses experience confusion, embarrassment (Pacitti & Thornicroft
2009), and avoidance (Quinn et al. 2011) when faced with sexual issues in care. The participants considered the education session as valuable in increasing their knowledge, understanding, and awareness of the sexual issues that can be experienced by consumers in mental health settings. Participants reported a perceived improvement in their understanding of the many areas of a consumer’s sexuality that can be affected, such as sexual dysfunction arising from the side-effects of medication, relationship issues, and the right of all people to have access to relationships that are free from harm (World Health Organization 2001). This finding supports previous observations that practices regarding sexual concerns of consumers improve when nurses receive education on the topic (Gianotten et al. 2006; Katz 2005b; Saunamaki et al. 2010).

The participants identified the need to develop rapport before engaging on the topic (Katz 2005b), and described their approach as one of legitimizing the topic (Krebs 2007; McCann 2003). This represents the intention behind the first stage of the BETTER model: ‘bring up’ is intended to achieve; to open the door to the discussion of sexual issues (Mosley & Jett 2007). Furthermore, the experience of the participants demonstrates that the more they discussed sexual issues with consumers, the greater their comfort and confidence with the topic became (Gianotten et al. 2006). The steps of the BETTER model were not followed strictly. Perhaps this was due to mental health nursing being one that is underpinned by person centred care (Goodwin & Happell 2007; O’Brien 2001; Rydon 2005; Shattell et al. 2007), and as such, specific stages of the model to assist the therapeutic approach of engagement were not as helpful as responding to the needs and circumstances of individual consumers. The participants described value in using the intent of the model to raise the issue of sexuality with consumers. The BETTER model, as one part of the education sessions, took approximately 40 min to introduce, and along with its simplicity for practice (Martinez 2007), it is more likely to be successfully implemented than an intervention requiring a lengthy training programme. This is a particular benefit, given that nursing workloads limit the ability of nurses to include evidence in their clinical care (Bahtsevani et al. 2005; Pravikoff et al. 2003; Young 2003).

This study represents the first documented research into the effectiveness of the BETTER model; therefore, it is difficult to determine whether similar findings would emerge in other settings or whether they are unique to the mental health environment. The nurse–patient relationship is fundamental to mental health nursing (Goodwin & Happell 2007; O’Brien 2001; Rydon 2005; Shattell et al. 2007). A structured approach might, therefore, be less appropriate in this setting than in specialties with a greater focus on physical care. Participant responses support this explanation. In almost all instances, participants referred to discussing sexuality within the context of their relationship with the consumer. The relationship, as perceived by the nurses, determined when and how the topic was introduced. The BETTER model might, therefore, be too structured and formal for effective use in mental health settings.

However, participants described feeling more confident and more likely to initiate discussions
around sexuality issues with the consumers than had previously been the case. This is important, given the serious implications of sexual issues and difficulties that tend are more commonly associated with people diagnosed with a mental illness (Cook 2000; Dyer & McGuiness 2008; Elliott et al. 2004; Goodman et al. 2001; Higgins et al. 2006; King et al. 2008; McCandless and Sladen 2003; Rosenberg et al. 2005). Strategies that enhance nurses’ comfort in addressing these difficult issues are likely to lead to greater identification of sexual problems, and ultimately to the opportunity to resolve them and improve the quality of care provided to consumers.

For most participants, this change in practice appears to be reflective of greater awareness of the importance of discussing sexuality with consumers, rather than the model itself. If this assumption is correct, consideration of ways to increase this awareness should be considered. Inclusion in undergraduate and postgraduate curricula would hopefully embed the importance of sexuality in health care from the outset, with postgraduate curricula increasing the specific focus on consumers of mental health services. Sexuality could be incorporated into professional development programmes for nurses, and included in all formal documentation relating to assessment and ongoing care, to effectively become part of practice. Further research is required to understand how mental health nurses can most appropriately be educated to understand the importance of, and feel confident to, introduce the discussion of sexuality as part of routine practice.

**Limitations**

Qualitative research has the advantage of allowing for detailed exploration of opinions and experiences. However, given the relatively small number of participants, all employed in the one mental health service, it is difficult to estimate the extent to which the findings can be considered transferable to another setting.

The focus of these findings is on participant perceptions, rather than measurable change. No formal testing of their knowledge occurred at the onset or at the time of the second round interviews. Further research and evaluation are required to examine whether education can improve practice around the inclusion of sexuality in practice.

**CONCLUSIONS**

Sexual issues and difficulties are common for consumers of mental health services, and can have significant adverse effects on care and treatment. These problems have likely been exacerbated by the reluctance of nurses to discuss sexuality with consumers. The BETTER model, initially introduced in oncology settings to facilitate nurses to discuss sexuality, was introduced to 14 mental health nurses in Queensland, Australia. Subsequently, most participants described including sexuality as part of practice, and had developed more confidence in discussing this topic with consumers. However, it appears the BETTER model itself was of limited use, as most participants preferred a less formal approach. Given the significant changes in practice evident in the participants, it appears that knowledge and awareness raising can contribute substantially to positive changes in practices relating to sexuality.
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REFERENCES


The findings from this publication build on those of the previous publication in highlighting the change in practice for the participants where they were now appreciating the importance of including consumer sexual concerns in their practice. Under the theme *greater awareness* participants discuss in broader detail a range of consumer sexual concerns such as the effects that psychotropic medication and illness can have on sexual function; the impact of social stigma associated with being diagnosed with a mental illness and the possible consequences of this on relationships; sexual health risk factors; and issues related to sexual vulnerability.

For the participants improvement in their practice was attributed to their increased awareness that occurred from the education session about the importance of sexuality, sexual health and intimacy for consumers. Participants reflect upon the usefulness of the BETTER model in relation to bringing-up the topic. However, they reveal that they did not follow every stage of the BETTER model. It appears from these findings that the BETTER model may be of limited use as most participants preferred a less formal approach than working to the 6 stages of the BETTER model. The participants also discuss that the more they engaged in such discussions with consumers, the easier it became for them, which is presented in the second theme of this publication: **Becoming part of practice**.

**Acknowledgement**

The findings at Stage 3 are presented in the following publication entitled: *Talking about sex as part of our role: making and sustaining practice change*. The aim of this publication was to explore whether the practice changes revealed at Stage 2 of the research had been sustained, and whether the participants had continued to overcome any barriers of avoidance regarding the sexual concerns of consumers.
The findings of the previous stages of the research present the initial clinical avoidance by the participants towards discussing sexual concerns with consumers. The importance of awareness building and the provision of approval to engage with consumers can have for the practice of mental health nurses in assisting them move from avoidance was a major finding of the second stage of the research. The findings presented here occurred two years following the initial interviews and strongly suggest the BETTER model was less influential for the ongoing inclusion of consumer sexual concerns than was awareness building and approval. Further to this was the personal commitment of the participants to include consumer sexual concerns in their practice. The participants reported applying their skills; and acknowledging the importance of including care towards the sexual concerns of consumers as an important component in the provision of holistic care.

The findings are discussed under two themes where the participants acknowledge that the inclusion of the sexual concerns of consumers is an essential component in the provision of holistic care, and that this area of care, had become embedded in their practice. The themes are:

- Holism: from rhetoric to reality
- Part of what I do
Feature Article

Talking about sex as part of our role:

Making and sustaining practice change

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ABSTRACT: Sexual issues are common for consumers of mental health services and have many adverse consequences for quality of life as well as impacting negatively on the mental illness itself. Nurses in mental health settings are well placed to assess for the presence of and provide interventions for sexual concerns. To date, little research has been undertaken to explore nurses’ attitudes and whether sexual issues would be accepted as part of their care. This paper presents findings from the third stage of a qualitative, exploratory research study with mental health nurses working in an Australian mental health service. The findings from the first two stages suggested that the participants had tended to avoid discussion of sexual issues, but a brief education intervention had produced a greater willingness to address sexual issues as part of care. The aim of the third stage was to determine the degree to which changes in practice had continued over time. Two main themes that emerged from this data were: (i) holism, from rhetoric to reality; and (ii) part of what I do. Addressing sexual issues became part of practice, a change sustained 2 years following the intervention, because participants recognized its importance for holistic nursing care.

KEY WORDS: attitudes, consumers, educational intervention, nurses, mental health, sexuality.

INTRODUCTION

For the past 30 years, nurses have been urged to include aspects of human sexuality in care (Albaugh & Kellog Spadt 2003; Lion 1982; Magnan et al. 2005; Waterhouse & Metcalfe 1991). Despite these efforts, providing reduced opportunities to discuss sexual concerns (Higgins et al. 2008) and avoiding the topic appears to remain widespread in mental health nursing (McCann 2003). The impact of illness on libido (Ostman 2008) and lack of privacy during hospitalization are
major barriers to sexual satisfaction for consumers (McCann 2010), with approximately 50% reporting dissatisfaction with their sex life (Cook 2000). Consumers have also reported lacking warmth, intimacy, and a satisfying social life (Cook 2000). Issues relating to social stigma and social withdrawal have been identified as creating further difficulties resulting in reduced opportunities for establishing and maintaining sexual relationships (Volman & Landeen 2007).

Female consumers are particularly vulnerable to sexual harassment or assault (Copperman & Knowles 2006). Impaired judgement (Earle 2001; McCandless & Sladen 2003) resulting from illness can increase the likelihood of abuse (Cole et al. 2003; Judd et al. 2009). The incidence of adult sexual abuse for consumers has been estimated at 40% for males and up to 68% for females (Coverdale & Turbott 2000; Goodman et al. 2001; Warne & McAndrew 2005).

Furthermore, Read et al. (2006) report that 78% of female consumers were not asked about abuse during their initial assessment. Trauma from sexual abuse can result in long-term mental health concerns such as depression, poor self-esteem, anxiety, sexual performance problems, substance use issues, suicide, self-harm behaviours, psychosis, and dissociative disorder (Read et al. 2006; Warne & McAndrew 2005).

Sexual side-effects from psychotropic medications have been described as the most common reason for consumers ceasing their medication and risking relapse (Deegan 2001; Kodesh et al. 2003). The rate of sexual difficulties resulting from psychiatric medications has been reported to be as high as 90% (Balan 2006; Basson et al. 2010; Montejo et al. 2010; Schweitzer et al. 2009; Smith et al. 2002; U’cok et al. 2008; Wernke et al. 2006). It has been suggested that the associated distress from the experience of sexual side-effects of medication may contribute to an exacerbation of psychotic symptoms (Apantaku-Olajide et al. 2011; Kelly & Conley 2004), yet the response by mental health nurses tends to be one of avoidance (McCann 2003).

Clearly, nurses have a crucial role in sexuality assessment and providing support, information, and education for consumers (Cole et al. 2003; Katz 2002; Magnan & Norris 2008; Magnan et al. 2005). To provide holistic, consumer-focused care, nurses need to integrate consumer sexuality as a component of their role (Albaugh & Kellogg-Spadt 2003; Peck 2001; Wright & Pugnaire-Gros 2010). By legitimizing the topic of sexuality, nurses provide a clear message to consumers that it is okay to talk about their sexual concerns (Mick et al. 2004; Odey 2009). Consumers report feeling safe and secure and able to discuss sexual issues with nurses (Phillips & McCann 2007) without feeling embarrassed (McCann 2010). Indeed, consumers often feel relieved when nurses initiate discussions on the topic as they are often reluctant to do so themselves (Bartlik et al. 2005; Magnan et al. 2005).

The recognition that mental health nurses have an important role in addressing sexuality concerns of consumers led to a qualitative exploratory study with mental health nurses conducted over three stages. During the first stage, the participants were individually interviewed on whether they include a discussion of sexual issues in consumer care. Most expressed avoiding the topic and did not regard it
as a priority (Quinn et al. 2011a). When issues of sexuality did arise they generally referred the consumer to another health professional despite believing others also avoided the topic (Quinn et al. 2011a). Participants were concerned about discussing the topic as they believe they may become at risk of the consumer misinterpreting their actions, or their colleagues considering this practice a boundary violation (Quinn et al. 2011b). Participants also expressed concern that informing consumers of possible sexual side-effects from medication would lead to increased rates of non-adherence (Quinn & Happell 2012). Towards the end of the first interview, participants were invited to be involved in a brief education session conducted by the principal researcher. The focus of the education session was on sexual safety, sexual abuse and exploitation, sexual vulnerability, and sexual side-effects from medication and the impact on consumers. They were also introduced to the BETTER model (Mick et al. 2004: B, bring up; E, explain; T, tell; T, time; E, educate; R, record) by the principal investigator. They were provided with an overview of the development of the BETTER model as a tool to assist oncology nurses to establish open communication with consumers about sexual issues.

Each stage of the model was presented as a structured approach to assist improving the participants’ confidence in raising the topic of sexuality with consumers. Participants were encouraged to ask questions and clarify any concerns that they might have regarding each stage of the model. They were also provided with a personal prompt card on the model that they could refer to in their clinical settings along with literature discussing the model (Mick et al. 2004).

Participants were asked to trial the model in their practice, and were interviewed again after 4 weeks (stage 2). The findings suggested that participants had utilized their newfound knowledge and were including the topic in consumer assessments (Quinn & Happell 2012). Interestingly, despite the strength of the BETTER model in giving legitimacy to the topic, most participants did not use the model as a framework for informing their discussion around sexual health needs of the consumers (Quinn & Happell 2012).

While these findings were pleasing, it was necessary to determine whether changes were maintained over time. Evidence suggests that adults do not retain all new information they receive in training and tend to forget knowledge and skills not used on a regular basis (Bastable 2008; Chance 2008). The aim of this article is to present the findings about whether the participants continued to include sexual concerns as part of their practice and the reasons for the continued inclusion.

**METHODS**

**Design**

An exploratory qualitative research approach was chosen as it allows an opportunity for participants to describe in detail their experiences, beliefs, and opinions regarding the topic of investigation, in this instance, the participants’ experiences of addressing the sexual concerns of consumers as part of their mental health assessment and nursing care (Polit & Beck 2004). This research approach is designed to elicit from participants in-depth understandings and personal insights of
their subjective experiences (Liamputtong 2010; Polit & Beck 2004) with the intent to increase knowledge of the topic (Polit & Beck 2004).

Participants and setting
Participants were recruited from a Queensland mental health service. The sites included a community mental health continuing care team, an inpatient extended treatment unit, and an inpatient rehabilitation unit. Fourteen participants were interviewed in the first two stages but by stage 3 (2 years later), four participants had left the service and could not be located. Participants included seven women and three men. Their ages ranged 26–54 years, with a mean age of 43.6 years. One participant was a clinical nurse consultant (a nurse with advanced clinical skills) and nine were clinical nurses (2 years postgraduate experience). Their level of experience varied from 4–29 years, with a mean of 17.3 years. Length of time in their current position ranged 28 months to 11 years, with a mean of 5.2 years.

Procedure
In-depth individual interviews were conducted to obtain a detailed understanding of the participants’ perspectives (Ritchie & Lewis 2007). A conversational approach was utilized to allow participants the opportunity to speak freely and openly about their experiences and practices (Horsfall et al. 2007). Broadly, participants were asked whether they continued to include sexual issues as a topic in their assessments and interactions with consumers, and whether there had been any significant change in their approach to that reported in the previous findings; and second, to explore their reasons for continuing to include sexuality where relevant.

Ethical issues
In qualitative research, ethical considerations are of great importance due to the intimate nature of the relationship the researcher has with the research participants (Liamputtong 2010; Polit & Beck 2004). Ethics approval was obtained from the health service and university. Participants were provided with a verbal and written explanation of the study and advised that participation was voluntary and therefore, they had the right to withdraw their consent at any time during the study. Participants’ names and their locality of employment have been de-identified by allocating a pseudonym to each participant. As this research occurred in three stages, a once-off approach to gaining consent from participants would have been insufficient (Usher & Arthur 1998); therefore, consent was renegotiated with the participants at all stages of the research. This type of consent is referred to as ‘process consent’ (Polit & Beck 2004; Usher & Arthur 1998), allowing the participants to have a more collaborative role in deciding on their contribution and involvement in the research (Polit & Beck 2004; Usher & Arthur 1998).

Data analysis
Interviews were digitally recorded and transcribed verbatim by the principal researcher with the aim of immersing him/herself in the data. The data was analyzed using the five-step thematic analysis framework developed by Ritchie and Lewis (2003) of familiarization, identifying a thematic framework, indexing; charting, mapping, and interpretation.

