

Where is the Sex in Mental Health Practice? A Discussion of Sexuality Care Needs of Mental Health Clients

Linda McClure RN BScN MSc

Thompson Rivers University, School of Nursing
Kamloops, BC, Canada

ABSTRACT

Sexual activity among hospitalized clients is often a challenging concern of health care providers, particularly within institutions. This is especially true for practitioners working in mental health settings. While most mental health professionals agree that sexuality is integral to being human, few address sexual issues in practice. A review of the relevant literature regarding the exclusion of sexuality in mental health practice clearly cites the lack of practitioner knowledge and comfort and their anxiety about talking with clients about sexuality as some of the reasons for this exclusion. People living with mental health problems often experience sexual difficulties relating to medication and the effects of depression and schizophrenia. Health care that provides education about medication induced sexual difficulties, negotiating healthy sexual relationships, and managing sexual difficulties generally enhances the quality of life in those with mental health problems. Agency policies that promote healthy sexuality and support professionals to address sexual health concerns in practice need to be developed. This paper examines several factors relating to the sexuality and sexual health of mental health clients while considering the ethical challenges of dealing with client sexual activity in care. It concludes with a discussion about future directions for health care practice and education in this regard.

Key Words: sexual behavior; sexuality; mental illness; mental health practice; ethics

Hospitalized Clients: sexual health or wealth

Sexuality is a fundamental and complex aspect of being human, affecting all areas of life and health, yet it is largely neglected in health care, particularly in the care of clients with mental illness. While most health practitioners agree that sexuality is an important part of life and health, practitioners' lack of knowledge

about sexuality, comfort in talking with others about sexuality, and anxiety about the appropriateness of including sexuality in healthcare practice are reported to be some of the reasons why sexuality is not often addressed in healthcare contexts. Including sexuality care in mental health clinical practice is a multifaceted problem with several contributing factors. The lack of basic professional sexuality education, historical views of those with mental health problems as being asexual and incapable of making appropriate sexual decisions, and the lack of comprehensive policies within mental health settings have been found to be some of the challenges in improving sexuality care for those with mental health problems.

Sexuality is broadly defined as "a central part of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction" (Public Health Agency of Canada, 2008, 5). Clearly, sexuality relates to all those things that contribute to how one feels, thinks, and behaves as men and women in this world. Sexual health is attained when "individual sexual rights are respected, protected, and fulfilled," and is accomplished when pleasurable and safe sexual experiences, "free of violence, discrimination and coercion" are possible (Ibid). Given that sexuality is integral to being human and sexual health is a fundamental right of all persons, the ethics of excluding sexuality care in mental health practice are clear. Sexual health is essential to overall health and sexuality care must be included in the treatment and support for persons with mental health problems.

The purpose of this paper is to discuss the literature regarding sexuality care in mental health practice and to address some of the specific issues concerning the provision of sexuality care for those with mental health problems. It will begin with a review of evidence about how mental health problems or their treatment can negatively impact sexual health and sexuality, emphasizing how practitioners' ability to address issues of sexuality is an ethical imperative. This will be followed by a discussion of what people with mental health problems need from practitioners in regard to education and support in relation to sexuality and sexual health. A discussion of the implications for future practice, education, and research are also provided.

Background

While many health practitioners agree that sexual health is important to overall health, the topic is rarely addressed in practice (Cort, Attenborough & Watson, 2001). This is especially true for practitioners caring for people with severe mental health problems. People with mental health problems, especially those treated with psychiatric medication, experience greater rates of sexual difficulties than those in the general population (Perlman et al., 2007). For example, in the general population the rate of occurrence of sexual difficulties is estimated to be about 43% in women and 31% in men. The rate of sexual difficulties in those with mental health problems is considerably greater, about 78% in individuals with depression, 30-50% in people receiving antidepressant medication, and 30-54% in people with schizophrenia receiving anti-psychotic medication (Ibid). It is important to note, however, that these numbers are likely underestimated as sexuality and/or sexual difficulties are rarely discussed in healthcare practice. Sexual difficulties in those with mental health problems can be attributed to the use of psychiatric medications, low self-esteem, a lack of general education about sexuality, and greater rates of higher risk sexual activity. Disadvantaged social and economic status due to repeated hospitalization and an inability to maintain employment also affect sexuality and sexual functioning of such clients (Higgins, Barker & Begley, 2008).

