ELSEVIER
SAUNDERS

Nurs Clin N Am 42 (2007) 685–696

NURSING
CLINICS
OF NORTH AMERICA

Including Sexuality in Your Nursing Practice

Judith A. Shell, PhD, LMFT, RN

Osceola Cancer Center, 737 West Oak Street, Kissimmee, FL 34741, USA

Sexuality is a topic of great interest today, given the exposure in the electronic and print media, and one would think that this exposure would elevate the medical professional's comfort level with communication regarding sexuality issues. However, writers continue to comment on clinician discomfort or lack of discussion with their patients about sexual concerns and anxieties [1,2]. And, perhaps because of the media in general, if a discussion around sexuality does occur, it is often reserved for the young and healthy because the needs of people in their elder years, or those who face chronic physical illness or other functional alterations, are downplayed or felt to be less important.

Within the realm of cancer care, as one example of a chronic illness, if sexuality is discussed, this discussion is more likely to take place with those patients whose sexual function may be directly impacted (eg, cancer of the breast, cervix, prostate, testes, or colon). Patients who have other cancers, such as lung, gastric, or head and neck, may not be afforded communication about how these cancers may influence their sexuality and self-image [2,3]. Others who may be left out of a sexuality discussion are the elderly or gay, lesbian, bisexual, and transgendered individuals; even those of a different culture such as Hispanics, Asian Americans, Indian Americans, or those of European heritage may cause increased anxiety for the clinician. Nurses who care for chronically ill patients may help foster a more positive self-esteem for the patient, and may influence patient–partner attitudes about worthiness, self-concept, and body image, by providing opportunities to talk about feelings and fears about how treatment may affect their sexuality [3].

Even though their desire for survival may overshadow sexuality and a desire for intimacy immediately after a diagnosis of diseases such as diabetes, heart

E-mail address: shelljashell@aol.com

doi:10.1016/j.cnur.2007.08.007

disease, or cancer, many patients want to learn about the implications of their treatment and medications on their sexuality [4]. Patients are usually pursuing validation of their concerns and want to hear that other people have similar issues with intimacy and sexuality. They want practical advice so they can take control of their health and reaffirm themselves as sexual beings, and they want this advice from a health care professional whom they know, rather than by being referred to someone else [5,6]. Many times, patients are ignorant of some aspects of their sexuality and the nurse is in a position to enlighten them with valuable information. One study examined the questions men with prostate cancer wanted answered. From a possible list of 93 questions formulated by the researchers, 5 related to sexuality and included such matters as how treatment would affect sexual functioning and for how long, whether the cancer would worsen if the patient had sex, and whether the patient could have sex during treatment [7]. In an assessment of 73 women with gynecologic cancer, it was learned that 60% wanted more information, and more than 50% had received little or no information regarding how their sexuality might be affected by the cancer. These women (60.3%) preferred a personal discussion with their health care provider [8].

If the patient has a partner, communication with the couple together is important to treatment outcomes and relief of sexual distress. Changes in body image or self-perception can affect intimacy and social relationships, especially if there is a crisis during the illness [9]. The nurse plays a key role in encouraging patients to explore these changes in sexuality and intimacy with their partners. Providing assessment and guidance relating to the different types of treatment, resumption of sexual activity, and feelings of femininity and masculinity is imperative because most patients will not initiate this discussion. Kneece [10] reports that only about one third of 126 women who had surgery and chemotherapy for breast cancer asked their health care providers about sexual side effects, and the responses received were rated as insufficient. Professionals can no longer forget or avoid these discussions.

Attitudes and comfort levels of health care professionals

Sexuality is not a static concept and varies across time and place. Our ideas about normal and appropriate sexual behavior, whether these relate to gender roles, sexual identity, or the experience and expression of sexual desires, originate from the interaction of social and cultural forces [11]. Although the nurse may recognize the role of social factors in the sexual issues of their patients, they may fail to see their own cultural biases. Along with these biases comes the simple discomfort of talking about the patient's sexuality. Nurses rarely have difficulty talking about bowel habits, the most unpleasant side effects of treatment, or impending death, but they often stop short of discussing topics of a sexual nature, which may impair provision

of total disease management. Often the attitude is, ''It isn't my job,'' ''It's too personal,'' ''I never learned this in school,'' or ''I might offend my patient'' [4].