Trustworthiness
Trustworthiness of the research findings was based on Guba and Lincoln’s (1989) criteria of
credibility, transferability, dependability, and confirmability. Credibility, which is concerned with ensuring that the participants’ experiences are captured and mirrored in the researcher’s analysis of the data, was achieved by promoting a conversational style to the interview, allowing sufficient time for participants to contribute their thoughts and opinions in a comfortable environment (Guba & Lincoln 1989). Interviews were transcribed verbatim to avoid misinterpretation and independent analysis was undertaken by members of the team to achieve consistency and regular discussion of emerging themes (Polit & Beck 2004). The principal researcher also kept a journal to avoid his/her own experience and opinions from influencing the interviews or interpretation of data (Guba & Lincoln 1989). Transcripts for each interview were offered to participants for review for accuracy, however, they all declined, being satisfied the interviews had been recorded and transcribed verbatim.

Transferability, which refers to the degree to which salient conditions overlap or match, was achieved by providing thick descriptive data including detailed descriptions of the major themes and using participant quotes to illustrate where relevant (Polit & Beck 2004). Providing such detailed information provides a database for transferability judgements by others (Guba & Lincoln 1989).

Dependability, which is concerned with the stability of the information, was achieved through an audit trail. All interview transcripts have been coded with line numbers to enable cross-checking with audiotapes (Guba & Lincoln 1989).

Findings
Data analysis revealed two main themes. The findings are presented and supported by indicative quotes from participants.

Holism: from rhetoric to reality
The participants discussed their thoughts on why they had continued to include sexual issues in their care, reporting that they had to overcome personal fears and shortcomings. They discussed their professional responsibility in the provision of holistic care to engage with consumers on sexual health topics:

I think it’s a part of holistic approach to nursing care It’s about honouring the whole person, honouring the whole human being and all aspects of that person. Oh it’s such an essential part of being human, being a human being and part of recovery, quality of life. It’s part of our essence. (Shannelle.)

Similarly, for Lisa, it meant moving beyond the medical model approach and seeing the person as a whole:

I think in mental health we can get too narrowly focussed upon illness, symptoms, medication and forget about other areas of a person’s life that can be affected.

Overcoming personal fears and becoming increasingly comfortable with discussing sexuality issues was viewed by participants as a contributing factor to their continued inclusion of the topic in their assessment of and care for consumers:

I’ve continued to include the topic] just because it’s important. I’ve realized it is important. So I’ve just overcome any fears I had and have just become very comfortable with talking about sex. (Joanne.)
Participants expressed that they had become increasingly aware of sexual health issues experienced by consumers and their impact on consumer quality of life. Arriving at this point of realization has been a significant motivator in their continued inclusion of sexual health concerns as part of their professional practice as articulated by a number of participants:

Why do I keep talking about it, I guess it has something to do with knowing about the issues. If you don’t know about the importance of something you simply don’t include it. Being aware of sexual issues creates the situation where you just need to ask about it. (Mick.)

and:

Being aware that it is such a big problem, it becomes part of your job to talk with them about these issues. Ask whether they are having any problems, inform them that there could be problems, and be prepared to work with that person to help them with the problem, this is what we should be doing: helping out consumers with their needs no matter what they are. We are the professional so we should be okay to do this. (Frank.)

For Olivia, it was important to question all consumers even when there was no reason to suspect a problem, particularly because the possible consequences can be serious but can often be treated:

Imagine having a problem like not getting it up and thinking there was something terrible going on when it might be simply related to the medication, something we can solve. So it’s important to me to talk about sexuality and see where it leads to. It may not lead anywhere but then we ask about suicidality and not every consumer is suicidal.

Part of what I do

For the participants, the inclusion of sexual issues as part of their professional practice for the prior 2 years had been influenced by a range of motivators. The use of the BETTER model was influencing their continued inclusion of sexuality in their practice. As Frank discussed:

That model I can’t really remember. For me why do I talk about it? Well, I will ask them if they have sexual concerns and if they do then I am ready to help out. This is what we should be doing: helping out consumers with their needs no matter what they are. We are the professional so we should be okay to do this.

There was recognition by the participants that sex is an important quality of life issue for consumers, and should therefore be included in assessments. As they continued to include the topic, they reported improved confidence as their practice developed to such an extent where they felt more comfortable discussing a range of sexual health related topics and, when required, the provision of referral to sexual health services. The participants reported that the inclusion of sexual health was now part of what they would describe as ‘normal practice’, as articulated by Olivia:

I do more and more all the time ever since we first talked about it and I’m aware of [how sexual concerns are] such a big issue especially for males. They want to discuss it, because they are quite heavily medicated and experience a lot of side-effects . . . And when you ask people about it, they actually want to talk about it . . . So I talk about emotions, weight gain, and I’ve really tried hard to incorporate sexuality into every assessment.

As their confidence developed, the participants reported that they gradually introduced a range of sexually-related topics including sexual side-
effects, safe sex issues, and sexual health as components of a more comprehensive assessment, as described by Louise:

The work I’m doing involves completing a very thorough assessment of a person and sexuality is one of the areas I cover. I go through relationship issues, safe sex, sexual health history, and when I discuss any medication they might be taking I ask about side-effects including sexual side-effects.

Rhys also saw discussions about sex as an important opportunity to provide some education:

So when I’m doing an assessment on a new consumer and I’m asking them all sorts of questions about their life, I simply just ask about the sexual stuff. A lot of these guys still have no idea about safe sex. Some still think that only poofs [sic] can get AIDS so I find I spend quite a bit of time talking about these issues.

In describing her experiences of raising the topic of sexual health concerns, Lisa spoke of her work with women and her greater comfort in dealing with consumers of the same sex:

With females, I probably discuss things in greater detail: talk about their sexual health, ensure referrals are made, and appointments are kept. So I talk to them about a range of issues from menstrual problems to STIs. So I’ll get them to ring up with me and make the appointment, that way they’re seeing the experts, getting the best care and support they might require.

While a few participants continued to express caution regarding discussing sexuality issues with consumers of the opposite sex, most described a growing confidence in discussing sexuality issues with both sexes:

I talk to both sexes. I’m not concerned about any gender issues, not in a general assessment. (Joanne.) and,

I think when I last talked to you I had spoken with a few of the female clients, but now I’ve got no [concerns], I just bring it up with anyone and see how it goes [laughs] . . . No problem at all. I think they feel comfortable with me. [Jean.]

Providing consumers with information related to their sexual health needs and arranging referral to sexual health services was now viewed as a core aspect of care for these nurses. Participants were now confident about providing the required sexual health information and assuming responsibility for ensuring that consumers were given the opportunity for referral to sexual health services, and to ensure they understood the information they were given rather than showing it to them and moving on:

[To ensure consumers have] the right information, up to date information, you’ve got a responsibility that any information you’ve provided is understood by them. (Joan.)

Written information was sometimes useful but was certainly not an alternative to open communication:

We have a few brochures so will hand these out, but I find it easier just to talk about some stuff, like the need to wear condoms, and be safe. (Rhys.)

Lisa indicated how this change in practice occurred as a direct result of the educational intervention introduced in stage 1 of the research:

Since your talk, our practice in rehab has changed, where we ensure that the consumers are referred to sexual health. When we first set-up, we might have organized someone to come
to us for the odd Pap smear. It’s just so appropriate to refer to sexual health. They not only get their Pap smear, but get all the other bibs and bobs taken care of. (Lisa.)

Discussing medication and the side-effects that can occur from psychotropic medications remained a comfortable way for some participants to include sexuality in consumer assessments. However, in using this approach, there was a greater confidence in asking the participants about sexual side-effects and getting to the point in a more direct manner as described by Rhys:

Just ask them straight up. These medications can cause some sexual side-effects, like problems in getting it up or cumming [sic], so if you’re having any problems you can talk to me about it.

For others, the topic of sexuality has become as important as other topics that a mental health nurse would include in routine practice, such as routine Mental State Examinations and assessing risk of harm to self or others:

I include sexuality, asking the consumer whether they have any concern . . . Ever since we spoke last time, the education, it’s just stayed with me. I make sure that in an assessment that I am covering everything I should. (Joan.) and,

I just bring it up during a general assessment, you know. When I get through all the psychiatric stuff, about their diagnosis and mental state, I start in with something about whether they are in a relationship, any hassles here, what about your medication, how’s that going for you, then I might mention a few side-effects and include sexual side effects at this time. (Jean.)

Similarly, As I practiced, it has just become part of my practice. Discussing mental state is ingrained in me. Discussing sex has become ingrained in me and I’m more confident in my skills and knowledge. So if you are experiencing problems, sexual concerns, come and talk to me about it.

(Olivia.)

Although the inclusion of sexual health needs has now become an integral part of their assessment and care, participants were cognisant of the sensitive nature of the topic and the importance of not making sexuality the focus of the assessment. In discussing how this is achieved, Jenny described her approach:

I just include it as a quality of life issue so in that respect it is no more important than other quality of life issues . . . I don’t go out of my way to mention sexuality or raise it as a separate issue.

DISCUSSION

The published work clearly shows that avoiding the topic of sexuality means consumers do not receive comprehensive holistic care (Deegan 2001), and continue to have unmet health needs. Findings from the first stage of this research support those reported in other studies, that nurses tend to avoid discussing sexual issues in their practice (Higgins et al. 2008; Peck 2001; Quinn et al. 2011a; Saunamaki et al. 2010). However, findings from the subsequent stages suggest that with increased awareness and some basic training about consumer sexual issues and encouragement to engage with consumers on the topic, that mental health nurses can open the door to consumers, allowing them to discuss their sexual concerns (Volman & Landeen 2007). Supporting evidence reported elsewhere.
Montura et al. (2001) suggest that when nurses are provided with education and opportunities to improve their self-awareness, they can develop the necessary attributes to include the topic in their practice. Furthermore, participants recognized the positive impact on consumers of talking with them about their sexual concerns (Crouch 1999).

The third stage of the research is reported in this paper. The importance of a holistic approach to nursing care in mental health was central to participant responses for this stage. They had come to recognize sexuality as part of the totality of being a person and an aspect of that person’s unique human character (Cort et al. 2001; McCann 2000). Addressing the sexual concerns of consumers requires a holistic approach to achieve resolution of the problem (Wright & Pugnaire-Gros 2010). Participants discussed their professional responsibility in the provision of holistic care.

Holism is espoused as a primary philosophical underpinning of nursing practice (McRae 2012). However, the ideal is not always evident in reality, with an avoidance of sexual issues being an obvious example (Higgins et al. 2006; Magnan et al. 2005). To have a holistic approach to nursing, there is a need to look beyond how consumers present, and take a broad view of the consumer’s overall situation (Fulder 2005). Given that consumers are reluctant to raise their sexual health concerns with health professionals (Bartlik et al. 2005; Magnan et al. 2005), the provision of holistic care requires nurses to include sexual health and sexuality concerns (Jolley 2002; Wright & Pugnaire-Gros 2010) as part of their daily professional practice.

Mental health nursing places great importance upon the establishment and maintenance of an interpersonal relationship with consumers (O’Brien 2001; Perraud et al. 2006) that supports, sustains, and assists the consumer in finding meaning in their illness experience (Travelbee 1971). Through the development of a therapeutic relationship, nurses are able to gain insight into the sexual health needs of consumers, help dispel myths and stereotypes about human sexuality (Holmes & O’Byrne 2006), and be able to explore the consumer’s situation. As sexuality involves the totality of being a person (Hayter 1996), the inclusion of sexual concerns is therefore important to the promotion of health for individuals. Nurses are in an ideal position to address sexuality in care (McCann 2010; Nakopoulou et al. 2009).

The available published work discussing the use of the BETTER model (Katz 2005; Mick et al. 2004) does not discuss the implications of not following the model directly as intended; however, a strength of these findings has been supported by Krebs (2007) in that discussions about sexuality may occur only when nurses are prepared, schedule time, and are willing to initiate the interaction (Krebs 2007). The participants in the current study indicated they did not follow the structure of the model because it was not necessary. The simple and straightforward training provided offered them permission to discuss a topic that had previously been seen as taboo and actively avoided.

It is difficult to make a decisive claim that the change in practice was due solely to the education intervention with these participants. It is possible that other changes within the
organization may have been influential. However, the findings reveal that nurses can overcome their avoidance of addressing the sexual health needs of consumers and improve their understanding of sexuality as an important quality of life issue (Cook 2000; Mick et al. 2004). Improved understanding that sexual health is an important part of consumer care (Earle 2001) has led participants to consider a discussion of sexual issues as ‘part of what we do’. Such findings support the suggestion that with enhanced understanding about the importance of sexual health for consumers and enhanced self-awareness of the topic, nurses are in a position to challenge their personal stance, move from a position of avoidance to one of inclusion, and in the process develop the necessary skills and confidence required to address the topic as part of the provision of holistic care (Montura et al. 2001).

Professional development training is considered an effective way to educate nurses and assist them in acquiring new skills (Armstrong et al. 2012; Cooper 2009). However, time constraints and increased workloads create a situation where it is difficult for nurses to be released from patient care to attend training, presenting a significant barrier to the inclusion of evidence in practice (Happell 2005; Skelton & Matthews 2001; Young 2003). Lack of access to information (Young 2003) and lack of support from management (Bahtsevani et al. 2005) due to the cost of sexual health education (French 2010) present further barriers to evidence-based training. Even when the obstacles are overcome and training is provided, the retention of knowledge and skill has been found to decline over time and often falls short of contributing to a sustained change in practice (Kerfoot et al. 2007; Tippett 2004).

The education session provided in this research took approximately 30 min to deliver, representing a cost-effective strategy without the necessity of lengthy absences from the workplace. Not only did the education session contribute to a change in practice, but also has been reported by participants as a sustained practice over time, to the extent that participants believed they had now embedded the inclusion of sexual issues as part of their day to day practice. Such a sustained practice change should be viewed as an obvious cost-effective training method to improve consumer care (Young 2003).

**Limitations**

Given the small sample of mental health nurses from the same service in Queensland, it is possible these findings may not represent the practices and views of other mental health nurses (Polit & Beck 2004). Furthermore, the findings reflect reported rather than observed behaviour. In discussing sensitive topics, such as sexuality, there is the risk of participants censoring their responses or offering responses that they believe to be acceptable rather than reporting their actual practice (Magnan & Norris 2008).

**CONCLUSION**

The findings from this research suggest that a brief education program about sexual issues of consumers of mental health services can result in sustained practice change. Participants discussed that the more they included sexual issues in assessments, the easier it became, and as their confidence developed, mastering of skills began to develop. A further driver for these participants
towards the inclusion of sexual health and sexuality in their practice is illustrated in the appreciation they had of the importance of the topic for consumers and in the value the participants placed upon the provision of holistic care. Addressing sexual issues and concerns is an important and legitimate part of practice. Given that the skills and knowledge can be easily taught, this type of education needs to become a priority in mental health nursing preparation and professional development.

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Wilkins.
The findings from this publication reveal a process where the inclusion of consumer sexual concerns for these participants had become part of routine practice. The participants acknowledge that sexuality is an important component of who we are as a person and therefore, for these participants to practice in a holistic manner consumer sexual concerns were required to be incorporated into their practice.

Summary

This chapter presented the findings of the three stages of the research which have been reported in the publications as presented. The initial publications illustrate a journey for the participants from avoidance though to acknowledgement of the importance of including consumer sexual concerns. The findings also provide an insight that for these participants the BETTER model itself was not as useful as awareness building and being given approval to include sexual concerns in their practice. The concluding chapter is a discussion of the findings, the suggested recommendations for mental health nursing practice and implications for future research. The chapter also includes a discussion of the 5 A’s framework for including sexual concerns in mental health nursing practice which was developed directly from considering the practice changes evident in the research findings. The 5 A’s framework is presented in a final publication entitled: The 5 A’s framework for including sexual concerns in mental health nursing practice.
CHAPTER FIVE:
DISCUSSION

“Would you tell me, please, which way I ought to go from here?” said Alice

“That depends a good deal on where you want to get to,” said the Cat.

(Carroll 1949 p.59)
Introduction

This concluding chapter begins with a summary of the key findings from this exploratory qualitative research. It is presented under sub-headings for each of the three stages of the research along with a discussion justifying the research approach utilised. The chapter concludes by identifying the limitations of the research followed by recommendations for mental health nursing practice and for further research.

Summary of Key Findings

Initial findings from this exploratory qualitative research supports current literature suggesting that mental health nurses like nurses in other specialties (Katz 2005a, Mick et al. 2004), avoid the inclusion of consumer sexual concerns hindering the achievement of holistic nursing care (Bartlik et al. 2005; De Santis & Vasquez 2010). Further findings from subsequent stages of the research demonstrate that with awareness building nurses can acknowledge the value and importance for including the sexual concerns consumers might have in their provision of holistic care.

