DESTIGMATISATION: A GROUNDED THEORY OF THE WORK OF SEXUAL HEALTH NURSES.

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ABSTRACT

The aim of this grounded theory study is to identify, describe, and generate a theoretical explanation of what it means to practice sexual health nursing care in New Zealand in the 1990's and new century. Further, to investigate individual nurse's experiences within the current sociopolitical climate of health care. Sixteen participants from six sexual health clinics in New Zealand were interviewed over a period of eight months and a total of 24 hours of tape recorded data were collected. Constant comparative analysis of data eventuated in the identification of four conceptual categories named as *identifying, personalisation, respecting and dignifying, advocating and empowering*, and *doing deviant work.* These conceptual categories were drawn together in the core category, which is termed *destigmatising.*

Countering stigma emerged as a recurrent problem for nurses in this study. An analysis of nurses' counter reactions is compared to Gilmore and Somerville's (1994) model of stigmatised reactions towards people with sexually transmitted diseases. The model describes the processes of disidentification, depersonalisation, scapegoating, and discrimination, which characterise stigmatised reactions. *Destigmatising* in the context of this study means that the nurse is engaged in the process of counteracting the prejudice and negative social attitudes towards people who attend sexual health clinics and who have sexually transmitted infections. The process occurs in the interactions between the nurse, the client and the community. This process is dynamic and reflects changes in patterns of social sexual relations in society and community attitudes towards these.

Essentially this study shows that nurses' processes of destigmatisation are based on a complex of factors affected by the gender, culture, and sexuality of both the practitioner and the client. Nurses' understandings of the impact of socioeconomic conditions and gender/power relations in society have an important role to play in how nurses manage care.

The understanding of client fears and anxieties, of underlying social attitudes and of the problems of marginalised subcultures and individuals is important information for

practicing sexual and reproductive health nursing care. As well, nurses in this study encountered professional stigma. The practice of sexual health care results in being professionally marginalised. Implications and recommendations in regard to sexual and reproductive health nursing education, practice, and further research are made.

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Key to Interview Terms and Abbreviations

The following conventions used are presented here to assist the reader in their interpretation.

Name	The personal names of research participants have been changed and pseudonyms used for identification.
Number	The number of the interview and line of the transcript.
(...)	Material which has been edited.
...	Incomplete sentences without editing.
" "	Single words, or short phrases/ sentences used by the interviewee.
' '	Words developed by the researcher or other authors.
[ ]	Insertion of additional material to make context and/or meaning clear.
Client	The term client has been used throughout this study.
STDs / STIs	The abbreviations for sexually transmitted diseases and sexually transmitted infections are used. A sexually transmissible infection is the medically correct terminology, however the former term has more common colloquial usage.
VD	The term venereal disease was the terminology formerly used to refer to sexually transmitted infections.

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CHAPTER ONE
INTRODUCTION AND OVERVIEW

Sexual health care is acknowledged as socially complex and difficult work. A contributing factor is the widespread stigma associated with sexual health clinics and with sexually transmitted infections (Brandt & Jones, 1999). The biomedical, and political difficulties inherent in sexual health are defined by Brandt and Jones (1999, p. 20) as care that:

> engenders powerful social conflicts about the meaning, nature and risks of sexuality; the nature and role of the State in protecting and promoting public health; the significance of individual rights in regard to communal good; the nature of the doctor [nurse] patient relationship and social responsibility in times of epidemic disease ... Attempts at either moralising or education have had limited impact.

In addition, sexual health nurses encounter negative public and professional reactions to their work. Describing the interactions that occur between sexual health nurses and their clients has implications for improving care in this and other related fields of practice. There has been considerable attention paid to improving nurse's attitudes, values and beliefs towards sexuality, however there has been little attention to the practical management strategies of nurses in sexual health settings (Lewis & Bor, 1994; Giddings & Wood, 1998; Savage, 1987; Waterhouse & Metcalfe, 1991).

In the first section of this chapter the background to recent changes in sexual health services in New Zealand is given, in order to locate the study in the context of a decade of health policy reforms. In the second section the contemporary role of sexual health nurses is explored. In New Zealand the role of the nurse in sexual health settings is comprehensive, providing clinical, psychological and social management which addresses the broader social environment and subculture of the client. In the third section definitions of sexual health and sexuality, outlined by the World Health

Organisation are critiqued in the context of contemporary sexual health care along with prevailing sociopolitical views of sexuality (WHO, 1975; 1987). The influence of the historical context of sexually transmitted infections in New Zealand is examined in the fourth section.

The impact of recent social and political movements on sexual and reproductive health care are explored in the fifth section. Local history, culture and politics influence interactions between nurses and clients in sexual health clinics in New Zealand. Sexual health services have adopted mainstream liberal views in the 1980's and 90's as sexuality has increasingly gained centrality in public and scholarly debate (Connell & Dowsett, 1993). The fifth section examines the influence of feminist and gay theoretical perspectives in relation to the contemporary role of sexual health nurses in New Zealand and the current delivery of services. Critical social paradigms have contested the medical model of sexual health care, adding significant modifications from cultural, psychological, and sociological perspectives supportive of social action (Miller, 1997; Weeks, 1985). Nurses have developed roles that encompass social advocacy and activism for marginalised groups in society. A retrospective look however, at the establishment of sexual health services in the early twentieth century shows that far from being emancipatory, they served as agents of social control (Tulloch, 1997).

Contemporary sexual health services are steeped in a history from which they struggle to disidentify, of 'moral panics' about 'contagious diseases' and the punitive state regulation of sexuality. The colonial period began with European whalers, sailors, itinerant and migrant men, a thriving Maori and Pakeha sex industry and the social purity counterreactions of the early feminists (Belich, 1996). Moral persuasion and the Contagious Diseases Act (1869) failed to control male sexual behaviour and was replaced during World War One with quarantine measures and enforced treatment for the returning soldiers. In the 1920's diseases among soldiers and sailors were perceived to threaten public health leading to compulsory attendance for cure at state provided Venereal Diseases clinics. The international Brussels agreement in 1924 mandated the treatment of merchant seamen in all ports to protect the public from foreign sexual diseases. The second wave of feminist social reformers in the 1970s promoted women's

sexuality as a matter of sexual freedom and reproductive control, rejecting the sexual moral and health threats of earlier feminists. In the 1980s travelling gay men posed a new threat to public safety in New Zealand, introducing Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) from abroad. Public reactions to the fatal disease AIDS reflected a contest between social reform and social control measures, resulting in the implementation of health promotion and prevention strategies.

The significance of the present study is in examining the practical everyday realities of sexual health nurses and their clients. Specifically for this study, grounded theory methodology is utilised to explore interactions with clients in sexual health settings from the perspective of the nurses who work in those settings. The aim is to uncover and articulate the phenomena of the social management of the client. The theoretical approach to the study is therefore 'grounded' in nurses' practical experiences. Grounded theory is based on the symbolic interactionist approach to understanding and explaining human interactions and society (Annells, 1996). It is a particularly valuable approach in areas of complex behavioural interactions 'where salient variables have not been identified' (Stern, 1980, p. 116). Interpretations of social, political and cultural interests in sexuality have not been explored from the perspective of sexual health nurses. According to symbolic interactionism people attribute meaning to social activity such as sex and act on the basis of the context in which interactions occur. It is through the processes of social interaction and the interpretations that they are given that the values, attitudes and beliefs of communities are developed. Studies of this nature have been used to represent the interests of the socially marginalised and stigmatised (Crotty, 1998).

Little is known about the values, attitudes and beliefs of sexual health nurses and the models of nursing care that has evolved within sexual health services in New Zealand. By studying human interactions the social symbolism of going to a sexual health clinic and having a sexually transmitted disease (STD) can be explored. Symbolic interactionists have, for instance, addressed why it is that society wants to exclude some

members considered sexually diseased and deviant and how this process occurs (Becker, 1963; Goffman, 1963).

BACKGROUND

An outline of national trends and developments in sexual health service provision in the last decade provides the political context for this study. Since 1993 general changes in health care provision in New Zealand led to a split between the Health Funding Authority (HFA) and health providers, in the right wing market led strategy of the National government (Franklin, 2000). This led to competition between public health providers and, for sexual health services, the loss of contracts to private primary health care. During the period of health reforms from 1993 to 1999 sexual health services have been downsized from a network of twenty-three to twenty-one. Remaining sexual health services had significant funding reductions (Anderson & Mortensen, 2000). In comparison with primary care providers, sexual health services were considered to be costly, particularly those services in larger urban centres offering specialist training programmes. In Wellington City, sexual health services were tendered out in 1999 to an independent general practitioners association. A similar proposal was planned for Auckland City sexual health services for February 2000, however the election of the Labour government secured free publicly funded sexual health services in New Zealand. Subsequent to the considerable downsizing of services nationally the numbers of nurses working in sexual health services in New Zealand are small. Sexual health services are mainly located in cities and only six percent of nurses work in small towns or rural locations. In 1997, there were thirty-three sexual health nurses, the majority, working part-time (Anderson, 1997). The numbers have reduced since 1997 to twenty-five. Of this number 92% are female and 8% male. A 1997 study reports that of thirty-three nurses working in sexual health services, 50% had a graduate certificate, 29% a degree, 15% were working towards a degree, 6% had a post graduate diploma and 2% had a masters degree. Most nurses in the study had been employed in sexual health services for more than five years (Anderson, 1997). The 1999 Labour government's Minister of Health is 'committed to the continuation of a free specialist sexual health service nationwide' (King, 1999, p.21). The Ministry of Health is setting up an advisory

committee to formulate a national strategy on sexual health that will allow for the planning of future services. At present the New Zealand Nursing Council is considering a proposal to allow sexual and reproductive health nurses to gain prescribing rights.

THE CONTEMPORARY ROLE OF THE SEXUAL HEALTH NURSE

In the year 2000 the role of the nurse in sexual health services is increasingly recognised as specialised. In a clinical context nurses provide assessment of symptomatic and asymptomatic patients and treatment of genital warts, candida, gonorrhoea, chlamydia and nonspecific urethritis. Reproductive health care includes contraceptive advice and the provision of combined oral contraception, depo provera, the emergency contraceptive pill, pregnancy testing and counselling for pregnancy options. Health prevention activities involve cervical screening, teaching testicular self examination, Hepatitis A and B vaccination programmes, partner notification, and HIV pre and post test counselling.

In New Zealand sexual health nurses have evolved a range of non-clinical roles in accordance with local community needs and contractual obligations. Seminars are offered to health professionals and students on sexual health management and preventive care. Community based education takes place in secondary schools, community groups and on marae. Nurses outreach marginalised groups including sex workers, at risk adolescents and men who have sex with men. Increasingly nurses are initiating research and working collaboratively on medical and social science projects. An important shift in the non-clinical role of the nurse has been the development of sexual health counselling skills to manage psychosexual issues (Mulhall et al., 1995). This has evolved in response to a shift in focus away from disease control and the policing role of contact tracing in sexual health services to health education prevention and promotion strategies.

Until the mid 1980's and the first appearance of cases of HIV/AIDS in New Zealand, measures used by nurses to prevent and control STDs were traditional and served to

support the biomedical model of venereal disease control. Treatment, condoms, confidential counselling and contact tracing was provided (Darrow, 1997). Epidemiological trends in at risk communities have led to awareness that an emphasis on medical interventions is ineffective for long term behaviour change. Prevention programmes, targeted interventions at identified risk groups for the transmission of HIV including, men who have sex with men, sex workers and injecting drug users. Sexual health nurses have developed a comprehensive approach to sexual behaviour change, involving improving interpersonal skills and establishing safer sex social norms. Moving sexual health out of hospital sites and into community settings has increased the acceptability and accessibility of services to young people and to marginalised populations. It is recognised that multiple prevention strategies are needed to prevent the spread of HIV, STDs and related diseases. The inclusion of needle exchange in sexual health services is an example of additional interventions to prevent associated lifestyle risks. A number of innovative safer sex interventions have been adopted from international social and behavioural theory and modified for New Zealand cultural and social settings.

Sexual health nurses in New Zealand have implemented community interventions (Darrow, 1997). For people with genital herpes self help groups are used as a means of social support and destigmatisation. In Auckland, a peer sexuality education programme operates in secondary schools, involving sexual health nurses in training young people as educators (Elliot & Lambourn, 1999). Services for sexual assault care operate within the context of sexual health services, providing social assessment and intervention to prevent the long term sequelae of child and adult sexual abuse and rape (Campbell & Ahrens, 1998; Shew & Hurst, 1999). Maori nurses have developed culturally appropriate health promotion interventions targeting a range of issues including cervical screening. The role of the sexual health nurse is dynamic and changing reflecting wider social, political and intellectual movements in New Zealand (Guthrie, 1999).

DEFINING SEXUAL HEALTH AND SEXUALITY

Concepts of sexuality have undergone radical revision according to culture, history and prevailing scientific philosophies (Van Ooijen & Charnock, 1994). From the early 1900s until the 1970s, research was sexology rather than sexuality orientated (Guthrie, 1999). The works of Freud, Ellis, Kinsey, and Masters and Johnson concentrated on biological sex in accordance with the positivist, scientific nature of research at that time. In the 1970s social constructivists such as Simon & Gagnon (1969) and Foucault (1976; 1979) began to contest traditional biological definitions of sexuality with specific social, cultural and historic perspectives. The analysis revealed that concepts of sexuality, sexual identity and gender described as integral components of sexual health, are themselves highly contested social and cultural constructions (DeLamater & Hyde, 1998; Ussher, 1997; Weeks, 1985).

Commonly sexuality is defined in nursing literature as a distinct personal quality involving thoughts, feelings, actions and behaviours which determine who we are, our self perception, response to and response from others (ENB, 1994; Paul & O'Neill, 1983; Savage, 1987; Van Ooijen & Charnock, 1994). This definition of sexuality promotes ideologies of sexuality as intimate closeness, meaningful relationships and deep emotions (Taylor, 1995; Van Ooijen, 1996). These perceptions reinforce traditional romantic sexual stereotypes of femininity and masculinity (Few, 1997; Taylor, 1995). Traditional constructions of sexuality are predominant in nursing ideology and are challenged by feminist and constructionist perspectives (Few, 1997; Kippax, Crawford & Waldby, 1990).

Social deconstruction has been incorporated into aspects of sexual health clinical management such as the language used in sexual history taking however, the nursing literature predominantly reflects the concepts of sexual health defined by the World Health Organisation (WHO, 1975). The basis of the WHO advice to health professionals warrants close examination from the perspective of the clinical realities of practicing sexual health care in New Zealand. In 1974, the World Health Organisation held a meeting on 'Education and Treatment in Human Sexuality'. The purpose of the meeting

was to discuss the role of sexology in health education programmes and therapeutic approaches to sexual dysfunction. In response to changing patterns and perspectives of sexuality in the western world in the 1970's, WHO developed a definition of sexual health for training health professionals (WHO, 1975). The WHO report stated that sexuality is:

> the integration of the somatic, emotional, intellectual and social aspects of sexual beings, in ways that are positively enriching and that enhance personality, communication and love. Every person has a right to receive information and to consider accepting sexual relationships for pleasure, as well as for procreation. (WHO, 1975, p.6)

The implication of the definition was that health professionals should focus on:

> a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation or sexually transmitted diseases (WHO, 1975, p. 7).

Medical concern to see sexuality as integral to the development of a healthy personality overrode the fact that people were being infected with STDs. Enhancing sexual technique designed to improve sexual well being was situated in the prevailing ethos of sexology (Connell & Dowsett, 1993). For 'preventive and curative health services' to meet sexual health needs it was considered most important for health professionals to have:

- positive attitudes toward sexuality;
- personnel who show understanding and objectivity towards the expression of sexual complaints, to inform and advise regarding sexuality and sexual problems;

- sufficient knowledge and resources to deal with complex problems of sexuality (WHO, 1975, p. 7).

The approach of the World Health Organisation in 1975 prioritised healthy sexual functioning and sidelined the prevention of sexually transmitted infections and the promotion of safer sex. The relationship between enhanced sexual pleasure and rising rates of sexual infections was not theorised as an issue of sexual health management. In spite of the contradictions apparent in the conceptual framework of sexual health offered by the 1974 working party, it has been unequivocally accepted in nursing literature. Three components of sexual health were outlined by WHO as:

1. A capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.
2. Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships.
3. Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions, or both (WHO, 1975).

The response in the nursing literature was to promote the need for a comprehensive, holistic approach to sexual health care (E.N.B., 1994; Gamel, Davis & Hengeveld, 1993; Grigg, 1997; Katzman, 1990; Koch, 1985; Rafferty, 1995; Savage, 1987; Van Ooijen, 1996; Van Ooijen & Charnock, 1994). In the late 1980's there is a marked shift in nursing theory away from reductionist, medical problem-solving approaches towards social and political analyses of sexuality. Carr (1996) concludes that this change occurred, as a direct response to the political and social pressure exerted by gay activists and not as a response to the development of holism in nursing knowledge which includes sexuality. Carr claims that challenges to societal homophobia have had a marked impact on nursing discourses. While a shift away from heterosexist dominance in sexual health discourses is emphasised in the literature the continuing effects of sexism on the sexual health and lives of women have not been sufficiently addressed (Delacour, 1991).

Finding consensus on definitions of sexual health has proved problematic to the World Health Organisation. In 1987 after considerable debate a WHO working party concluded

that 'due to the range of individual, cultural and social differences, and the various patterns of lifestyle, social and gender roles, there can be no single definition of a sexually healthy individual' (WHO, 1987). The group met in response to the upsurge of the AIDS epidemic in the mid 1980's and the need for WHO to be able to address the issues of sexuality raised by the HIV virus. The WHO report on concepts of sexual health recognises that sexuality is socially constructed (WHO, 1987). From the constructionist perspective, sexuality is the creation of history and culture. Members of societies choose behaviours and relationships as 'sexual' (DeLamater & Hyde, 1998). Sexuality in constructionist terms is not an individual personality trait, or a universal phenomenon, but a dynamic construct that changes with time and culture (Foucault, 1976).

The 1986 WHO concept of sexual health discussed the knowledge, awareness and competence needed for people to achieve healthy sexual lives. The qualities discussed in the report included a sense of self-esteem, respect for self and others, and control over the consequences of sexual behaviour. Societal gender power relations are not discussed in the context of sexual control, although the need for support for sexual abuse victims is considered part of 'personal resources' (Ehrhardt et al., 1999). While both the 1974 and 1986 reports emphasise sexual well being, neither mentions control over safe sex to avoid 'the consequences of sexual behaviour'. An analysis of gender sexual relations has become central to psychological and sociological studies of barriers to safer sex practices (Civic, 1999; Gavey & McPhillips, 1999; George, 1993; Hale & Trumbetta, 1996; Hollway, 1983; Hynie, et al., 1998; Kippax et al., 1990; McKernon, 1997; Taylor, 1995). The report cautions health professionals to promote in young people understandings that romantic ideals of relationships need to be reconciled with 'the reality that a relationship involves growth, tension and change' (WHO, 1987, P. 14). The report indicates that there may be variance in sexual need and expression according to 'gender' and 'the existence and status of a sexual relationship' (WHO, 1987, p. 19). The relationship between sexual status and health status however is not made explicit.

In New Zealand in 1988 the Royal Commission on Social Policy defined sexuality as having three inter-related parts: reproductive function; erotic response; and gender role

(Richardson et al., 1988, p. 245). Discussing the latter, the report noted that while gender roles have changed for women in public life, sexual relationships remained unequal. The report concludes that:

> Sexuality, economic survival and social acceptability are seen as closely intertwined for women. This leads to the conclusion that they have little real choice in, or control over, sexual relations. Yet, they have traditionally been held responsible for controlling men's sexual behaviour as well as their own (Richardson et al., 1988, p. 246).