Perlman et al. (2007) found that some of the reported physical sexual difficulties among people with severe mental illness include a lack of sexual interest and desire, dyspareunia (i.e., painful sexual intercourse), anorgasmia (i.e., absence of orgasm), premature ejaculation, and erection difficulties. The authors also found that social problems relating to the mental illness can negatively affect interpersonal relationships. This, in turn, may impact the person's sexual interest or desire to engage in sexual relationships. Anti-depressants and antipsychotics are well known to affect both physical and psychological components of sexual function such as libido, erections, orgasm, and lubrication (Ibid). This can be especially troublesome as those taking such medication may begin to feel better physically and emotionally and may want to engage in a sexual relationship, yet may be plagued by medication induced side effects of erection difficulties, lack of lubrication, and delayed or inhibited orgasm.

Many people receiving psychiatric medication feel inadequately informed about the medication they are prescribed, particularly as it relates to sexual functioning (Deegan, 2001). While the use of psychiatric medication is often considered essential in the treatment of mental illness, the side effects may severely impact the quality of life of the person taking them and as a result they may stop taking them. In a study of 2000 people with mental health problems, 39% experienced sexual side effects when taking psychiatric medication and 44% reported reducing or stopping the medication before discussing it with their healthcare practitioner (National Schizophrenia Foundation, 2000). It is well documented that psychiatric medication, particularly traditional neuroleptic medication, may cause a loss of sexual interest or desire, difficulty with erection, lubrication, and may delay or inhibit orgasm in men and women. While newer, 'atypical' medications such as olanzapine and risperidone have fewer side effects, retrograde ejaculation and priapism (i.e., persistent erection) are commonly reported (Quinn & Browne, 2009). Sexual function usually

returns once medication dosage is adjusted or the medication is stopped. Deegan (1999) claimed that people who take psychiatric medication tend to blame themselves for their sexual problems and often feel too ashamed or embarrassed to disclose their concerns to their health practitioner. They may even avoid intimate relationships altogether. Anticipating the need for and providing information about medications and sexuality, as well as education for non-drug coping strategies can lead to successful management of sexual difficulties (Deegan, 2001).

Sexuality is a concern for people of all genders and ages. However, women and youth living with mental health problems have particular needs in regards to their sexuality and sexual health care needs. For example, women may be at greater risk of sexual abuse and exploitation due to unequal power balances in relationships and/or experiences of sexual abuse in childhood, resulting in increased rates of re-victimization in adulthood (Wiederman & Sansone, 2009; Nillsson, Bengtsson-Tops & Persson, 2005). Wiederman and Sansone reported that people with diagnoses of Borderline Personality Disorder (BPD), thought to be mostly women (Swartz et al. 1990), are frequently forced or coerced into sexual activity. Impulsive sexual behaviour in women diagnosed with bipolar disorder is also thought to be a concern, putting them at greater risk for sexually transmitted infections (STIs) and unplanned pregnancies (McCandless & Sladen, 2003). Youth with mental health problems may be more susceptible to high risk sexual encounters, unplanned pregnancy, exposure to STI, and are more likely to engage in sex with high risk populations; all of these interfere with sexual maturation and potential future sexual relationships (Waddell & Shepherd, 2002). Gay, lesbian, and bisexual youth are at greater risk for negative health outcomes than heterosexual youth (Saewyc et al., 2007).