It has been well documented that within nursing practice (Gamlin1999; Higgins et al. 2008; Kautz et al. 1990; Krebs 2007) and nursing education (French 2010; Montura et al. 2001; Shell 2007) that the topic of sexuality is avoided or considered a taboo topic. The review of the literature informs us that, mental health consumers experience a variety of sexual concerns (Cook 2000; DeLamater & Friedrich 2002; Dyer & McGuiness 2008; Fortier et al. 2003; Magnan et al. 2005; Volman & Landeen 2007) that receive little attention from health professionals (French 2010; Katz 2005a; Krebs 2007; Shell 2007; U’cok et al. 2007; U’cok et al. 2008) including mental health nurses (Higgins et al. 2008; McCann 2000; McCann 2010). This is further complicated by nurses’ apparent belief that consumers do not want to
discuss sexual concerns and therefore, these discussions would be considered by the nurses and consumers as inappropriate (Magnan & Norris 2008).

**Avoidance**
The initial stage of this research explored whether the participants discussed sexual concerns with consumers and if so, what approach these participants used in raising the topic. From this initial stage, findings suggest the topic is generally avoided. Avoidance stemmed from a variety of causative factors such as limited knowledge and the personal belief systems of the participants that created barriers to the inclusion of the sexual concerns of consumers.

Most participants described avoiding initiating discussions preferring to wait for the consumer to approach them. Avoidance of sexual concerns by nurses (Higgins *et al.* 2008; Peck 2001; Saunamaki *et al.* 2010), and waiting for consumers to initiate the discussion has been observed in other nursing cohorts (Crouch 1999a; Shell 2007) where avoidance was justified based on the belief that consumers would initiate these conversations if they wanted to. On the contrary, the literature suggests consumers do not tend to raise the topic, possibly being too anxious or shy (Gianotten *et al.* 2006).

Sexual concerns of consumers were considered a lesser priority than the routine tasks and assessments required by these participants in their nursing roles. This finding is consistent with those of Guthrie (1999) and Magnan *et al.* (2005) who also reported that nurses justify avoiding the topic of sexual concerns as they perceive them to be a low priority. These findings highlight a lack of understanding by the participants about the impact sexual concerns can have for consumers coupled with their avoidance in challenging their lack of personal comfort, creating a major barrier towards the inclusion of the sexual concerns of consumers (Cort *et al.* 2001; Kautz *et al.* 1990; Ruane & Hayter 2008; Skelton & Matthews 2001).
Participants reported referring consumers to another clinician, usually a psychiatrist, when they became aware that the consumer might be experiencing a sexual concern. It would appear that personal discomfort in discussing sexual concerns results in a practice of moving the responsibility to address these care needs to another clinician absolving the nurses of their responsibility to engage with the consumer in these situations. However, the nurses are aware that consumers’ needs are unlikely to be addressed as participants acknowledged that other clinicians also do not include sexual concerns in their practice. The assumption by the participants that other health professionals also avoid consumer sexual concerns has been well established (McInnes 2003; Stevenson 2004; U’cok 2007; U’cok 2008).

Participants avoided discussing possible sexual side effects of psychotropic medications despite their knowledge that these side effects occur. This is a prime concern given that the experience of sexual side-effects is a major causative factor for ceasing psychotropic medications (Anderson et al. 2010; Deegan 2001; Mahone 2008; Malic 2007; Perlman 2007; Schweitzer et al. 2009; Smith et al. 2002). A reason for avoiding provided by participants was that if consumers were to become knowledgeable about sexual side effects that this might lead to or encourage non-adherence, which has been reported by others (Jordan et al. 1999, Cort et al. 2001, Magnan et al. 2005, Krebs 2007, Shell 2007) despite evidence suggesting that providing consumers with education regarding potential side effects can improve adherence (Happell et al. 2002; Raja & Azzoni 2003; Roberts et al. 2006; Smith & Henderson 2000). This finding validates evidence that information shared with consumers is selective in nature (Gray & Gournay 2000; Higgins 2007; Smith & Henderson 2000) where avoidance towards the discussion of sexual side effects from psychotropic medication occurs (Higgins et al. 2008; McCann 2000; Medley 1988).
When participants talked about sexual concerns experienced by consumers, their focus was towards the impact of sexual side effects from psychotropic medications for young men, with far less attention towards other male or female consumer groups. Perhaps these findings reflect the broader view held by society where sexual potency should be one that mirrors that of young adult males and the importance associated with erections and intercourse (Goodrich et al. 1988; McCarthy & Bodnar 2005, Tiefer 2010) influencing the focussed attention of the participants. The accounts of participants may have also arisen as a result of the strong influence that medicalisation has had on human sexuality and where the sexuality of women is often defined in a male context, mimicking the sexual experience of men (Corrigan & Matthews 2003; Heaphy 2007; McCarthy & Bodnar 2005; Peplau 2003; Tiefer 2002). Further influence of the medicalisation of sexuality has resulted in the sexual needs of women receiving less attention (Atwood & Klucinec 2007; DeSantis & Vasquez 2010) than the needs of men (Pacey 2008; Tiefer 2010). As such, perhaps the responses of the participants reflect the powerful influence that has occurred as a result of the medicalisation of sexuality.

Female consumers were discussed in relation to sexual safety. Participants described their need to protect these women from the possible consequences of the promiscuity they were experiencing, a dynamic previously reported by Phillips (2009). There was no mention by the participants of the libido of female consumers, their sexual functioning, or their physiological responses. Participants voiced concerns about the vulnerability and exploitation of female consumers resulting in their practice incorporating strategies to promote the protection of female consumers. Further justification for these protective measures was provided by participants who argued that because of the consumer’s behaviour and the way that they might dress, might invite unwanted attention from a potential abuser. So, for female consumers, the participants adopted a paternalistic
approach where protective safeguards and moralistic guidance were provided. A further question that could be raised at this stage of the discussion concerns the protective strategies used in defense of male consumers who might also be vulnerable to sexual exploitation, and were not considered by the participants. While this issue does not receive much attention there is evidence supporting the increased risk of male consumers in inpatient mental health settings (Denborough 2005).

Older adult consumers were not mentioned. This omission may be attributed to the cultural medicalisation of sexuality previously discussed (Corrigan & Matthews 2003; Heaphy 2007; McCarthy & Bodnar 2005; Peplau 2003; Tiefer 2002). As a result the way we consider older adults in relation to sexuality will have a bearing on the attention nurses provide in addressing the sexual needs of older adults. Shell (2007) observed that when sexuality is discussed with consumers, the discussion is limited to those consumers nurses regard as being sexually active. If nurses do not view older consumers as being sexually active or considered that sexuality was important to them, they may be less likely to discuss. There is a common held false belief within society that once a person reaches physical maturity their sexual development stops however as we age we continue to be sexual beings (Sharpe 2003). Sexuality is better understood as a life-long process of change that affects and is affected by all aspects of one’s life (De Santis & Vasquez 2010; Sharpe 2003). Overlooking the sexual concerns of older adults as was the case in the findings presented here, highlights a need for further attention by nurse researchers and nurse educators to develop educational strategies to improve nursing care for older adult consumers.

Participants described feeling more secure when discussing personal and private issues with consumers of the same sex. They were concerned that discussing sexual concerns with a consumer of the opposite sex might be misinterpreted by the consumer as a possible boundary violation. These
concerns have been discussed elsewhere (Albough & Kellog-Spadt 2003; Bartlik et al. 2005; Krebs 2007; Skelton & Matthews 2001), however the findings do make a considerable contribution to the limited evidence (Higgins et al. 2007; 2009) exploring the avoidance by mental health nurses towards the sexual concerns of consumers.

Participants also believed consumers would be too embarrassed to discuss any possible sexual concerns. However, given that the participants avoided initiating discussion in relation to the sexual concerns of consumers, one could suggest that this assumption that consumers would be too embarrassed to discuss the topic had not resulted from their experience. Challinor (2008) has purposed that this dynamic might arise from nurses putting their own needs such as avoiding embarrassment and not having time, before the needs of the consumer, despite evidence clearly demonstrating that consumers in hospital environments (McCann 2000) and community settings (McCann 2010) are able and open to discussing their sexual concerns with nurses. Discussions with fellow nurses about their experiences in talking about sexual health and sexuality may well improve effectiveness in sexuality practice with consumers (Peck 2001). Clinical supervision is a process where a nurse meets with a supervisor (a more experienced clinician) to discuss practice issues (Cleary et al. 2010b). The role of clinical supervision in terms of addressing nurse attitudes towards sexuality can provide a framework for nurses to reflect upon their thoughts and feelings regarding consumer’s sexual concerns in a constructive manner, allowing an important opportunity to explore attitudes towards consumer, sexuality (Hayter 1996).

Awareness
The participants described the education session about common sexual concerns for consumers and the introduction to the BETTER model as valuable, increasing their knowledge, understanding, and awareness of the
sexual concerns that can be experienced by consumers. In particular they referred to sexual function problems arising from the side effects of psychotropic medication, relationship issues, sexual health, sexual safety and sexual diversity concerns. Participants attributed improved practice directly to the awareness raising that occurred from the education session particularly about the importance of nurses opening the door to consumers to discuss their sexual concerns (Volman & Landeen 2007). Supporting evidence reported by Montura et al. (2001) who discuss that when nurses are provided with education and opportunities to enhance their awareness, they can develop the necessary attributes to overcome barriers and develop skills to include the topic in their practice.

Participants described bringing the concerns of consumers to the attention of psychiatrist, contributing to treatment decisions concerning the sexual concerns of consumers and hopefully assist in leading to a resolution of the consumer’s sexual concerns. This is an important finding given that the evidence informs us that psychiatrists are unlikely to enquire about any sexual concerns that consumers might be experiencing (Stevenson 2004; U’cok et al. 2007; U’cok et al. 2008). Consequently, as the participant’s awareness improved, so did their commitment to assist the consumer to resolve their concern. One strategy to achieve this resolution was to advocate the need for attention by the treating psychiatrist.

The most common method used to invite consumers to comfortably disclose whether they were experiencing any sexual concerns involved asking consumers whether they experience side effects from medications. The participants would then ask about the experience of sexual side effects. It has been identified that nurses find difficulty in knowing how to initiate a discussion regarding sexual concerns (Peck 2001) as such, a simple question nurses feel comfortable in asking the consumer can assist in opening up a conversation on the topic. The simple question acting as a
starting point, creating minimal discomfort for the nurse (Higgins 2007; Shell 2007; Warner et al. 1999). The participants in the current study did describe feeling comfortable when asking a simple question for example, “Are you experiencing any sexual side effects?” or “Were you aware that the medications you are on can also cause sexual problems?” These are simple and direct questions that promote dialogue and remove ambiguity for the consumer (Skelton & Matthews 2001). Enhanced awareness resulting from the education session appears to have facilitated a role development for the participants, to one where they create opportunities for consumers to discuss their concerns (McCann 2010; Mosley & Jett 2007; Wright & Pugnaire-Gros 2010).

The findings from this research reinforce the important role nurses have as educators for consumers around medication related issues (Happell et al. 2002; Savlon 2007), and the role they can play in openly discussing sexual concerns with consumers to improve their adherence to taking medication (Gray et al. 2010; Savlon et al. 2007). It also demonstrates a significant change in practice when compared to the initial stance of avoidance where little importance was attributed to sexual side effects (Higgins et al. 2005; Smith & Henderson 2000). However this approach was one employed by the participants with male consumers only. This is a concern given that the prevalence of sexual side effects for female consumers is reportedly experienced at much higher rates and more frequently than that reported by male consumers (Smith et al. 2002; Apantaku-Olajide et al. 2011).

Participants discussed feeling less concerned with gender and boundary issues than the concerns identified at the initial stage of the research. They were overcoming their personal concerns, and were less concerned with the possibility of having their actions questioned by consumers and fellow colleagues. This finding does appear to challenge the gender preference for care discussed by others (Brooks & Phillips 1996; Chur-Hansen 2002; Inoue
et al. 2006; Kerssens et al. 1997) which might suggest that when nurses overcome personal barriers and challenge their belief systems, the provision of sexual care becomes a legitimate area of practice that they can approach in a professional manner.

Female participants stated that they were addressing the sexual concerns of female consumers however when asked to provide examples, their discussion remained directed towards examples of how they had engaged with male consumers. When participants did discuss female consumers, this continued to occur in the context of their vulnerability to exploitation, with the role of the participants providing guidance and moral policing of sexualised behaviours and protective measures to ensure the sexual safety of female consumers (Brown et al. 2011; Cole et al. 2003; Judd et al. 2009; McLindon & Harms 2011). Despite this, the participants demonstrated improved awareness about the risks for female consumers resulting from promiscuous behaviours as a result of their illness experience (Apantaku-Olajide et al. 2011; McCandless & Sladen 2003) along with the increased incidence of sexual abuse and sexual vulnerability as identified within the literature (Agar et al. 2002; Barlow & Wolfson 1997; Cook 2000; Coverdale & Turbott 2000; Elliot 1997; Goodman et al. 2001; Warne & McAndrew 2005). There was little mention by the participants about changes that might occur to the libido of female consumers, their sexual functioning, or their physiological responses. While participants were aware of sexual safety issues for female consumers there remained a degree of reluctance to engage with them regarding these concerns. Vulnerable female consumers are unlikely to bring-up their abuse unless directly asked (Agar et al. 2002; Cook 2000; Elliot 1997) and avoiding these discussions possibly compounds the silence around issues of vulnerability and abuse for these women (Agar et al. 2002; Cole et al. 2003; Cook 2000; Elliot 1997).
The participants described being surprised by the positive responses from consumers towards them raising the topic by asking whether they were experiencing any sexual concerns. The embarrassment they expected occurred rarely. Participants reported that consumers appeared relieved by the opportunity to discuss their sexual concerns and appeared to appreciate the opportunity to discuss their sexual concerns with a nurse. Supporting existing evidence that consumers are open to discussing their sexual concerns when these discussions are initiated by nurses (French 2010; McCann 2003; McCann 2010; Sharkey 1997; Waterhouse & Metcalfe 1991).

Participants did not use the BETTER model as prescribed considering it too structured and not conducive to the informal communication style between nurses and consumers that is characteristic of mental health nursing. The participants reported that while the BETTER model was easy to understand, rather than use it as intended, they took from it what they thought was useful in supporting their interactions. For example, no participant explained that sexuality is about quality of life and that nurses are open to discussing these concerns (Mick et al. 2004), nor did participants discuss the importance of timing the discussion (Katz 2005a; Mick et al. 2004). They did however find the initial stage of the BETTER model “Bring up” relevant; however this stage is not unique to the BETTER model. Initiating conversation begins with asking a question, and as such, this stage could be referred to as initiate, commence, or “Permission” to proceed as is the case with the PLISSIT model.

Participants identified the need to develop rapport and trust prior to engaging on the topic, and described waiting for the appropriate time for them and for the consumer. Rapport building has been identified as a core component of the ability of nurses in developing therapeutic relationships (Travelbee 1971) and central to the development of trust to discuss sensitive issues (Higgins et al. 2006) along with being important in discussing sexual concerns (Katz
2005b; Krebs 2007; McCann 2003). The importance of rapport building appears to have been well recognised by the participants and in the absence of a strong therapeutic relationship there was awareness by participants that both consumers and nurses may feel uncomfortable discussing sexual concerns (Perlman et al. 2007). A limitation of the BETTER model is in not providing adequate emphasis on the importance of developing rapport. The first two stages of the BETTER model: ‘bring up’ is intended to open the door to the discussion of sexual concerns (Krebs 2007; Mick et al. 2004; Mosley & Jett 2007) and to ‘explain’ that you have concern for all aspects of the consumer’s life and that you are open to discuss any concerns they might be experiencing (Katz 2005a; Mick et al. 2004). However, in considering the importance these participants placed on the need for developing rapport, these first two stages fall short, and hence, bringing-up the topic in the absence of rapport may well create a further barrier to the discussion of sexual concerns. Sharkey (1997) recognised this and states that in the absence of strong interpersonal skills, sexual intervention models are ineffective.

The experience of participants demonstrated that the more they discussed sexual concerns with consumers, the greater their comfort and confidence with the topic became. This dynamic has also been observed by Gianotten et al. (2006) and others who report that the more nurses practice and include sexual concerns in their practice, the greater the opportunity for them in becoming comfortable with this practice (Katz 2005b; Peck 2001; Saunamaki et al. 2010). Further to this, discussions about sexual concerns are likely to occur only when nurses are prepared, schedule time, and are willing to initiate the interaction (Krebs 2007). For this to happen, nurses need to accept that including sexual concerns in nursing assessments and in providing care to assist in improving the person’s well-being is a component of a nurse’s role. To support this, nurse educators need to provide the
educational basis for this practice so that nurses feel capable and comfortable in this role (Skelton & Matthews 2001).