In an attempt to be at ease with a conversation regarding sexuality, the nurse may wish to explore several avenues, such as bibliotherapy; consultation with other nurses who are comfortable with sexuality; observation of those who incorporate sexual assessment into their practices; role-playing; attendance at seminars or workshops designed to assist in examination of attitudes, values, and beliefs about sexuality; or participating in a self-assessment for the professional (Box. 1) [4,12]. The development of good communication skills though role-playing, by asking questions that proceed from less sensitive to more sensitive issues is most helpful. It is suggested that the nurse take a set of questions and experiment with a friend, colleague, partner, or even a patient with whom he/she an established relationship. After several practice conversations with known and trusted people, comfort levels are often enhanced, and it becomes easier to ask questions or carry on a discussion about sexual issues.

Knowledge and education of the professional

Because most physicians and nurses have not had any type of sexuality training in school, an increase in one's sexual health knowledge is important. This knowledge may include studying textbooks and dedicated journals that deal with the topics of sexual anatomy and physiology, psychosexual development, the sexual response cycle, effects of aging on sexual functioning, and cultural, religious, and ethical implications [13]. In addition, a grasp of the range of human sexual expressions and behaviors assists the nurse in maintaining a nonjudgmental approach when caring for patients who practice nontraditional sexual behaviors [14]. Another method to enhance knowledge could be communication with other professionals in book and journal clubs. This method allows for interaction and the sharing of experiences and knowledge, along with other possible patient concerns that impact sexuality related to many chronic conditions, such as diabetes, hypertension, cancer, heart disease, and the medications used to control them [4].

Assessment: how and when

Ideally, a sexual assessment would be an in-depth, fact-finding mission that understands the context of the patient's life (ie, age, relationship status, living arrangement, career status, parental status, and much more) and would comprise questions about past and present sexual functioning, and intrapsychic, environmental, and interpersonal risk factors for sexual difficulty. These risk factors may include people who do not have a committed

Box 1. A guide to self-assessment for professionals

Level of comfort

Desensitization is used to increase the level of comfort. This process involves exposure to anxiety-producing material while in a relaxed atmosphere. It might include discussions about sexuality with trusted colleagues or attending a sexual attitude reassessment seminar. This process allows the professional to become more comfortable with dealing with sexuality.

1. How comfortable do you feel discussing sexual matters?
2. Notice physical tension, body position, eye contact, and facial expression when listening to specific sexual content. What content makes you feel uneasy?
3. What sexual terms can you comfortably use to describe sexual fantasies, interest, arousal, orgasm, and behaviors? Try describing these experiences to a colleague.

Attitudes

The importance of knowing your sexual attitudes is to assess your ability to guide clients/patients regarding sexuality. Positive attitudes toward sexuality are important to communicate to patients.

1. List three values you have about sexual behavior.
2. How would these values affect the way you would work with clients/patients whose problems reflect a conflict with your values?
3. List any areas regarding sexuality which are unacceptable to you.
4. What could you do to compensate for your attitudes if a patient presented something in one of these areas?

Knowledge

A knowledge base about normal sexual functioning and the possible changes with cancer is important for assisting patients.

partner, those in already unhappy relationships, those who are younger and will wish to have more children, and people who already have sexual problems or a history of sexual trauma like rape or molestation. However, most nurses do not take this type of history, nor do they have the time to do so [15]. Two particular models may be helpful and provide a guide to procure and provide sexuality information for patients and partners. One model is the PLISSIT model (P = permission, LI = limited information, SS = specific suggestions, IT = intensive therapy), and the other is the BETTER model