While the literature about the provision of sexuality care for persons with mental health problems is sparse, it is well documented that nurses and other health practitioners feel a lack of knowledge and personal comfort when talking with clients who have a mental illness about sexuality and sexual health (Quinn & Browne, 2009; Deegan, 2001; Waterhouse, 1996; Woolf & Jackson, 1996; Bhiu & Puffel, 1994). Waterhouse suggested that the lack of attention to sexuality in basic nursing education contributes to nurses' reports of feeling inadequately prepared to provide sexuality care to such clients. This is a concern in health professional education (Sengupta & Sakellariou, 2009; Dunk, 2007; Shell, 2007; Jones, Weerakoon & Pynor, 2006). Dobal and Torkelson (2004) found that the practitioners' professional education about STI, knowledge of how to talk to clients about sexuality, and comfort surrounding personal attitudes and sexual values directly contributes to their willingness to include sexuality care in practice. Woolf and Jackson (1996) reported that 72% of nurses in a psychiatric facility only talked about sexuality if the client brought it up, and 10% of nurses never discussed sexuality or sexual health with a client. This is problematic as most clients will not initiate a discussion about sexual concerns unless first approached by a professional (Higgins, Barker & Begley, 2006; McCann, 2003). Sexuality tends to be a taboo subject and as a result, most clients do not feel comfortable talking about it without being asked about their sexual concerns by their health practitioner (Taylor & Davis, 2006).

Quinn and Browne (2009) reported that personal beliefs and attitudes about sexuality directly relate to practitioners' practice

behaviors. If nurses, for example, feel that distributing condoms in mental health settings is inappropriate, they will not distribute condoms. Nurses who have conservative beliefs and attitudes about sexuality tend not to include sexuality care in practice (McCann, 2003 and 2000; Crouch 1999).

According to Deegan (2001), the historical view of sexuality in people with mental health problems has been one of pathology and dysfunction. Mental health clients were frequently labeled as hypersexual, hyposexual, or asexual and it was felt they lacked capacity to make appropriate decisions about their sexuality (Ibid). Higgins, Barker & Begley (2008) found that people with mental health problems have similar patterns of sexual behaviour to people not diagnosed with mental health problems.

Although currently most mental health practitioners acknowledge sexuality as integral to human life, there continues to be reluctance to address sexual issues in clinical practice. Practitioners often struggle with the need to protect people who may demonstrate poor judgment or who are vulnerable to abuse from others, even as the practitioner attempts to encourage and promote the client's freedom of choice in sexual decision making (Higgins, Barker & Begley, 2008; Deegan, 2001; Woolf & Jackson, 1996). Deegan (2001) indicated that prior to a diagnosis of a mental health problem, people engage in sexual behaviour as they choose to without being scrutinized. She questioned why mental health practitioners commonly scrutinize the sexual behaviour of those in care based on general assumptions about the client's capabilities. Hospitalization does not mean that private activity should become public (Ibid). Weiss (1990) noted that people with mental health problems are not automatically less competent to make appropriate decisions regarding their sexual behaviour, nor should clients in care lose their rights to privacy and intimacy (Dobal & Torkelson, 2004). Commons et al. (1992) stated that mental health practitioners need to examine personal beliefs and attitudes about sexuality among people with mental health problems.

There is little question that providing information about sexuality and sexual in practice benefits and enhances the quality of life of people with mental health problems as they have a fundamental right to adequate and appropriate sexuality and sexual health care (Higgins, Barker & Begley, 2006; Deegan, 2001; Bhui & Puffel, 1994; Commons et al., 1992). When sexual concerns are not addressed, unresolved sexual issues continue to impact self esteem, interpersonal relationships, and overall health and well-being. Ethical, moral, and holistic mental health practice must take greater steps to ensure that sexuality, as a normative part of life, is addressed in treatment.