It has been argued that nurses need training and skills (French 2010) to engage with consumers regarding sexual concerns. The education session provided in the initial stage of the research took approximately 40 minutes to deliver. The findings from this study suggest that the education session contributed to a change in practice where participants began including the sexual concerns of consumers as part of their day to day practice and this change was sustained when interviewed at two years post. This intervention therefore appears an effective training method to improve nursing practice and contribute substantially to positive changes in practices relating to sexuality. These results also suggest that mental health nurses possess the counselling skills required to support engagement on what can be a sensitive topic, and can develop these skills when provided permission and encouragement to engage on the topic. Discussing sensitive topics such as suicidality, or childhood trauma (Happell et al. 2008d) has been described as an unavoidable component of mental health nursing (Crowe & Carlyle 2003), and perhaps this aspect of mental health nursing of discussing sensitive topics, provided these participants with a solid foundation for discussing sexual concerns.

Furthermore, this change in practice appears reflective of greater awareness of the importance of discussing sexual concerns with consumers, rather than the BETTER model itself. Reinforcing the finding by Montura et al. (2001) that with knowledge and self-awareness, nurses can build the skills and comfort required to discuss the topic and that specific expertise in sexual health is not a requirement to effectively intervene with consumers about the sexual concerns they might be experiencing (Bartlik et al. 2005). Adding to this, the education session that was provided resulted in assisting the participants to develop positive attitudes and acceptance towards the sexual
concerns of consumers (Duldt & Pokorny 1999; Guthrie 1999; Magnan & Norris 2008). Others have reported that the inclusion of sexuality into nurse education is of little value if nurses cannot integrate this knowledge into their practice (Duldt & Pokorny 1999; Magnan & Norris 2008). The participants in this research were encouraged to engage with consumers. They accepted this challenge and commenced engaging with consumers by asking whether they were experiencing any sexual concerns. The participants were able to overcome their initial avoidance towards the sexual concerns of consumers and in doing so they also demonstrated that as they continued to include the sexual concerns of consumers their understanding of the importance of sexuality to their individual self-concept also developed.

The importance of a holistic approach to mental health nursing care was central to participant responses. Participants discussed their professional responsibility towards the provision of holistic care, recognising what Bartlik et al. (2005) described as the intimate connection that health and sexuality have, and that addressing the sexual concerns of consumers requires a holistic approach to achieve resolution of the problem (McCann 2000). Holistic nursing is more than considering the needs of the person as a whole (Povlsen & Borup 2011). It is also about how nurses understand the relationship between biological, psychological, social and spiritual dimensions of the consumer (Zahourek 2008). Furthermore, it seems logical to suggest that a holistic approach to nursing would include sexuality as part of the whole person and as an integral part of a biopsychosocial approach to nursing (Cort et al. 2001; Earle 2001). As such, nurses have a responsibility to engage with consumers on sexual concerns in an informed and sensitive manner (Katz 2005b; Higgins et al. 2006b; Jolley 2002; Wright & Pugnaire-Gros 2010). The participants demonstrated that with awareness building consumer sexual concerns can be considered an important component of nursing care, challenging the frequently reported imbalance where sexual concerns of consumers are considered not as important as other areas of
care (Shell 2007). This is in contrast to the findings of Magnan et al. (2005) who report that nurses find difficulty in integrating awareness of sexual concerns into practice and highlights the importance for nurses to develop self-awareness and sexual health related knowledge so they are able to engage and assist consumers with sexual concerns (Montura et al. 2001).

The comfort and confidence of participants developed within a relatively short period of time of four weeks where they moved from a position of avoidance and anxiety around the topic, to a position where they were open to discussing sexual concerns with both male and female consumers.

The heavy workloads for nurses in mental health settings have been acknowledged as a barrier to their participation in staff development and ongoing education in a formal sense (Happell 2008; White & Roche 2006). Time is scarce and experiencing a lack of time is considered a barrier to the inclusion of evidence best practice (Bahtsevani et al. 2005; Hewitt-Taylor et al. 2012; French 2010; Parahoo 2000). The education sessions at Stage 1, took around 40 minutes. This brief educational approach is more likely to be successfully implemented than an intervention requiring a lengthy training program. This is a particular benefit given that nursing workloads limit the ability of nurses to include evidence in their clinical care (Bahtsevani et al. 2005; Pravikoff et al. 2003; Young 2003). This cost effective, brief training with demonstrated positive outcomes for nursing practice should be considered as an alternative option by managers who are reportedly reluctant to release nurses to training for lengthy periods of time (Bahtsevani et al. 2005; French 2010; Hewitt-Taylor et al. 2012; Parahoo 2000; Sitzia 2002; Young 2003).

Acknowledgement

At the final stage of this research, no participant referred to the BETTER model as a framework that resulted in this sustained practice change. The responses of the participants suggest they already had the core counselling
skills required to support discussing sexual concerns (Beck & Justham 2009; Bartlik et al. 2005; Higgins et al. 2006b; Warner et al. 1999). An approach that is structured and formalised like the BETTER model might, therefore, be less appropriate for mental health nurses than in specialties where there is a greater focus on physical care and less emphasis on the therapeutic use of self. Participant responses support this explanation. In almost all instances, participants referred to discussing sexual concerns within the context of their relationship with the consumer (Higgins et al. 2006b; Shattell et al. 2007). The nurse-consumer relationship, as perceived by the nurses, determined when and how the topic was introduced. The identified need to engage and create a therapeutic environment to support discussion regarding sexual concerns as identified by the participants in the research has been well recognised by others (Duldt & Pokorny 1999; Higgins et al. 2006a; Lewis & Bor 1994; Montura et al. 2001).

The findings from this research suggest that mental health nurses can overcome the tendency to avoid discussing sexual concerns with consumers resulting in sustainable changes to practice. The continued inclusion and value of human sexuality in the practice of these nurse participants has much to do with awareness building and the perceived relevance of the educational approach to their practice. The increased awareness about the impact sexual concerns can have for the lives of consumers resulted in a commitment and willingness by the participants to create time to discuss these concerns with consumers. Willingness and commitment have been identified as vital nursing qualities for supporting the person experiencing sexual problems (Krebs 2007; Shell 2007). Increasing awareness and giving permission to engage with consumers on the topic appear to have been more effective than providing a structured skill-based framework such as the BETTER model. Further assistance towards the inclusion of sexual concerns for these participants may have resulted from the context of their work with consumers. All participants worked in continuing care teams, where engagement with
consumers occurs over an extended period of time. Brief admissions and lack of time have been identified as barriers to the inclusion of sexual concerns (Herson et al. 1999).

At this stage of the research the restricted views initially expressed by participants that created personal barriers (Evans 2000) and resulting in avoidance, were no longer a concern for the participants. The participants stated that they were now providing support for consumers struggling with their sexual identity and sexual choices; and the participants reported taking advantage of opportunities to provide education regarding sexual safety and the importance of having sexual health checks. The experiences of participants here support findings that overcoming gender and boundary concerns can occur when nurses develop knowledge and challenge personal biases and attitudes towards human sexuality (Crouch 1999a; McCann 2000; Ruane & Hayter 2008).

The 5 A’s Framework
The findings from the research informed the development of The 5 A’s Framework for including sexual concerns in practice from the initial standpoint of where the participants demonstrated avoidance of consumer sexual concerns to acknowledging the importance of including the sexual concerns of consumers in providing comprehensive holistic nursing care. The awareness building participants developed from the education session increased their understanding towards sexual concerns frequently experienced by consumers. This broader understanding towards these issues along with being encouraged and provided with permission to discuss sexual concerns, assisted them to overcome personal barriers and engage with consumers. Applying these skills, creating opportunities for consumers to discuss their concerns resulted in positive reinforcement for the participants from the responses of consumers, and it is this
acknowledgement of helping the consumer that has kept these participants including the topic in their practice.

The 5 A’s Framework for including sexual concerns in practice, identifies five stages. These are: Avoidance; Awareness; Approval; Applying; and Acknowledgement, and are illustrated in Figure 7.

Figure 7: The 5 A’s Framework for including sexual concerns in practice

The 5 A’s Framework for including sexual concerns in practice is an evidenced based framework developed directly from the responses of mental health nurse participants. The framework aims to assist mental health nurses to overcome personal fears and concerns that tend to result in Avoidance of the sexual concerns of consumers. It illustrates the importance of Awareness building to assist nurses overcome their fears and concerns, legitimising the topic as a matter for the role of nurses. From this point permission to engage on this topic with consumers occurs resulting in an improved likelihood for nurses to include the topic as part of assessment, which has been labelled as Approval. The next level of the framework is called Applying, referring to
nurses valuing the importance for consumers and their nursing role towards including the sexual concerns of consumers in their practice. The final level is Acknowledgement, where the inclusion of consumer sexual concerns becomes a fixed part of their nursing practice, acknowledging the importance of sexuality in the delivery of holistic mental health nursing care.
The 5-As Framework for Including Sexual Concerns in Mental Health Nursing Practice

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Available evidence informs us that sexual health concerns of consumers are commonly avoided within mental health services. This paper describes the findings of a qualitative exploratory research project. This research was conducted in three stages, all involving in-depth interviews with 14 nurses working in a mental health setting. Stage 1 involved an exploration of participants' views about including sexual concerns in their practice and included an educational intervention designed to encourage sexual inclusivity in practice. Stage 2 involved follow up interviews 4–6 weeks later to discuss the effectiveness of the intervention and whether practice change had resulted. Stage 3 was conducted two years later with the aim of determining the extent to which practice changes had been sustained. The themes emerging throughout the research emphasised five main stages in the nurses' experience: avoidance; awareness; applying; approval; and acknowledgement. Avoidance of the topic was commonly noted in the early stages of the research. The education program led to awareness raising of sexual concerns and approval towards the importance of this area to which lead to applying it to practice. This ultimately resulted in acknowledgement of the need for sexual concerns to become part of mental health nursing practice. These five stages are represented in the Five A’s for including sexual concerns in mental health nursing practice, the framework developed by the first author.

Sexuality is considered an essential component of how one defines their sense of self (Foucault, 1998; Wilmoth, 2007; World Health Organization [WHO], 2006) and is therefore a legitimate area for nursing care (Saunamaki, Anderson, & Engstrom, 2010; Volman & Landeen, 2007). The practice of nursing is often described as holistic in nature (Albaugh &Kellog-Spadt, 2003; Fulder, 2005; Zahourek, 2008), however it is difficult to accept that nursing embraces the notion of holism, when in practice sexual health concerns are frequently avoided when all enduring mental illness experience sexual health concerns in significant proportions, including unsafe sexual practices (Dyer & McGuinness, 2008; Kelly & Conley, 2004; Rosenberg et al., 2005), increased risk of acquiring an STI (King et al., 2008), engaging in sexual activity while under the influence of alcohol or illicit substances (Campos et al., 2008), and sexual assault and sexual abuse at reported rates three times that seen in the general population (Coverdale & Turbott, 2000; Goodman et al., 2001; Warne & McAndrew, 2006).
Sexual vulnerability and sexual exploitation, especially for female inpatient consumers, is a further concerning occurrence (Brown, Lubman, & Paxton, 2011; Cole, 2003; Judd, Armstrong, & Kulkarni, 2009; McLindon & Harms, 2011), resulting in some mental health units providing additional safety and security measures for women (Price, 2009). The incidence of sexual side effects from psychotropic medications also has significant implications (Balon, 2006; Basson et al., 2010; Schlachetzki & Langosch, 2008; Schweitzer, Maguire, & Ng, 2009; Werneke, Northey, & Bhugra, 2006) for example, non-adherence and subsequent risk of relapse (Basson et al., 2010; Deegan, 2001; Schweitzer et al., 2009).

Within adult mental health settings, the sexual health concerns of consumers remain for the most part a taboo topic (Gamlin, 1999; Odey, 2009). There is widespread avoidance of sexual health concerns (McCann, 2010; Nakopoulou, Papaharitou, & Hatzichristou, 2009; Quinn, Happell, & Brown, 2011a), notable absence of content in nursing curricula (French, 2010; Montura et al., 2001; Shell, 2007), and absence of any reference in professional practice standards to nursing competency in caring for consumers (Australian College of Mental Health Nurses [ACMHN], 2010).

Models of clinical practice have been developed to include human sexuality in nursing care (Anderson, 1990; Mick, Hughes, & Cohen, 2004; Schain, 1988; Annon, 1976; Taylor & Davis, 2006) with most progress toward addressing sexual health concerns in nursing practice occurring within the clinical speciality of Oncology. The purpose of this paper is to present and describe the development of the 5-As framework for including sexual concerns in mental health nursing practice. The research began as an exploration of nurses’ attitudes to including sexual concerns in practice and the extent to which the BETTER model (Mick et al., 2004) might influence inclusivity of this topic. The BETTER model was selected after a detailed review of the models with relevance to this topic:

- ALARM (Anderson, 1990);
- PLEASURE (Schain, 1988);
- PLISSIT (Annon, 1976);
- ex-PLISSIT (Taylor & Davis, 2006); and
- BETTER (Mick et al., 2004).

The ALARM model (Anderson, 1990) was designed for assessment and communication about sexuality and sexual activity (Anderson, 1990). The model consists of five stages: activity; libido; arousal; resolution; and medical information. The ALARM model was designed to assist clinicians in assessing each stage of sexual performance and to obtain a relevant medical history to facilitate a diagnosis of a sexual problem (Anderson, 1990). The model has a focus on the physical aspects of sexuality such as sexual activity, arousal, the quality of lubrication, the ability to reach orgasm, resolution following orgasm, and the person’s medication (Anderson, 1990). The model does not address intimacy, closeness, and self-image (Hordern, 2008), and has been criticised for its limitations in gaining personal insights into the person’s experience of his or her sexual health concerns (Hordern, 2008).

The PLEASURE model (Schain, 1988) has a focus on psychosexual issues. It is comprised of eight assessment domains: Partner; Lovemaking;
Emotions; Attitude; Symptoms; Understanding; Reproduction; and Energy. It is cited frequently within the literature as a model that can assist oncology nurses in the provision of sexual health care (Audette & Waterman, 2010; Kotronoulas, Papdopoulou, & Patiraki, 2009; Mick, 2007; Mick et al., 2004). However, the literature is scant on details of the application of the model in practice. There is also no documented evaluation of the model’s effectiveness (Yarbo, Wujcik, & Gobel, 2011).

The PLISSIT model (Annon, 1976) was developed for the assessment and management of sexual health problems and consists of four levels. The first is Permission where the nurse creates the appropriate environment for the person to discuss sexual concerns and any related issues that he or she may have (Annon, 1976). The second level is Limited Information, which involves the provision of general information relating to sexual health and sexuality (Annon, 1976). It is generally accepted that nurses can intervene with comfort at these first two levels (Cort, Attenborough, & Watson, 2001). The third level is Specific Suggestions about sexuality and sexual health interventions. Nurses are required to have had post graduate experience in sexual health to intervene at this level (Annon, 1976; McCandless & Sladen, 2003). The final level is Intensive Therapy where the nurse uses his or her advanced counselling skills and knowledge to address specific problems faced by the person or couple (Annon, 1976).

The Ex-PLISSIT model (Taylor & Davis, 2006) is an expansion of the PLISSIT model where permission giving questions are required at each level. These questions allow the clinician to check-in with the person, clarify the person’s situation and experience, and provide the clinician with an opportunity to reflect on their interventions (Taylor & Davis, 2006, 2007). The PLISSIT and Ex-PLISSIT models do not contain sufficient guidelines on the interpersonal communication strategies required by mental health nurses (Higgins et al., 2006b; Hordern, 2008).