Traditional responses to sexuality have shaped men's and women's sexual behaviour patterns in New Zealand and form the background to sexual health issues in contemporary society.

HISTORICAL CONTEXT

Successive attempts have been made to control sexually transmitted infections since the colonisation of New Zealand in the 1860's in spite of this:

> It is a ... tragic irony that despite medical efforts against sexually transmitted diseases and the existence, since the 1940's, of powerful treatments for them, these diseases persist, even thrive, in the 1990's. Historical analysis can reveal the substantial obstacles that have presented successful management of these epidemics. For instance the cultural meanings associated with sexual relations. STDs thus become not just biological and medical problems, but also social and political problems. Both medical and public health interventions fail to address the full complexity of these social diseases (Brandt & Jones, 1999, p.15).

European colonisers brought venereal diseases to New Zealand which began to afflict Maori from the 1790's (Belich, 1996). From this time missionaries portrayed a massive sex industry supplied by Maori women for the thousands of visiting sailors. While the missionaries were spreading Christian ideas to Maori, sailors spread syphilis and gonorrhoea to their women. The latter had a near fatal impact on Maori who had no history of sexually transmitted diseases. Sexually transmitted diseases along with other European diseases led to an enormous increase in Maori death rates and a falling birth rate. There is evidence that women's sexuality in pre colonial Maori culture was more freely expressed than their European counterparts in the Victorian era (Belich, 1996).

In the 1860's there was a rapid growth of Pakeha prostitution in New Zealand, every city had a well known 'red-light' district (Belich, 1996). Legal measures to contain and treat sexually transmitted infections intensified in the early twentieth century in response to the rising rates of disease, increasing prostitution and an expanding population of itinerant migrant men (Coney, 1993). Prevention efforts focused on the enforced detention, examination and treatment of prostitutes under the Contagious Diseases Act (CD Act), 1869. Women suspected of prostitution were detained in Lock Hospitals where they were forcibly held down and roughly examined. Men were treated but were not subjected to any form of examination. The act was designed to suppress prostitution and had little effect on controlling venereal diseases. The CD Act was viewed by the nineteenth century feminists as a blatant case of discrimination against women. Any woman could be picked up and forcibly examined. Furthermore, the Women's Christian Temperance Union (WCTU) argued that the provision of 'clean' prostitutes would only encourage the Victorian double standard. Women's suffrage was gained in New Zealand in 1893 and the demands of first wave feminists and social purity reformers could no longer be ignored by politicians (Tulloch, 1997). The Contagious Diseases Act was repealed in 1910.

For nineteenth century feminists the solution to the spread of sexually transmitted diseases was not the enforced treatment of prostitutes, but for men to practice 'continence', sexual restraint and abstinence. The ideologies of the British suffrage movement took a strong hold among 'good women' in New Zealand. Christabel

Pankhurst in her book titled *The Great Scourge and How To End It* was a strong advocate for social purity (Tollerton, 1992). The solution to stopping the spread of venereal diseases was in her words (cited in Tollerton, 1992, p. 96) that:

> Women should have nothing to do with men either politically or sexually, she proposed, until they became as chaste as women.

The views of an Australian doctor delivered to a conference to teach sex hygiene in Sydney in 1916 represented the prevailing societal views of the time. Smyth (1916, p. 191) condemned the economic conditions that drove women into prostitution. He attacked the Victorian moralism that accepted male moral weakness and punished women severely for 'immoral' behaviour:

> The double standard asserts that for man there shall be, in the matter of illicit intercourse, a judgement which condones or punishes lightly, and for the woman the scorn or the ostracism of society.

The late nineteenth and early twentieth century was dominated by warnings of the physical and moral dangers of sex by politically important lobby groups such as the Women's Christian Temperance Union, the National Council of Women, and the Canterbury Women's Institute (Tollerton, 1992). The feminist and social purity activists called for an end to the policy of 'the Conspiracy of Silence':

> Which is the natural outcome of the double standard and prevents people from learning the truth on these diseases (Smyth, 1916, p.191).

The dangers of sex were real and women were kept in a state of ignorance about the nature of their illness. An eminent Dunedin gynaecologist, Dr Batchelor found that half of the married women admitted to the gynaecological ward in Dunedin Public Hospital had venereal diseases given to them by their husbands (Tollerton, 1992). General

practitioners treated men but decided against telling or treating wives, for venereal diseases because of the intense stigma involved. Groups such as the WCTU separated the 'innocent' victims of venereal diseases from the 'guilty' party. The claim of 'innocent victim' had validity in the sense that both husbands and the medical profession kept women in ignorance of their condition. For women prevention and treatment were not discussed and subsequently children were born with infection. The rates of venereal disease posed a serious threat to the birth rate in New Zealand (Tollerton, 1992). Politicians and feminists agreed that rising rates of venereal disease constituted a major problem, whether this was a moral or medical problem was a point of disagreement.

In 1917 the Minister of Health, George Russell introduced the Social Hygiene Bill into parliament. Feminists had opposed previous attempts at the compulsory notification of venereal disease, claiming that 'innocent' people would be unjustly stigmatised for contracting the disease (Tulloch, 1997). Politicians argued that education and moral persuasion could not stop the spread of disease. Findlay, Minister of Justice in 1910 proposed treating venereal disease as any other notifiable contagious disease. This in his view was a public health issue and not an issue of morality. Women's organisations opposed the move to compulsory treatment for all venereal disease sufferers and the Act that was passed instead empowered the Minister of Public Health to establish Women's Health Patrols. The aim of the WCTU was to provide 'lady patrols' to:

> Give moral guidance to the wayward young; advise parents of the need to protect their children from immoral influences (Tulloch, 1997, p. 233).

Politicians were becoming alarmed at the impact of venereal diseases on New Zealand soldiers in Egypt, France and London (Tulloch, 1997). They recognised that promoting social purity in the community would not provide a solution to the prevention of sexually transmitted diseases, however the feminist vote was so powerful that few were brave enough to say so publicly.

During World War 1, Ettie Rout was a lone figure in the campaign for the introduction of prophylactics. In Europe, stationed in Paris, Rout supplied 'safe sex' kits and counselled New Zealand and Australian soldiers on the prevention of syphilis and gonorrhoea (Tollerton, 1992). There was substantial public resistance in New Zealand to the safer sex campaign among soldiers in Europe. The prevailing view was that handing out condoms to troops would only encourage sexual activity. Ironically the most vociferous attacks came from women, who later would be significantly affected by the STDs brought home by their husbands. The public panic over the syphilis was rife and returned soldiers were blamed for the rise in disease. Soldiers invalided home were escorted by train to Quarantine Island in Dunedin 'as if they were criminal lepers' (Tollerton, 1992, p. 196). Although the army declared soldiers treated for syphilis uncontagious, in New Zealand, the Public Health Department required continued treatment. Free Public Health Department Venereal Disease clinics were set up for soldiers in Auckland, Wellington, Christchurch and Dunedin. This was the beginning of sexual health services in New Zealand.

The social purity movement had formed social hygiene societies firmly committed to stamping out 'immorality' at all costs. The association of sex with cleanliness and purity revealed deep seated eugenic and racial prejudices (Brandt & Jones, 1999; Smyth, 2000). Revisionist authors have reinterpreted the social aims of early feminists as an integrated political campaign to transform the gender order and to protect women from endemic, incurable, sexually transmitted diseases (Ballard, 1993). Feminists pushed for contaminated sex to be outlawed along with the infected. The societies now wanted the imposition of compulsory notification and premarital venereal disease tests. In 1922 concern about venereal disease was so persistent that the government set up a special committee to investigate the seriousness of the problem and to make recommendations which would be acceptable to the public. The committee favoured early treatment for venereal disease, but not prophylaxis as this would only encourage vice (Tollerton, 1992). The committee in 1922 did not want it made public that more than half the births that took place in the first year of marriage were conceived out of wedlock. Even 'good women' did not practice chastity.

The New Zealand government was well aware of the political risks of alignment with Rout's safe sex campaign. While the Minister of Defence authorised the provision of condoms to soldiers, this decision was not publicised and he continued to condemn Rout in public. Rout on her return from Europe in 1936 was publicly vilified for her 'safe sex' campaign and uniformly shunned by New Zealand society. In the same year she committed suicide in the Cook Islands. The government in 1936 expressed alarm at the falling birth rate in New Zealand and raised the 'moral danger' to family life of all forms of birth control. European women however were aborting one in five pregnancies. Women were dying from septic abortion in such large numbers that an official inquiry was called. Post World War One feminists headed a campaign for birth control, setting up in 1936 the Sex Hygiene and Birth Regulation Society. The demands of women in New Zealand for effective birth control were influenced by their British counterparts. Twentieth century sexology is claimed by British authors to have undermined early feminism in an emphasis on 'natural sex' and multiple motherhood, however this appears to have had lesser ideological influence in New Zealand (Coveney et al., 1984; Jeffreys, 1990; Tulloch, 1997).

The sex reform movement in Britain influenced by the work of sexologists had a positive impact on medical views of sexuality which were later to influence second wave feminism (Boston Women's Health Book Collective (BWHBC), 1971; Hawkes, 1996). The scientific study of sexology emerged changing medical attitudes towards sexuality which would form the basis for definitions of 'sexual health' in use in contemporary nursing literature (WHO, 1975). Sexual liberalism dominated twentieth century sexuality research (Weeks 1985; Jeffreys, 1990). Ellis, an early pioneer in sexuality research at the turn of the century saw sexuality as essential for psychological health, particularly for men (Nicolson, 1993b). Ellis promoted sex as a 'natural' activity in which male domination and female submission is normal, desirable and inevitable. Later, sexologists Kinsey in the 1940s, and Masters and Johnson in the 1950s and 1960s, shared essential characteristics in their theories that if male desire does not find legitimate outlets then men will search for illegitimate means for example, rape. Whilst Masters and Johnson provided fundamental information about the physiology of human sexual response, they gave no attention to the use of sexual power and control (Connell

& Dowsett, 1993). Jeffreys (1990) points out that the resulting 'marriage manuals', seemed very consistent with the sexual needs of men.

Population concerns in the 1940s were replaced with a new moral panic over the free sexual behaviour of adolescents in the 1950s (Smyth, 2000). The New Zealand government set up the Special Committee on Moral Delinquency in Children and Adolescents known as the Mazengarb Inquiry (Smyth, 2000). As a result legislation was rushed through forbidding the giving of contraceptives, including condoms and contraceptive information to under sixteen year olds. The legislation was not to be removed until 1990. Sexual behaviour was liberalising and the prevalence of sexually transmitted infections was increasing. In response radical and intrusive legal steps were introduced to penalise people who had sexually transmitted diseases. Public health officials succeeded in introducing the Health Act 1956 and later the Venereal Diseases Regulations in 1982. The new legislation permitted infected people to be fined and imprisoned, barred from some employment, the use of public transport, and from contracting to a marriage (George, 1993). The legislation enabled the contact tracing of partners of infected people and notification of the infection to the health authorities and mandatory testing and treatment.

In New Zealand in the late sixties and early seventies changing social and economic conditions led to marked changes in patterns of sexual behaviour. Women joined the labour force in greater numbers and university education became accessible to the middle class. Greater female autonomy gave impetus to the women's liberation movement and a redefinition of female sexuality that was active, assertive and liberal. Kinsey's studies record in this period in America, a marked increase in the variety of sexual relationships: the extensive use of sex workers by men, homosexuality among men and women and a significant rate of extramarital affairs (Gilmore, Schwartz & Civic, 1999). However, while sexual behaviours were changing rapidly, prevailing gender power relations were not.

The 1960s brought wider possibilities of reproductive control for many women. The availability of the contraceptive pill and abortion was seen by clinicians as relieving women of biological obstacles to sexual 'freedom', allowing full expression of female sexuality. In practice, however, these developments pressured many women to be

available for sex without emotional commitment and further hindered female sexual liberation (Connell & Dowsett 1993; Dworkin, 1987; Mackinnon, 1987). Many women could no longer refuse sex on grounds of risk of pregnancy. The Boston Women's Health Book Collective, an American feminist health group in the early seventies, while acknowledging a deep indebtedness to Masters and Johnson for their creative and positive work on sexuality, commented that:

> The oppression of women has gone on for so many generations we don't know what our optimal sexual lives might be like (BWHBC, 1971, p. 38).

The first wave of feminism in New Zealand left a legacy of social sexual puritanism along with improvements in reproductive health care for married women. The second wave in the 1970's was committed to sexual liberation without moral overtones. Improved access to birth control exposed women to an even greater degree, to sexually transmitted diseases Although there was medical evidence and public knowledge of sexual infections, condoms were not widely used or promoted (Smyth, 2000). In a climate in which unwanted pregnancy was the main concern, feminists focused on freely available safe effective contraception and abortion on demand (Dann, 1985). In New Zealand in the 1970's, the first women's liberation groups were formed. The groups represented an upsurge of interest in militant and radical feminism and created as well conventional and liberal support (Dann, 1985). The first National Women's Liberation conference held in Wellington in 1972 addressed abortion and sex education. The conference proposed that 'realistic' sex education, free from moralising, be given in schools at primary and secondary levels. This required that the Contraception, Sterilisation and Abortion Act (1977) preventing the giving of contraceptive advice to adolescents under the age of sixteen be repealed. In 1973 women's groups started a number of projects which were to have a significant impact on women's sexual and reproductive health and sexual freedom. The Wellington Women's Workshop formed Women Against Rape and began to set up a rape crisis line, the Women's National Abortion Action Campaign (WONAAC) was started and in Auckland an Organisation for Women's Health was founded (Dann, 1985).

The women's health movement in New Zealand was strongly influenced by the American 'Self-Help' movement and particularly by the Boston Women's Health Book Collective publication (BWHBC), *Our Bodies, Ourselves* (1971). The book in a section on education and morals stated that:

> Information on the relationships between different kinds of birth control and a person's susceptibility to VD is not widely disseminated. Consequently the popularity of The Pill has aided the spread of VD. The Pill is often blamed as the primary cause of the recent VD upsurge, but no consideration is given to the lack of information about its drawbacks (1971, p. 172).

The collective rejected the advice of the American national Public Health funded VD hotline, that condoms were the only effective prevention against sexually transmitted diseases. They claimed that prevention methods that relied on male compliance were biased against women and that there had been a lack of research into improved methods of prevention for women. Feminists claimed that the fear of VD had been used to limit women's sexual activity outside marriage and that:

> With the advent of widespread birth control, which eliminated the fear of pregnancy, fear of VD became the last effective deterrent to complete "sexual license." Until recently, many people were morally opposed to contraception, so foams, creams and jellies, which were probably also good VD preventives, were not openly displayed...we have to change the official stance that seems to view VD as punishment for 'immoral' sex (BWHBC, 1971, p. 172-173).

While the collective provided up to date information about sexually transmitted infections they did not offer sound advice about prevention or safe sex. It was strongly stated that medical and public health officials considered it their ethical duty to warn the public of epidemics of infectious diseases but not however if they were sexually

transmitted. Venereal Diseases clinics were recommended as the best places to go for the diagnosis and treatment of sexually transmitted infections. New Zealand women formed groups to learn about birth control, gynaecological examination, and common vaginal infections. They learned cervical self examination that had more of a symbolic than preventive value however as:

> feminists themselves were not always fully aware of the significance of self examination, and where it would lead (Dann, 1985, p.82).

Feminism had a significant impact on sexual health medicine in New Zealand. Until the 1970s sexual health care remained a covert activity, 'VD' clinics provided hidden health care in unadvertised locations. Services continued to be dominated by the medical model and were primarily concerned with the detection, treatment and cure of sexually transmitted infections. The contact tracing of sexual partners was central to the role of nurses in sexual health services, and the primary focus of prevention. Gay and feminist social activism challenged the medical model and provided new concepts for a community model of nursing care in sexual health services. In the 1980's the practical projects of feminism, women's health and rape crisis centres became mainstreamed within existing sexual health services (Campbell, Baker, & Mazurek, 1998). Sexual health nurses became involved in teaching health professionals assessment and management skills for survivors of rape and sexual abuse.

The instigation of the Cartwright inquiry in 1988 into the medical management of cervical cancer at National Women's Hospital, by feminists Sandra Coney and Phillida Bunkle had a significant impact on women's health care in New Zealand. The inquiry challenged nurses in New Zealand to act as advocates for their patients. Nurses in sexual health services developed a strong ethos of 'right to know' regarding sexual risk factors for cervical cancer. Nurses worked from the premise that women should be told of the link between cervical abnormality and the genital wart virus, and gave information about the prevalence and transmission of the genital wart virus. This view was unpopular with the 'protectionist' stance taken by the cervical screening register which

tended to focus on the preventive aspects of regular screening rather than STD prevention (Braun & Gavey, 1999b).

It took the fear of HIV/AIDS to change attitudes towards condom use and more open attitudes towards sexuality education and health prevention strategies (Smyth, 2000). In 1988 David Caygill, appointed Minister of Health after the 1987 general election, started a condom campaign. He stated that promoting safer sex education was a political duty to protect public health that should be put before the interests of maintaining the 'moral majority' voters (Smyth, 2000). The National Council of Women rejected the promotion of condoms and recommended instead that the ministries of health and education promote marital fidelity and sexual restraint outside marriage (Smyth, 2000). It was not until 1990 and the repeal of the Contraception, Abortion and Sterilisation Act in 1989, that safer sex and contraceptive education could be provided to under sixteen year olds.

Gay activism, HIV/AIDS and the homosexual law reform movement in the 1980's contested the traditional attitudes and assumptions of health professionals. Sexual health professionals developed a practical awareness of their role in the social construction of sexuality. A Foucauldian perspective was adopted which allowed for a framework of care that related sexuality to other social phenomena, particularly economic, political and social structures. The role of nurses in the social construction of sexuality was examined in this paradigm. Miller (1997) discusses the Foucauldian concept of the normalising discourses used by nurses, to define acceptable and unacceptable sexual behaviours and lifestyles. Foucault contested the power exercised by the majority heterosexual identity, over minority sexual identities and behaviours, such as homosexuality, fetishism and sex work (Foucault, 1976). Deconstructed concepts were introduced in sexual health history taking, changing the language used to 'normalise' and to empower heterosexuality over homosexuality (Miller, 1997). Sexual health services gained a reputation as safe places for people of diverse sexual lifestyles. The emergence of HIV/AIDS in New Zealand led sexual health services to expand the range of effective prevention strategies. Harm reduction strategies were introduced in collaboration with consumer groups such as the gay community, New Zealand

Prostitutes Collective, injecting drug user groups; self help groups and the transgender community.

A shift away from stigmatising labels such as venereal disease clinics to sexually transmitted disease clinics and in the late 1980s sexual health clinics, reflected social change and the integration of sociological with medical perspectives. The relabelling of services for people with sexually transmissible infections has attempted to remove the embedded historic association of clinics with contagion, enforcement and social ostracism. The impact of these changes on the realities of sexual health practitioners and clients has not been explored. As Browne and Minichiello say (1998, p.28):

> The ways in which the STI [Sexually Transmitted Infections] testing experience is predicated on both how the patient's experience of 'felt' stigma reflects their own attitudes and feelings, or how clinician's attitudes and feelings are conveyed to patients has not been examined. Nor do we know about how these two experiences mesh to create a social situation in which prejudice may be one of the primary determinants of what happens.

Historic fears and the social prohibitions that served to limit threatening sexual activity shape contemporary social attitudes towards sex, sexuality and sexually transmitted infections. As a prevention strategy social prejudice has been remarkably unsuccessful.