Clients' Needs for Sexuality Education

Most authors situate clients' needs for sexuality and sexual health in practice as an ethical imperative related to the issue of autonomy. Mental health practice that is responsive to the ethical principle of autonomy provides opportunity for clients to provide input and feedback about what they need in relation to education and support, including their right to make informed decisions about their disease management (Halpern et al., 2004). Quinn

and Browne (2009) found that when people with mental health problems are encouraged to manage their sexual issues in the same way they manage their illness, they regain a sense of who they are as sexual beings. Sexuality education and support are key in learning how to manage sexual issues. For example, Higgins, Barker, and Begley (2006) found that people with mental health problems who attended sex education programs engaged in less risky sexual behaviour, had more favourable attitudes towards condom use, engaged in fewer high risk sexual behaviours, and the numbers of casual sexual partners were reduced. Information regarding risky sexual behaviour, skills training in communication, condom application, and role play opportunities to reinforce learning were some of the components of successful sex education programs (Ibid). In addition, addressing specific sexual health issues such as HIV and other STI prevention, pregnancy prevention and reproduction, dating and relationship development, intimacy in relationships, human sexual response, sexual function, and medication sexual side effects help to promote sexual health (Assalian et al., 2000; Woolfe & Jackson, 1996). Sexual health education should not be provided on a one-time basis only, but be part of regular and on-going mental health treatment (Higgins, Barker & Begley, 2006)

People taking psychiatric medication need to be informed about the medication they are prescribed and have a right to participate in the decision to use medication or not (Deegan, 2001; McCann, 2000). One of the barriers to providing such education in practice is a fear of medication noncompliance. Many practitioners believe that telling clients of potential medication sexual side effects may result in their stopping the medication (Higgins, Barker & Begley, 2005). Gray, Wykes, and Gournay (2002) reported that informing people about their medication simply increases understanding and does not impact peoples' decisions to continue or stop taking medication. Unwillingness to discuss medication sexual side effects not only negates opportunities for freedom of treatment choice, but also conflicts with current practices relating to informed consent, partnership, therapeutic alliance, and client involvement in care decisions (Higgins, Barker & Begley, 2005).

Agency policies must be developed that clearly guide practitioners about how to address issues and occurrences related to clients' sexuality. Sexual behavior among clients in mental health settings presents practitioners with some of the most challenging decisions (McCann, 2000). Without clear and comprehensive policy regarding sexuality care within agencies, professionals are left to deal with client sexual behaviour on their own. How private and public displays of sexual behaviour such as masturbation, sexual touching, and intercourse are dealt with depends largely on the view of the practitioner and the agency's policies regarding sexual behaviour (Dobal & Torkelson, 2004).

Deegan (2001) suggested that sexual activity itself is not the problem, but rather the problem exists as agencies do not provide for the private and dignified expression of sexuality. Sexual relationships may be strongly discouraged, yet condoms may be freely distributed. Woolf and Jackson (1996) found that condom distribution alone is not effective in ensuring condom use but is more effective when combined with skills based training on condom use. Condom distribution can be a confusing contradiction to clients if on the one hand, expressions of sexuality are taboo, yet on the other hand, condoms to practice safer sex are freely handed out (Deegan, 2001).

Given the complexity of human sexual behaviour and the perceived need of agencies to protect consumers, policies that prohibit sexual activity are rather unrealistic. Sexual activity occurs regardless of whether or not the agency prohibits it (Ibid; Buckley et al., 1999). Institutions must develop clear and comprehensive policies that acknowledge and address the rights of consenting adults to seek intimacy, love and physical comfort. Deegan (2001) suggested a number of ways that policies could be used to enhance the quality of life for those in care. For example, in longer term mental health settings, policies that allow privacy and perhaps even include a private space where people can engage in consensual sexual relations must be developed, policies such as knocking before entering, allowing as much privacy as possible when providing one to one observation, and ensuring breasts and genitals are covered whenever possible reduces shame and humiliation for people involved. Clear, inclusive policies that protect the sexual rights and dignity of people with mental health problems as well as protect the agency and the staff are necessary.