(B = bring up the topic, E = explaining sexuality as part of quality of life, T = tell patient about appropriate resources, T = timing, E = educate about side effects, R = record in patient chart) (Table 1) [16,17]. Both models promote communication in a uniform manner, which usually increases confidence in the nurse and validates the patient. However, even these models may be seen as too cumbersome. Spaulding [18] explains that she uses one simple question during an initial assessment, which is, ''Do you feel that your sexuality has changed since your diagnosis?'' She further says that

Table 1
Sample sexual assessment questions and statements

PLISSIT model	BETTER model
Permission: Many patients who have heart disease have questions about how their treatment will affect their sexuality. Would you like to discuss that at this time?	*Bring up the topic:* Many patients who have diabetes have questions about how their treatment will affect their sexuality. What questions do you have at this time?
Limited information: Many women who take tamoxifen for breast cancer complain of a vaginal discharge or a dry vagina during intercourse. If you have problems with dryness, you may use a vaginal lubricant like Astroglide.	*Explain:* I am also concerned with sexuality, which is a quality-of-life issue like sleep or emotional contentment. I will answer your questions to the best of my ability.
Specific suggestions: Men who have had colorectal surgery like yours find they may get an erection and ejaculate, but have no discharge of semen. This situation is normal, and if you want to try to have children, specific techniques are available to obtain your sperm from your urine for artificial insemination or in vitro fertilization.	*Tell:* I understand you have several question about how your chemotherapy treatment will affect your ability to have children. I will obtain literature for you from Fertile Hope, which is a foundation that assists all cancer patients during and after treatment is finished with information and other resources.
Intensive therapy: Most nurses are not educated well enough to provide a patient and his/her partner with appropriate sex therapy. It is appropriate to refer these patients to a local therapist who is certified by the American Association of Sex Educators, Counselors, Therapists (AASECT) or who has experience with cancer patients regarding sexuality issues.	*Timing:* If the timing does not seem right during your first encounter with the patient, explain to him/her that you are willing to talk about sexuality issues and questions at any time during the treatment trajectory.
—	*Educate:* Give patients written materials along with verbal explanations regarding how their treatment will affect their sexual function. An excellent source for cancer patients is the American Cancer Society sexuality booklets written by Leslie Schover for men and women with cancer [40].
—	*Record:* Document all conversations, who was present (patient only or patient and partner), and educational materials given.

she informs her patient that she asks this question to all of her patients and she wants to increase his/her comfort in discussing these matters with her at any time, even if he/she does not want to talk about them during the present assessment. If an open-ended question is preferable, one can modify this question by asking, ''What has your physician told you about how your heart attack will affect your sexuality?'' or ''What questions can I answer for you about how your medication will affect your sexuality?'' An example of a specific, disease-related sexual assessment form is the International Index of Erectile Function, which ascertains pre-and posttreatment erectile function for prostate cancer patients [19]. Regardless of when assessment takes place or with what method, the guidelines in Table 2 will enhance patient and nurse comfort levels. Other strategies involve the timing of the assessment and counseling, use of predetermined interview questions, and phrasing responses in nonthreatening language.

Nine participants in a focus group conducted by Bruner and Boyd [20] of women treated for gynecologic or breast cancer commented on the timing of

Table 2
Sexuality assessment guidelines

Essential elements	How accomplished
Ensure privacy.	For in-patients, close the door or draw the curtain and speak in low tones, or move to another area, such as an office or conference room.
Ensure confidentiality.	Reassure the patient and partner that the conversation is confidential. Meet privately with the patient first unless otherwise requested, and then include the partner.
Address sexual concerns early and throughout treatment.	Initiate discussion early in the relationship, thereby implying that sexuality is an important component of good health. Use sexual terms before expecting the patient to use them. Use the patient's language.
Determine patient goals.	Remember that all patients do not experience sexual satisfaction in the same manner. A patient may not have a partner, or want one. Sexuality may not be a part of his/her concept of quality of life.
Avoid overreaction.	Listen to the patient with genuine interest, which conveys acceptance. Present a positive, relaxed attitude. Do not reveal shock or surprise with facial expressions. Keep personal feelings to yourself.
Refer patients for complex problems.	Know your referral sources and use them if a complex problem arises that is beyond the scope of help you can provide.