SOCIOPOLITICAL CONTEXT

Social issues have the most influence on the transmission and prevention of STIs (Gilmore, Schwartz & Civic, 1999). The social conditions of poverty, gender inequality, inadequate education and minority culture discrimination increase the prevalence of STIs in marginalised populations. Sexual health discourse combines epidemiology, feminist, gay and psychosocial theory in finding solutions to the growing STI, HIV and AIDS figures. Aral and Holmes (1991), eminent American venereologists state that

sexual health interventions must be coupled with projects that address poverty, unemployment, violence, housing, drug and alcohol issues, along with targeted behavioural interventions for specific communities. Further barriers to effective prevention interventions are the secretive and hidden nature of sexual lives and the stigma attached to the transmissibility of sexual diseases (Eng & Butler, 1997). Becoming societally overt about sexual realities is a major key to uncovering the populations at risk. As Brandt and Jones (1999, p.15) state:

> Understanding how the mode of transmission and the attached cultural attitudes can be of critical importance in both clinical and public health approaches to STDs, and recognising that STDs require an integrated model of medical, ecological, social, and political influences on disease, are crucial if we are to produce realistic strategies for managing sexually transmitted diseases in both national and international contexts.

Cultural attitudes to gender and sex role stereotypes have the biggest impact in impeding the prevention of STIs (Ehrhardt et al., 1999). Medical researchers in transmission factors for sexually transmitted infections have concluded that women's and men's gender roles significantly modify the negotiation of sexual practices and the means of protection (Ehrhardt et al., 1999). Women have a greater biological susceptibility to STIs, however their social vulnerability that places them at greatest risk (Doyal, 1995). The reasons for women's poor sexual and reproductive health status is more likely to be found in the inequality of their sexual relationships, the double standard and sexual coercion, than in biological predisposition (Aitken & Reichenbach, 1994). Health promotion strategies need to address sexual inequality in heterosexual relationships before safer sex for women can be effectively promoted. Medical reviews of sexual risks accept that realistic health prevention strategies for women are ' embedded in the social and gender-specific contexts of their relationships with men' (Bolan, Ehrhardt & Wasserheit, 1999, p.118). To change women's sexual risk behaviour women need to be taught the behavioural skills of empowerment, negotiation, and refusal. Such studies do not, however, acknowledge the obligation of women to men

when they are financially and socially dependent. Women are embedded in powerlessness around their sexual safety out of their learned sense of duty, trust, belonging and dependence, for which their survival and security depends (Matthews, 1992; Over, 1999). Recent studies have documented that women still think that their male partners have an automatic right to unprotected sex (Holland et al., 1996; Hollway, 1983). Over (1999) in analysing the operation of gender in sexual risks and the social cost of STDs takes the view that there should be continued state intervention in the provision of sexual health information and services.

The Royal Commission on Social Policy in New Zealand (1988) reporting on 'Women's Personal Wellbeing' emphasised a need for awareness of 'safe sex' practices. The report also acknowledged that for women, economic survival and social obligation often compromised sexual safety:

> The historical record since European settlement shows that women have had great difficulty obtaining the knowledge, means and power necessary to take charge of their sexuality and fertility ... education about sexuality and encouragement of self-determination for women ... need to be a major priority in health and education policy development.... (Richardson et al., 1988, p.245).

Men enjoy greater sexual freedom than women. A study of New Zealand sexual culture found that not only are males twice as likely to report ever having had same gender sex, with 8% of the male population having had anal sex, but also twice as likely to have had multiple partners in the previous years and during the length of their sexual career (Davis et al, 1996). The study concluded that New Zealand patterns of sexual activity are conservative compared to the United Kingdom and the United States of America. He notes however, uniformity in the discrepancy in sexual behaviours between genders in all countries. The ability to describe this pattern as conservative emphasises that male dominance and power in sexual relationships is societally normalised.

Sexual health services are involved in stopping sexual abuse and rape. Sexual health professionals are extensively trained in care and support of clients who have been abused and assaulted. Policies and protocols for the prevention, detection of, and appropriate care and safety of children, adolescents and adults, who have been sexually abused and raped, have been developed in New Zealand sexual health services. Sexual health professionals have challenged rape myths perpetuated in medicine and have undertaken responsibility for training professionals in related fields, in the sequelae of childhood sexual abuse and rape and the impact on adolescent and adult risk behaviour. The work of sexual health doctors and nurses has had an extensive role in challenging the myths that women invite rape through dating, occupation, location, their appearance, drugs and alcohol use (Ward, 1995; Segal, 1990). Through professional and community education the normalised sexual activities of date rape, marital rape and the rape of sex workers has been exposed and made unacceptable. Sexual health educators train health professionals to address the impact of sexual coercion on women and men to ensure that they receive health care which is therapeutic, supportive and enabling, rather than stigmatising and blaming (Ward, 1992).

The continuing differences between male and female sexual freedom are well demonstrated in the thriving sex industry in New Zealand. Sexual health services have a complex role in the care of sex workers. Women are empowered by healthcare workers to demand and negotiate condoms use, to address issues of sexual abuse and rape and to access free contraception, condoms and vaccinations. Contemporary discourse has not acknowledged this covert male sexual activity. It is hidden from research on sexual behaviour.

Heterosexual men are missing in safe sex discourses. Models of psychosexual care have advanced for homosexual men and for other at risk marginalised groups. McKernon (1997) in a study of condom use among heterosexual male clients at Auckland Sexual Health Service found that multiple approaches are needed to effect change in male sexual behaviour patterns. McKernon shows that health professionals will have more success in increasing condom use in low or non users through client education and by supporting men to improve interpersonal communication about safer sex. Barriers to

condom use included low self-efficacy, poor condom technique, shyness about taking the initiative, and expectations of female responsibility. McKernon (1997) found that it is not the 'macho' ethic that prevents men from using condoms, but the fear of humiliation at the loss of erection and failing at intercourse if condoms are used. More careful attention needs to be paid to the reasons why men reject condoms and appropriate individualised strategies for change made.

The social stigma associated with STDs is a major barrier in prevention. As Eng and Butler state (1997, p.86):

> It is notable that although there are consumer-based political lobbies and support groups for almost every disease and health problem, there are few individuals who are willing to admit publicly to having an STD. STDs are stigmatised because they are transmitted through sexual behaviours. Although sex and sexuality pervade many aspects of our culture, and sexuality is a normal aspect of human functioning, sexual behaviour is a private-and –secret-matter.

Although it is well recognised that social, economic, cultural and political factors have a major influence on the prevalence of STDs there is however a continuing view among the public and health professionals that 'STDs are a just punishment for immoral behaviour' (Brandt & Jones, 1999, p. 15).

SIGNIFICANCE OF THE STUDY

The present study addresses the management of clients in sexual health services. The social processes of managing sexuality in the context of nursing care are a little known phenomenon. It includes not only specific sexual health care settings, but all other nursing practice contexts (Lawler, 1991). Mainly, research in this area has addressed nurses' values, attitudes and beliefs (Giddings & Wood, 1998; Kautz et al, 1990; Lewis & Bor, 1994; Waterhouse & Metcalfe, 1991). The conclusion drawn from such studies have indicated a need for more and improved sexuality education at both graduate and

post graduate levels. In order to be effective in improving nursing practice however, sexuality education needs to be informed by the practical everyday realities of experienced nurses in the context of their practice settings (Artinian, 1998; Lawler, 1991). Sexual health care needs to be examined in the interactions that take place between the nurse and the client (Swanson, 1986). Exploring care from the perspective of nurses in sexual healthcare settings is essential in understanding the meaning of practice. Nursing care, to be understood, needs to be considered in the light of the context and of the setting.

External social forces impact on definitions of sexuality, on the ethos of the nurse and on sexual health practice. The history and politics of sexuality and sexual health care impact on nursing behaviour (Foucault, 1979). An analysis of the relationship between societal and personal ideologies about sexuality and nursing action is essential to an understanding of nursing behaviour. The range and variation of sexual health care can be understood in particular settings, conditions and contexts at particular times. Currently research in sexual health care internationally and in New Zealand has focused on quantitative studies of nurses' knowledge, values and attitudes towards sexuality. Lawler (1991) has studied the experiences of nurses involved in the intimate care of the body. Her findings regarding sexuality in this context will be discussed in the literature review in Chapter Two. Nurse researchers have not explicitly explored the social processes involved in providing sexual health care. The significance of this study is to articulate the processes by which nurses manage their work, their role and the ideological frameworks that assist or impede this role. It is intended that nurses' knowledge will become explicit, theoretical and organised. In this way, the knowledge and skill which nurses take for granted becomes transferable to other contexts and therefore useful in designing and implementing educational programmes (Artinian, 1998; Lawler, 1991).

THE AIM OF THE STUDY

The aim of this study is to examine the management of sexual health practice from the perspective of nurses employed in sexual health clinic settings using a grounded theory

approach. The study will focus on uncovering the processes of the everyday interactions between sexual health nurses and their clients. The established norms and processes of nurse/client interactions during sexual healthcare will be examined through the interviewing of nurses. Data collection will be guided by the question "How do nurses manage their encounters with clients in sexual healthcare settings?"

STRUCTURE OF THE THESIS

The first chapter of the thesis has outlined the history of sexual health care in New Zealand. The effects of contemporary social and political changes are discussed as a background to the research undertaken. In Chapter Two, New Zealand and international research and literature relevant to the study are reviewed and critiqued. The methodology of grounded theory is explained and the utilisation for this research is discussed in Chapter Three.

The findings of the study are presented in Chapters Four to Eight. Stigmatisation is explained in Chapter Four. The processes engaged by sexual health nurses are described sequentially as *identifying with people, personalisation, respecting and dignifying,* and *advocating and empowering,* in Chapters Five, Six, Seven and Eight respectively. In Chapter Nine, the process of *doing deviant work,* explains professional responses to the work of sexual health nurses. In order to do justice to the participant's voice some quotations are long. In these cases, paraphrasing would have reduced the richness of the data. This, in addition to the large number of participants has made for a lengthy thesis.

In the discussion of findings in Chapter Ten, the processes discovered, are integrated with the relevant literature to form a central concept of *destigmatising.* The limitations of the present study are discussed along with the implications for future education, practice and research.

CHAPTER TWO

REVIEW OF THE LITERATURE

In this chapter literature from the humanities, and health, behavioural, social and political sciences are examined and critiqued in the context of the phenomenon of the nursing management of sexuality and sexual health care. In the first section first-time user views of sexual health services in Britain and North America are explored, showing that clients had better experiences than they expected. The second section reviews nursing research about the values, attitudes and beliefs that enable sexual health care to occur. A number of quantitative studies of this nature have been undertaken in New Zealand, North America and the United Kingdom. The nurses surveyed have worked in a variety of settings but not, however, in sexual health clinics. The quantitative studies have offered a perspective on educational interventions designed to improve individual nurses' attitudes and practice, these are discussed in the third section. The role of nurses as sexual health educators and health promoters is examined in the context of critical social theoretical perspectives in the fourth section. In the fifth, the relevance of concepts of marginalisation, diversity and difference for the health care of people with sexually transmitted infections is explored. In the section on the social issues in the management of sexual health care, the complexities that nurses' face in dealing with sexuality are compared and contrasted. In the last section a methodological approach developed by Lawler (1991) to the everyday problem of routine intimate nursing care in general settings is reviewed. While the next section is concerned with studies of client's views about attending a sexual health service, the literature has not however, addressed the difficulties specific to managing sexual health care in sexual health settings.

STUDIES OF CLIENT VIEWS OF SEXUAL HEALTH SERVICES

British and North American studies have sought user views on the appropriateness, nature and quality of sexual health services (Celum et al., 1997; Evans & Farquhar, 1996; Monteiro, 1995; Munday, 1990; Rogstad, 1991). In the studies people who used sexual health services for the first time reported arriving with high levels of anxiety and perceptions that they would be made to feel dirty, unacceptable or unusual. Interviews with study participants however, indicated that clients had instead very positive experiences. In the studies friendly staff attitudes, privacy, safety and confidentiality were of most importance to clients. The concerns expressed by people visiting services were mostly about how they would be treated, whether they would be recognised and, for men, whether treatment would be painful. The majority of women said that a woman-only waiting area would make them feel *'safe'*. Female service users were reported in one study to be significantly more likely to feel nervous or embarrassed than male users (McLean & Reid, 1997). In some cases strong emotions accompanied attendance, for instance when this was as a result of a partner's infidelity. Being greeted well at reception made a significant difference to reducing anxiety. In one study a young woman stated that '*whatever they were trying to do to make me relaxed worked*' (Evans & Farquhar, 1996, p. 225). Clients were relieved to find that clinical staff showed them respect and were non-judgemental. Strict confidentiality was a major factor in choosing to use a sexual health service even when primary care could be accessed free of charge (Celum et al., 1997). Most clients wanted visits to a sexual health clinic kept private from other health professionals and did not want the results of their investigations sent to their general practitioner (Munday, 1990). Client insistence on privacy and confidentially reinforces the view that they do not consider sexual health to be 'normal' care. Secrecy and the levels of anxiety expressed by patients reflect the continuing stigma attached to attending a sexual health service.

NURSES' VALUES, ATTITUDES AND BELIEFS ABOUT SEXUALITY

Clients' expectations that they would feel embarrassed, irresponsible and dirty did not eventuate in those studies conducted in British and American genitourinary medicine clinics (Evans & Farquhar, 1996; Monteiro, 1995; Munday, 1990; Rogstad, 1991). The critical factor was that clients experienced sexual health practitioners as being respectful and non-judgemental. Studies specific to the values, attitudes and beliefs of nurses who work in sexual health services are absent, although a number have been undertaken in other settings. Research in Britain and North America consistently reports nurses, personal discomfort, uncertainty, embarrassment, conservatism and conflicted political and religious views, when faced with sexual health care (Lewis & Bor, 1994; Ross & Channon-Little, 1993; Savage, 1987; Waterhouse & Metcalfe, 1991).

A North American study of nurses who care for adolescents found that although they were theoretically capable of addressing sexuality, it was avoided as a topic (Wall-Haas, 1991). Nurses in the study did not consider sexual health to be a nursing intervention, did not use resource materials available or refer on to sexual and reproductive health care providers. Most surveyed 'strongly agreed' that an adolescent client would feel very uncomfortable receiving sexuality counselling from a nurse. The nurses in the sample were considered to be liberal and accepting in their attitudes towards sexuality. Giddings and Wood (1998) undertook a study in New Zealand of nurses' knowledge and attitudes towards sexuality. The study reports that New Zealand nurses have more liberal attitudes towards sexuality than do American and British counterparts but face the same barriers. The longitudinal study between 1988 and 1991 surveyed pre and post registration nursing students. Giddings and Wood found that overall nurses' general knowledge of sexual health care was adequate but they identified a need to increase knowledge levels, awareness, and to provide a safe environment in which to discuss sexuality issues. They concluded from their study that there is a need for thorough and ongoing sexuality education, for both undergraduate and postgraduate nurses. Invariably

the conclusions reached by researchers investigating barriers to sexual history taking are for more education and improved practice.

The focus of educational interventions in the literature is teaching about a range of sexual practices, using appropriate and non-judgemental language, and confidence with sexual history taking. Attitudinally, importance is given to the practitioners comfort with their own sexuality, to the establishment of a safe and trusting environment for clients and to methods of interaction with different ages and genders (Temple-Smith, Hammond, Pyett & Presswell, 1996). Factors other than a lack of sexual health education and experience, have rarely been considered in relation to the difficulty of practicing sexual health care. Research has attempted to correlate the variables of sex, race, occupation, educational level and marital status with nurses' comfort with sex and sexuality issues (Kautz et al., 1990; Lewis & Bor, 1994; Waterhouse & Metcalfe, 1991). The use of self-report tools in these studies has limitations in identifying why it is that nurses do not meet established sexuality nursing care standards. The information gained is descriptive, superficial and does little to convey the meaning of sexual health care for nurses. Kautz et al., (1990) suggest that good professional role models and peer support are needed to change nursing behaviour and knowledge. This suggests that research methodologies that enable nurses to describe, in their own words, how it is that they manage care and respond to their own and their client's anxieties and fears around sexuality, may uncover important practical and theoretical information.

Personal discomfort with sex and sexuality care may come from the experience of sexual abuse (Hardman et al., 1998; Duldt & Pokorny, 1999; Savage, 1987). Research into child and adult sexual abuse experiences among nurses supports a higher prevalence than in the general population (Hardman, Jones, Scott, & Stevens, 1998). Hardman et al., (1998), recommend that nurses who have a past history of sexual abuse may need counselling to feel safe in discussing the sexual health issues of clients. Concepts that attempt to normalise sexuality care do little to address why it is that sexuality care is so difficult for many nurses. Negative personal experience may conflict internally with the prevailing viewpoints that explain sexuality as a basic human need,

an intricate part of a person's identity, and a normal part of general nursing care (Kautz et al., 1990; Van Ooijen, 1996).

Hayter (1996) argues that given societal distaste for openly discussing one's sexual life and behaviours, it is hardly surprising that nurses feel unprepared to discuss these matters professionally with clients. It is important for educators to:

> acknowledge how difficult it is to talk to a stranger about sexual matters and then examine that person. This is contrary to accepted social behavior of being modest and polite. However, such social standards are misplaced in the healthcare setting. (Duldt & Pokorny, 1999, p. 30).

Nurses' perceived lack of skills and confidence in discussing sex is real. Talking about such matters inside and outside the health care setting is commonly considered impolite and immodest. Polite conversation does not generally enter into open, deep and detailed discussions of personal sexual practices and behaviours, nor reveal traumatic childhood or adult sexual experiences. Societal norms keep this information private and hidden. As Simon and Gagnon (1969, p.11) comment:

> Although we talk a lot about sexuality, as though trying to exorcise the demon of shame, learning about sex in our culture is in large part learning about guilt; and learning how to manage sexuality commonly involves learning how to manage guilt.

There is a lack of research on the topic of how to manage personal views and experiences and provide safe, sensitive sexual health care. The recommendations of the report of the World Health Organisation (1975, p. 6) on sexual health training for health professionals, are to define and discuss sexuality as a positive, enriching and enhancing concept. Changing nurses' attitudes has been shown to have little success in improving the quality of practice of sexual health care in general settings because there has been

superficial understanding of the problems to be overcome. The reality of the topic as shameful and socially forbidden is not discussed thoroughly in qualitative research findings. It is more realistic in Hayter's (1996) view for health professionals to suspend judgements than to be 'non judgemental'. Nurses' values, attitudes and beliefs are reflective of their wider social, political and cultural experience and context. It is therefore inevitable that nurses will involve their own attitudes and values in relating to clients. Crouch (1999), in discussing nurses' 'lack of enthusiasm' for sexual health care, attributes this partly to the inherent beliefs and values that are brought to the workplace.

The role of the workplace in creating an environment that enables nurses to manage sexuality comfortably has not been explored. Creating a climate and culture of safe sexual health practice has wider implications than staffing services with people who have liberal attitudes towards sexuality. How do nurses, in some settings, like and respect the clients considered elsewhere to be 'off putting', is critical social information (Reynolds, Scott & Austin, 2000). It is evident that in settings outside sexual health clinics nurses' do allow their attitudes to negatively influence care for people with sexuality and sexual health issues. Hayter (1996) cites studies that show that clients with sexual health needs are least likely to be popular and in particular homosexuals. The literature does not, however, investigate the experiences of nurses for whom sexual health care is a matter of professional choice and expertise.