The BETTER Model (Mick et al., 2004) was developed to assist nurses to include sexual health assessment in the care of people affected by cancer. There are six stages. The first stage is called, Bring-Up, where the topic of sexual health is raised with the person and an opportunity is provided to discuss what the topic means and whether the person has any sexual concerns (Mick et al., 2004). Explain, the second stage, focuses on normalising the topic and reducing possible embarrassment by indicating that sexual health is an important quality-of-life issue for many people (Mick et al., 2004) and that the nurse is available to discuss these. The third stage of the model, Tell, is concerned with letting the person know that any resources required to address sexual health concerns will be provided (Mick et al., 2004). The fourth stage, Time, refers to ensuring that any discussion is respectful of the person’s readiness to talk about sexual health concerns and to assist him or her with any information required on the topic (Mick et al., 2004). The fifth stage Educate, focuses on providing education regarding sexual side effects of treatments or medical conditions. Informing people about sexual side effects is as important as informing people about any other adverse effect of treatment (Mick et al., 2004). Recording is the
The inclusion of sexual health in mental health nursing has received limited attention within the literature (McCann, 2000; Quinn & Browne, 2009). Consumers are willing and able to discuss their sexual health concerns (McCann, 2010), and there is an identified need for mental health nurses to facilitate communication about the sexual health concerns of consumers (Phillips & McCann, 2007). However, little progress has been made in meeting such needs of consumers (Higgins, Barker, & Begley, 2008; Wright & Pugnaire-Gros, 2010). With this in mind, research was conducted to explore the usefulness of the BETTER model for mental health nurses in discussing the sexual health concerns of mental health consumers. The BETTER model was selected as the preferred model for this research project because it is person-centred (Hordern, 2008), has relevance for nurses working across a variety of clinical settings (Katz, 2005), and because it acknowledges human sexuality as more than purely sexual function (Hordern, 2008). The BETTER model has been reported as providing a useful framework that can assist nurses in improving this area of care (Katz, 2005; Mick et al., 2004), however the effectiveness of the BETTER model for mental health nurses has not as yet been evaluated.

**METHODOLOGY**

**Design**

A qualitative exploratory methodology was utilised to conduct this research. This approach is used frequently in mental health nursing research (Bennetts, Cross, & Bloomer, 2011; Happell, Scott, Platania-Phung, & Nankivell, 2012; O’Brien et al., 2011) and allows the researcher to...
provide a detailed exploration of the participants’ beliefs, opinions, and experiences in relation to the area of interest (Liamputtong, 2010; Polit & Beck, 2004) and to broaden the knowledge base (Polit & Beck, 2004), which in this instance, is the inclusion of human sexuality concerns in mental health nursing practice.

**Setting and Sample**

The sample for this research was mental health nurses from a community and two inpatient teams in a mental health service in Queensland, Australia. The managers of each team were contacted in-person by the principal researcher. The managers suggested that the principal researcher approach nurses at team meetings. Nurses who indicated interest were given a face-to-face meeting, a common and a preferred method of recruitment (Polit & Beck, 2004).

A convenience sample of 14 mental health nurses agreed to participate in the research, including 8 females and 6 males. At the commencement of this research, their age ranged from 24 to 60 years with a mean age of 44.4 years, and they had between 2 and 39 years of experience in mental health nursing, with a mean of 14.9 years. Theoretical saturation occurred following the fourteenth interview, and as a result, recruitment of further participants was not required (Liamputtong, 2010; Polit & Beck, 2004). At all stages of this research, the participants continued to practice within the same mental health service.

**Ethical Considerations**

Ethics approval was obtained from the mental health service where the research was conducted and from the relevant university. A plain English explanation of the intended research was provided to all potential participants, who were informed of the voluntary nature of their participation along with their right to withdraw their consent at any time during the research (Liamputtong, 2010; Polit & Beck, 2004). As this research occurred in stages over a two-year period, process consent was used, where a form was initially signed, and consent renegotiated at each stage of the research (Polit & Beck, 2004). A pseudonym was assigned to each participant to maintain their confidentiality. All research data have been securely stored for the sole purpose of this research with only members of the research team having access.

**Procedure**

The research was conducted in three stages. Stage 1 involved a broad exploration of nurses' views of and practice in relation to discussing sexuality issues with consumers of mental health services. At the conclusion of the interviews the participants were provided with a brief education session regarding sexual safety; sexual abuse and exploitation; sexual vulnerability; and sexual function problems associated with psychiatric medications. The education sessions were intended to increase participants’ awareness about sexual concerns experienced by consumers, and included a discussion of the BETTER model (Mick et al., 2004). Each stage of the BETTER model was described to participants and they were encouraged to ask questions to clarify their understanding of each stage and the model as a whole. They were asked to adopt this approach in their practice over a four-week period. The focus of Stage 2 (conducted approximately 4–6 weeks after the initial interviews) was to explore the extent to which the BETTER model had been
utilised and whether any changes in practice had resulted. Participants were asked whether the model had been helpful and, if so, what aspects had been helpful and how they had contributed to a change in practice.

Stage 3 was conducted approximately two years later with the primary aim of determining whether any changes in practice had been sustained over time and, if so, to ask participants whether the BETTER model had been influential in this change.

The research utilised individual in-depth interviews at each of the three stages. On each occasion the interviews were conducted in private locations to avoid interruptions. Initially participants were asked to discuss their practice in relation to the sexual health and sexuality concerns of consumers using an open style of questioning to encourage the participants to speak at length (Horsfall, Cleary, Walter, & Hunt, 2007). The same 14 nurses were interviewed at Stage 1 and 2. There was no contact between the principal researcher in relation to the research between Stage 2 and Stage 3. By Stage 3, four of the nurses were no longer employed at the study setting and the researcher was not able to contact them, resulting in only ten nurses being interviewed at Stage 3.

Data Analysis

All interviews were digitally recorded. To become familiar with and sensitive to the data, the principal researcher transcribed each interview verbatim. Data analysis occurred utilising the five stage framework of familiarisation, identifying a thematic framework, indexing, charting and mapping, and interpretation (Ritchie & Lewis, 2007). The transcripts were carefully read and re-read to identify the themes and subthemes (Polit & Beck, 2004; Ritchie & Lewis, 2007). This article presents a brief overview of the findings at each stage with a specific focus on participants’ attitudes to addressing sexual concerns and the usefulness of the BETTER model as a guide for practice.

FINDINGS

This section provides a brief overview of the findings of each stage of the research, including the main themes to emerge from each. The themes are presented in Table 1.

Stage 1

Avoidance

Initial individual interviews with participants revealed that avoidance of sexual health and sexuality concerns was common. Participants believed that the topic was not as important as other presenting issues:

I will ask in an interview if they have a partner but that is all they will get and if they say no, you will stop there, you won’t actually go any further. — Frank

Another commented that:

To be honest it’s something I don’t initiate conversation about. — Louise

Table 1: Main Research Themes

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Avoidance Awareness</th>
<th>Avoidance:</th>
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<tr>
<td></td>
<td></td>
<td>• Talking about or avoiding sexual health concerns</td>
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<td>• Not an important priority</td>
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<td>• Refer to others / not my job</td>
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<td></td>
<td>Gender issues:</td>
<td>• The impact of gender</td>
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<td></td>
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<td>• Professional boundaries</td>
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| Stage 2 | Approval Applying | • Using the BETTER model |
|---------|-------------------|• Consumer responses |
|         |                    |• Greater awareness |
|         |                    |• Becoming part of practice |
If a consumer was to raise a sexual health concern, it was often viewed as less important than other clinical issues and would be referred to another health professional, even though participants believed the topic would be poorly addressed or avoided by other health professionals. Furthermore, participants expressed concerns that by discussing this personal topic their actions might be professionally questioned by colleagues, misinterpreted by consumers, and ultimately be viewed as a professional boundary transgression, particularly with consumers of the opposite gender as Rhys, a male participant states:

I can see that of course it’s important [issue for female consumers], I just don’t want to go there with [female consumers] I think in mental health you don’t want to touch on these subjects with [female consumers]. — Rhys

Awareness

After the participants’ experiences of whether they include sexual concerns in their practice had been fully explored, a brief education session was provided by the principal researcher with each participant regarding common sexual concerns experienced by consumers with an enduring mental illness. The education sessions were intended to increase participant awareness of the relevance of sexual health assessment and care, included a discussion of the BETTER model. The education sessions took approximately 40 minutes to complete for each participant, and signified the end of their initial interview. The participants were then asked to try using the BETTER model with consumers over a four-week period as a framework to assist in the inclusion of sexual health and sexuality as part of the assessment and intervention practice. Following the education session the participants discussed their growing awareness:

It’s something I need to be aware of. ... Perhaps we need to take more control and initiate the area of conversation I guess, because clients clearly aren’t. — Louise

I think it sits quite well and makes good sense and it’s probably something you just overlook, I guess. I think a lot of nurses probably overlook it. I’ll definitely put a lot more effort into it, it seems so straightforward and common sense. — Chris

A lot of them do have problems, they just don’t have the urge anymore and don’t want to talk about it. So if he tries to have a relationship, and let’s face it everybody wants someone, then he’s going to have trouble with that, and the chances are that he will stop taking his medication. — Mick

STAGE 2

Applying

After four weeks the participants reported increased confidence and a willingness to engage with consumers. Several participants expressed surprise that consumers were willing to engage on the topic:

Yeh good, they’ve just been open about it. I was surprised about this, I thought they might have thought it was strange and unusual for a nurse to talk about sexual health but they were okay with it. They were happy to discuss any issues that they might be experiencing. — Joanne

And:

Amazingly those who want to talk about it seem to be able to, just once you’ve brought it up it just comes out. — Shannelle

They felt the education session had increased their overall knowledge regarding sexual health and sexual concerns experienced by consumers:

The sessions with you raised an awareness with me. I’ll say to them now, “So you’ve talked to me..."
about some of your side effects, do you have any side effects on the sexual part, you know, like do you have any problems getting an erection? — Lisa

For these participants, sexuality was becoming an important issue for them and an important topic to include in their practice:

The guys seem to want the information [about sexual health] so it’s my job to do it and tell them or find out some info for them. — Rhys

Approval

In meeting with the participants and discussing the relevant literature pertaining to consumer sexuality, validating their concerns about the inclusion of sexual concerns in their practice, and encouraging them to try the BETTER model approach, we provided these participants with permission to include the topic in their practice. With regard to the BETTER model, participants reported it was easy to understand; however, they were reticent to follow the stages of the model as intended, preferring a less structured approach by adapting the concepts of engagement and education embedded in the model. This suggests limited usefulness of the BETTER model for mental health nurses:

Did it change my practice … I have to say the model went on the shelf. Perhaps if it was reinforced I would have used it more often and if it was introduced systematically across the unit, then perhaps … I did notice though that for me it was an awareness thing for me helping people [consumers with their sexual concerns]. — Jenny

Stage 3

Acknowledgement

The main finding at this stage was that participants had vague memories of the BETTER model but continue to include sexuality as part of routine practice:

I talk about emotions, weight gain, and I’ve really tried hard to incorporate sexuality into every assessment. … it is an important issue, and as I practiced, it has just become part of my practice. — Olivia

And:

I just talk to them about [sexual health]. I mean this is what we should be doing. It’s a problem for so many patients … Before all of this, I wasn’t so concerned about the sexual things, I didn’t realise what a big problem it can be, and when I have talked about it the consumers are okay to talk with me. — Frank

Participants’ scope and confidence had expanded, with participants demonstrating an ability to engage with consumers on a range of sexual health concerns, offering support, education, advice, and referral to specialised services:

After I talked with you, it increased my awareness. A mental prod to include it because it’s really important when you’re looking at the whole person … we are supposed to look at holistic nursing, including all aspects of a person, and the ability to have intimate relationships with another is a key element to being accepted and feeling satisfied as a person. — Shannelle

Participants’ confidence and skill improved as they continued to value and include human sexuality in their practice, suggesting that the brief training regarding the importance for consumers in acknowledging their sexual health concerns can result in prolonged practice change.

DISCUSSION

The findings from this research suggest that prior to their involvement in the research, the participants tended to avoid referring to the sexual health concerns of consumers in their clinical practice. Similar findings have emerged in the limited research in mental health (McCann, 2003; Quinn et al., 2011a) and other health care settings (Hordern, 2008; Katz, 2005; Kotronoulas
et al., 2009). Perceived issues around gender and professional boundaries were not found in these other settings, suggesting that these may be specific mental health issues presenting additional barriers. The participants in the current study described consumer sexual health and sexuality concerns as not a priority of care and/or the responsibility of other health professionals, which has been found elsewhere (Magnan, Reynolds, & Galvin, 2005; Quinn et al., 2011a).

The findings from the second and third stage of the research suggested a marked change in practice, acknowledging the importance of addressing sexual health concerns and incorporating them into routine practice. However, participant responses suggest the BETTER model itself (Mick et al., 2004) was not helpful. Indeed most did not use the prescribed approach, considering it too structured and not conducive to the more informal communication style between nurses and consumers that is characteristic of mental health settings.

Given the importance of including sexual health concerns as part of quality, holistic nursing care, subsequent data analysis focused on the processes that led to the change in practice. Over a two-year period, participants had moved from Avoiding inclusion of sexual health concerns within their practice not only to its inclusion, but to Acknowledging it as a crucial component of holistic care. This analysis contributed to the development of the 5-As (Avoidance, Awareness-building, Approval, Applying, and Acknowledgment) for including sexual concerns in practice. The framework is presented in Figure 1.

The 5-As for including sexual concerns in practice, identifies Avoidance as the participants’ original practice relating to sexual health concerns (McCann, 2003; Quinn et al., 2011a). Awareness-building occurs through the provision of specific education on sexual health concerns for consumers, such as sexual safety, sexual abuse and exploitation, sexual vulnerability, and sexual function problems associated with medication along with the effects illness and symptoms can have upon sexual response and sexual confidence (Cort et al., 2001; Krebs, 2007). Awareness-building is concerned with assisting nurses to overcome personal sexual feelings, behaviours, beliefs, attitudes, and knowledge that strongly influence the practice of nursing (Nakopoulou et al., 2009) and legitimising the importance of sexual health for nurses (Higgins, Barker, & Begley, 2006b; Krebs, 2007). From here, nurses are given Approval to engage with consumers on the topic. Approval is a vital step in this process (Volman & Landeen, 2007), because of the common barriers related to boundary and gender concerns (Quinn, Happell, & Browne, 2011b). There is a need to provide
nurses with permission to talk about this topic (Magnan et al., 2005; McCann, 2010; Odey, 2009; Wright & Pugnaire-Gros, 2010) and to let them know, that consumers are not only willing to engage, but are in a position where they are waiting for nurses to initiate discussion on the topic (Kelly & Conley, 2004; McCann, 2010).

Applying refers to nurses including sexual concerns in their assessment and care as part of their ongoing practice and beginning to value the importance of both this area of care for consumers and their role in providing this care (Quinn & Happell, 2012a, 2012b; Quinn, Happell, & Welch, in press). These skills require practice (Gianotten, Bender, Post,&Hoing,2006). As nurses continue to apply these skills Acknowledgement results. The participants came to value the importance of sex for consumers. This led to sexual concerns becoming embedded in their professional practice, increasing their confidence in addressing this important aspect of care (Quinn & Happell, 2012). Ultimately human sexuality was acknowledged as part of their practice, an important component of holistic care (Albaugh & Kellog-Spadt, 2003). The 5-As framework for including sexual concerns in practice demonstrates participants’ progress from avoidance of consumer sexual health concerns to a comprehensive holistic approach to nursing care.

This 5-As framework for including sexual concerns in practice has the potential to guide changes to practices of nurses in addressing sexual concerns of consumers of mental health services. Unlike the models commonly used (Anderson, 1990; Annon, 1976; Mick et al., 2004; Schain, 1988; Taylor & Davis, 2006), it focuses on awareness-building required for nurses to value the importance of including consumer sexual health in their practice. Rather than focusing primarily on skills, educational initiatives must provide opportunities to explore sexual health concerns and highlight their importance for consumers of mental health services. It appears that this awareness-raising legitimises sexual health concerns as part of practice and gives nurses permission to raise them as part of practice.

The findings from this research suggest that raising awareness of the sexual concerns of mental health consumers can contribute to substantial and sustained changes in practice. Given that holism is the philosophical underpinning of nursing practice, it is essential that nursing curricula include sexual health and sexual awareness as part of curricula. By being included in nursing curricula, sexual issues will be seen as important parts of the nurse’s role and therefore more likely to be acknowledged as core skills and knowledge.

LIMITATIONS
While the qualitative nature of this research provided an ideal opportunity for the exploration of issues, it does not allow for the generalisation of findings. The framework reflects the views and opinions of the nurse participants in this research. Its applicability to a larger cohort of nurses across a larger number of mental health settings would be necessary before the framework can be considered for wider use in practice.

