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Revisiting the concept of vulnerability: Recognising strength and resilience in the context of risk and susceptibility

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Authors
Jackson, D
Hayter, M
Carter, B
et al.

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Editorial

Mark Hayter, Debra Jackson, Bernie Carter & Adeline Nyamathi

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Patient sexuality and sexual health can be one of the most delicate areas, provoking strong reactions for nurses and patients alike. One universal trait which human beings ascribe to is the fact that we are all sexual beings – but it is often among the most vulnerable and/or marginalised that this aspect of care can be neglected. This editorial endeavours to explore the way in which the issue of sexuality has developed in nursing over the last four decades and in so doing, address future trajectories. It is intended to describe a process by which sexuality has developed as an issue in all general areas of practice – leaving to one side services that, by their very nature, have always directly addressed sexuality. Nursing is essentially entering a process midstream by attempting to address the sexual dimensions of patients and thereby incorporating such traits into nursing care. It also suggests that – out of the most extreme cases of social oppression and stigmatisation involving prejudice towards sexual minorities and negative attitudes towards sexual expression by the ill, the disabled and the elderly – some good eventually emerges.

When the definitive history of HIV, as well as AIDS, is written it will, inevitably, contain a record of tragedy and loss, communities ravaged and the oppression of individuals and groups based purely on their sexuality or marginalised social status. It is not necessary to rehearse the way in which most of society – including many health professionals – responded in the mid-to-late 1980s as HIV emerged (Hayter, 1996, 1997). The ensuing marginalisation and stigmatisation of sexual minorities also needs little explanation here – it happened on a grand scale. Driven by fear and ignorance – but also, we suspect, by the sense among many that HIV finally legitimised them to express their prejudices. These were dark times and healthcare did not, universally, respond well to this new disease and the accompanying issues of sexuality, sexual orientation and lifestyles that were different from the norm.

However, our view is that we can now look back and also see something more positive emerging from this period. It marks the origin of the debate around human sexuality and nursing practice and begins a process that we believe can be conceptualised with three distinct developmental phases: (1) emerging into the light; (2) tentative steps; and (3) the next chapter.

**PHASE 1: EMERGING INTO THE LIGHT**

The struggle to convince many practitioners that sexuality is an essential element of nursing care has been challenging – even in an era where the concept of holistic care was accepted. Many held that this private topic should stay that way – private; or, held quite negative views on sexuality generally and sexual minorities specifically. One aspect of care, which has often been negated, is that expressing sexuality is mainly due to the fact that the nursing profession struggled to address the sexuality aspect of the human experience for patients.

As HIV/AIDS emerged and forged this issue into a larger forum, a triumvirate emerged, in particular, sexuality, sexual orientation and sexual practices became positioned on the healthcare agenda unlike previous decades. Sexuality also became much more prominent in social discourse and much of this can be undoubtedly negative, bringing to prominence an area of life neglected and ignored. The primary issue in this phase was to simply achieve the recognition that sexuality was an integral part of holistic nursing care. We suggest that this argument has, mainly, been successful – and credit to those pioneers who laboured long and hard conducting training, research and generating a published discourse on this subject at the time. We would also suggest that HIV/AIDS also did so much to drive the ‘patient’ advocacy movement.
The specific knowledge base is composed of two arms: (1) sexuality and (2) sexual health evidence base as it relates to specific client groups. As care providers, nurses are aware of the need to avoid a ‘one size fits all’ approach, but there is growing evidence of the particular sexual dimensions of various health issues. These issues can focus on stage-of-life issues, such as particular issues for children with disorders of sexual development (Sanders, Carter, & Goodacre, in press), adolescents and young people (Kang, 2009), social disparity issues, such as those faced by the homeless, or disease-related issues such as those that may be associated with disease processes or treatment.

While it is adequate to recognise that sexuality is important (phase 1), and that it should be addressed (phase 2), for practitioners, it is imperative that questions need to be raised which heighten the provision of healthcare. Specifically, practitioners should seek out evidence pertinent to their client group and how to adequately address these services:

• How can diabetes affect sexuality – in men, women?
• How can neurological conditions affect sexual satisfaction?
• After a myocardial infarction – when can sexual activity be resumed?
• What sexual positions could be suggested for patients with severe mobility problems?

Similar issues arise for health professionals working in an acute child healthcare setting who feel uncomfortable about asking either the child or the parent questions about sexual and relationship health (Bray, McKenna, Sanders, & Pritchard, 2012). This is of concern as children and adolescents are often preoccupied with puberty, sexual health, their sexuality and relationships. Studies of nurses working in child healthcare generally show an acceptance of the nurses’ role within sexual health, but also demonstrate a lack of knowledge (Johnston, 2009) and a sense of uncertainty about how to manage this aspect of care. Bray et al. (2012) noted that some healthcare professionals talked of avoidance and reluctance to engage in dialogue about sexual and relationship health because of personal beliefs that the discourse was inappropriate for a children’s setting.

However, a sexual health dialogue occurred if it tended to focus on ‘fertility, physiology and...
medication, with only a very limited focus on exploring young people’s experiences, understanding, beliefs and emotions’ (Bray et al., 2012). Concerns about whether a health professional should be chaperoned whilst asking intimate and/or sexual health and relationship questions were raised; perhaps reflecting safeguarding issues and wider concerns about talking about sex and the perceived need to protect children and young people from any mention of the word.

Considering these types of issues can be illuminate this critical discussion, and will be a catalyst, ultimately enhancing an understanding of how patients and clients manage their sexuality. In seeking to understand young women’s experiences of being diagnosed and living with a sexually transmitted infection (STI), nurse researchers have been able to highlight the influence of romantic love on young women’s attitudes to condom use (East, Jackson, O’Brien, & Peters, 2007), difficulties young women can have in negotiating safer sex (East, Jackson, O’Brien, & Peters, 2011a; Hayter & Harrison, 2008), how women manage the flow of information about their STI status, healthcare experiences of these young women (East, Jackson, O’Brien, & Peters, 2011b) and how living with STI can affect a young woman’s whole sense of herself (East, Jackson, Peter, & O’Brien, 2010; East, Jackson, O’Brien, & Peter, 2012).

This has generated further discussion in the literature (East, Jackson, Peters, & O’Brien, 2011; Hayter, 2010), thus contributing to a published discourse that could assist nurses and other health providers to deliver more appropriate sexual healthcare for young women.

The history of sexuality in nursing care is a relatively short one and shows how much ground has already been covered. Our analysis is that more can eventually emerges from the most adverse situations in health – and that sexual health is a paradigm example of that. It is perhaps fitting to recall remarks attributed to the late Richard Wells, UK Royal College of Nursing and HIV and Sexuality Nursing pioneer: ‘AIDS brought out the worst and best in health care professionals’. We believe it is the ‘best’ that has endured and stood the test of time.

**REFERENCES**