It is evident that the central preoccupation in nursing literature relating to sexuality is heterosexism and homophobia (Bor & Watts, 1993; Gray et al., 1996; Grigg, 1997; Katzman, 1990; McHaffie, 1993; Rafferty, 1995; Tanner, 1996; Van Ooijen & Charnock, 1994). Much of the literature on sexuality consists of descriptions of the negative attitudes of health professionals towards homosexuals, and the lack of willingness to care for clients perceived as sexually deviant (Eliason & Randall, 1991; Ross, 1985; Stevens, 1995; Tanner, 1996). Gay and lesbian clients report health care givers to be prejudiced, condemnatory and ignorant. Client mistreatment by hostile and rejecting health professional is described in the literature (Stevens, 1992). For example, lesbian participants in Steven's study commonly experienced that health care providers

stopped interacting with them after learning of their homosexuality. Gay clients reported non-verbal cues to indicate nurses' dislike much more than verbal cues. Hayter's study (1996) indicated that nurses expressed their dislike of gay patients through facial expression, tone of voice and the use of touch. Such encounters are experienced by clients to be threatening and unsafe. The findings of studies of gay, lesbian and HIV positive people conducted in the 1980's and 1990's have had a considerable impact on establishing professional codes to prevent discriminatory practices in health care.

The poor treatment given to people who have sexually transmitted infections is unacknowledged and undertheorised in nursing and midwifery literature. Few studies directly relate nursing practices to client feedback, except for those conducted in sexual health services on user views of care services (Celum et al., 1997; Evans & Farquhar, 1996; Monteiro, 1995; Munday, 1990; Rogstad, 1991). How nurses bracket their own feelings and attitudes when dealing with issues outside their comfort zone becomes a matter of professional importance for client safety. In spite of the anxiety clients express encountering health care. There has been a lack professional interest in countering client anxiety and low expectations of appropriate care where sexual health problems are concerned. While professional codes exist for the concept of cultural safety and non-discrimination towards sexual minorities there are no standards of safe cultural practice for sexual health care (NCNZ, 1996).

SEXUALITY EDUCATION FOR NURSES

Surveying nurses' knowledge and attitudes towards sexuality has been a common approach to assessing the effectiveness of educational interventions to improve sexual health care (Bower, Webb & Stevens, 1994; Lewis & Bor, 1994; Matocha & Waterhouse, 1993; Swanson et al., 1990; Waterhouse & Metcalfe, 1991). Studies however, show that educational interventions have made little or no impact on changing nurses attitudes and practice (Kautz, et al, 1990; Waterhouse & Metcalfe, 1991). There has been little comparison made of the success of various educational strategies in relation to sexuality education for nurses. The literature addresses a wide range of

concerns relating to sexuality and sexual health nursing care, including: the physical and psychological problems of sexual function and dysfunction, issues of sexual identity and reproductive health, as well as to health promotion and prevention strategies (Guthrie, 1999; Hayter, 1996; Irwin, 1997; Longworth, 1997). The advice given to nurses working in a range of inpatient and community practice settings is general and summarised by Van Ooijen and Charnock (1994, p. 165):

> The important issue is for the topic to be on the agenda at all times, and for nurses to realise the sexuality definitely falls within the remit of holistic nursing care.

Conversely nurses in practice settings outside sexual health clinics recognise that sexuality is a topic to avoid (Lewis & Bor, 1994; Waterhouse & Metcalfe, 1991). The advice given to nurses does not take account of the settings, contexts or roles in which nurses practice. Guthrie (1999), in a grounded theory study of the meanings given to sexuality by nurses in an acute surgical setting refers, for instance, to practical considerations such as the sexual harassment of nurses. In the study Guthrie (1999, p. 5) finds that:

> The attitudes these nurses formed may be particularly strong and difficult to overcome when they are placed in situations where they are forced to confront patient sexuality ... The overall conclusion is that the nurses studied find it problematic to provide nursing care relating to sexuality. They are unwilling to introduce sexuality as a facet of patient care for a variety of reasons, some contextual, some residual.

The expression 'forced to confront sexuality' is used frequently in nursing literature indicating the challenging and threatening nature of sexual health care (Guthrie, 1999, p. 10). The phenomenon of social threat in regard to sexuality needs further investigation before improvements in nursing care can be made. Savage (1990) acknowledges that for

women in health care the fear of becoming the object of male innuendo and sexual harassment is a factor in avoiding discussion that involves sex. The gender power issues involved in female nurses discussing sexuality with male clients has not been adequately discussed in the literature. Instead, the most common approach to improving care is to introduce nurses to counselling models derived from sex therapy based on the biological science of sexology, with the expectation that such approaches will improve openness and communication between the nurse and the client (Crouch, 1999; Duldt & Pokorny, 1999; Longworth, 1997). While counselling techniques improve the management of sexuality care, the literature suggests an appeal to holism as a rational for the therapeutic inclusion of sexology, has had little influence on advancing sexual health care (Guthrie, 1999). The findings of sexual health care studies indicate that sexuality rather than being a normal, natural, integrated part of every nurses practice is instead complex, threatening and specialised.

How nurses learn to manage sexuality in specific sexual health settings has not been identified as a source of information for educators. Sexuality education is assumed to make a difference to the clinical management of sexual health care. However, as Guthrie (1999, p. 11) states:

> Introducing sexuality as part of the nursing curriculum is of little use if nurses cannot integrate such theory into practice. Education should be geared not only towards providing nurses with knowledge about sexuality, but also to equipping them with the communication skills necessary to operationalize that knowledge.

Giddings and Wood (1998) suggest that an investigation of the approaches taken to the sexuality education of nurses, particularly in practice contexts, would be valuable. Teachers using critical social perspectives report that they were effective in changing nurses' views and practice in areas such as womens' health, HIV/AIDS and gay health

care (Boughn & Wang, 1994; Bower, et al., 1994; Cerny et al., 1996; Patsdaughter, Hall & Stevens, 1996). Such approaches recognise that the conservative values, attitudes and beliefs of nurses are socially constructed and part of the hegemony of dominant masculinist and heterosexist institutions (Foucault, 1976). Teaching approaches that utilise critical social theory include, inquiry based learning, critical experiential learning and feminist perspectives and teaching processes (Boughn & Wang, 1994; Cerny, et al., 1996; Patsdaughter et al., 1996). There is, however, a lack of information about the implementation of critical social learning strategies for sexual health care generally or for heterosexual men's sexual health.

Putting aside prejudice is a constant theme in the literature about sexuality. Hayter (1996) discusses approaches to changing nurses' prejudices towards sexuality and gay sexual orientation and concludes that creating destructive dissonance is not a solution. Hayter does not discuss the critical social learning strategies that have been successful in increasing nurses' awareness of the health effects of heterosexism and sexism. To be effective in changing attitudes, educational strategies that enable nurses to develop an awareness of their political responsibility for change need to be implemented (Bevis & Watson, 1989; Carr & Kemmis, 1986; Delacour, 1991; Miller, 1997). Researching sexual health practice realities informs educators of the potential opportunities nurses have to intervene and advocate for social change.

Feminist perspectives offer an approach to sexuality education that theorises the social difficulties in which sexual health care takes place (Few, 1997). Sexuality, sexual abuse and rape are examined in the context of societal gender/power relations. Nurses are enabled to develop self-awareness and autonomy related attitudes and behaviours, such as advocacy for the self and others (Boughn & Wang, 1994). This perspective also highlights the social responsibility of the nursing profession to provide care for marginalised groups (Bevis & Watson, 1989; Hall, et al., 1994). Nurses need to be able

to question independently the role of stigma and prejudice in relation to maintaining patterns of social sexual dominance (Few, 1997; Hall, et al., 1994).

Sexual health nurses are confronted daily with the social problems of sexuality, but how they explain and resolve this is unknown. Educational perspectives informed by social constructions of sexuality and of power relations problematise sex (Few, 1997). Conceptual understandings of sexuality are widely theorised but rarely correlated with what occurs in nurses' encounters with patients. The impact of feminism and of the women's health movement on the practice of Family Planning nurses is explored by Joffe (1986) but has not been investigated in the context of sexual health services. Key aspects of the feminist health agenda have been women's rights to knowledge about their bodies, the demystification of medicine and a belief in advocacy for clients in health care settings. Specifically how this related to sexual health care settings and particularly interactions with male clients is unknown.

Nursing education based on practice information derived from sexual health care is lacking. Studies show that levels of knowledge and attitudes are not good predictors of the quality of sexual health care (Giddings & Wood, 1998). In spite of this finding there is a singular focus in nursing education on changing nurses comfort with the practice of sexual health care (ENB, 1994; Kautz, Dickey & Stevens, 1990; Lewis & Bor, 1994; Rafferty, 1995; Stephenson & Lee, 1998). Lewis & Bor (1994), reported that sexual health history taking continued to be avoided and a source of discomfort and embarrassment for nurses, in an admission ward in a London hospital, even after completion of training in sexuality. It is clear from the study conducted by Lewis and Bor (1994) that more is needed to inform and advance nursing practice than liberal attitudes and sexuality education programmes.

The literature on sexuality education for nurses does not include care for the client who has been sexually abused or raped (English National Board for Nursing, Midwifery and

Health Visiting (ENB), 1994; Grigg, 1997; Paul & O'Neill, 1983; Savage, 1987). Existing concepts of sexuality ignore sexual violence, trauma and the impact that this has on sexual identity and behaviour (Kitzinger, 1990a; Kitzinger, 1990b). Nursing care involving sexual health will require more than an attitude change and may include managing extreme distress, dissociation and flashbacks (Kitzinger, 1990a; Kitzinger, 1990b). Current studies add little practical and theoretical knowledge to client management when clients have been traumatised. Models of nursing care and management that incorporate the clinical and psycho-sexual aspects of nursing care for clients who have been sexually assaulted are relevant to sexuality education.

PERSPECTIVES ON CHANGING SEXUAL BEHAVIOURS

Promoting healthy sexual behaviours in nursing practice has traditionally been limited to clinical interventions such as the teaching of contraceptive methods and condom use (Irwin, 1997). Nursing strategies to reduce unplanned pregnancies, STD's and HIV have largely focused on individual lifestyle changes. Typically, promoting sexual health as a nursing activity has meant information giving to increase client awareness of risk. In sexual health services nurses have developed a counselling role to address the psychosocial aspects of client care to promote sexual behaviour change (Swanson et al., 1999). In terms of clinical practice, importance is attached to the development of communication, counselling skills and behavioural interventions (Hiltabiddle, 1996). Nurses learn techniques for establishing quick rapport, develop acuity for non-verbal communication and body language and learn to make quick interventions. Counselling techniques such as brief therapy, motivational interviewing and neurolinguistic programming (NLP) have been incorporated into sexual health nursing care. Nurses are integrating and recognising therapy as part of care whereas previously they would have referred the client to a counsellor or psychotherapist (Irwin, 1997). Swanson (1999) in a study of young adults with genital herpes tested the outcomes of group psycho-educational interventions. The groups were facilitated by nurses in the community and focused on reducing sexual health risks and healthy psychosocial adaptations to genital herpes. The study concluded that the experimental group had significantly more

knowledge than the control group and also reported more frequent condom use. Little research appears to have been directed at developing practice based models of sexual and reproductive health nursing psychosexual interventions. In practice the processes of making a therapeutic alliance with the client from the first introduction, through history taking and examination, is unknown.

The processes and procedures established by nurses in managing complex client issues within organisational and time constraints effectively become the public policies they carry out. Joffe (1986), discussing the role of Family Planning workers, emphasises the importance of 'front-line' staff in the development of social policy. Nurses are involved in community interventions to change sexual behaviour in New Zealand however, their participation in safer sex campaigns and other health promotion activities has not been discussed in the literature. Research has found a correlation between adolescent culture, high-risk sexual behaviours and drug and alcohol use (Elliot & Lambourn, 1999; Hiltabiddle, 1996). It is not known how or if sexual health nurses assess for other risk behaviours when taking a sexual health history.

Nurses have a role in encouraging women to protect themselves in their sexual lives and relationships. It is argued that nurses need to incorporate an awareness of sexual disempowerment processes, inequalities and power relations for safer sex education to be effective (Boughn & Wang, 1994; Few, 1997; Irwin, 1997; Miller, 1997). Safer sex messages tend to ignore the context of women's sexual status in society (Gavey & McPhillips, 1999). Changing the lives of individual women at risk, in practice, involves a complex of interventions. The literature on health promotion emphasises the nursing profession's responsibility to effect social change but there is however, little information about how this could be achieved in clinical practice. The nursing role in reinforcing or challenging wider social sexual issues is discussed in the literature, but it has not been researched in practice (Boughn & Wang, 1994; Few, 1997; Irwin, 1997; Miller, 1997).

Irwin (1997) addresses the social, political and cultural context of nurses as sexual health promoters. A professional focus on lifestyle change to prevent disease is identified as largely ineffective. Irwin argues that sex is not perceived in general as a health issue but rather an issue of pleasure or danger and that therefore the concept of healthy sex within health promotion is outside the meaning that sex represents in peoples' everyday lives. The prevailing approach to promoting sexual health is to medicalise sex by focusing on research into sexually transmitted diseases. Changing sexual behaviour patterns involves more than identifying rates of STDs and HIV in at risk subcultures however. Models that are behavioural and biomedical oversimplify the complexity of sexuality and sexual health as Browne and Minichiello (1998, p. 29) state:

> We need to better understand how a patient's 'sexual story' is obtained as a complex of negotiation between clinician and patient ... research programs that identify how sexual stories, once obtained, are used by clinicians to formulate an intervention or management program appropriate to the patient's interactive, relational, psychologic and socio-behavioural barriers to safe sex are essential.

Irwin suggests that models of prevention, based on social construction theory, allow the development of multiple strategies according to the cultural context of the target group and the sexualities of the people being educated (Few, 1997). Investigations of the strategies used by experienced nurses in the field have value for promoting sexual health. Few conclusions can be made about nurses' health promotion styles and practices without local investigation.

The discourse that is absent is that of health promotion for heterosexual men. Taylor (1995) is one of the few authors reviewed who acknowledge that men are also constrained and limited within current societal expectations of their sex-gender roles. What is sexually healthy and for whom, in an environment of increasing and dangerous infections and sexual inequality, concerns nurses in practice. Multiple strategies and

discourses are needed to promote the interests of men and women, sexualities, and lifestyles. While the literature addresses safer sex promotion for targeted 'at risk' groups it does not address the practice complexities of multiple interventions for different genders, diverse sub cultures, lifestyles, communities, and social networks. An overview of current strategies reveals inconsistencies, contradictions and inadequacies for promoting sexual health in contemporary society. The differences between managing safer sex interventions with male and female clients are important and poorly addressed in the literature.

CONCEPTS OF MARGINALISATION, DIVERSITY AND DIFFERENCE

Academics in public health nursing have utilised marginalisation as a guiding concept for identifying vulnerable and diverse populations (Canales, 1998; Hall, Stevens & Meleis, 1994; Ramsden, 1993; Wood & Schwass, 1993). This framework has been applied to conceptualising sexuality in the nursing literature. The contemporary politics of the gay and lesbian movement, of body positive groups and of rape and sexual abuse survivors have been incorporated into health discourse in the last two decades (Plummer, 1995). Concepts of sexual inequality, marginalisation, exploitation and powerlessness have been utilised in research, theory development and practice. The focus of the literature relating to sexual health care has been the scapegoating of groups of sexual 'outsiders' to reinforce a single heterosexual moral 'reality' (Hall et al., 1994; Hitchcock & Wilson, 1992; Missener et al., 1997).

Recognising sexual diversity and difference has become an issue of human rights in health care (Gray et al., 1996; Hawthorne, Liggins, Rampton & Wille, 1993). Accordingly, traditional professional language and assumptions about sexual relationships have been deconstructed to include multiple realities. In the words of Plummer (1995, p.147), society is moving to '*a radical pluralistic, democratic, contingent, participatory politics of human life choices and difference*'. Public sexual story telling has played a significant role in raising awareness and transforming the

social order. The stories of HIV positive people, of gay relationships and of abuse survivors have become highly public (Fonow & Richardson, 1992; Herman, 1992; Plummer, 1995; Plummer, 1999; Worth, 1997). How this awareness has been incorporated into nursing practice has not been studied. Sexual health nurses constantly hear private sexual stories unspoken in the community. From a nursing perspective it is of importance to reflect on the relatedness of public and private discourses of sexual lives. Populations attending sexual health services are hidden and their vulnerability unknown except in poor health statistics and the privacy of the practice setting.

A study by Carr (1996), of representations of sexuality in nursing discourses, found that concepts of sexual normality were significantly challenged and changed by the adoption of diversity and difference politics. Through thematic analysis of articles relating to sexuality in the *Nursing Times* from 1980 to 1990, the language used to construct sexuality was examined. Throughout the decade under study the inclusion of sexuality as part of a holistic concept of care is thematic, but this frequently occurs in the context of discussion about groups which constitute a problem for health care in terms of their lifestyle and stigmatised diseases (Hall, et al., 1994). To illustrate this, Carr argues that there was a shift in the conservative moralising discourse of nursing publications to more liberal views towards sexuality with the impact of HIV/AIDS. The impact of feminist activism on nursing discourse is not noted and presumably is not apparent within the texts under study. Carr's categorisation of texts precludes organisation around thematic representation of sexuality from the perspective of gender-power relations (Few, 1997). The claim that the inclusion of sexual diversity concepts has brought about a paradigm shift in discourses of sexuality in nursing is unconvincing.

In the late 1980's there was a marked shift in nursing theory away from reductionist, medical problem-solving approaches, towards social and political analyses of sexuality. Carr (1996) concludes that this change occurred as a direct response to the political and social pressure exerted by gay activists and not as a response to the development of holism in nursing knowledge which includes sexuality. Carr claims that challenges to

societal homophobia have had a marked impact on nursing discourses. While a shift away from heterosexist dominance in sexual health discourses is emphasised, the continuing effects of sexism on the sexual health and lives of women are not discussed (Delacour, 1991).

Carr (1996) identifies the limitations of confining the study to one nursing publication, the *Nursing Times* which does not specifically focus on sexuality issues and reflects a British point of view only. The study reports the successful liberalisation of nurses' attitudes towards homosexuality as a direct result of the pressure of gay activism. The conclusion is misleading in that it is concluded that therefore all sexualities are equally empowered in sexual and reproductive health care discourses and in practice. In the study the impact of feminist activism on nursing discourse is not noted and presumably is not apparent within the texts under study. The categorisation of texts precludes organisation around thematic representation of sexuality from the perspective of gender-power relations (Few, 1997). The discourses of women, lesbians, sex workers, sexual abuse survivors and ethnic minorities are not included in the thematic analysis undertaken by Carr. The sexualities of women in effect are thematically excluded and therefore marginalised.

Discursive analysis of nursing perspectives on the sexual exploitation, assault and rape of women is missing in this theoretical framework. In a framework that privileges majority heterosexual culture, women's sexual lives and difficulties are not problematised. Conceptually discussing sexual health care on the basis of marginalised sexualities ignores the sexual vulnerability and coercion of women. The sexual realities that present in everyday practice as the clinical concerns of nurses in sexual and reproductive health care are not evident in the literature. The relatedness between social critique and the practice experiences of nurses in sexual health care need to be examined (Maxwell, 1997).

A greater awareness of marginalising discourses has led to considerable professional attention to language that is free from heterosexual assumption and bias (Bor & Watts,

1993; Ross & Channon-Little, 1993; Van Ooijen & Charnock, 1994). The neutralisation of language is a device for gaining trust and rapport with clients and for obtaining an accurate sexual health history. The terminology used in sexual health services is inclusive of a range of sexual relationships; for instance partners are referred to instead of wives, husbands, boyfriends or girlfriends. Instructions to practitioners on sexual health interviewing skills are careful not to stigmatise the sexuality or lifestyle of clients (Hicken, 1994; Irwin, 1997; McCorriston & Law, 1993; Nelson, 1997). Other aspects of management are, however, less explicit and a matter for investigation. The literature on marginalised populations provides little information about the range and complexity of the lives of people in the care of sexual health clinics.