CONCLUSION
Notwithstanding the stated limitation, the findings from this research suggest that nurses
employed in mental health settings can overcome the tendency to avoid discussions of a sexual nature with consumers. The continued inclusion and value of human sexuality in the practice of these nurse participants has much to do with awareness-building and perceived relevance of the educational approach to their practice. Increasing awareness and giving permission appear more effective than providing a structured skill-based model. Achieving holistic nursing care in mental health settings requires attention to the sexual concerns of consumers. Because of the qualitative approach in this study, further research is recommended to explore the efficacy of the 5-As framework for including sexual concerns in mental health nursing practice with a larger number of participants from a broader range of mental health settings.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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The 5 A’s Framework for including sexual concerns in practice has the potential to guide changes to the practice of nurses in addressing sexual concerns of consumers. Unlike the models commonly used within other areas of nursing practice such as ALARM (Andersen 1990); PLISSIT (Annon 1976); BETTER (Mick et al. 2004); PLEASURE (Schain 1988); and Ex-PLISSIT (Taylor & Davis 2006) the 5A’s Framework focuses on awareness building required for nurses to value the importance of including consumer sexual concerns in their practice. Rather than focusing primarily on skills. The 5 A’s Framework provides a platform to assist nurses to commence exploring this area of care with consumers based on awareness building occurring from education and approval for nurses to discuss sexual concerns with consumers. Furthermore the framework is an evidenced based framework developed directly from the response of the participants in this research.

**Benefits of the research approach**

It has been argued that the cultural identity of nurses, that is that nurses are trustworthy, honest and down to earth, are qualities that assist nurses in effective researcher roles (Leslie & McAllister 2002). Furthermore, it has been observed that nurses are not satisfied describing a phenomenon and will explore and search for meanings to assist them in their clinical roles (Thorne et al. 2004). As such, qualitative research is a popular research methodology for nurses (Leeman & Sandelowski 2012) who “want to do it, can do it and can do it well” (Annells 2007 p. 224). Qualitative research has been criticised for its seemingly simplistic approach (Neergaard et al. 2009) and has been viewed as not having the sophistication of quantitative methods (Dixon-Woods et al. 2006). However as Sandelowski (2000) clearly highlights that there is nothing trivial in exploring meaning with participants and the reporting of these meanings (Leeman & Sandelowski 2012) in a manner that can be understood and useful.
In examining the essence of mental health nursing, Cutcliffe and Goward (2000) draw parallels between the roles of developing therapeutic relationships with consumers and the role of the qualitative researcher. The engagement, rapport, empathy and trust that develops between the nurse and consumer are also required with the role of the qualitative researcher who requires these qualities to fully understand the world of research participants. Claiming that as a result of the qualities required to foster therapeutic relationships, mental health nurses gravitate towards qualitative research methods and describes this as a mutual attraction (Cutcliffe & Goward 2000). These views resonate well for me, and provide me with a personal justification for my choice towards utilising an exploratory qualitative approach along with my personal comfort with this type of research. Perhaps this is a reason for exploratory qualitative research being such a popular method for gathering data (Giacomini & Cook 2000). Moreover, it is a method that has been widely used within nursing research as a means to collect detailed information about an issue of interest (Beaver et al. 2007; Chen 2010; Hayter & Harrison 2008; Manias et al. 2005).

Limitations

As with all research, this exploratory qualitative research is subject to limitations. The research made use of convenience sampling. Convenience samples are also subject to selection bias because participants self-select by responding to an invitation to participate in the research (Polit & Beck 2010). Participation in the research was entirely voluntary so there is a potential problem that the participants in this research may not be representative of those nurses who chose not to participate (Polit & Beck 2010). Due to the exploratory qualitative approach used in this study, it is not possible to generalise these findings to a broader population. Given that the 14 mental health nurses who participated in this study were from the same service within Queensland their views and practices may not represent those of
mental health nurses elsewhere. Although this exploratory qualitative research reflects the views of a specific population with a small sample size of mental health nurses, it does however make a significant contribution to the literature in understanding the practice of mental health nurses in relation to nursing practice towards the sexual concerns of consumers.

Credibility is an important component of qualitative research. There is the risk that the personal interests of the principal researcher, who conducted the interviews, may have influenced the data. To reduce this risk, the principal researcher received supervision from the research team prior to, and following interviews to reduce possible bias. The focus of these findings is on participant perceptions, rather than measurable change. No formal testing of their knowledge occurred at the onset or at the time of the second round interviews. A further limitation is that in discussing sensitive topics, such as sexuality, there is the risk of participants censoring their responses, offering responses that they believe the researcher wants to hear (Magnan & Norris 2008; Polit & Beck 20010). To minimise this risk I was aware not to closely scrutinise participants which could result in a change in their normal behaviour, and lead them to alter responses in order to please me (Liamputtong 2010).

**Recommendations**

The importance of consumer sexuality in mental health care needs to be embedded into practice at assessment and throughout the treatment trajectory. With this in mind, the following recommendations are made:

- To develop teaching strategies to assist mental health nurses to improve their confidence to discuss sexual concerns with consumers. This requires consideration at an undergraduate and postgraduate level, with curricular that supports the importance of human sexuality as a legitimate area of nursing where issues such as sexual diversity,
sexual functioning, relationship issues, and education regarding safer sexual practices are included;

• Inclusion of consumer sexual concerns in undergraduate and postgraduate curricula would acknowledge the importance of sexuality in health care from the outset, with postgraduate curricula increasing the specific focus on consumers and the sexual concerns they can experience;

• To better understand issues related to gender and boundary concerns when discussing sexual concerns from both a consumer and nurse perspective, and take steps to ensure assessment documentation includes human sexuality in a broader manner than the obligatory questions regarding marital status and gender;

• Strategies to improve awareness of nurses towards sexual safety issues for consumers, such as the increased risk of STI, multiple sexual partners, engaging in unsafe sex with other high risk populations and more specifically for female consumers the increased risk of sexual violence and issues related to being sexually vulnerable;

• To improve nursing knowledge regarding the impact that sexual side-effects from psychotropic medication can have for consumers and their ongoing commitment to medication adherence, and to improve the skills of nurses to engage with consumers on medication related issues to improve adherence;

• Provide education to improve nurses’ awareness of evidence related to the importance of consumer education to improve adherence and address issues related to sexual side effects and to consider these discussions to be an important part of routine nursing care;

• That education programs for nurses avoid the heteronormativity focus of the medicalised view of sexuality so the sexual needs and sexual concerns of all consumers are provided equal importance;
• To develop strategies to ensure that nurses are aware that sexuality is an important aspect for all adults so that the sexual concerns of older adults are not over-looked;

• To evaluate the effectiveness of the 5 A’s framework for including sexual concerns in practice with a larger cohort of nurses across a larger number of mental health settings; and

• The inclusion of sexuality in professional practice standards to assist nurses in optimising the holistic health outcomes of consumers.

Further research

Suggestions for further research to better understand the implications of the findings of this research and the benefit for mental health nurses in utilising the 5 A’s framework for including sexual concerns in practice include:

• To explore and identify the cultural barriers within mental health nursing to the assessment and inclusion of consumer sexual concerns and investigate measures to overcome them;

• Research and public discussion could also seek to clarify issues of comfort and confidence in discussing sexuality with nurses from a consumer perspective, which might well assist in clarifying existing beliefs around professional boundary practices;

• To examine how mental health nurses can most appropriately be educated to understand the importance of, and feel confident to, introduce the discussion of sexual concerns as part of routine practice; and

• To investigate whether the 5 A’s framework for including sexual concerns in practice is an effective approach to assist mental health nurses with the confidence to discuss sexual concerns with consumers in other settings.
Summary and Conclusion

The purpose of this research was to explore the practice of mental health nurses regarding the inclusion of consumer sexual concerns in their practice; and whether the BETTER model was a useful framework to in support mental health nurses in discussing sexual concerns with mental health consumers. This is the first known Australian study investigating the practice of mental health nurses on this topic. In addition to exploring the issue the aim was to develop strategies to improve this area of practice. Furthermore, this is the first known research exploring the effectiveness of the BETTER model in a mental health setting.

The findings from this research indicate that sexuality is both an important and neglected issue in the delivery of mental health nursing care. The participant’s views highlighting that the sexual concerns of consumers are a relatively low priority in their day to day role, and is also a low priority for their colleagues. There was a lack of confidence by participants about dealing with the sexual concerns of consumers. During the initial findings participants discuss that consumer sexual concerns are best dealt with by another clinician, with the practice of referring the consumer on, despite their observation that these concerns are also poorly addressed by others.

Participants in this research overcame their personal barriers and issues of avoidance and commenced including a variety of sexual concerns with consumers. And while it was thought that the BETTER model might provide mental health nurses with the appropriate guidance and support, the findings strongly support that awareness building and the components of the 5 A’s Framework for including sexual concerns in practice were responsible for the change in practice for these participants rather than the structure of the BETTER model.
Sexuality must be part of holistic nursing care. However there are significant barriers to nurses discussing this topic with consumers. Clearly the nursing profession needs to discuss and debate how we can address nursing’s neglect towards addressing the sexual concerns experienced by consumers. If mental health nurses are to provide holistic care for consumers, it is important that barriers to the assessment and discussion of sexual concerns for all adult mental health consumers are identified and measures are taken to overcome them.
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Statement of Contribution by Others

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I, Chris Quinn, contributed to ≥ 80% of the content of the following publications as the "primary author". The initial draft of the work was written by me and subsequent editing in response to co-authors and editors was also performed by me to the publications entitled:


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Professor Brenda Happell
Statement of Contribution by Others

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I, Chris Quinn, contributed to ≥ 80% of the content of the following publications as the "primary author". The initial draft of the work was written by me and subsequent editing in response to co-authors and editors was also performed by me to the publications entitled:


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Associate Professor Anthony Welch
Statement of Contribution by Others

To Whom It May Concern

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Doctor Graeme Browne

(Signature of Co-Author)
Sexuality of people living with a mental illness: A collaborative challenge for mental health nurses

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\textbf{ABSTRACT:} This article is a review of the literature examining the sexuality of mental health consumers and the role of mental health nurses. A search identified 72 English articles on the topic. The evidence clearly indicates that sexuality is a critical aspect of who we are as individuals, and of how we view ourselves, but discussion of this topic is neglected by mental health nurses. Discussion focuses upon the wide acceptance of sexuality as a legitimate area for nurses to address in their care, and addresses mental health nurses’ lack of knowledge about sexuality, conservative attitudes, and anxiety when discussing sexual issues. Consumer sexuality is poorly assessed in mental health, and is infrequently explored by mental health nurses. The result is that issues of sexuality for the consumer continue to affect many areas of their lives, including their relationships and ongoing commitment to treatment. The nurse–consumer relationship provides an opportunity to take sexual history into consideration, promote safe sexual practices, discuss sexual problems, and educate clients about sexual issues. This literature review identifies the need for further discussion of this topic and for research to point the way ahead for this important but neglected area of mental health nursing.

\textbf{METHODOLOGY}

The Clinical Knowledge Network (CKN) databases of CINAHL, MEDLINE, and PsycINFO, and the Internet were searched using a combination of the key words: sexuality, sexual health, sexual dysfunction, nursing, and psychiatric nursing. The aim of this search was to identify articles investigating sexuality in relation to mental health consumers and the care received by these consumers by mental health nurses. This search identified 472 articles. Of these, only 15 key English articles with relevance to mental health nursing, and mental health clients were located. These articles were manually searched for further relevant articles, resulting in a total of 72 articles to form this review.
OVERVIEW
Sexuality is fundamental to health, quality of life, and general well-being. Sexuality affects the way we relate to ourselves, our sexual partners, and all other people. Although there is wide acceptance of sexuality as a legitimate focus for nursing, lack of knowledge about sexuality, conservative attitudes, and anxiety when discussing sexual issues are widespread among nurses (Cort et al. 2001; Katz 2002; McCann 2003; Shield et al. 2005; Woolf & Jackson 1996).

The sexuality of consumers of mental health services is infrequently explored by mental health nurses. The result is that unresolved issues of sexuality of the consumer continue to impact many areas of their lives, including their relationships and their ongoing commitment to treatment. The nurse–consumer relationship provides an opportunity to take sexual history into consideration, promote safe sexual practices, discuss sexual problems, and educate consumers about sexual issues. However, consumers unfortunately face sexual health difficulties with poor support. Models providing guidelines can assist nurses to make sexual health enquiries to consumers (Katz 2005; Mick et al. 2004).

SEXUALITY
Sexuality is an important part of how we view ourselves, and is fundamental to health, quality of life, and general well-being. The World Health Organization (2001) informs us that sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is an integral part of normal life for most individuals and is a quality-of-life issue (Crouch 1999; Higgins et al. 2006; Katz 2005; McInnes 2003). Sexuality can be influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors (World Health Organization 2001).

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality. 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. The sexual rights of all persons must be respected and protected (World Health Organization 2001).

The responsible exercise of human rights requires that all persons respect the rights of others. Sexual rights embrace human rights that are already recognized in national laws, international human rights documents, and other consensus statements. They include the right of all persons to receive the highest attainable standard of sexual health, including access to sexual and reproductive health-care services; to seek, receive, and impart information related to sexuality; and sexual education (World Health Organization 2001). The diagnosis of illness can often alter the course of sexual development and the way in which consumers express their own sexuality (Peck 2001; Warner et al. 1999).

SEXUALITY AND MENTAL ILLNESS
Chronic illness can have profound negative effects on relationships and the sexual satisfaction of both consumers and partners.
Illness touches not only a person’s physical being, but also has an impact on our psychological and social well-being. It affects self-image, erotic desire, emotional and sexual intimacy between partners, and reproductive decisions (Warner *et al.* 1999).

There is a paucity of published data exploring sexuality of people with mental illness (McCann 2003; Volman & Landeen 2007); however, mental health professionals working with this group are frequently confronted with client issues relating to sexual health (Shield *et al.* 2005). Despite this, the majority of mental health nurses have been reluctant to take up the challenge of assessing the sexual health needs of consumers (Woolf & Jackson 1996).

The rate of reported sexual dysfunction in consumers with a major mental illness is as high as 67% (McCann 2003). Social stigma impacts upon consumers’ self-image, making it more difficult for consumers to have sexual experiences and share themselves with a sexual partner. The onset of illness during teenage development has been identified as interfering with all aspects of psychosexual development. As a result, some consumers do not engage in sexual activity until later in life and do not acquire the knowledge or skills required for the fulfilment of sexual roles and the formation of sexual relationships (Shield *et al.* 2005; Volman & Landeen 2007).

McInnes (2003), who addressed the sexuality of people affected by chronic illnesses, informs us that it is sadly assumed that, because of chronic illness, a discussion about sex is irrelevant because this person is ‘unlikely to form a relationship’. Historically, the notion that consumers with severe mental health problems might marry each other has been met with disapproval.

McCann (2003), commenting upon historical views, informs us that there was a general assumption that people with schizophrenia were somehow asexual, and in the review of mental health literature, identified that prejudice, discrimination, oppression, and negative attitudes towards those with schizophrenia can only have a detrimental effect on self-esteem and personal development, including sexual and relationship possibilities (McCann 2003). Society is generally uncomfortable with the notion that people who are ill or disabled might still want or have sex. Historical policies, such as segregation of the sexes in psychiatric institutions and the sterilization of female psychiatric consumers, resulted in the desexualization of consumers and pathologizing of sexual expression (Cort *et al.* 2001).

The reality for consumers today is very different from these historical negative attitudes. Consumers are sexual beings and have every right to enjoy their sexuality; unfortunately, they are vulnerable because of their illness and the prejudice that exists in the community.

Research on sexual risk behaviour among consumers experiencing serious mental health problems has suggested that they are more likely to engage in high-risk behaviour, such as infrequent condom use, sex with high risk groups, casual sexual encounters, or trading sex for some material gain (Cook 2000; Higgins *et al.* 2006). Consumers experiencing ‘serious’ mental health problems may be more vulnerable
to sexual exploitation, as they may lack the assertiveness needed to negotiate safer sexual relationships, and may have coexisting drug and alcohol problems often associated with sexual risk taking (Higgins et al. 2006; Shield et al. 2005; Woolf & Jackson 1996).

McCandless and Sladen (2003) examined the sexual health of women with bipolar disorder and found that sexual impulsivity can have a negative effect on their self-esteem and self-image, as they reflect upon their behaviour in the post-manic period. Sexual impulsivity and associated behaviours may conflict with a client’s cultural or religious background, or could be inconsistent with usual standards of personal sexual behaviour. Conflict can arise in interpersonal relationships as a result of sexual indiscretions. These consequences can add to the stress already experienced by vulnerable consumers (McCandless & Sladen 2003).

There is reluctance on the part of consumers to bring up their sexual concerns with nurses, and they are often unaware that their sexual dysfunction is related to their medical condition or treatment (Higgins et al. 2006; McCann 2003). These authors call for a constant drive towards facilitating communication about sexuality, correcting myths and misinformation, providing education, and encouraging exploration of consumers’ feelings and resources (McCann 2003).