Discussion

The preceding has highlighted an important area of neglect within mental health care, for example, attention to clients' sexuality and sexual health. There are a number of implications that arise from this review of the relevant literature. Professional education, particularly relating to personal views of sexuality and people with mental health problems directly relates to a willingness to address sexual issues in practice. Excluding sexuality care in mental health practice can not continue. Basic professional health education programs need to include sexuality as a core subject and universities must work towards that end. Workshops must be developed and implemented for practitioners currently practicing and attendance must be required. Negative, historical views of people with mental health problems must be challenged in such education. Practitioners need to be encouraged to challenge previous knowledge and values about the sexuality of people with mental health problems. Education about sexuality, sexual health, human sexual response, drug-induced sexual problems, STI, pregnancy, fertility, and communication that promotes healthy sexual relationships must be provided to practitioners so they can adequately educate people in care.

One of the roles of mental health practitioners is to provide clients with the information and support they need to achieve sexual health. Basic education regarding sexual development, sexual response along with information about STI prevention, intimacy in relationships and communication for the purpose of negotiating healthy sexual relationships must be provided as consistent and regular components of mental health treatment. Information about how the prescribed medication affects sexuality and sexual activity must be included to provide opportunities for clients to make informed decisions regarding their care. Practitioners and healthcare agencies need to demonstrate the value of on-going sexuality education for people with mental health problems by developing and providing formal and ongoing education regarding sexuality.

Agencies and mental health staff must be concerned about the rights of people who are more vulnerable, incompetent, or

dependent, while at the same time be responsive to the needs of those who are competent and able to make informed sexual decisions. Policies must be developed to assist professionals to deal with sexual behaviour in an appropriate manner, respecting the rights and dignity of those with mental health problems in care. Clear and comprehensive policies must acknowledge and address the rights of consenting adults to seek intimacy, love and physical comfort. People with mental health problems need to share their personal knowledge and expertise and be involved in such policy development. Agencies must begin by working with clients, consultants and by grouping practitioners and administrators to build appropriate policy regarding sexuality and sexual behaviour in mental health settings. The time is right for sexuality and sexual health concerns to be included in mental health practice as essential contributions to overall health and well-being. Agencies and professionals must take responsibility to create this change and to demonstrate an acceptance of people with mental health problems as sexual, responsible, and capable human beings. The answer to these challenges must be based on the needs of the clients receiving service and cannot be generalized to all clients in all settings. Agencies must work to develop policy that reflects the needs of those receiving service and this is best done through recognition and acceptance of sexuality as important to overall health.

The need for further research regarding sexuality care in mental health treatment is apparent. More research is needed to examine the impact of including sexuality care in mental health practice on the quality of life in those with mental health problems and to examine how sexuality education influences mental health practice. This research would serve to inform educators about the need for sexuality education in basic professional education programs. Clinical research that looks at improving client sexual education and the outcomes associated with that research would influence mental health practices regarding sexuality care. Resulting effects of policies that reflect a healthy approach to human sexuality and sexuality education in treatment would greatly improve the quality of life of those receiving treatment.

Conclusion

The human need for intimacy, love, and sexual expression is widely accepted. However, for those with mental health problems these needs are often denied. It is clear from a review of the literature that mental health practitioners often feel poorly equipped to address sexuality or sexual health concerns of people with mental health problems. Further research and discussion is needed to better understand the complexities of providing sexuality care in mental health practice. Providing sexuality education for mental health practitioners, sexuality education for those with mental health problems, and developing clear and comprehensive agency policies will enhance the quality of life of those in care.

This paper was intended to provoke discussion about how sexuality care is provided in current mental health practice and to raise questions about the ethics of not addressing sexuality in the treatment of those with mental health problems. Clearly, sexuality education and support are generally lacking and mental health agencies must take a greater responsibility to ensure this essential

part of life is addressed in care. Agencies must work in partnership with clients to determine ways to include sexuality care in mental health practice. The literature is clear about the importance of including sexuality in practice and the time to make the change to include sexuality care is now.