Health discourse has recognised sexuality as a social construction (Few, 1997. Conceptual awareness of sexual behaviours, identities, and orientation has been incorporated into clinical guidelines, generally in relation to male sexual activity (Ross & Channon-Little, 1993). It is recognised that behaviours are not necessarily consistent with identity and that identity politics is itself a construction (Weeks, 1985). In health care the term "men who have sex with men" is used to refer to males who have sex with males, as the "homosexual" description does not include all male to male sexual practices. Clients' relationships are categorised into "regular", "casual" or "multiple" partnerships. Sexual partnerships are a matter of personal choice that is value free. In postmodern terms all sexualities are equal (Foucault, 1979, 1976). This language is definitely preferable to the judgmental terms previously used such as "unfaithful" and "promiscuous". Deconstructed medical discourse has attempted to avoid dominant heterosexist discourses (Few, 1997). Detecting changes in sexist discourses has been given less theoretical attention in relation to sexuality in the nursing literature. Concepts of marginalisation have had a profound impact on shaping nursing education and in creating safer health care environments for cultural minorities (Canales, 1998; Hall, Stevens & Meleis, 1994). In New Zealand standards of cultural safety have been widely adopted and endorsed by the profession of nursing (NCNZ, 1996). The engagement of professional leadership in changing health care for culturally marginalised peoples has deep significance for changing attitude and practices to sexuality:

> ... the first was that the power holders in nursing education had to be convinced that there was credibility in changing the curriculum to include an intensive process of historical and cultural self examination for students. The second was that this process had to be related to nursing practice (Ramsden, 1993, p.7).

Theories of marginalisation enable communities to have a voice in health care, but not all vulnerable health care populations constitute communities who want to be identified or to speak out. Health professionals are the only visible representatives of the sexual health problems of clients. The health politics and status of people who visit sexual health clinics have not been addressed in this paradigm. Concepts of advocacy and empowerment need to be addressed by health professionals in relation to the specific social issues of having an STD. The generation of theoretical explanations about nurses' encounters with their clients in sexual health settings uncovers the social problems occurring in that context.

A review of the literature shows that there are no paradigms for the management of the stigmatisation process for sexual health care. Cultural safety in New Zealand is an examinable professional subject. The sensitivity and safe practice required for sexual and reproductive health, while an integral and essential part of nursing care does not receive the same attention. Definitions of cultural safety are informative for care involved with sexuality. Wood and Schwass (1993) define culturally unsafe practice as any nursing actions that diminish, demean or disempower the client. Culturally safe behaviour is to recognise, respect and acknowledge the rights of the client. The Nursing Council of New Zealand adopted the principles of cultural safety and believes that through a process of education "social and personal attitudes can be identified and changed if they have negative implications for cultural safety" (NZNC, 1996). Specific frameworks have been developed for changing attitudes in cultural safety. The model of

education outlined by Wood and Schwass (1993) involves movement from sensitivity, to awareness, to safety. The process begins with consciousness-raising about the cultural realities and attitudes that nurses bring to their work and clients. History and culture shape psychological responses. The model recognises that people respond to 'foreignness' with fear, dislike, and distrust and that these are complex and intense cultural attitudes that are deeply embedded and difficult to shift. Through a process of values clarification and analysis, support and challenge, new information and insights are gained resulting in liking, trust and respect for other cultures. The model has not been related to sexuality, although research suggests that something threatening is being encountered by nurses when they are required to talk about sex (Browne & Minichiello, 1998).

SOCIAL ISSUES IN THE MANAGEMENT OF SEXUAL HEALTH CARE

Sexuality is addressed as if it is a marginalised topic of discussion although sex is a common social interaction. However normal sex is, talking about sex is taboo and much clinical talk is hampered by professional sexophobia (Browne & Minchiello, 1998). Brandt and Jones (1999, p. 16) describe this behaviour as pathological:

> In the case of STDs, the stigmas associated with sexual behaviour are often transferred to the diseases transmitted by that behaviour, often resulting in denial and clinical awkwardness. Thus social pathology is superimposed on top of the clinical pathology of the disease.

While health care practitioners have a trusted position in society as discreet and confidential, they are reluctant to learn the skills of communication required to deal with patients' sexual concerns. There are numerous guidelines on obtaining a sexual history from the client, most refer to the management of embarrassment. The nursing skills involved in managing embarrassment have become a focus in the literature about sexual health care, managing shame has not.

SHAME

Theoretical frameworks for the stigmatisation of people who have HIV/AIDS and STDs discuss the processes of scapegoating and labelling whereby shaming occurs (Gilmore & Somerville, 1994). The second component of sexual health described by WHO in 1986, is "Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships". Shame has not been theorised as an issue of nursing management. Shame entails self-blame or self-disgust, whilst embarrassment arises from concern with one's public image. Meerabeau (1999) identifies shame as more devastating than embarrassment. Shame undermines what it is to be a worthy human being, whereas embarrassment relates to idiosyncratic conceptions of the self. Meerabeau concludes that current research data are too patchy to give clear guidelines for professional practice that involves embarrassment and shame, and that the issues should be explored in a more systematic way in multi disciplinary professional education.

STIGMA

There has been little research into the effects on nursing practice of the stigma associated with STDs. Stigma alters the interactions between health professionals and their clients and leads to discriminatory and prejudiced treatment. Stigma is particularly linked with STDs because of the association with people considered to be deviant and immoral. The association of morality with disease alters social and professional

interactions, the consequence of which is discrimination or prejudicial treatment. As Brandt and Jones (1999, p.16) state:

> the presence of a sexually transmitted disease exposes the implicit presence of a certain sexual behaviour. The victims of that disease then fall victim to the stigmas of that behaviour.

People with STDs internalise stigma in a number of ways and such internalisations become issues of management for sexual health practitioners. How stigma is perceived and felt by clients is of critical importance in therapeutically managing care. Ross and Channon-Little (1993, p. 69) describe a hierarchy of social explanations for STDs. This hierarchy parallels the degrees to which clients internalises blame:

1. STDs are a deserved outcome of indiscriminate sexual behaviour and punishment for sexual sins
2. STDs are a consequence of individual inadequacy that leads to sexually indiscriminate behaviour
3. STDs are a consequence of a breakdown in traditional social values and rapid social change
4. STDs are the result of an individual coming into intimate contact with a virulent pathogen
5. STDs are a sign of being sexually active and a matter of pride.

An understanding of this process is important to practitioners in adopting counselling approaches that are appropriate to client perspectives (Joachim & Acorn, 2000). Having an STD has culturally embedded meanings. Individuals who have STDs are considered by society to be spoiled and are devalued. There has been little research about the meanings that STDs have to the individual or how best to manage psychological reactions.

Having an STD is not inherently pathological, immoral, or deviant, but it is considered to be socially unacceptable. Individuals with an STD, HIV and AIDS are stigmatised differently according to societal views of their 'innocence' or 'guilt' (Alonzo & Reynolds, 1995). Sexually transmitted diseases are associated with certain types of people who are generally thought to be irresponsible, immoral and promiscuous. To avoid labelling women who are found to have abnormal smears, health practitioners avoid stating that genital wart virus is the causative agent and that it is sexually transmitted (Braun & Gavey, 1999a; Braun & Gavey, 1999b). Discourse analysis reveals the extent to which health professionals in New Zealand will protect women from the taint of STDs (Braun & Gavey, 1998). Braun and Gavey (1999a) suggest that health professionals adopt strategies that disrupt the association between sexuality, cervical cancer, stigma and blame. How nurses counter stigma in sexual health nursing practice is not well understood. Brandt and Jones (1999, p.16) state that:

> The analysis of sexually transmitted diseases as a metaphor for sin provides insights into public and professional reactions past and present to people who are affected, and to those services which are provided for such people.

Treating STDs occurs in a hostile conservative climate. There has been no analysis of the impact that this has on the professional status of those engaged in sexual health work. Goffman (1963, p.40) describes the phenomenon of stigma by association as:

> they who share the noted person's stigma suddenly become accessible to the normals immediately around and become subject to a ... transfer of discredit to themselves.

Marginalisation and stigmatisation has not been discussed in the literature as a process that occurs towards health care workers who work with clients considered to be outside the norm. The process nurses engage to resolve the social difficulty inherent in managing care is not theorised in the literature. Strong and close collegial bonds were reported in a study by Joffe (1986) of American Family Planning workers as a response to intensive political attacks from sexual conservatives. The impact of moral conservatism on the work of sexual health nurses has not been investigated. Opponents of family planning services viewed the work of clinics as a leading cause of the breakdown of sexual morality (Smyth, 2000). The impact of public perceptions of sexual health services on the work of the nurse has not been studied. Sexual health nurses are distinguished by their colleagues as working with socially unacceptable clients, providing care that is not normal health care. Nurses in these settings however provide a necessary social function, the sociological importance of which has been unexplored. The public perceptions that nurses do 'dirty work', theorised by Lawler (1991) has not specifically addressed the issues of caring for the sexualised and sexually diseased body.

DEVIANCE

Gilmore and Sullivan (1994) developed a model to describe reactions of fear, stigmatisation, scapegoating, and discrimination towards people who have HIV/AIDS and STDs. They discuss the ancient dividing lines between 'them' and 'us' that result from these reactions and offer possibilities for professional counterreactions to scapegoating (Gilmore & Sullivan, 1994, p. 1339). Analysing processes of deviance and labelling are a means of representing the interests of the socially marginalised. Particular subcultures that visit sexual services, sex workers, homosexuals and injecting drug users, are targeted as deviant and stigmatised accordingly. Goffman (1963, p.164) identifies an important distinction in the social operation of the stigma process as it is applied to immorality and cultural difference:

> The stigmatisation of those with a bad moral record clearly can function as means of formal social control; the stigmatisation of those in certain racial, religious and ethnic groups has apparently functioned as a means of removing these minorities from various avenues of competition (Goffman, 1963, p.164).

The nursing practices that are engaged to counteract the stigmatisation of these groups are unknown. From an interactionist perspective individuals and groups in society label certain behaviours as deviant and act towards those behaviours in stigmatising ways (Plummer, 1975). Conflicting social sexual norms in interactionist terms become exchanges between 'deviants' and 'controllers' (Becker, 1963). Labelling is a powerful social process described by Becker (1963, p.9) as the means whereby insiders and outsiders are created:

> Social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label.

In sociological and psychological literature the correlation between stigma, prejudice and discrimination towards HIV/AIDs and STDs and the label of 'deviant' or undesirable is well recognised (Alonzo & Reynolds, 1995; Browne & Minichiello, 1998; Gilmore & Somerville, 1994; Plummer, 1995; Plummer, 1975). As an issue impacting on health care delivery, the relationship between social stigma and client 'popularity' needs greater recognition in nursing literature. Interactionists have not addressed the social processes of counteracting stigma.

THE SOMOLOGICAL APPROACH

Embarrassment is a recurrent theme in health care literature involving sexual issues. According to Meerabeau (1999) the effects of embarrassment have the most implications for nursing practice when matters of ' delicacy and privacy' are involved. Intensive levels of embarrassment are considered to deter staff from broaching the topic of sex and clients from seeking treatment and practising safer sex. Meerabeau explores embarrassment in interactionist terms as a theoretical explanation for the avoidance of sexuality discussion in health care. Such conceptualisation has not been informed by the everyday practice experiences of nurses who are prepared to broach the subject of sex with clients. Nursing activities that pose potentially threatening and embarrassing situations are the focus of a study by Lawler (1991). The methodologies of grounded theory and ethnography were used to explore everyday nursing practice. In the study of nurses working in medical and surgical settings in a Sydney hospital, the management of basic nursing cares that are intimate, such as washing the client, is investigated. Lawler uncovers, by means of observation and interview, the skilful negotiations that take place between the nurse and the client to maintain safety and dignity. The specific social sensitivities that nurses require in respect of sexual health care were not specifically addressed. The methodology used by Lawler is relevant to the present study as it addresses the difficulty that nurses have in finding language and description for what it is that they do when they are involved in intimate care. Otherwise, such care is socially hidden. An understanding of the body in a social context and the covert rules which structure the nurse and client relationship is termed somology.

At a practical level the study explores nurses' knowledge of bodily care. It is the kind of complex knowledge that nurses need to know in order to manage embarrassment, physical exposure, intimacy and sexuality. Research of this nature helps to explain the practical knowledge needed to improve nurses' ability to take sexual health histories and to discuss sexual health care with their clients. The nature of the questions raised by the grounded theory methodology allows Lawler to get at the sensitive, silent, submerged aspects of nursing practice and to allow nurses to articulate their professional

knowledge. The social difficulties that nurses have in carrying out this care are made overt. In the study undertaken by Lawler nurses experience feelings of embarrassment and discomfort, in spite of the professional permission that they have to cross social norms about touching (Estabrooks & Morse, 1992; Lawler, 1991; Savage, 1987). Lawler discusses public perceptions that nurses are involved in 'dirty work' (Lawler, 1991). In particular work involving sexualised parts of the body is considered socially taboo in society.

SUMMARY

In the literature reviewed in this chapter, it is evident that the role of the sexual health nurse is a complex process. The evolution of sexual health nursing is dynamic and changing according to emerging epidemiological trends, shifts in legal and moral climates and changing patterns of sexual lives. Managing interactions with clients in sexual health care involves being a clinician, counsellor, educator and community worker. A review of the professional education provided for nurses to improve sexual health care and health promotion demonstrates that little change has occurred in practice. The literature indicates that simplistic explanations for the difficulties of managing sexual health care have limited value in improving nurse's attitudes and practices. Feminist and social constructionist perspectives offer explanations for the cultural and social practices that shape values and attitudes towards sexuality. A symbolic interactionist approach offers analysis in health care settings of the social phenomena of embarrassment, stigma and deviance. In order to uncover skills that nurses have in managing social difficulties, Lawler has used somology, an interactionist approach to study the social processes occurring with clients to allow routine intimate nursing cares in general settings.

The broad question of the present study is " How do nurses manage their encounters with clients in sexual health care settings?" This inquiry is open-ended as is typical of the grounded theory methodology. The general question allows the researcher to get at

what is going on in the setting of sexual health care in the interactions between nurses and their clients. This is explained in terms of the basic social and psychological processes that occur in a particular setting. Further areas of research exploration emerge from the data when interactional processes are understood and the conditions and contexts investigated. In the next chapter the research methodology used in the study is described and the design and method, study participants, setting and ethical considerations of the research are discussed.

CHAPTER THREE

RESEARCH METHODOLOGY

Research in the area of sexuality and nursing management presents methodological challenges. The line of inquiry chosen has to be suitable for probing socially sensitive issues because the work under study is unconventional, controversial and considered by some 'dirty' (Cowles, 1988; Lawler, 1991). Sexual health nurses are private and protective about how they manage client encounters. The subject is socially awkward and embarrassing. While the technical aspects of routine care such as genital examination, cervical smear taking and screening for sexually transmitted infections are obvious the psychosocial aspects of management are not.

These observations are the starting point for this research, which is principally concerned with uncovering the reasons for the difficulties inherent in sexual health delivery and the construction of care to overcome this. The method best suited to this project is one that identifies, explores and describes the social processes, meanings and significance of sexual health care and that aims to generate theoretical understanding. An awareness of the wider social and historic contexts of nurse and patient interactions in sexual health clinics adds to an understanding of what occurs in practice (Kirby & McKenna, 1989; Plummer, 1999).

In this chapter the research methodology used in the study is presented. In introducing the chapter the congruence of grounded theory with the research topic is explained through description of the philosophic paradigm, evolution in the social sciences, and methodological perspective. The applicability of grounded theory to the study of sexuality care is explored. The steps taken to maintain an ethical approach are described. In conclusion, issues of rigour are addressed in relation to qualitative methodologies specifically in the area of sexuality.

PARADIGMS OF INQUIRY FOR NURSING RESEARCH

Historically qualitative methodologies have dominated nursing research. From the late 1930s to the 1960s lines of inquiry for medicine and nursing research were positivist and derived from objectivist philosophies (Hutchinson, 1993). Objectivism during this period was at the forefront of the theoretical perspectives of the social sciences. In the 1960s however, positivist theorists lost their dominance in sociology and health research with radical social unrest, and the reaction to the majority views enshrined in quantitative research methodologies. New lines of inquiry were demanded by minority groups and by the feminist movement that would represent oppressed and marginalised lives (Hutchinson, 1993). A post positivist paradigm shift occurred. In science there was a move away from the objective view that reality was provable and testable by independent researchers, through the hypothetical prediction and control of variables (Annells, 1996). A new epistemology, constructionism, rejected the notion of objective truth. The constructivist stance is that:

> all knowledge and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context (Crotty, 1998, p. 42).

The development of scientific approaches to cultural interpretations of social life led to radical changes in lines of inquiry. New research paradigms evolved to interpret and explain human and social realities. The qualitative methodologies that evolved were legitimated as valid scientific studies. Symbolic interactionism emerged as a theory about why humans behave as they do and a method of inquiry about human conduct and collective behaviour (Annells, 1996).

A BACKGROUND OF SYMBOLIC INTERACTIONISM

The foundations of symbolic interactionism were laid in the 1920's by W.I. Thomas and Charles Cooley, two American sociologists (Annells, 1996). This tradition maintains that the relationship between the self and society is an ongoing process in which people make sense of social interactions and interpret social symbols such as language, clothing and religious objects, in order to create a social reality (Burns & Grove, 1993; Lo Biondo-Wood & Haber, 1994; Plummer, 1991; Polit & Hungler, 1997). Symbolic interaction theory explores how people define reality and how their beliefs are related to their actions.

The social background to the evolution of qualitative theoretical perspectives was the rapid change occurring in American society in the 1920s. At this time the trend towards industrialisation brought urbanisation and mass immigration. There was a proliferation of qualitative community studies of the 'alien others' by ethnographers such as Robert Park and Robert Redfield (Denzin & Lincoln, 1994). This data was being used to highlight the conditions of the migrant and urbanised poor. Photographs, portraits and interview materials were used to bring about social change in these conditions (Hutchinson, 1993). During the 1920s and 1930s, sociologists used qualitative strategies extensively to study such social phenomena as race relations, ethnicity and delinquency. In an era of American Pragmatism the work of Dewey, Mead and Pierce was notable for an emphasis on social action and problem solving.

Mead, who taught philosophy at the University of Chicago at this time, argued that definitions of social and antisocial activities were socially constructed and learned through the socialisation process (Annells, 1996). Mead, a social psychologist, was a leader in the development of symbolic interactionism in the 1930's (Lo Biondo-Wood & Haber, 1994). He theorised that social life is based on meanings, which are shared by groups. Symbolic interactionism takes an approach to understanding and explaining human interactions and society and establishes a set of assumptions. Basic social interactions such as language, communication and interrelationships are given meaning

in human society. People act on the basis of their interpretation of these interactions. Through the processes of social interaction we develop the attitudes, values and beliefs of a community. In essence, it is about the process of becoming human, being able to put ourselves in the role of others. In Crotty's words:

> This role taking is an interaction. It is symbolic interaction, for it is possible only because of the 'significant symbols'- that is language and other symbolic tools- that we humans share and through which we communicate. Only through dialogue can one become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent. Hence the term symbolic interactionism (Crotty, 1998, p. 75).