Adapted from Shell J. Impact of cancer on sexuality. In: Otto S, editor. Oncology nursing. 4th edition. St. Louis (MO): Mosby-Year Book, Inc.; 2001, p. 854.

a sexual assessment. Married women said that they would prefer to talk about sexuality issues after their treatment was finished (between 6 months and 1 year) because if they had received a questionnaire right after diagnosis, they would probably have thrown it away, whereas the two single women said they would have embraced the questionnaire immediately (one woman was in a relationship that was primarily sexual and it was an important aspect in her life). A study of 73 women with gynecologic cancer reported that 23.3% preferred information after diagnosis but before treatment, and 39.5% wanted information given after completion of treatment [8]. Mallinger and colleagues [21] agreed with these findings and also agreed that, during diagnosis and treatment, comprehension of medical information may be lacking and patients may be unable to verbalize their needs. These researchers advocate discussion of sexuality at various points along the treatment trajectory, rather than at one particular point in time. Also, a study of heterosexual couples by Sanders and colleagues [22] revealed that men think and respond differently from women to intimacy and relationship challenges that happen during treatment for prostate cancer. Consequently, the investigators recommended that health care providers working with prostate survivors must consider the unique relationship and intimacy needs for men and women. However, as Wilmoth [4] so aptly expressed, ''One important caveat to talking about sexuality with your patients is that most of the conversations will happen serendipitously, in an informal, unexpected manner. You should be sensitive to hidden clues in conversations with your patients that may mask sexual concerns and follow up with open-ended questions.''

Cultural influences on assessment

Little research in the literature addresses the sexuality issues of minorities [23]. Speculation regarding the reasons why minorities have been absent in sexuality research includes a possible mistrust of health care professionals because of negative past experience, or beliefs around sexuality that are more conservative [24]. This lack of research, in turn, makes it difficult for the nurse to be sure about when and how to speak to the patient, or to know whether he/she would even be a willing recipient of this information. A conversation about sexuality could be highly intrusive or embarrassing to the patient and partner, depending on their culture and what they believe is proper for discussion.

African american culture

Many elements influence the African American within the medical care system. Some of these components may include contextual factors (eg, lack of health insurance, few minority health care providers); religious and spiritual factors (faith in God); factors of general distrust in the medical

system, which can lead to alternative medical practices; socioeconomic factors; social support; and empowerment factors [25,26]. Although these elements are related to health care in general, they must be kept in mind when making an attempt to assess and inform the patient about how his/her specific treatment will affect his/her sexuality.

Regarding discussing with a woman the sexual matters related to an illness like breast cancer, communication within the African American family may be minimal or absent, and grandparents, parents, aunts, and uncles may hesitate and be uncomfortable [23]. Wilmoth and Sanders [23], in their study of 16 African American women in a focus group setting, reported that the participants admitted that, in their culture, discussions about how their sexuality had changed during breast cancer treatment rarely happened, even among close female friends. They did verbalize interest in the sexual changes that had occurred in their bodies during treatment and said that they would prefer information in a one-on-one consultation, rather than in a group setting; they also said they thought they would be more open in a one-on-one conversation. However, they thought that a group setting was another suitable method for the nurse to provide information to them. One other study, with 12 African American heterosexual couples, revealed that, during the treatment process for breast cancer, sexual intimacy was difficult to maintain primarily because the husbands "were concerned about their wives' level of comfort with sexual intimacy, whereas women were more concerned about their physical appearance" [27]. Overall, the men were supportive, and reassured their wives that they would not leave them because of breast cancer. This study further mentioned the fact that these couples did not talk about sexuality issues with their health care provider, even though they felt it was important. These couples affirmed that some of their health care providers had been supportive, whereas others had not. Other reports stated that some African American women with breast cancer felt their providers were not sensitive to their particular needs and concerns [28,29].

Nurses providing assessment and intervention for African Americans must be aware of the hesitation of these patients to talk about sexuality issues within their own families; the exception seems to be the spouse or partner [27]. If hesitation exists, even within the family, the patient may not be willing to express concern about his/her sexuality, and it is paramount for the nurse to broach this subject first. One other issue is the "insider/outsider" dilemma (eg, whether or not the nurse is of the same ethnicity or culture as the patient); consequently, trust must be built and maintained by the nurse [26].