References

- Assalian, P., Fraser, R., Tempier, R. & Cohen, D. (2000). Sexuality and Quality of Life of Patients with Schizophrenia. *International Journal of Psychiatry in Clinical Practice*, 4(1), 29-33.
- Bhui, K. & Puffel, A. (1994). Sexual Problems in the Psychiatric and Mentally Handicapped Population. *British Journal of Hospital Medicine*, 51, 459-464.
- Buckley, P., Robben, T., Friedman, L. & Hyde, J. (1999). Sexual Behaviour in Persons with Serious Mental Illness: patterns and clinical correlates. In P.F. Buckley (Ed.), *Sexuality and Serious Mental Illness* (pp. 1-20). Newark, N.J.: Gordan & Breach Publications.
- Commons, M., Bohn, J., Godon, L., Hauser, M. & Gutheil, T. (1992). Professionals' Attitudes Towards Sex between Institutionalized Patients. *American Journal of Psychotherapy*, 66(4): 571-580.
- Cort, E., Attenborough, J. & Watson, J. (2001). An Initial Exploration of Community Health Nurses' Attitudes to and Experience of Sexuality-Related Issues in their Work with People Experiencing Mental Health Problems. *Journal of Psychiatric and Mental Health Nursing*, 8(6), 489-499.
- Crouch, S. (1999). Sexual Health 1: sexuality and the nurses' role in sexual health. *British Journal of Nursing*, 8(9), 601-606.
- Deegan, P. (2001). Human Sexuality and Mental Illness: consumer viewpoints and recovery principles. In P.F. Buckley (Ed.), *Sexuality and Serious Mental Illness* (pp. 21-33). Newark, NJ: Gordan & Breach Publications.
- Deegan, P. (1999). Human sexuality and mental illness: consumer viewpoints and recovery principles. In: P.F. Buckley (Ed.). *Sexuality and Serious Mental Illness* (pp. 21-33). Newark, NJ: Gordan & Breach Publications.
- Dobal, M. & Torkelson, D. (2004). Making Decisions about Sexual Rights in Psychiatric Facilities. *Archives of Psychiatric Nursing*, 18(2), 68-74.
- Dunk, P. (2007). Everyday Sexuality and Social Work: locating sexuality in professional practice and education. *Social Work & Society*, 5(2), 135-142.
- Gray, R., Wykes, T. & Gournay, K. (2002). From Compliance to Concordance: a review of the literature on interventions to enhance compliance with antipsychotic medication. *Journal of Psychiatric and Mental Health Nursing*, 9(3), 277-284.
- Halpern, J. Johnson, M., Miranda, J. & Wells, K. (2004). The Partners in Care Approach to Ethics Outcomes in Quality Improvement Programs for Depression. *Psychiatric Services*, 55(5) 532-539.
- Higgins, A., Barker, P. & Begley, C. (2008). Veiling Sexualities: a grounded theory of mental health nurses responses to issues of sexuality. *Journal of Advanced Nursing*, 62(3), 307-317.
- Higgins, A., Barker, P. & Begley, C. (2006). Sexual Health Education for People with Mental Health Problems: what can we learn from the literature? *Journal of Psychiatric and Mental Health Nursing*, 13(6), 687-697.
- Higgins, A., Barker, P. & Begley, C. (2005). Neuroleptic Medication and Sexuality: the forgotten aspect of education and care. *Journal of Psychiatric and Mental Health Nursing*, 12(4), 439-446.
- Jones, M., Weerakoon, P. & Pynor, R. (2006). Survey of Occupational Therapy Students' Attitudes towards Sexual Issues in Clinical Practice. *Occupational Therapy International*, 12(2), 95-106.
- McCandless, F. & Sladen, C. (2003). Sexual Health and Women with Bipolar Disorder. *Journal of Advanced Nursing*, 44(1), 42-48.