The centrality of taking the perspective of the other aligned the theoretical perspective of symbolic interactionism with the methodology of ethnography. Ethnography has been applied widely in health research and has formed a number of theoretical approaches. The dramaturgical approach is especially associated with Erving Goffman (Crotty, 1998). Studies of this nature view people interacting in life situations as on stage. Social rituals can be explicit or hidden. This form of interactionist research identifies the meanings and outcomes of social rituals. Goffman's work on stigma and embarrassment has formed the basis for the study of behaviours of people in the uncomfortable situations of healthcare settings (Goffman, 1963; Goffman, 1956; Emerson, 1970; Meerabeau, 1999). Another form of interactionist research studies deviance in society. Labelling theory emerged from ethnographic studies that looked at the ways in which certain individuals and groups in society become labelled as 'deviant'. Becker (1664) explores deviance from a symbolic interactionist perspective studying the process of labelling and why it is that society excludes some members. Symbolic interactionist studies of this nature are widely considered to represent the interests of the socially marginalised.

The development of theoretical ideas in grounded theory can be viewed as a specific form of ethnographic inquiry. The carefully planned steps that form the basis of analysis

are grounded in the data from which it derives. Grounded theory emerges from the vigorous debate that took place between sociological theorists over methodology, from the 1930's and 1960's. The debate focused on the verification of qualitative research. Sociologist Herbert Blumer, previously a student of Mead, coined the concept symbolic interactionism and refined and developed the theory. Symbolic interactionism provides the philosophic perspective of grounded theory. Advocates of the use of quantitative methods to verify sociological research also exerted their influence during this period. The influence of the two opposing schools of qualitative and quantitative American sociology led to the development of the methodology of grounded theory by Glaser and Strauss.

THE EVOLUTION OF GROUNDED THEORY

Glaser and Strauss (1967) viewed the intense debate in sociology not as a clash of quantitative and qualitative methodologies but as a difference of emphasis on either the verification or generation of theory. Chicago University where Strauss was trained adhered to constructionism and naturalist paradigms of inquiry. Glaser on the other hand was trained in quantitative methodology at Columbia University, most notably by Lazarsfeld. Glaser (1992) emphasised the importance of acknowledging this analytic heritage and the procedures of inductive quantitative analysis developed at Columbia University during the 1950s and 1960s. Quantitative analysis underpins the analytic methodology of grounded theory and involves sampling, coding, reliability, validity indicators, frequency distributions, conceptual formalisations and hypothesis construction (Glaser & Strauss, 1967). Glaser and Strauss validated the use of both approaches to create sociological theory. While rejecting the tenets of positivism, they did not reject the scientific rigour of empiricism (Glaser, 1992). The collaboration of Glaser and Strauss brought to qualitative inquiry, an examination of the researcher as objective. They looked at the influence of the pre-existing cultural values and beliefs of the researcher in the defining and interpreting of scientific standards (Strauss & Corbin, 1990). Glaser and Strauss challenged the expert, value free, independent observer stance of the scientist (Glaser & Strauss, 1967). Instead, they maintained that the

researcher's preconceived values and beliefs were inevitable and vital to the research (Hutchinson, 1993).

In the early 1960s Glaser and Strauss undertook a fieldwork study of dying in a hospital setting. In 1967 they published their work *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). The methodology provided the basis for uncovering and describing social phenomena in health care settings. Glaser and Strauss were co-originators of the methodology. Twenty years later as grounded theory became increasingly popular for social science research, methodological disagreements between Glaser and Strauss began to emerge. The publication in 1988 by Strauss of *Basics of Qualitative Research* has led to a divergence of methodology, a development claimed by Glaser to have undermined the logic of grounded theory which is:

> to ask two formal- not preconcieved- questions. They are: What is the chief concern or problem of the people in the substantive area, and what accounts for most of the variation in processing the problem? And secondly, what category does this incident indicate? ... (Glaser, 1992, p. 4).

Glaser asserts that the methodology developed by Strauss forces the data and results in 'derailing' grounded theory studies (Glaser, 1996). Glaser has continued to state his methodological opposition to the direction taken by Strauss in the 1980's (Glaser, 1998; 1996; 1995; 1994; 1992):

> *Basics of Qualitative Research* cannot produce a grounded theory. It produces forced, preconceived, full conceptual description, which is fine, but is not grounded theory. (Glaser, 1992, p.3)

Glaser recognises that grounded theory is an evolving and creative methodology. Nurse researchers have in particular used models for grounded theory based on a basic social processes theoretical code (Birks, 1995; Christensen, 1990; McCallin, 1993; Wilson,

1997; Woods, 1997). Glaser comments that while a basic social process is only one theoretical code among many, they have emerged as producing a particularly rich grounded theory when used as a core variable (Glaser, 1996).

Glaser is emphatic that while researchers can become to some degree 'their own methodologists' they must, from start to finish, 'stick closely to the essential elements of grounded theory' (Glaser, 1994, p. 1). The present study has closely adhered to the core ideas of grounded theory as outlined by the co-originators, Glaser and Strauss and later developed by Glaser in *Theoretical Sensitivity* (Glaser & Strauss, 1967; Glaser, 1978). Applying the methodology accurately requires constant comparison and coding, theoretical sampling, memo writing, sorting, integration of the emerging categories and their properties, densification, and saturation.

THE METHODOLOGY OF GROUNDED THEORY

Glaser (1995) claims the utility of grounded theory for the health sciences, where social issues are crucial to the lives of both the participant and the professional. Nurses share common circumstances in particular practice settings. Inherent in the work that they do, are special social problems, which they resolve through social, psychological processes. These processes of shared meanings and behaviours may not be explicit and it is the discovery of these social processes, which is the basis of grounded theory in nursing (Hutchinson, 1993; Wilson, 1993).

THE UTILISATION OF GROUNDED THEORY FOR THE STUDY OF SEXUAL HEALTH NURSING CARE

Quantitative studies have had limited value in informing the practice of sexual health nursing care (Kautz et al., 1990; Lewis & Bor, 1994; Metcalfe & Waterhouse, 1991). The intention of the present study is to discover how nurses manage their encounters with clients in sexual health settings. This is practical information, which derives from the professional experience of the sensitive and intimate care of the client. Grounded theory is appropriate for this purpose as it has the ability to explore relatively little

known areas of nursing practice and to build theory inductively from data collected in the field (Glaser & Strauss, 1967; Lawler, 1991; Parahoo, 1997).

Research methodology that explores the social context of the care of the body is beginning to uncover why it is that intimate care is considered dirty, disgusting and socially unacceptable. Further, qualitative studies are beginning to uncover and to explain why it is that people inside and outside the profession of nursing avoid discussion of the intimate practices involving genital examination, except with derision and curiosity (Lawler, 1991; Savage, 1987). Lawler (1991) suggests that sexuality 'lies on the margins of what is considered dangerous and potentially polluting'. It is not seen as a suitable topic for public or professional discourse. This area of care is not normal, it transgresses social rules and boundaries (Lawler, 1991). There are no theoretical models which describe the social aspects of sexual health care (Savage, 1987).

A study of sexual health nursing practice has the methodological problems of a largely secretive and hidden culture that Lawler encounters in studying care of the body. Details of care are the private domain of nurse and client. Grounded theory allows the researcher to make explicit those practices which nurses take for granted. The experience of the expert nurse in managing sensitive care outlined in the study of somology makes a significant contribution to discovering the practices that enable the management of intimacy. The research indicates that the hidden barriers to sexual health care are discoverable by this methodology. Lawler suggests that professional role models and peer support are needed to change nursing behaviour and knowledge. This suggests the appropriateness for researching sexual health care, of methodologies that use in-depth interviews, in which nurses are able to describe how it is that they manage care and respond to their own and patients' anxiety and fears.

The hidden and privatised professional knowledge and skills of nurses in sexual health care practice can be better understood through an examination of their experiences. In daily practice complex and subtle social skills have been developed to deal with situations that are exposing, embarrassing, threatening and shaming. The social methods developed by sexual health nurses are transferable to other areas of practice including

midwifery, obstetrics and gynaecology, family planning and practice nursing. The discovery of the social processes of sexual health nurses has significance for teaching nurses how to structure care situations so that the client/nurse interaction is manageable during invasive and intimate procedures.

THE DESIGN AND METHOD OF THE PRESENT RESEARCH

The utilisation of the methods of grounded theory in this study is described in this section. The design of the study, setting, entry to the field, the procedures for the recruitment of participants, ethical considerations, data collection strategies, and methods of data analysis are indicated along with other concerns related to this study.

The study setting

The study occurred in a number of sexual health settings outside Auckland. Nurses at Auckland Sexual Health Service were excluded from interviews because the researcher's relationship to staff as nurse manager may have influenced the outcome of the research. Auckland nurses were however invited to participate as an expert panel, to critically examine the researcher's analyses.

Entry into the field

An initial approach was made to the manager of sexual health services in a formal letter requesting permission to approach nursing staff (Appendix One). Included with the letter was an outline of the proposed study and letters of introduction and information for potential participants (Appendix Two and Three). When the service managers had granted approval, nurses were then invited to participate. Seven services were selected for size and geographic location. It was important to locate as many potential participants in a single site as possible due to time and cost constraints. The study design provided a number of sampling locations around New Zealand, increasing the opportunity for confirming the establishment of categories, which were either common or different between nurses in distant settings.

Participant Selection

For reasons of time and the cost of travel, nurses in services closest to Auckland were first invited to participate in interviews. In total nurses in all seven centres selected, participated in the study. Nurses were selected who were willing to participate and had experience, in the past two years, working in sexual health services.

A sample of nine nurses was initially selected. The sample expanded to eighteen as initial participants advised the researcher of sexual health nurses in other services who would be interested in participating in the study. The practical limitations in regard to the number of informants available for the proposed study included the geographical distance to be travelled to sexual health services outside Auckland and the small numbers of nurses working in this field in New Zealand.

To introduce the study to potential participants, a letter of request for volunteers was sent to nine sexual health nurses working in services in the North Island (Appendix Two). When participants responded to the invitation, an information sheet entitled 'Research into the Management of Sexual Health Nursing Practice' was sent to them (Appendix Three).

Included in the initial information provided to potential volunteers was the following:

(a) That the intention of the researcher was to study the management of sexual health nursing practice.
(b) That nurses who worked in sexual health services currently or recently were invited to volunteer
(c) That agreement by volunteers to the research would involve one or more interviews and that cumulatively there may be up to four hours time involved
(d) That interviews would take place at a time and place convenient to the participant
(e) That typical questions asked would be

"Tell me about problems you have encountered in the practice of sexual health care?"

"Tell me about managing genital examination?"

"Tell me about managing the patient's discomfort?"

"Tell me about any problems which you may have had with inappropriate sexual behaviour?"

"Tell me about the perceptions that others in the nursing profession and in society in general have towards your work?"

(f) That the rights of the participant were to decline to take part or to withdraw from the research up until data was analysed, to ask any questions about the research, to refuse to answer any question, to ask that the cassette recorder be turned off, to examine any notes taken, to read their own subsequent transcriptions, to terminate the meeting at any time and to be informed of the results on completion of the research.

Volunteers were initially asked to make telephone contact with the researcher. Each volunteer was then contacted and sent the information letter (Appendix Two). The researcher then made arrangements to meet with the volunteer for further clarification and explanation. If the volunteer wished to participate in the study, written consent was gained (Appendix Four).

Procedures in which the research participants were involved

Nurses who agreed to take part in the study were asked to participate in interviews, a process involving one or more hours of audiotaping. Arrangements were made at times and places that were convenient to the participant. The interviews were conducted between June and November 1999. During the interviews a series of open-ended questions were asked. In addition to the audiotaping of responses, the researcher made written observations and reflections in the form of field notes and memos that could be accepted as data.

Procedures for handling information

The written consent forms of participants were held in a locked filing cabinet by the researcher. All data collected, including audiotapes, written material, and field notes, were stored in a locked filing cabinet separate from the consent forms, for the duration of the study. All research data was kept in strict confidence by the researcher, her supervisor and the transcriber of the audiotapes. The transcriber was required to sign a confidentiality agreement, stating that transcription would occur in privacy, that the confidentiality of tapes was assured and that tapes would be stored securely. Audiotapes were available to be returned to participants should they request this following the study.

The participants

The initial sample of nine participants increased to eighteen, as the researcher was given further names of nurses working in sexual health services, who were interested in the study. The participants work in both urban and rural settings. Nurses who participated had an age range from the twenties to the fifties, were male and female and Maori and Pakeha. Additionally, an expert panel of sexual health nurses at Auckland Sexual Health Services participated in a critical examination of the researcher's analyses. The panel was presented with the preliminary findings of data analysis but not the transcripts.

ETHICAL CONSIDERATIONS

Informed consent

The process and procedures of gaining informed consent by participants to this project followed the guidelines of the code of ethical conduct for research and teaching involving human subjects, (Massey University, 1994) and of the Health Funding Authority (1998) (See Appendix Four).

Anonymity and Confidentiality

All processes and procedures possible occurred to maintain the anonymity and confidentiality of participants. Participant consent forms were lodged with the supervisor of this project in a locked cabinet. Difficulties in guaranteeing complete anonymity were presented, as sexual health services in New Zealand are small and identifiable. It was possible that variations in the roles and practices of nurses in different locations might have revealed of the identity of the participant. Every effort was made to disguise the identity of participants, including the use of pseudonyms. To overcome any potential compromising of the privacy of participants, their permission was sought before data collected from them was published. Additionally their agreement was sought on the dissemination of research findings.

Potential Harm to Participants

For participants the process of reflection on their client interactions may have been psychologically sensitive. Every care was taken in conducting interviews to ensure that the process was not damaging to the participants personally or professionally. The participants understood that counselling services would be made available if this was encountered. At no time throughout the study was this required.

Potential Harm to Clients

To ensure that client anonymity and confidentiality was maintained, participants were informed in the subject information sheet that no identifying information would be used (Appendix Two). This was further explained prior to interviewing, when participants were requested not to use client names or to give details, descriptions or locations, which could be recognisable.

The Participants right to decline to take part

Participants were informed of their rights to decline to continue to take part at any time during the research in both the subject information sheet (Appendix Three) and the Consent Form (Appendix Four). Further, this was discussed with participants prior to the interviews.

Ethical Committees

Ethics Committee approval was gained in March 1999 from Massey University, Human Ethics Committee and the Auckland Health Funding Authority Ethics Committee.

Researcher Involvement

The researcher was involved in setting up interviews with participants. It is recognised in grounded theory, as in the case of this study, that the researcher will have more theoretical sensitivity in their particular area of expertise (Glaser & Strauss, 1967). Experience as a sexual health nurse was considered important in sensitising the researcher to issues concerning the management of interactions with clients, in sexual health settings. Glaser however warns the researcher who is familiar with the area under study to remain completely neutral to the phenomena under study and to resist the tendency to force the data (Glaser, 1992). In order to acknowledge bias a journal of personal reflections was kept as the study proceeded. The researcher used journaling to compare her own views and experiences of sexual health care with others in the field. This ensured that the emphasis remained on the data being analysed.

Artinian (1998) maintains that while the researcher's previous education and practice may influence interpretation and interview topics, it is only the concepts that emerge from the resulting data that are of theoretical importance. Previous knowledge is added to data collection and memoing, to provide comparison with and to expand the scope and density of emerging concepts (Glaser, 1978).

Data Collection Methods

Data collection included interviews with participants who were outside the Auckland area and with expert panel members at Auckland Sexual Health Services. Interviewing was chosen as the most effective method to get at sensitive issues (Cowles, 1988; Lawler, 1991). Participant observation of practice would have been inappropriate in sexual health settings. Nineteen interviews were conducted. Each of the participants was interviewed once over a period of six months and a second interview was conducted with two participants together, who worked in the same service. Interviews lasted from one to two hours. The last of the participants were able to expand on the theoretical leads established in earlier interviews. The ability to conduct second interviews with all participants was limited by the time constraints of the project and the distances to be travelled out of Auckland to meet participants.

Interview Structure

A semi-structured technique was used in each of the initial interviews. Questions related to the participant's experience of client interactions and progressed to areas of difficulty, strategies used to manage contexts and variations and the conditions under which these occurred (Appendix Seven). The researcher explored the way in which these processes had been learned using interview probes (Appendix Nine). The interviews allowed time for participants to question the researcher and for information from the session to be clarified.

After the first six initial interviews, further participants were presented with the emerging themes, for comparison with their own experiences (Appendix Eight). This allowed further exploration of the phenomenon under study. Constant comparisons established commonalities and differences between nurses in their interactive management and accounted for variations between them. This process continued until theoretical saturation was achieved and the information confirmed the data collected.

Throughout the research project, informal discussions with nurses, nursing students and doctors who work in sexual health were also held which gave more scope, meaning and accuracy to the data. Ongoing reading of the literature was also used in constant comparative analysis.

DATA ANALYSIS

Concept Formation

To begin analysing data and to ensure that the study was ' grounded', the researcher began a process of immersion in the data. Each audiotape was repeatedly listened to and transcriptions read and reread. Transcripts were analysed line by line. Simultaneously field notes and memos were made and became part of the constant comparative analysis. In the first three interviews, at the first sexual health service, the researcher began to look for meaning, patterns and uniformity within descriptive incidents. From the beginning to the final draft of the study every piece of data was compared with every other for commonalities and differences, underlying meaning, and concept formation. This was the substance of the data and the process, substantive coding, produced initial tentative codes.

Coding

The focus of early data analysis was to manage the volume of data by substantive coding. Pseudonyms were used to ensure participant anonymity in all quotations. Data was reduced into concepts and categories through line by line analysis. The purpose of this process is to label data to note what is going on. Looking for words, gerunds, which indicate action, does this. Initially the participant's language was used, to ensure that concepts remained factually grounded in the data as in the following example:

> But it's how they experience an STD. A lot of people experience an STD as a punishment. You know, I shouldn't have gone and had sex or I shouldn't have done this. You know

> I shouldn't have had sex before marriage … And experience us as punishers. So we're going to tell them off for having unprotected sex. We're going to tell them off for losing their pills. We're going to tell them off for being here or something. It's not until they've actually been here and got to trust us and seen what you're like as an individual, that they know they're not going to get that.
> (Jill, 1:253).

In this description, the initial tentative substantive code was "developing trust with the client" which was recategorised into the selective code " treating people with respect". This subsequently became part of an overall category of *respecting and dignifying*. Similarly:

> … I treat people in this room as I would want to be treated myself, so therefore, if someone trusts people in here enough, [to come into a sexual health clinic], the things that they think are going to happen which generally don't, you know, that we're going to shove these things into their penis, they've actually taken a huge amount of trust in coming in here. I think you need to just treat people with respect, that's the bottom line, I think for me. It doesn't matter who they are. Ninety nine point nine per cent of the people I really like. There's a couple of real creepers that come but I still believe that they deserve respect …
> (William, 1:102).

The initial substantive code in this case was " treating people with dignity" which was recategorised as the selective code of "treating people with respect" and later became part of the theoretical code *respecting and dignifying*. A further example of coding and categorising is:

> ... to be more aware of like, well I suppose about their fertility awareness and about keeping healthy so if they do want to have healthy bodies and look after themselves. So about having more empowerment for individuals so that they can say yes and no about choices and stuff. So I suppose some of the workers with, telling new sex workers that they have a right to their own bodies, they are going to say what they want, that just because a man's paid for them doesn't mean they've paid for whatever they want. So some of that is involved. So empowering people about their own choices is probably the biggest part and seeing what alternatives there are ... (Merryl, 1:180).

The substantive code from this statement was "teaching people to look after themselves" which was recoded into the selective code " empowering patients" and was later categorised as " teaching survival skills". The final broader theoretical category, which included this selective code, was *advocating and empowering.* In subsequent data analysis of interviews the researcher continued to categorise, building up a descriptive conceptual framework based on recurring incidents, social interactions and processes. As described by Glaser (1995) a circular method of simultaneously collecting, coding and analysing continued to the completion of the study.

