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 & Kellogg-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% (Balon 2006; Basson et al. 2010; Montejo et al. 2010; Schweitzer et al. 2009; Smith et al. 2002; U’cok et al. 2008; Werneke 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; Odely 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 (2007) of familiarization, identifying a thematic framework, indexing, charting, mapping, and interpretation. [Correction added on 22 August 2012, after first online publication: Citation ‘Ritchie and Lewis (2003)’ has been replaced by ‘Ritchie and Lewis (2007)’ and the former has been deleted from the reference list.]

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 to 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

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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 concerns . . . 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; Saunamäki 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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REFERENCES


SEX AND THE ROLE OF THE NURSE