Asian American culture

East Asians can be of various cultural backgrounds (eg, Chinese, Japanese, Vietnamese, Cantonese, and so forth). For the most part, discussions of a sexual nature are essentially taboo in these families, and the older

adults prefer not to talk about sex, often because they received an inadequate sex education [30]. Schools in Japan and Korea provide little in sex education, and sex is considered a private matter not to be discussed in public society [31,32]. East Asians have been found to be more conservative, have less sexual knowledge and experience, a later onset of sexual intercourse, and fewer sexual responses, when compared with other ethnic groups [33,34]. In Korea, parents are more tolerant of the sexual activities of their sons than of their daughters, and sex education emphasizes premarital virginity in girls. Premarital sexual activity is frowned on for both boys and girls, but a girl's premarital sexual activity is definitely viewed as a negative [35]. In general, health care professionals also shy away from discussing sexuality [36].

Reports in the literature acknowledge that Asian women have lower cancer screening rates than their Caucasian counterparts, which is thought to be partly because of fear or embarrassment, lack of time and money, and language limitations [37]. Acculturation (the process that occurs when a person moves to another culture and attempts to integrate into the new culture by taking characteristics and values of the new culture into his/her personality and self-identity) has also been noted to be a factor in cancer screening behaviors. In a study done by Woo and Brotto [38] with Euro-Canadian ($n = 86$) and East Asian ($n = 78$) women, the Canadian women had a significantly higher rate of Pap testing than the East Asian women. The Canadians were also found to be more knowledgeable about sex and to have a higher level of sexual functioning and a broader repertoire of sexual activities. The East Asian women cited embarrassment as a barrier to Pap testing; however, if more sexually permissive, they tended to be more likely to have had a Pap test. Acculturation to western culture was found to relate significantly to greater sexual desire. If the East Asian woman maintained strong ties to her culture, increasing mainstream acculturation did little to liberalize her sexual attitudes. But if she did relinquish her heritage culture to a certain degree, increasing exposure to North American culture led to more liberal sexual attitudes, and these women had higher Pap testing rates [38].

For the nurse with an East Asian patient, it must be ascertained whether or not this patient is a first-generation Asian and whether or not he/she has acculturated to this country. If embarrassment is associated with a simple Pap test, discussion of the patient's sexuality or sexual relationship may also cause embarrassment. Ishida [37] reported that Chinese women preferred information through the mail and not by telephone, and many Asian groups (Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese) showed little interest in an educational class format to acquire information. Consequently, the nurse should attempt to provide a one-on-one encounter with the patient for provision of information regarding sexuality issues, which provides privacy and decreases the potential for embarrassment.

Hispanic culture

Hispanics include primarily those persons from Mexico, Central and South America, Puerto Rico, and Cuba, and about 8% from other Spanish-speaking countries [39]. Social networks that include family and friends can be instrumental and a positive factor when providing medical care because they usually are involved in visits to the doctor and in the treatment that is to be delivered [40]. Because family involvement is valued and important to this culture, health care may be discussed and decided on by more than just the patient and partner. They may, however, be averse to seeking out medical care when an illness encompasses something involving sexuality. Adams and colleagues [41] report that ''women have presented with longstanding gynecologic symptoms, such as bleeding after intercourse, which they were too embarrassed to bring to the attention of a health care provider.'' Hispanic women have a 7.3 times greater incidence of cervical cancer than Caucasian women, which may be because of a younger age at first intercourse. Overall, Hispanics are also reluctant to share marital problems that are caused by sexuality issues [41].

Traditionally, the Hispanic woman has been respected and is known to have a strong relationship with her children. Even after children are grown, this woman remains loving, caring, and nurturing [41]. On the other hand, in this culture, the male has created a submissive, self-relinquishing female who is fixated on procreation, and is necessarily devoted to her spouse and children [42]. Often, though, her strong dedication to family has put her own personal needs secondary to her family, with resultant delays in medical treatment for her own ailments.