Concept Development

Reduction of Categories

The development of theoretical concepts occurred through the process of reduction of categories. Participant pseudonym, interview and line number identified the substantive codes from transcripts. The substantive codes were printed and manually cut up and grouped according to similarity and difference under initial headings. When substantive codes had been refined into a selected code they were entered into the computer using Microsoft Word. These codes were then further revised to determine theoretical coding categories. Using this system a comparison of categories for each subsequent interview

was made to identify variations, overlap and lack of clarity in the data. Concepts were connected together by this process of reducing categories. The original categories could then be clustered together in a more abstract category, providing a context for analysing all incoming data. For example the initial selected codes "teaching women's rights", "preventing unwanted pregnancy", "encouraging good choices", "teaching safer sex", "teaching self care skills", and "raising awareness of lifestyle risks" were finally abstracted as the theoretical code *teaching survival skills.* As each theoretical code emerged all new data was compared with it for commonalities and variances. Previous tentative codes were recategorised and reorganised. Line by line data analysis amounted to one hundred and two thousand words. This was eventually refined into sixty-five pages of selectively coded text.

The initial data collection with three participants at the first sexual health service was continued with a further fifteen interviews of nurses in six other sites. The purpose of the interviews was to obtain adequate descriptions and interpretations in the participant's own words for data analysis. In the initiating stage of the interview administrative matters provided a 'warming up' period. The interviewer's focus was on ensuring privacy, comfort and openness. The interview began with an introduction and informed consent, secondly, background data and demographic data was collected. A general theme was introduced for each interview with open-ended questions. It was essential that participants could talk openly and honestly with minimal intrusion from the interviewer. As far as possible the researcher facilitated the discussion through interviewing techniques such as reflecting back and carefully chosen silences. The gathering of material in the participant's own words, in order to establish an authentic database for analysis, was critical in this phase of data collection.

In some interviews more probes and prompts were required than in others to enable exploration of particular issues and to meet the timeframe of the interview (Appendix Nine). The content and direction of each interview was varied with participants' responses. Initial interviews were minimally structured (Appendix Seven). In the analysis of the first three interviews, initial themes began to emerge. Subsequent interviews were therefore semi-structured to explore preliminary theoretical leads

(Appendix Eight). Participant accounts were compared, meanings clarified and variance in the data explored.

Selective sampling of literature

Once the researcher had become totally immersed in the data and emerging categories began to be integrated, selective sampling of the literature took place. The researcher searched for what, from that which had been written about the management of sexual health nursing care, would fit the emerging concept.

The reduction of categories into a conceptual framework, reinforced by relevant literature led to selective sampling of the data, from which gaps and problems were identified. The selection of further data was directed by what was being indicated about the study problem.

Emergence of the Core Variable

As descriptive categories were identified, it became necessary to explain the process or patterns of behaviour, which were occurring to resolve the problems encountered by sexual health nurses. At this stage a core variable began to emerge "counteracting the stigmatisation of sexual health care". This central process synthesised a number of related themes of social interactions and applied to a range of concepts and conditions. Glaser (1978) indicates that the core variable is realised when it accounts for most of the variation in patterns of behaviour. It draws together relationships between concepts and functions to integrate a theoretical framework.

Concept Integration

When the core variable *destigmatisation* had been identified, the process of selective coding was refined. A conceptual framework was produced, through delimiting coding only to those variables that related to the core variable. The significance of the emergent, theoretical codes are that they are relevant, workable and that they fit (Glaser,

1978). Through these means the theoretical framework integrated the substantive codes. The theoretical codes provided the means of testing the conceptual framework. The complex processes: the nature, context, conditions and potential consequences of the core variable were clarified using theoretical codes. Memoranda were made of theoretical statements as they occurred in order to keep track of the analyses. Theoretical coding was preparatory to the formation of the conceptual framework.

Conceptual Categories

An initial concept map was developed to depict the processes occurring in this study. The researcher identified a focus for the study and developed a hypothetical title, "Getting Close Enough", after months of intensive and repetitive analysis of data and personal reflections on professional experience. The preliminary concept map, "Getting close enough" was presented to the expert panel as a possible core category that would explain all the nurse/patient interactions in the data. Further questions arose from discussion with participants and colleagues concerning what it was that the nurse was getting close enough to do. The researcher recognised that what the data was conveying was that the social difficulty that nurses were resolving was the social stigmatisation of being a sexual health clinic client. The concept, "Getting close enough to counter the stigma of sexual health care", emerged from further discussion with colleagues. Conceptual maps were continuously tried and tested against the data for best "fit". "Getting close enough to counter the stigma of sexual health care" changed to "counteracting the stigmatisation of sexual health care" as the most inclusive core variable. This was represented to selected participants and expert panel members and was considered to have better "fit".

Simultaneously processes of parallel professional marginalisation were identified and had "fit" within the conceptual framework of stigmatisation and counterstigmatisation. Finally after months of discussion with participants and colleagues, and ongoing comparisons with an extensive range of literature, the core category *destigmatising sexual health care* finally emerged. A final conceptual framework best representing the phenomenon under study is shown in Figure Six: The Process of Destigmatisation (see page 83).

Memoing

As ideas about interrelationships in the data occurred, they were noted down. Memoing started early in the process of the constant comparison of data, as patterns and themes emerged. Initial memos were tentative becoming more 'grounded' as memos were sorted and ordered to cluster concepts into categories. This process continued until fit occured.

ESTABLISHING RESEARCH RIGOUR

A number of measures derived from Sandelowski (1986) and Sandelowski et al., (1989) were taken to ensure rigour in this study. Sandelowski adapted the criteria of credibility, dependability, confirmability and transferability from Lincoln and Guba (1985). Sandelowski (1993) offers a perspective on rigour that addresses the concerns and goals of nursing research. The four indicators of trustworthiness outlined by Sandelowski are audibility, credibility, fittingness and confirmability.

Audibility asks that the researcher provide evidence that independent researchers would reach the same findings, based on the same data. An audit trail was established that would determine if the conclusions and interpretations reached could be sourced to the data and were supported by the inquiry. The data available for review included: raw data, data reduction and analysis products, conceptual developments, process notes, material relating to hunches, questions, and recurring themes, and instrument development information (Glaser, 1998). Raw data included audiotapes and transcripts, both original and corrected as well as all memos and written field notes. A trail of reduced and analysed data was recorded in write-ups of the levels of coding and abstraction of transcripts, memos and field notes. Conceptual developments were mapped in notes of tentative conceptual frameworks, diagrammatic models and summaries. Process notes are apparent in the methodology of structured coding processes. Material relating to hunches and themes are recorded in the personal notes made in the form of memos and field notes. Instrument development information is attached as Appendices Seven, Eight and Nine. As recorded by Glaser (1992) the trail is demonstrated by means of a detailed research report and of the decision trail that was

used to arrive at conclusions. To enable this a full description of the data collection process was documented. In line with Glaser's (1992) approach the nature of the decisions made about the data and the reasoning behind the decisions on which they were based, was also recorded in the researcher's journal.

The credibility of qualitative research addresses the internal validity and truthfulness of findings and interpretations. If participants are able to recognise the phenomenon described in the study and its theoretical significance, credibility has been achieved (Glaser & Strauss, 1966). In this study the researcher sought verification of all transcripts by returning them to participants to crosscheck for accuracy and transcription errors. Verification of data obtained was addressed in presenting findings to participants to ensure that findings reflected participant experience. Participants in final interviews identified with the conceptual diagram of *destigmatisation*. The researcher utilised the critical reflections of an expert panel as a further means of validating the data analysis. For other readers and researchers, the description should be both meaningful and consistent with their experience. Comparison with existing theory and literature further establishes the credibility of the interpretation of meanings and processes uncovered from the data (Plummer, 1999). The researcher aimed to provide clearly argued links between the conclusions drawn from this study and the literature. Theoretical concepts related widely to a number of disciplines including sociology, psychology, nursing, medicine, psychotherapy and historical studies. The latter studies were important in the contextualising of the development of health care historically for sexually marginalised social groups by comparison with today. This level of analysis critically reflects on the wider social and historic phenomena of nurse and patient interactions in sexual health care.

Confirmability in qualitative research is indicated when the research accurately represents the reality it sets out to describe. Specific strategies were identified to ensure the applicability and truth of the present study. The sample of nurses represented a cross section of age range, geographic location, rural and urban settings, ethnicities, sexual orientation, and gender. The sample is diverse and yet descriptions of the social difficulties described and the processes of management used were remarkably

consistent. The researcher referred repeatedly to the interviews and questionnaire data when developing themes during data analysis. To authenticate the data, negative descriptions of the phenomena occurring in the study were requested in participant interviews and panel discussions. These conclusions were checked with participants on an ongoing basis. Each transcribed interview was printed and crosschecked for accuracy and transcription errors against the original tapes. The corrected version was then sent to the participant for confirmation of accuracy and further comment. The version resulting from this process is the primary data source for this analysis. During the process of coding, examples of negative cases and cases which did not fit emerging concepts, were looked for. The negative data either strengthened the researcher's interpretations or led to questioning of coding and classification as suggested by Glaser (1998). Confirmability was strengthened by the interview design, which tested the patterns and congruence of the data.

The conclusions of this study must be understandable and reasonable to others in different clinical settings (Appleton, 1995). Strategies for achieving fittingness were conducted in informal interdisciplinary discussion of the findings in order to verify the relevance of the process of *destigmatisation* to other professional and clinical settings. To test fit a formal presentation was made at a senior nurses' forum. Senior nurses reflected a range of experiences that related to the snippets of participant statements, theoretical concepts and the diagrammatic model presented. Of particular significance was the similarity of experience of nurses who worked in related fields such as urology and abortion services.

SUMMARY

This chapter discusses paradigms of inquiry in nursing research. The significance of the development of qualitative methodologies for the health sciences is outlined in the context of social movements. Social activism has brought new research methodologies and knowledge to nursing. The relevance for new paradigms of inquiry to this study are explained in the context of researching the phenomena of marginalised peoples and their social issues. Grounded Theory was chosen for this study as it enabled the phenomenon

of sexual health nursing care to be examined from a number of important perspectives. This methodology allows participants to describe their everyday realities, from which recurrent themes can be identified. By analysing the diversity of nurses' experiences in dealing with sexual health nursing care, their agency in resolving everyday complex social situations could be constructed. Grounded Theory offered for this study, a method of getting at a little known area and of developing plausible conceptual frameworks that could explain the contextual reality of nurses' behaviours. The descriptive data provides grounding for developing theory concerning nursing management of marginalised care. The process of constant comparative data analysis was outlined. This included reviewing the literature for comparison of the conclusions in this study and those reached by other researchers. The design and method of the study, selection of participants, data collection and analysis has been outlined. Ethical considerations have been explored and evidence of qualitative rigour in this study given.

In the next six chapters, the findings of the study are outlined and discussed. Each chapter identifies a key concept in the construction of the conceptual framework emerging from the process of grounded theory generation.

CHAPTER FOUR

DESTIGMATISATION

In the following five chapters the conceptual categories and codes derived from the current study involving nurses who work in seven sexual health services in New Zealand are presented. The core category that emerges from the data analysis is the process of the *destigmatisation* of sexual health care. This central concept, or basic core category, recurs frequently in the data, integrates and links data together and explains the major variations that occur in the emerging theoretical framework. Sexual health nurses understand stigma to be the main difficulty encountered by clients who visit sexual health services. Nursing interactions and interventions in sexual health services are underpinned by a knowledge of the impact of stigma on individuals and communities.

The process of *destigmatisation* reflects deep concern for the human rights of marginalised peoples and groups within New Zealand society. The basic social process of sexual health nursing discovered from the data is represented in the theoretical framework 'The destigmatisation of clients who attend sexual health services' (See Figure One). In this framework the process of stigmatisation is reversed during the process of *destigmatisation.* In the next five chapters the process of destigmatisation will be demonstrated through the exploration of the five conceptual categories generated from the data- *identifying with people, personalisation, respecting and dignifying, advocacy and empowerment* and *doing deviant work.*

THE DESTIGMATISATION OF CLIENTS WHO ATTEND SEXUAL HEALTH SERVICES

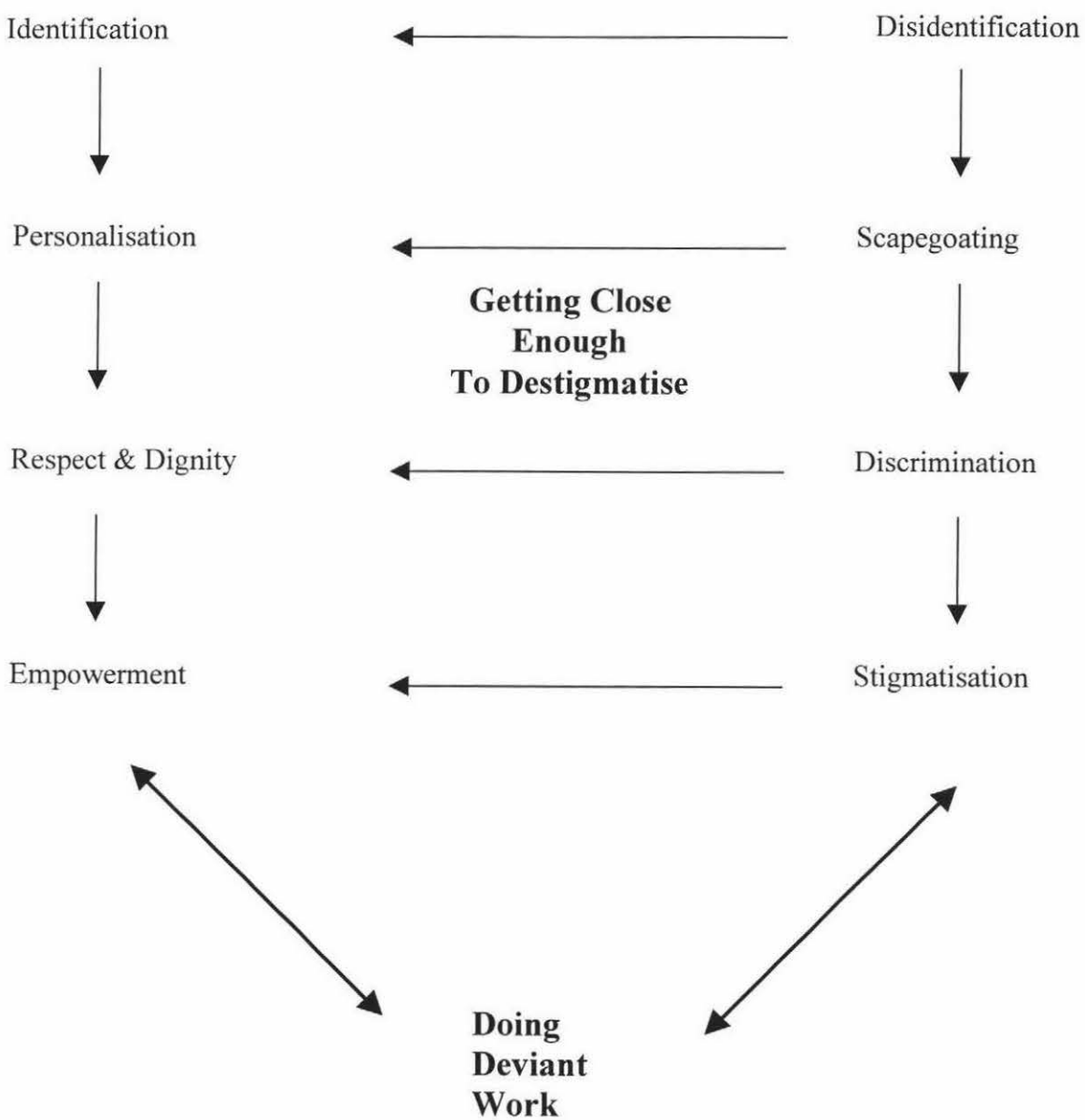

Figure One: The Process of Destigmatisation

DESTIGMATISATION

Stigma is a broad and multidimensional concept. Stigma is defined in the semantic sense in both positive and negative terms as "1. Mark branded on slave, criminal, etc. 2. Imputation attaching to person's reputation; stain on one's good name. 3. Definite characteristic of some disease. 4. Mark(s) corresponding to those left by the nails & spear at the crucifixion said to have been impressed on the bodies of St Francis of Assisi & others & attributed to divine favour" (Fowler & Fowler, 1964 p. 1262). Roget's Thesaurus (Dutch, 1981) defines stigma as to " label" and " slur" and to stigmatise as to "mark" and defame". *Destigmatisation* in the context of this study means that nursing interactions with clients who visit a sexual health clinic are designed to counteract and to overcome the stigma associated with this event. *Destigmatisation* is taken to mean the process of the restoration of dignity, respect and human rights. It also describes a simultaneous process in which the nurses who do this work themselves become stigmatised. This grounded theory of *destigmatisation* explains that the process is dynamic and changing to reflect the varying presentations and problems of stigmatisation within cultural, gender and sexuality contexts. In this sense the process of *destigmatisation* continually meets new challenges and requires the ongoing development of approaches to problem solving this phenomenon.

The concept of stigmatisation is well identified in the literature on the history of sexually transmitted diseases in New Zealand, the behavioural sciences, medicine, sociology and psychotherapy. Sexually transmitted infections were incurable until the advent of antibiotics in the 1940s (Brandt & Jones, 1999). Prior to this syphilis and gonorrhoea in New Zealand were difficult to treat. Venereal diseases were a serious threat as they could be fatal, commonly caused infertility, infected neonates and caused chronic debilitating illnesses (Tollerton, 1992). As Gilmore and Sullivan state stigma is a natural reaction (1994, p. 1339):

> When people ... are confronted with a frightening or intolerable situation ... and when escape or destruction is unavailable ... then denial or displacement, or possibly both are likely to be

> involved in the response. The measures used to achieve this can include disidentification, depersonalisation, stigmatisation, scapegoating and wrongful discrimination ...

Historically people with sexually transmitted infections have been stigmatised. Although medical treatment has been available for sexually transmitted infections since the 1940s, curable diseases such as chlamydia and gonorrhoea persist and are increasing (Brandt & Jones, 1999). Stigma continues to be a significant barrier to the prevention of curable infections when treatment is freely available. In health care it is considered that the client has deviated from the norms of respectable illnesses, and should be punished for doing so. In the words of Alonzo and Reynolds such individuals are treated as socially undesirable:

> In general, there is consensus in the stigma literature that stigma represents a construction of deviation from some ideal or expectation, whether the ideal is for 'correct' sexual orientation or to be free of a disfiguring or fatal infectious disease. At its most basic level, stigma from Goffman's perspective, is a powerful, discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons. When individuals fail to meet normative expectations because of attributes that are different and/or undesirable, they are reduced from accepted people to discounted ones. Thus, the discrepancy between what is desired and what is actual, 'spoils' the social identity, isolating the individual from self, as well as, societal acceptance (Alonzo & Reynolds, 1995, p. 304).

People with sexually transmitted infections become 'other". Gilmore and Somerville (1994), explore the process of dividing 'them', the indecent, dirty and diseased from 'us', the decent, clean and healthy. Through disidentification, scapegoating and discrimination 'them' become separate from 'us'. The tools of derogatory language, and mythology are used to shape negative social responses and attitudes towards targeted social groups. Nurses' interventions to counter stigmatisation are intended to remove the polarisation of people into clean and dirty, decent and indecent, healthy and unhealthy.

Gilmore and Somerville describe the removal of these polarities as essential in overcoming the long held association of STD's with stigma.

Health promoters in New Zealand recognise that associating the genital wart virus with sexually transmitted infection is a significant factor in stigmatising women with cervical cancer (Braun & Gavey, 1998). Braun and Gavey in a thematic analysis of interviews with key informants who were involved with cervical cancer prevention in New Zealand concluded that:

> Stigma was commonly regarded as an obvious disadvantage associated with prevention messages that highlight an association with a sexually transmitted disease. Informants suggested that if cervical cancer is associated with an STD, women who developed cervical cancer might feel stigmatised (p. 356).