Volman and Landeen (2007) found that when consumers deal with their sexual issues in the same context as managing their illness, they regained their sense of self, including their sexual self. The consumers in this study viewed their sexual self as an essential aspect of their core self. Sex remains an important contributor to quality of life for many consumers with chronic illness and to their partners (McInnes 2003). A study in which mental health consumers in an acute rehabilitation unit were interviewed about their sexuality, found that consumers ‘appeared to respond well to the interview. In fact many seemed to be pleased to be asked about concerns regarding something as fundamental as sex and relationship issues’ (McCann 2000; p. 136). No participants in this study reported distress about having a discussion regarding their sexual history, and they experienced no ensuing exacerbation of psychotic symptoms.

As well as the effects of mental illness and community attitudes towards mental illness, consumers also have to contend with the adverse effects that medication can have upon their sexuality.

**MEDICATION AND SEXUALITY**

According to DSM-IV-TR (2000), sexual dysfunction associated with medications or other substances is characterized by a disturbance in the processes that characterize the sexual response cycle (desire/arousal– excitement– orgasm–resolution) or by pain associated with sexual intercourse. The dysfunction results in marked distress or interpersonal difficulties, and is fully explained by the use of medication. Symptoms develop within 1 month of medication use, or the use of the medication is etiologically related to the disturbance.

Neuroleptic medications can have many adverse sideeffects, which severely impact the quality of life of the consumer. These
medications can have a significant negative effect on the consumer’s sexual function, with consequential effects to self-esteem and relationships. The extrapyramidal side-effects have been considered to be the most common, the most troublesome for service users, and the most likely to result in non-adherence. Therefore, they are the side-effects that are focused upon in the literature (Gray & Gournay 2000; Smith & Henderson 2000).

Higgins et al. (2005) informs us that when side-effects that impact on sexual health are mentioned in the literature, they are often mentioned towards the end of the list. Despite this, consumers are more concerned with the sexual side-effects of their medications than any other side-effect; this may be an important reason as to why many decide not to take prescribed medication (Kodesh et al. 2003; Smith et al. 2002). Sex education needs to be offered to consumers around issues of medication and possible side-effects, including sexual dysfunction (McCann 2000).

It remains unclear how much of this dysfunction is attributed to medication effects, in particular hyperprolactinemia, which has been associated with a range of sexual dysfunctions, or the disease process and the psychosocial factors associated with psychiatric morbidity (Halbreich & Kahn 2003; Malic 2007). Anticholinergic effects of psychotropic drugs may cause loss of desire, inability or delay in orgasm, and reduced libido. Usually, when medication was ceased, sexual functioning improved (McCann 2003).

The ‘atypical’ medications, such as olanzapine, and risperidone, appear to cause fewer extrapyramidal symptoms. However, they still carry the risk of unwanted sexual dysfunction. Risperidone is known to be associated with galactorrhea (Gupta et al. 2003). Both olanzapine and clozapine are considered to cause less sexual side-effects; however there is an increasing number of case reports of retrograde ejaculation and priapism with all three medications (Higgins et al. 2005; Storch 2002). Findings suggest that consumers treated with clozapine show increased desire for more meaningful relationships and more sexual contact (Higgins et al. 2005).

Sexual dysfunction is underreported by consumers with depression, unless they are specifically asked. Sexual dysfunction, including loss of desire, erectile dysfunction, delayed ejaculation, and anorgasmia, are widely accepted as frequent side-effects of treatment with selective serotonin reuptake inhibitor (SSRI) antidepressants (Balon 2006). The lack or decrease of sexual desire, or libido, has long been a known part of depressive symptomatology. Reduced interest in sexual activity has been reported in 50–90% of depressed consumers with or without drug treatment (Balon 2006; Ekselius 2001).

Studies by Jordan et al. (1999) and Cort et al. (2001), that explore the attitudes of community mental health nurses related to sexual issues, report that some nurses agreed that informing consumers of side-effects that impact on sexual function leads to non-adherence. This seems to ignore our professional obligation to inform consumers of the indications and contraindications of treatments prescribed. Nurses need to recognize that they have a role in
educating recovering consumers in areas, such as relationships, courtship, and safe sexual practices (Higgins et al. 2005).

**NURSE–CONSUMER RELATIONSHIPS AND SEXUALITY**

The Standards of Practice for mental health nurses, as outlined by the Australian and New Zealand College of Mental Health Nurses (1995), state that mental health nursing is a specialized interpersonal process, where an established partnership that provides systemic nursing care and promotes health and wellness is established.

Nurses, by virtue of this close relationship with consumers, are in a unique position to promote sexual health and provide sexual health advice. Nursing care ‘is concerned with helping the person achieve a healthy lifestyle in their world’ (Graham 2001; p. 335). The nurse–consumer relationship provides a safe environment for the consumer to talk. Spending time with the consumer, allowing them to talk, and helping the consumer make sense of their experience, assists nurses to understand the consumer as a person (Dearing 2004). Nurses have a responsibility to engage with consumers on sexual health concerns in an informed and sensitive manner (Higgins et al. 2006).

The central theme of the nurse–consumer relationship is the necessity for the development of the therapeutic relationship that flows with the consumer, adapting to the consumer’s changing needs (Barker 2001). This relationship, where nurses spend time with consumers, has long been assumed to be therapeutic (Buchanan-Barker & Barker 2005). Caring for consumers with mental illness within the context of this relationship requires knowledge of the consumer. To gain this knowledge, understanding the consumer’s perceptions and concerns is essential. Shattell et al. (2005) suggest that this understanding does not always occur.

In each dimension of assessment and intervention, emphasis is given to engaging the consumer fully in the process of determining, and where possible, contributing to the interventions that might meet the consumer’s needs (Barker 2001). According to Travelbee (1971), the nurse–consumer relationship is the means through which the purpose of the nursing is achieved; that is to say, to attend to the consumer or family to prevent or to confront the illness experience and suffering, and to help the consumer to find meaning in these experiences. For this to occur, nurses adopt an intellectual approach to problems to create the ‘educated heart and the educated mind’ (Travelbee 1971; p. 19). It ‘requires self-insight, self-understanding, an understanding of the dynamics of human behaviour, ability to interpret one’s own behaviour as well as the behaviour of others, and the ability to intervene effectively in nursing situations’ (Travelbee 1971; p. 19).

Roper et al. (1985) addressed consumer sexuality and highlighted its importance when planning care. The model centres around three related notions: activities of living, the dependence–independence continuum, and the concept of lifespan. The consumer is a system that has the ability to undertake activities of living, and nursing is the activity of assisting the consumer in meeting their activities of living. The model identifies the expression of sexuality
as an important area for nurses to address in their practice.

NURSES’ ATTITUDES TOWARDS SEXUAL HEALTH AND RELEVANCE TO MENTAL HEALTH NURSING

The changing nature of nursing is creating an environment where previously taboo subjects, such as sexuality, are becoming more integrated into practice. Sexual adjustment is an important component of mental health and a client’s overall well-being. Sexuality involves the totality of being a person, and therefore, nurses and consumers are only given their full respect as people when nursing care has firm foundations in a truly holistic approach, incorporating sexuality as a vital aspect of humanity (Hayter 1996; Higgins et al. 2006; Katz 2005). A consumer’s sexual and relationship histories are important aspects of a consumer’s social and developmental histories that forms part of a client’s holistic assessment (Cort et al. 2001).

Despite broad acceptance of sexuality as a legitimate focus of nursing, there is still ambivalence about discussing sexual issues, which can lead to the risk that consumer needs may go unmet. It is abundantly clear from the literature that nurses’ attitudes towards consumers are often negatively reflected in the nurse–consumer relationship (Cort et al. 2001). This is particularly true in the area of sexuality and sexual orientation (Hayter 1996). Nurses feel that it is up to the consumer to initiate discussions about sexuality and that consumers would initiate these conversations if they wanted to. It may be that while nurses are waiting for consumers to disclose their sexual concern, the consumer is waiting for the nurse to invite a discussion to examine personal sexual concerns (Higgins et al. 2006; Katz 2005; McCann 2003).

To deal with the sexual components of illness and health, nurses need to recognize their own sexual dimensions as valuable and integral parts of themselves and integrate the goals of nursing with the sexual being, with personal attitudes to sexuality being assessed. This can be done privately or at workshops, where opportunities for discussion can occur (Katz 2005). Some nurses have conservative and rigid attitudes regarding sexuality and undertake nursing interventions that may have a detrimental effect on consumers’ sexual health. Nurses who were raised in a family where sexuality was a taboo subject were found to have strong attitudes regarding sexuality that were difficult to overcome and actually formed barriers towards sexual conversations (Kautz et al. 1990).

Lewis and Bor (1994) interviewed 161 nurses. They found that one of the biggest obstacles to having discussions with consumers about their sexual health concerns were the beliefs held by the nurses. This study demonstrated that the attitudes held by nurses are influenced more by emotional elements than by cognitive factors. If nurses understand their own attitudes concerning human sexuality, biases may be reduced and communication enhanced (Crouch 1999; McCann 2000; 2003).

Guthrie (1999) found that nurse conversations with consumers tended to be limited to routine topics, with many nurses regretting not being able to build a closer relationship with their consumers. Although some of the reasons given
by the nurses, such as heavy workloads and lack of privacy, were legitimate, they might also be used by the nurses as excuses to avoid sexual conversations and to steer conversations towards safer topics (Crouch 1999; McCann 2000). The nurses in Guthrie’s (1999) study stated that sexuality was not discussed with the consumers because it was not a priority of care. Nurses need to have the courage to look at their attitudes without being defensive in order for them to become effective when taking sexual history into consideration. Authors, such as Cort et al. (2001), suggest that when nurses work to develop personal insights into their own sexual attitudes and sexual self-awareness, they will notice an improvement in their own sexuality-related nursing practice.

There is a tendency for sexual history to be omitted (McCann 2003), even though most consumers feel that sexual counselling by nurses is appropriate (Katz 2005; Mick 2007). The literature strongly suggests that discussion initiated by nurses in regards to the sexual concerns of the consumers is appropriate, and that nurses must stop assuming that consumers do not want to discuss sexual issues; consumers appreciate the opportunity to talk to their nurse about sexual issues and are unphased by the assessment content (Higgins et al. 2005; Waterhouse & Metcalfe 1991; Woolf & Jackson 1996).

Nursing is a discipline that has enjoyed a closeness with consumers living with a mental illness, and mental health nurses can be seen as having the greatest opportunity to help or harm the consumer (Barker 2001). While mental health nurses are in a unique position to engage consumers in addressing their sexual concerns, they can also create compounding problems if they do not engage with consumers on certain issues. Mental health nurses are obliged to ask consumers about sexual and relationship issues (McCann 2003).

Cort et al. (2001) interviewed 122 community mental health nurses on how they regarded issues broadly framed within the concept of sexuality. They report that 52.5% of the nurses encountered sexual issues on an ‘occasional’ basis, and 32% reported the frequency as ‘often’; only one of 100 mental health case notes audited contained a detailed sexual history. With sexual risk behaviours of exchanging sex for money, drugs, or a place to stay, being pressured into unwanted sex, and unprotected sex after the use of alcohol or illicit substances (Purdie 1996), mental health nurses have a duty to address the sexual concerns of consumers. This includes not only the identification of sexual problems, but the provision of sexual health education, sexual health support, and referral to appropriate services.

McCann (2003), argues that future mental health research needs to go beyond investigating perceived risky behaviours and should include potential therapeutic responses in all areas of sexuality.

DISCUSSION

The area of sexual health of consumers has been poorly addressed and is often neglected by mental health service providers (Cort et al. 2001; Higgins et al. 2005; McCann 2003). It has been suggested that mental health nurses do not discuss consumers’ sexual concerns and
problems for a number of reasons, including lack of sexual knowledge, a possible de-emphasis in nurse education, insufficient time, not part of the nurses’ role to discuss sexual issues; consumers are too ill to discuss sex, discussing sexuality causes the consumers/nurses anxiety, it is hard to discuss sex, and there is discomfort asking for peer help (Cort et al. 2001; Katz 2002; McCann 2003; Shield et al. 2005; Woolf & Jackson 1996).

The uniqueness of the nurse–consumer relationship provides an opportunity to take sexual history into consideration, promote safe sexual practices, discuss sexual problems, and educate consumers about sexual issues. Taking sexual history into consideration allows nurses to assess a consumer’s past sexual history and current functioning (Higgins et al. 2006; Peck 2001; Tomlinson 1998).

If mental health nurses are to be truly responsive to the needs of mental health consumers and their carers, they have an obligation to ask about sexual and relationship issues. Nurses need to enquire about subjective experiences and a consumer’s hopes, feelings, beliefs, and aspirations regarding sexual and relationship fulfilment (McCann 2003; Volman & Landeen 2007). As nurses, it is important that we open the door for our consumers to discuss their sexual issues. Nurses recognize the importance of sexual health; however, it has not as yet been integrated into our practice. Consumers perceive nurses as approachable and as a safe person to discuss sexual problems that they experience (Phillips & McCann 2007; Shattell et al. 2005).

Purdie (1996; p. 47), states that to ‘keep people in ignorance and in emotional confusion about intimate aspects of their personal lives is to do them a crippling disservice’. When nurses do not take sexual history into consideration, assessments are not complete and could lack vital information that may affect a consumer’s recovery (Warner et al. 1999).

Nurses are likely to wait for the consumer to initiate discussions about sexual health or believe that such discussions are someone else’s responsibility. This may result in sexual problems not being recognized and addressed (Katz 2005). By initiating sexual conversations, nurses can act as role models, educating consumers that sex can be openly discussed and is not something to feel shameful or guilty about.

The National Competency Standards for registered nurses practicing within Australia direct nurses towards assessing a consumer’s sexuality. Based on these standards, nurses are required to recognize that ‘ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual’s responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately’ Australian Nursing and Midwifery Council (2006; p. 2). Nurse education does not prepare nurses for dealing with consumer sexuality in an effective manner, and nursing curricula need to include human sexuality, addressing the importance of taking sexual history into consideration and providing sexual counselling (Katz 2005; Volman & Landeen 2007).
IMPLICATIONS FOR PRACTICE AND RESEARCH

Nurses are in agreement that sexual health assessment and sexual education are part of their roles; however, research findings inform us that the majority of nurses do not teach, support, or provide counselling to consumers or advise them on the management or treatment of sex-related issues (Higgins et al. 2006; McCann 2003; Waterhouse & Metcalfe 1991).

The challenge for nurses is to create a care context that conveys to the consumer that sexuality is an area that can be discussed. There is a need to acknowledge that the consumer may be uncomfortable talking or answering questions about sexuality (Higgins et al. 2006). By legitimizing the topic of sexuality, the nurse gives the consumer permission to think and talk about sexuality and its relation to illness (Mick 2007).

The data suggest that most consumers want information about the effects of illness and treatment on sexuality, and want nurses to initiate the discussion (Katz 2002; Salvon et al. 2007) Higgins 2007 informs us that the most effective treatment of sexual dysfunction begins in making an enquiry with the consumer, as you cannot treat a problem if you do not know it exists.

Mick (2007) provides 10 strategies gained from qualitative interviews with nurses to assist nurses in improving sexuality assessments: understand sexuality, provide information, address causes of discomfort, be an objective listener, perform independent assessments, use practice standards, ask broad questions, avoid making assumptions, learn about sexuality, and encourage questions about sexuality.

A number of models have been utilized to address the topic of sexuality in practice. The P-LI-SS-IT (Annon 1976) and BETTER models (Mick et al. 2003) are of most interest in the literature (Katz 2005; McInnes 2003; Martinez 2008; Mosley & Jett 2007). P-LI-SS-IT is an acronym where P stands for permission, LI for limited information, SS for specific suggestion, and IT for intensive therapy (Katz 2005; McInnes 2003; Mosley & Jett 2007). The BETTER model is an acronym representing the six stages of the model.

The first stage is to ‘bring’ up the topic of sexual health and raise the issue of sexuality with consumers. When performing the assessment, create the opportunity for clients to discuss sexuality and what it means to them, and identify any concerns. By raising the issue, even if the consumer chooses not to respond, nurses are informing the consumer that they are open and willing to discuss these issues if the consumer wishes to do so at a later date (Higgins et al. 2005; Katz 2005; Mick et al. 2004).

The second stage is to ‘explain’ that for many, sexuality is a quality of life issue, and that you are open to discussing these issues. Explaining that sex is a vital part of life helps to normalize the discussion and may help the consumer feel less embarrassed or alone (Katz 2005; Mick et al. 2004).