In today's society, level of acculturation may significantly impact these populations' traditional views of femininity and machismo; individuals less acculturated respond differently than those who hold more ''western'' views [41]. The nurse may need to be somewhat more assertive, although not invasive, with the Hispanic population because of their shyness and reluctance to discuss sexuality issues with a health care provider, especially one who is not from within their own culture. Gentle persuasion may be appropriate for the nurse to be able to provide a good quality of education related to the illness and its impact on sexual function.

Summary

When assessing the patient and partner for issues or concerns relating to their sexuality, the nurse must not be more interested in finding treatment options than in normalizing the fact that they each have these issues. Help for these patients and partners is needed to find the causes of low order sexual functioning and to offer treatment options so they can have a better sense of their own sexuality and a more meaningful sex life. Recognition of a patient's entire sense of his/her own sexuality along with patient-centered

goals acknowledges individual differences in sexual function. If the person is not troubled by a poor sexual performance, then he/she does not have a problem. During assessment and intervention planning, alternative sexual activities may be suggested; however, these may not be satisfying. Feelings of disappointment, failure, and distress may arise when none of the suggested strategies are helpful, and these feelings cannot be ignored. Essentially, no treatment program is 100% successful, and some patients and partners simply may not benefit from any treatment option.

References

[1] Huber C, Ramnarace T, McCaffrey R. Sexuality and intimacy issues facing women with breast cancer. Oncol Nurs Forum 2006;33(6):1163–7.
[2] Katz A. The sounds of silence: sexuality information for cancer patients. J Clin Oncol 2005; 23(1):238–41.
[3] Shell J. Impact of cancer on sexuality. In: Otto S, editor. Oncology nursing. 4th edition. St. Louis (MO): Mosby—Year Book, Inc.; 2001, p. 835–58.
[4] Wilmoth MC. Life after cancer: what does sexuality have to do with it? Oncol Nurs Forum 2006;33(5):905–10.
[5] Hughes MK. Sexuality and the cancer survivor. Cancer Nurs 2000;23(6):477–82.
[6] Wilmoth MC, Ross JA. Women's perception: breast cancer treatment and sexuality. Cancer Pract 1997;5(6):353–9.
[7] Feldman-Stewart D, Brundage M, Hayter C, et al. What questions do patients with curable prostate cancer want answered? Med Decis Making 2000;20(1):7–19.
[8] Bourgeois-Law F, Lotocki R. Sexuality and gynecological cancer: a needs assessment. Can J Hum Sex 1999;8:231–40.
[9] Hordern A. Intimacy and sexuality for the woman with breast cancer. Cancer Nurs 2000; 23(6):230–6.
[10] Kneece JC. Helping your mate face breast cancer. 5th edition. Columbia (SC): Educare Publishing; 2003.
[11] Ericksen JA, Steffen S. Kiss and tell: surveying sex in the twentieth century. Cambridge (MA): Harvard University Press; 1999.
[12] Haffner DW. Sexuality and scripture. Contemporary Sexuality 2004;38(1):7–10.
[13] Hyde J, DeLamater J, Byers E. Understanding human sexuality—Canadian edition. Toronto: McGraw Hill Ryerson; 2001.
[14] Rathus S, Nevid J, Ficher-Rathus L. Human sexuality in a world of diversity. 4th edition. Toronto: Allyn and Bacon; 2000.
[15] Carpenito-Moyet LJ. Nursing diagnosis: application to clinical practice. 10th edition. Philadelphia: Lippincott Williams and Wilkins; 2004.
[16] Annon J. The behavioral treatment of sexual problems. Honolulu (HI): Enabling Systems; 1974.
[17] Mick J, Hughes M, Cohen M. Sexuality and cancer: how oncology nurses can address it BETTER [abstract]. Oncol Nurs Forum 2003;30(Suppl 2):152–3.
[18] Spaulding S. No patient assessment is complete without asking one simple question. ONS News 2006;21(9):6.
[19] Rosen RC, Riley A, Wagner G, et al. The international index of erectile function (IIEF): a multidimensional scale for assessment of erectile dysfunction. Urology 1997;49(6): 822–30.
[20] Bruner DW, Boyd CP. Assessing sexuality. Cancer Nurs 1999;22(6):438–47.
[21] Mallinger JB, Griggs JJ, Shields CG. Patient-centered care and breast cancer survivors' satisfaction with information. Patient Educ Couns 2005;57(3):342–9.