- McCann, E. (2003). Exploring Sexual and Relationship Possibilities for People with Psychosis: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 10(6), 640-649.
- McCann, E. (2000). The Expression of Sexuality in People with Psychosis: breaking the taboo. *Journal of Advanced Nursing*, 32(1), 132-138.
- National Schizophrenia Foundation. (2000). *A Question of Choice*. London U.K.: National Schizophrenia Foundation.
- Nilsson, G., Bengtsson-Tops, A. & Persson, L. (2005). Childhood Abuse in Swedish Female Users of Psychiatric Services. *Journal of Psychiatric and Mental Health Nursing*, 12(3), 365-371.
- Perlman, C., Martin, L., Hirdes, J., Curtin-Telegdi, N., Perez, E. & Rabinowitz, T. (2007). Prevalence and Predictors of Sexual Dysfunction in Psychiatric Inpatients. *Psychosomatics*, 48(4), 309-318.
- Public Health Agency of Canada. (2008). *Canadian Guideline for Sexual Health Education*. Ottawa: Public Health Agency of Canada.
- Quinn, C. & Browne, G. (2009). Sexuality of people living with a mental illness: A collaborative challenge for mental health nurses. *International Journal of Mental Health Nursing*, 18, 195-203.
- Saewyc, E., Poon, C., Wang, N., Homma, Y., Smith, A. & the McCreary Centre Society. (2007). *Not Yet Equal: the health of lesbian, gay, & bisexual youth in BC*. Vancouver, BC: McCreary Centre Society.
- Sengupta, S. & Sakellariou, D. (2009). Sexuality and Health Care: are we training physical therapy professionals to address their clients' sexuality needs? *Physical Therapy*, 89(1), 101-102.
- Shell, J. (2007). The Scientific Aspect of Including Sexuality in Nursing Practice. *Nursing Clinics of North America*, 42(4), 685-696.
- Swartz, M., Blazer, D., George, L. & Winfield, I. (1990). Estimating the Prevalence of Borderline Personality Disorder in the Community. *Journal of Personality Disorders*, 4(3), 257-272.
- Taylor, B. & Davis, S. (2006). Using the Extended PLISSIT Model to Address Sexual Healthcare Needs. *Nursing Standard*, 21(11), 35-40.
- Waddell, C. & Shepherd, C. (2002). *Prevalence of Mental Disorders in Children and Youth: a research update prepared for the British Columbia Ministry of Children and Family Development*. Vancouver: Mental Health Evaluation and Community Consultation Unit (MHECCU). Department of Psychiatry, University of British Columbia.
- Waterhouse, J. (1996). Nurse Practice Related to Sexuality: a review and recommendations. *Nursing Times Research*, 1, 412-419.
- Weiss, F.S. (1990). The Right to Refuse: informed consent and the psychosocial nurse. *Journal of Psychosocial Nursing*, 28(8), 25-30.
- Wiederman, M. & Sansone, R. (2009). Borderline Personality Disorder and Sexuality. *Family Journal*, 17(3), 277-282.
- Woolf, L. & Jackson, B. (1996). Coffee & Condoms: the implementation of a sexual health program in acute psychiatry in an inner city area. *Journal of Advanced Nursing*, 23(2), 299-304.
- World Health Organization. (1998). *Health Promotion Glossary*.

Acknowledgements: *The author is grateful for the help and support of Dr. Barbara Paterson, Dean of the School of Nursing at Thompson Rivers University.*

Competing Interests: *None.*

Address for Correspondence:

*Linda McClure
Thompson Rivers University
School of Nursing
900 McGill Road
Kamloops, B.C. V2C 0C8
Canada*

Email: *lmclure@tru.ca*

Date of Publication: *November 22, 2012*