The third stage is to ‘tell’ the consumer that there are resources, and that you or your staff will assist in finding them. Even if the nurse does not have an immediate solution, others can help (Katz 2005; Mick et al. 2004). The fourth level
of the model is to ‘time’ the discussion to the consumer’s preference. Consumers who are not ready to deal with sexual issues can ask for information in the future (Katz 2005; Mick et al. 2004).

The fifth stage is to ‘educate’ the consumer regarding the sexual side-effects of treatments or medical conditions. Informing the consumer about sexual side-effects is as important as informing the consumer about any other adverse effect. The aim is to determine the consumers’ knowledge of symptoms and symptom management related to sexuality, their understanding of what is happening and why, and what to anticipate (Katz 2005; Mick et al. 2004). The final stage of the BETTER model is to ‘record’ the assessment, treatment, and outcome in the consumer’s medical record. Integrating information about sexuality into clinical practice can validate the consumer’s experiences and enhance their quality of life (Katz 2005; Mick et al. 2004).

With regard to direct communication, the P-LI-SS-IT and BETTER models can easily be incorporated into routine practice to improve communication and assist the practitioner in gradually introducing the topic of sexual health (Martinez 2008). Sexual intervention models can be used to open the doors for consumers to discuss sexual issues (Mosley & Jett 2007).

The BETTER model seems to be a more user friendly model than the P-LI-SS-IT model in daily practice (Lally 2006). Although widely used as a framework that can be used to guide nursing practice in the area of sexuality, the P-LI-SS-IT model does not contain sufficient guidelines on the interpersonal communication strategies required by mental health nurses (Higgins et al. 2006). Given the difficulty experienced by mental health nurses in raising sexuality as a topic for discussion, the P-LI-SS-IT framework may hamper further discussion rather than facilitate an exploration of the consumer’s concerns.

In addressing the sexuality issues of consumers, Katz (2005) comments frequently on the use of both the PLI-SS-IT and BETTER models to guide practice, and informs us that although both models are helpful, the BETTER model can be employed with all consumers.

CONCLUSIONS

It is clear from this review of the literature that mental health consumers experience a variety of sexual health concerns. The literature informs us that nurses are poorly prepared and equipped to address the sexual health concerns of consumers. Further discussion and research is required to explore models to support mental health nurses to include sexuality in their assessments to ensure practice standards are met and to provide holistic care. Integrating information about sexuality into clinical practice can validate consumers’ experiences and enhance their quality of life.

Clearly, there is a need to explore strategies to assist mental health nurses to have sexual health conversations with consumers to support their recovery. The BETTER model can assist nurses to include sexuality in their assessments to ensure practice standards are met to provide holistic care. By avoiding the topic, nurses are missing a valuable opportunity to educate
consumers and provide comprehensive, holistic preventive care (Mick et al. 2004).

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The usefulness of the BETTER model for mental health nurses in discussing the sexual health concerns of mental health consumers

Outline & Information Sheet: Individual Interviews

Investigators: Chris Quinn, Clinical Nurse Consultant
Dr Graeme Browne, Nurse Educator
Professor Brenda Happell, CQUniversity

Aims of the study

This study aims to explore the views of community mental health nurses on the usefulness of the BETTER model to their practice. This model will value the input of community mental health nurses.

This study will use individual interviews to investigate the BETTER sexual health model developed for use in oncology nursing and look at the relevance of the model for use in mental health nursing. This project will influence the nature of mental health nursing and the delivery of services in the Gold Coast region.

What participation in this study will involve

You are invited to engage in an interview with the principal researcher Chris Quinn about what you think is the best way to address the sexual health concerns of people living with a mental illness. This will be the initial interview, where you will be introduced to the BETTER model, and invited to share your views about the BETTER model.

Following this initial interview, participants will then be asked to trial the BETTER model in their practice for a period of two weeks, after which a follow-up interview will occur inviting the participants to share their experience. Each interview will not exceed 60 minutes.

The information collected will be treated by the researchers in the strictest confidence. No names of individuals or agencies or anything that may identify individuals or agencies will appear in any material published from the study. The only person, outside your interview, having access to information that may identify
you will be Dr. Graeme Browne. Only de-identified information will be available to other parties.

The interviews will be digitally recorded; the use of a digital recorder is to facilitate qualitative data analysis. The recordings will be transcribed and placed on a computer using identification codes that do not personally identify you. The research data collected during the study may be published or provided to other researchers, on condition that no information that may identify you is used.

Confidentiality

The conduct of this research involves the collection of your views on the sexuality of people living with a mental illness and the BETTER model. To conduct this study the researchers will need to collect contact information from you. Your names and the contact information collected are confidential and will not be disclosed to third parties. That is, except to meet government, legal or regulatory authority requirements. However, your anonymity will at all times be safeguarded.

The identifying information will be kept in a separate file from recordings, transcripts and data from participants. Any information that may identify participants will be removed from any reported or published material.

Consent to participate

Participation in this study is voluntary and you are free to withdraw your consent at any time, without giving a reason. Participation or non-participation in this study will not in any way affect your current or future treatment of yourself or people you care for. While participation in this study may not benefit you directly, it will provide information that may assist others.

You may contact Chris Quinn on (07) 5667 2000 if you have any questions, concerns or complaints about the conduct of this study that you wish to discuss. Gold Coast Hospital conducts research in accordance with the National Statement on Ethical Conduct in Research Involving Humans. If potential participants have any concerns or complaints about the ethical conduct of the project they should contact the Dr. Brian Bell, HREC Chair of the Gold Coast Health Services District, Ph: 5519 8274, or Professor Brenda Happell, Central Queensland University, Ph: 49306871.

Thanking you
Chris Quinn
The usefulness of the BETTER model for mental health nurses in discussing the sexual health concerns of mental health consumers

Consent Form: Individual Interviews

Investigators: Chris Quinn, Clinical Nurse Consultant
Dr Graeme Browne, Nurse Educator
Professor Brenda Happell, Central Queensland University

I __________________________ (print name) have read (or had read to me) and understood the information sheet about this project, and any questions I have asked have been answered to my satisfaction. I agree to participate in this research and for the two interviews to be digitally recorded, realising that I may withdraw my involvement in the study at any time.

I understand that the use of a digital recorder is to facilitate qualitative data analysis and that the information will be transcribed and placed on a computer using identification codes that do not personally identify me. I agree that research data collected during the study may be published or provided to other researchers, on condition that no information that may identify me is used.

The choice to participate or not to participate in this study will have no bearing upon your current or future employment conditions with Queensland Health.

Signature: __________________________ Date: ______________

Witness: ________________________________ (print name)
Appendix 6: The BETTER Model

The usefulness of the BETTER model for mental health nurses in discussing the sexual health concerns of mental health consumers

BETTER Model

There are 6 stages to the BETTER model (Mick et al 2004). The first is to:

**Bring-up the topic of sexual health.** Raise the issue of sexuality with consumers. When performing assessments, create the opportunity for consumers to discuss sexuality and what it means to them and identify any concerns. By raising the issue even if the consumer chooses not to respond, nurses are informing the consumer that they are open and willing to discuss these issues if the consumer wishes to do so at a later date (Lally, 2006; Katz, 2005a; Mick et al 2004). While this first stage is to “bring-up” the topic, mental health nurses might control the process, the consumer has the right to control the pace and content, and must be empowered to close the door on any line of questioning at any time. Unless nurses are willing to introduce the topic, they will be unable to assess the consumer’s needs regarding sexuality. If a consumer does not wish to pursue the issue then this has to be respected, but the opportunity for discussion needs to be available (Katz, 2005a; Mick et al 2004).

**Explain** that for many, sexuality is an important quality-of-life issue, and that you are open to discussing these issues (Katz, 2005a; Mick et al 2004).

**Explain**ing that sex is a vital part of life, helps to normalise the discussion and may help the consumer to feel less embarrassed or alone. This second level of explaining, involves explaining that sexuality is part of quality of life, and consumers should be aware that they can talk about this with the care team. **Explain** that you are concerned with all aspects of consumer’s lives (Lally, 2006).

**Tell** the consumer that there are resources, and that you or your clinicians will assist in finding them. Even if the nurse doesn’t have an immediate solution, others can help. Determine the severity of any concern and the consumer’s ability in managing their concerns regarding sexuality. Determine
the consumer’s perceptions of familiar and external help and help needs (Lally, 2006; Katz, 2005a; Mick et al 2004).

**Time** the discussion to the client’s preference. Consumers who aren’t ready to deal with sexual issues can ask for information in the future.

**Educate** the consumer regarding sexual side effects of treatments or medical conditions. Informing the consumer about sexual side effects is as important as informing the consumer about any other adverse effects (Lally, 2006; Katz, 2005a; Mick et al 2004). Determine the consumer’s knowledge of symptoms and symptom management related to sexuality, their understanding of what is happening and why, and what to anticipate.

**Record** the assessment, treatment, and outcome in the consumer’s medical record, to report that this topic has been discussed, record your assessments and interventions (Lally, 2006; Katz, 2005a; Mick et al 2004). Integrating information about sexuality into clinical practice can validate the consumer’s experiences and enhance their quality of life.
Appendix 7: The BETTER Card

The usefulness of the BETTER model for mental health nurses in discussing the sexual health concerns of mental health consumers.

This card was printed and laminated for the participants to use as a prompt regarding the steps of the model. The card is the same size as their Queensland Health staff identification, and can be worn by participants.

The BETTER Model

**Bring-up** the topic of sexual health
Raise the issue of sexuality with consumers

**Explain** that for many, sexuality is an important Quality of life issue, and that you are open to discussing these issues

**Tell** the consumer that there are resources, And that you or your staff will assist in finding them.

**Time** the discussion to the consumer’s preference.

**Educate** the consumer regarding sexual side effects of treatments or illness.

**Record** the assessment, treatment and outcome in the medical record.
Appendix 8: Queensland Health Ethics Approval

Mr C Quinn
Principal Researcher
58 Greg Norman Crescent
PARKWOOD QLD 4214

Dear Mr Quinn,

Re: Research Proposal 200878: “The usefulness of the BETTER model for mental health nurses in discussing the sexual health concerns of mental health consumers.”

Thank you for documentation on the above research proposal.

At the meeting of the Gold Coast Health Service District Human Research Ethics Committee held on 29 October 2006, the committee reviewed the above protocol. The Gold Coast Health Service District Human Research Ethics Committee is duly constituted and complies with the National Health and Medical Research Council’s ‘National Statement on Ethical Conduct in Research Involving Humans and Supplementary Notes, 1999’.

The Chairman of the HREC reviewed your further correspondence dated 19 November on 24 November 2006:

- Amended NEAF v1.1 dated 16 November 2008;
- Amended Appendix 1 BETTER Model Information sheet;
- Amended Appendix 2 Information Card;
- Amended Appendix 3 Consent Form, Individual Interview;
- Amended Appendix 4 Consent Form, Consumer Interviews;
- Amended Appendix 5 Information Sheet, Individual Interviews;
- Amended Appendix 5a Information Sheet, for Consumers;
- Amended Appendix 6 Interview Questions;
- Amended Appendix 7, References;

It is advised that on the recommendation of the Human Research Ethics Committee, the Executive Director of Medical Services, Gold Coast Hospital has approved your request for ethical approval of the following documentation, and the study has approval to commence.

- NEAF;

Office
Gold Coast Health Service
District HREC
Gold Coast Hospital

Postal
District Executive Office
108 Nerang Street
Southport Q 4215

Phone
07 5519 8010

Fax
07 5519 8718

Enquiries to: Sue Coventry
Telephone: (07) 5519 8010
Facsimile: (07) 5519 8718
Email: GCHEthics@health.qld.gov.au
During the conduct of the study you are required to adhere to the following conditions:

- All forms required when submitting reports to the HREC are accessible on the internet at http://www.health.qld.gov.au/ethics. In the first instance please access the Commencement Form and return to this office when the study commences. Please contact the Coordinator if you do not have access to this site.

- All investigations must be carried out according to the "Declaration of Helsinki 2000" as subsequently modified and the latest statement by the National Health and Medical Research Council on Human Experiments and on Scientific Practice. Should a copy of the 'Declaration of Helsinki 2000' as subsequently modified be required, please request a copy from the Coordinator Human Research Ethics Committee.

- Attachment 1 is a letter listing some matters specified by the National Health and Medical Research Council to which you as the research worker must adhere.

- Attachment 2 gives the Committee composition with specialty and affiliation with hospital.

- You are required to provide any report on any pilot study and the outcome of the study at the completion of the trial or annually if the trial continues for more than 12 months.

- If any subsequent change/amendment is made to the protocol it will be necessary for you to obtain approval from the Human Research Ethics Committee. The Amended documents must be accompanied by a letter, signed by the Principal investigator, providing a brief description of the changes, the rationale for them and their implications for the ongoing conduct of the study. All amended documents must contain revised version numbers, version dates and page numbers. Changes must be highlighted using Microsoft Word "Track Changes" or similar. Please contact the HREC Coordinator if assistance is required.

- Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

- If the results of your protocol are to be published, an appropriate acknowledgment of the Hospital should be contained in the article. Copies of all publications resulting from the study should be submitted to the Human Research Ethics Committee.

- Please ensure that a copy of any publication that results from this protocol is also forwarded to the Hospital Medical Library for future reference.
The Hospital Administration and the Human Research Ethics Committee (HREC) may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside the Gold Coast Health Service District. This may include consultation with the Principal Investigator and/or a visit to the research site by a member of the HREC and/or Coordination of the HREC.

Should you have any problems, please liaise directly with the Chairman of the Human Research Ethics Committee early in your program.
We wish you every success in undertaking this research.

Yours faithfully

Naomi Dwyer
Chief Operations Officer

GOLD COAST HEALTH SERVICE DISTRICT

5 December 2008
16 April 2009

Mr Chris Quinn
58 Greg Norman Crescent
Parkwood QLD 4214

Dear Mr Quinn

HUMAN RESEARCH ETHICS COMMITTEE ETHICAL APPROVAL PROJECT:
H09/04-028 THE USEFULNESS OF THE BETTER MODEL FOR MENTAL HEALTH
NURSES IN DISCUSSING THE SEXUAL HEALTH CONCERNS OF MENTAL
HEALTH CONSUMERS

The Human Research Ethics Committee is an approved institutional ethics committee
constituted in accord with guidelines formulated by the National Health and Medical
Research Council (NHMRC) and governed by policies and procedures consistent with
principles as contained in publications such as the joint Universities Australia and NHMRC
Australian Code for the Responsible Conduct of Research.

On 16 April 2009, the Chair of the Human Research Ethics Committee of the Central
Queensland University considered your request to transfer ethical approval granted by the
Gold Coast Hospital HREC (clearance number 200378) to Central Queensland University, for
research project titled: The usefulness of the BETTER model for mental health nurses in
discussing the sexual health concerns of mental health consumers.

It is advised that CQU HREC accepts this clearance, and hereby extends full clearance as a
CQU project (Project Number H09/04-028). Please note that you will be required to submit
to the Secretary, a full set of information sheets, consent forms and any research instruments
as soon as they have been amended with your new location and affiliation details.

The period of ethics approval will be from 16 April 2009 to 31 December 2009. The
approval number is H09/04-028; please quote this number in all dealings with the Committee.

The standard conditions of approval for this research project are that:

(a) you conduct the research project strictly in accordance with the proposal submitted
and granted ethics approval, including any amendments required to be made to the
proposal by the Human Research Ethics Committee;

(b) you advise the Human Research Ethics Committee (email: ethics@cqu.edu.au)
immediately if any complaints are made, or expressions of concern are raised, or any
other issue in relation to the project which may warrant review of ethics approval of
the project: (A written report detailing the adverse occurrence or unforeseen event must
be submitted to the Committee Chair within one working day after the event.)

(c) you make submission to the Human Research Ethics Committee for approval of any
proposed variations or modifications to the approved project before making any such changes;
(d) you provide the Human Research Ethics Committee with a written "Annual Report" by no later than 28 February each calendar year and "Final Report" by no later than one (1) month after the approval expiry date; (A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)

(e) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

Please note that failure to comply with the conditions of approval and the National Statement on Ethical Conduct in Human Research may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing within five (5) working days if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee wishes to support researchers in achieving positive research outcomes. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Secretary, Sue Evans or myself.

Yours sincerely,

[Signature]

Associate Professor Lorna Moxham
Chair, Human Research Ethics Committee

Co: Project file
    Professor Brenda Happell (supervisor)

Application Category: A