[22] Sanders S, Pedro LW, Bantum EO, et al. Couples surviving prostate cancer: long-term intimacy needs and concerns following treatment. Clin J Oncol Nurs 2006;10(4):503–8.
[23] Wilmoth MC, Sanders LD. Accept me for myself: African American women's issues after breast cancer. Oncol Nurs Forum 2001;28(5):875–9.
[24] Haynes MA, Smedley BD. The unequal burden of cancer: an assessment of NIH research and programs for ethnic minorities and the medically underserved. Washington, DC: National Academy Press; 1999.
[25] Jenkins R, Schover LR, Fouladi RT, et al. Sexuality and health-related quality of life after prostate cancer in African-American and white men treated for localized disease. J Sex Marital Ther;30(2):79–93.
[26] Wilmoth MC, Narine L. African American women and cancer. In: Hassey Dow K, editor. Nursing care of women with cancer. St. Louis (MO): Mosby Elsevier; 2006, p. 433–43.
[27] Morgan PD, Fogel J, Rose L, et al. African American couples merging strengths to successfully cope with breast cancer. Oncol Nurs Forum 2005;32(5):979–87.
[28] Ashing-Giwa K, Ganz P. Understanding the breast cancer experience of African American women. J Psychosoc Oncol 1997;15(2):19–35.
[29] Moore RJ. African American women and breast cancer: notes from a study of narrative. Cancer Nurs 2001;24(1):35–42.
[30] Bhugra D, de Silva R. Sexual dysfunction across culture. Int Rev Psychiatry 1993;5:243–52.
[31] Kameya Y. How Japanese culture affects the sexual functions of normal females. J Sex Marital Ther 2001;27:151–2.
[32] Youn G. Perceptions of peer sexual activities in Korean adolescents. J Sex Res 2001;38: 352–60.
[33] Cain VS, Johannes CB, Avis NE, et al. Sexual functioning and practices in a multi-ethnic study of midlife women: baseline results from SWAN. J Sex Res 2003;40:266–76.
[34] Brotto LA, Chik HM, Ryder AG, et al. Acculturation and sexual function in Asian women. Arch Sex Behav 2005;34(6):613–26.
[35] Youn G. Sexual activities and attitudes of adolescent Koreans. Arch Sex Behav 1996;25(6): 629–43.
[36] Chan DW. Sex misinformation and misconceptions among Chinese medical students in Hong Kong. Arch Sex Behav 1986;19(1):73–93.
[37] Ishida DN. Asian women and cancer. In: Hassey Dow K, editor. Nursing care of women with cancer. St. Louis (MO): Mosby Elsevier; 2006. p. 444–58.
[38] Woo JST, Brotto LA. Cancer-screening behaviors, attitudes towards sexuality, and acculturation. Report from Society for Sex Therapy and Research Annual Meeting Atlanta (GA). 2007.
[39] U.S. Department of Commerce Bureau of the Census. The Hispanic population in the United States: March 1988 (advance report). Series P-20, No. 431. Washington, DC: U.S. Government Printing Office; 1988.
[40] Velez-Barone G. Latino women and cancer. In: Hassey Dow K, editor. Nursing care of women with cancer. St. Louis (MO): Mosby Elsevier; 2006. p. 472–81.
[41] Adams J, DeJesus Y, Trujillo M, et al. Assessing sexual dimensions in Hispanic women: development of an instrument. Cancer Nurs 1997;20(4):251–9.
[42] Diaz-Guerrero R. Psychology of the Mexican: culture and personality. Austin (TX): University of Texas Press; 1975.