Eng and Butler (1997), discussing the hidden epidemic of sexually transmitted disease in American society, explore the deeply embedded secrecy that surrounds sexuality as a major contributing factor to effective prevention campaigns:

> Many of the obstacles to prevention of STDs at both individual and population levels are directly or indirectly attributable to the social stigma associated with STDs. It is notable that although there are consumer-based political lobbies and support groups for almost every disease and health problem, there are few individuals who are willing to admit publicly to having an STD. STDs are stigmatised because they are transmitted through sexual behaviours (Eng & Butler, 1997, p.86).

Sexually Transmitted Infections are threatening because they confront social ideals, norms and values. An unexpected discovery of an STI in a woman who perceives herself to be in a monogamous relationship presents social difficulties. Generally health professionals would rather leave women in ignorance than raise issues of infidelity:

> I'd be interested to know what's occurring if somebody examining the cervix sees inflammation and are they saying would you like me to do a check for chlamydia. Um I think it would be valuable to get together with the other groups to talk about that, as a woman's health issue. And I hear from people involved with cervical screening that it is a difficulty because there are social difficulties involved too… the ramifications of it really, of how you'd deal with the implications of finding STD's (Pia, 2: 170-179).

The finding of an STI in a person who is in a monogamous relationship is a social dilemma. The client in this case is conforming to the expected sexual norms of one partner, fidelity, trust and compliance with unsafe sex. In the eyes of the health professional the individual does not therefore either deserve to have an STI or to be stigmatised for doing so. As well, it is accepted professionally that infidelity is common and that the preservation of marriage should be the uppermost consideration. The health professional dealing with an unexpected STI in a client experiences dissonance. The issues are contradictory, as partners believe that they are protected from STIs in a monogamous relationship, discussing safe sex within marriage may lead to marital breakdown and failing to treat the partners and prevent further STIs would be professionally irresponsible.

UNDERSTANDING STIGMATISATION

Sexual health nurses understand stigmatisation. This is shown in the practices nurses use to overcome the psychologically damaging impact of guilt, shame, fear and isolation, encountered in clients. Nurses form the view that it is the negative characteristics attributed to people who attend sexual health clinics that is antisocial and not the individuals who present. In the words of Alonzo and Reynolds (1995):

> Stigma is not merely an attribute, but represents a language of relationships. An attribute that stigmatises one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself. Individuals are

> devalued less because they display attributes that violate accepted standards than because some communities have chosen to call certain attributes deviant. Thus a given attribute that is stigmatised is not inherently pathological, immoral or 'deviant' but derives from culturally embedded meanings. Thus various forms of 'deviance' are stigmatised in the context of a particular historic period and cultural context (Alonzo & Reynolds, 1995, p. 304).

Nurses position themselves to counteract the social stereotypes held of people who attend sexual health clinics and who have sexually transmitted infections and HIV/AIDS. An alternative experience is offered to clients in which nurses deliberately construct care to overcome anxiety and fear and to turn the event into a positive experience. The nurse, by identifying how they would feel in a similar situation, comprehends the social dilemma of the individual. A process of experiential reframing is occurring in interactions with nurses, in which clients are able to view themselves differently from the prevailing external views of people with STIs. The received view is to label individuals as sexually indiscriminate, irresponsible, unworthy and deviant. From the initiation of the interaction with the client, the nurse is engaged in an intensive process of rapport building:

> I think you have to have a special skill at developing rapport quickly with people who are extremely nervous about attending. And very uncomfortable. It's taken a lot of courage to walk through the door and I think that they pick up if you're uncomfortable so nurses have to be, or anyone working in sexual health not just nurses, nurses have to be particularly aware of their own sexuality and their own sexuality issues, values and beliefs. I think that's so important to know that so then if something sort of hits you in the face, you can think where's this coming from and then think I know, it's a value I have and it's coming hard up against that. And just being able to put that aside then and work with the client in a constructive way rather than a judging way ... (Jill. 1:69).

The social responses and attitudes of sexual health nurses are shaped by the wider context of societal prejudices, values and beliefs. A process of self-awareness and reflection is defined as the way that nurses put aside attitudes that may be detrimental to client care. This is part of an active process of personal and professional *destigmatisation.* Gilmore and Somerville (1994) state that the target of stigma must be identifiable, recognisable and assigned. In the case of sexually transmitted infections, people are not socially identifiable. Being identified occurs in private, intimate and vulnerable contexts. The points of identification are within sexual relationships, with health care practitioners, and in the act of entering a sexual health clinic. The meanings that STIs have for people will be influenced by the responses encountered in each of these contexts. Health professionals have a powerful role in determining how the individual will internalise the experience. One outcome may be the internalising of an experience of open distaste and condemnation. The health professional in this case is in the act of assigning the individual with the negative characteristics associated with stigma, the client in turn perceives those characteristics as belonging to them. For stigma to operate effectively the individual must own that they belong to the stigmatised category. Attending a sexual health service meets recognisable social criteria for people who should be stigmatised. Being seen in a sexual health service does identify people as different individuals from others who do not attend. Unless the professionals employed in those services construct the event as other than the social interpretation given to such health care, client self labelling is reinforced. Communities and the health professionals within them make individuals and groups, associated with sexual infections into social problems, to be distanced, separated, and disempowered. One nurse identified the use of social myth making about marginalised sexual minorities as a means of distancing 'them' from 'us':

> ... I think that people making that kind of person different ... yeah they don't want to be seen as anything like as what they see as a sexual deviant, whatever that is ... Um but I think that because it's a knowing that because it's so close, like just the whole sexuality thing, anybody who perhaps is perceived as being slightly different, the sex worker; the gay man you make myths about them just to get them away from being anything

> like you ... So all it's doing is making it work so that you're further away from it ... (April, 1:401).

Having an STI is a common experience, however in health care it is treated as if it was extraordinary. Sexual health nurses recognise the paradox of sexuality. Sex is considered normal and natural however having a sexual infection is not. One nurse quoted a colleague as saying:

> If you do something as natural as breathing, you risk getting the influenza virus, and if you do something as natural as having sex, you risk getting human papilloma virus (Pia, 1:18).

Unlike people with other communicable diseases, people with STIs are treated as if they were unnatural. People with sexual health problems frequently report that they are treated in general settings as if they were offensive as health care clients. Having an STI places people on the social margins along with stigmatised social groups. Behaviours towards people who are identified as having an STI are similar to those towards people who belong to populations where sexually transmitted infections are considered to be common, sex workers, injecting drug users, street people, and gay men. For many it is the first of experience of being on the outer. Attending a sexual health clinic is stressful as the client is entering a new social category and in doing so loses the status and power of social acceptability. A nurse states the significance of this event to clients:

> ...They're disempowered by coming in here anyway. You know, they're under an awful lot of stress (William, 1:319).

Clients seeking sexual health care in sexual health clinics do so in a way that is often fraught with concerns about social exposure, secrecy and privacy. One nurse indicates that the place and the people are experienced as threatening:

> I think it's such a big thing for people, they've got to ring up and make an appointment, then they've got to find the place without asking somebody "do you know..." So they've got a lot of hurdles to get through to come in this door and that's before

> they've even come in the door, I mean so it must make an impact on people ... (Emma, 1:610).

Staff who work in sexual health settings understand the danger that it represents for some clients. Sometimes clients are so afraid of what will happen to them if they are seen by members of their community, that they want to be hidden:

> ... Well in this job we have to be sensitive. And we make sure that we try and choose our receptionist, we've got a very sensitive receptionist who knows when someone is nervous and nearly pulling their hair out and that they might need a room for a bit of privacy ... (Sam, 1:627).

People who are overtly identified with sexual activity and the possibility of STIs are particular targets of discrimination. Talking about any sexual behaviour as a client or health professional breaches normality. Nurses referred to the practice of avoiding sex as a topic of discussion as a matter of perceived social contamination. A participant noted paradoxically that while everybody has a sexuality, the risk of being overtly associated with sex, is being labelled as not normal:

> ... there's so many myths about it (sexuality) ... stories about it, mysteries about it and you want to keep it away because it is actually too close...And yeah everybody does it. Everybody, well most people have sex or they have sexual feelings. and you know there's a line between being normal and you know being not normal and it's too scary ... (April, 1:386).

Many within the medical profession were perceived to have a difficulty with the stereotyped views that they held of people who have or are likely to have STIs. Although sexual social stigma has been well recognised as a health care phenomenon it has had little impact on changing medical practice.

> But in my studies that I've done it was very very strong, the social stigma, especially within the health professionals. And

> it's only just starting to be acknowledged in the 1990's that the medical profession has a huge social stigma that effects the people that they're dealing with ... even if it's known there's nothing done to change it ... There's nothing done to teach people how to take a sexual history because of the stigma and nobody actually knows how to teach it, so nobody actually does. So how can these people, even if they can sort out their non judgmental side, if they don't know how to do a sexual history and what they're looking for and ... (Jackie, 1:440).

The negative social meaning associated with STIs prevents the successful management of preventable sexually transmitted infections. Bacterial STIs are easily treated. The evidence is that chlamydial and gonorrhoea infections are common and increasing and that they are largely undiagnosed and treated. The treatment of STIs has a low priority in terms of health funding in New Zealand. Clients are frequently not asked about their sexual history as this may imply that the health professional considers that they are sexually indiscriminate. The concern to protect the client from social shame and stereotyping overrides concern with the long-term impact of untreated STIs. As one nurse states STIs are often overlooked as a possible diagnosis in the interests of protecting the client from victim blaming and labelling:

> ...There are a lot of completely missed [diagnosis] of chlamydia when you've got recurrent urinary tract infections and bleeding between periods. It's automatically looked at the pill. I'm sure a lot of it is because of the social stigmas that's not just out in society but also within the medical profession, which is why there has never been pressure ... to make chlamydia of higher importance. Because also they have fragmented so that you've got your sexual health and everything is done in pockets so that you've got a reproductive problem and IVF which is pitched at the late 20's and 30's but it hasn't been linked in with the sexual health of the 18 and 20's. ... like we're the grubby area so we don't get much funding, but here a lot of money IS being poured into it [IVF] but nobody is actually, looking at linking it up.

> Life is like a continuum but we're dealt with in little pockets instead of being seen as one person with a reproductive future that goes along the whole continuum ... (Jackie, 1:435).

While other services may be dealing with sexual issues it is the breaking of social taboos about discussing sex in an obvious and overt way that stigmatises sexual health services as offending social norms. It is therefore a shameful experience to attend a sexual health service. Health concerns about STIs may be the issue that clients present with, however this is often secondary to the psychological distress of guilt and fear. Nurses are concerned about the levels of anxiety related to sexual activity that clients present. One sexual health nurse describes the phenomenon in the following words:

> ... it's just such a shame that people are so ashamed of their sexuality and have such guilt associated with it. So you really feel sorry for that person if they've got that attitude or that they are really disempowered by that attitude ... So that they're worried sick because ... they've had sex with somebody three months ago without a condom and they're just really worried in case they've got something ... (Merryl, 1:602).

It is recognised that some aspects of sexual health care are more normalised than others. For instance, for women, the cervical smear test is a routine and 'normal' part of women's health care that is acceptable because it has been dissociated from sexual activity. The test, while related to the detection of genital wart virus, which is sexually acquired, is therefore less stigmatised than testing for other sexually transmitted infections. Nurses attempted to minimise the embarrassment of entering a sexual health service by indicating that they provide 'normal' screening activities for women. For men it was less easy to normalise the purpose of a visit to a sexual health service:

> And we often advertise that fact with women, you know. "Don't be embarrassed walking in because we do smear tests, we do, you know, you can come in with anything." But with a guy, you can't say that. You know, they're obviously here

> because they need to be, you know, some sexual issue … (Sue, 1:570).

Nurses challenged the labelling of people with STIs as sexual indecent, irresponsible and dirty and are critical of attempts by health professionals to disguise the relationship between STIs and long term complications, such as cervical cancer and infertility. The typing of women as sexually bad and sexually good is perpetuated in such health care practices (Braun & Gavey, 1999a). The approach taken by sexual health nurses is to break down the stereotyping of people into decent and indecent. The cervical screening campaign provides an example of professional wariness about associating sex with cervical abnormalities as association may deter women from testing. The policy of dissociating cervical screening from STI checks however means that the stigma around such infections is perpetuated. As one nurse stated:

> There was the whole business about well we haven't got the resources to deal with all the things that had come up, like checking contacts, how do we talk to people about it, their partners. I mean it's a cop out, it seems to be a cop out. And you can understand it, because people are not trained, it's a sensitive area, you have to be fully at home with your own attitudes about the whole sexuality business but it still is a cop out. It's just so detrimental. There's a whole discourse about decent women, that women would feel put off in any way that there was an implication that this was linked to an STD and this could be a strong chance for destigmatising all this stuff, a real chance to have all normal, decent, clean women realise that with one sexual contact you could get anything. You don't know what that person's done, and it's such a huge opportunity and it's missed. If you don't address it all, because if you can't deal with it at all as a health professional it's gone … (Pia, 2: 229).

The historic association of reproductive health care with 'clean' sexuality and STD clinics with 'dirty' sexuality has not changed with the renaming of STD clinics as sexual health clinics. Seeking contraceptive care is considered part of normal healthy

sexuality whereas checking for sexually transmitted infections has less acceptable implications:

> We're more like a sexual ill health centre and we're looking at like filling out your problems. .... if we were attached to Family Planning we could do enough about yeah planning a healthy sex life... Because you're promoting a healthy planning of a family. Or whatever, you're promoting healthy contraceptive use ... looking at sex as something great and what everybody does and quite normal. I don't think we have that focus but it would be good if we could... I don't think we ever really say like anything like sex is really great...There isn't really a normal [sexuality] is there? (Merryl, 1:50).

While sexuality is promoted as a normal, healthy integrated part of life, in reality as a health care concept it is disintegrated. Services are artificially separated according to the social acceptability of the sexually related health problem. It is acceptable to discuss pregnancy, contraception, fertility problems and cervical screening, not however STIs. However, while services may have developed separately, people think about sex and sexual relationships in an integrated way, and not in terms of specific sexual health problems:

> It's this bizarre split with funding which works against health promotion, with various bits of our anatomy. Contraception is dealt with here and the STD's are dealt with here and your cervix here (Pia, 2: 571-572).

Sexuality has differing meanings and values within cultures. Sexual health nurses who were Maori found that in some cases Maori clients would demonstrate a greater degree of discomfort and shame than would occur if the nurse at the clinic was Pakeha:

> My colleague that used to be in the clinic was a pakeha woman, mature woman, mid 40's ... they [Maori clients] used to go to her and there'd be no shame. You could see the same client and

> she could get all this history taking and she'd have a great interview and if I saw that same client, as a Maori nurse, suddenly it was completely different. I'd get an uncooperative, non eye-looking person ... almost like they're two different people. And whether it's because I am Maori and that somehow brings to them a different value to what they've done ... (Patricia, 1:530).

Another nurse speaking about previous work as a district nurse involved with HIV/AIDS care found the Maori whanau system (see Appendix Ten) more open, accepting and supportive of gay family members and able to provide care for HIV positive people.

> ... I think for the fact that there were a few of us that didn't stigmatise against the person, being gay. And that was ... the biggest advantage for us, being able to feel comfortable in going and nursing the person in their home environment. And also I think because that particular person was Maori and ... we understood his cultural values, where he was coming from and understood the father's values as well ... there was one family member that was also his main caregiver and I think ... as far as it was relating to her and giving her support and ... helping her through that process of making her comfortable about the way she cared for him ... I think that that's probably a lot more accepted within the Maori community in general ... (Rose, 1:73).

Maori nurses stated that sexuality was more freely discussed in Maori society than in Pakeha society:

> ... it's actually quite um comfortable to talk about that sort of thing on the Marae (see Appendix Ten). I mean you can, you feel that there's not quite the same stigmatisation because they want to understand and it's um an accepted thing amongst their

> society that a family member or part of one of their whanau that might be gay – that's quite accepted. It's not quite as stigmatised as what it is within probably the Pakeha community ... (Rose, 1:111).

The degree to which sexualities are stigmatised has been well documented (Foucault, 1979; Foucault, 1979). The psychological harm caused by the stigmatisation of STIs is less openly talked about and attracts little public sympathy. There has been little description of the meaning that STIs have for the individual. Nurses recognise that they are treating the effects of stigma, shame, guilt and self blame, as much as they are treating a physical health problem. As one nurse stated, finding out the reason for a client's discomfort is essential in understanding the nature of their fears and feelings:

> ... it's important to find out what it is that they're uncomfortable about. Is it because they've never had a smear before? Then have they never, ever been examined? Is it because they don't realise that warts are really common? Do they think they're the only person in the whole wide world who's got warts? I mean you know that's what a lot of people think. They think it's dirty, they think it's shameful, they think its their kind of punishment for having sex. You know, they shouldn't have had sex. Given me warts, that'll serve me right. And here I am having to come for treatment. More humiliation ... (Emma, 1:214).

It is a common attitude in society and in health care that STIs are the result of bad lifestyle choices and an individual lack of responsibility. While sexual behaviour change needs to be reinforced to prevent recurrence it needs to be acknowledged by health professionals that most people are more preoccupied with the social awkwardness of sexuality than with safety. People go out to enjoy themselves, drink and to meet new partners. For most people sex is a social event and not a health event. It is important that the health professional does not problematise the person but instead deals with the health problem that the individual has:

> ... it is difficult because there's a lot of shame in sexual health. They come in you know, I'm here and I've got a drippy dick and I've been drinking and it's almost like this should have happened to me because I was out drinking and I wasn't doing all the right things ... (Patricia, 1:521).

Clients internalise negative social views of people with multiple sexual partnerships and anticipate social rejection and disgust from health professionals. Sexual health nurses were aware of the feelings that clients projected on to them:

> you might say "how many people have you had sex with in the last six months?" Oh, five. And you say, "was that protected or unprotected, men or women." And they say, "oh unprotected. I know what you're thinking." Dirty whatever. And I'm saying "no, no. I'm just thinking that maybe you've got some things to learn about how to use them." Yeah. And also pointing out that we're not here to judge ... And we're not their conscience ...They try to use us ... And they put the blame on us. Someone saying "I know I shouldn't have done it. I know you think I shouldn't have done it." No, I say we all make mistakes and every single one of us who's here has made mistakes. That's life. We learn by them. They tend to play it down probably, some of those things. Those guilt things ... (Jill, 1:274).

Sexual history taking is therefore as much about getting an accurate picture of the clients sexual risk as it is about conveying complete neutrality about sexual lives. Nurses described the main issue as establishing enough trust with the client to allow self-disclosure without reinforcing negative self-perceptions:

> ... It's not reacting when you say particularly about anal sex and people say oh no and it's not hearing that oh no, not me either. You just tick the no box. You don't um because maybe they do and maybe they're lying. And maybe if I'd said ooh not me neither then that reinforces to them that you know that it

> isn't a good thing to do where as they're actually doing it ... But then at the same time, I'm contradicting myself ...You have to trust what people tell you. Um even when you know they're not telling you the truth but you know you have to trust them ... (April 1554)

Sexually transmitted infections have different social meanings. In particular viral STIs HIV, genital wart virus and genital herpes carry deeply embedded fears of social isolation and rejection. In understanding the nature of social and individual reactions nurses developed analysis of the historic associations of STIs:

> ...it's really a lot about the mythology and stigma related to genital wart virus. So I actually went back historically and looked at um genital wart virus ...(Mia, 1:5)

Often the clinical management of STIs was secondary to the social impact that this had on the client and their fears for future relationships:

> ... a young woman I saw time and time and time again who had huge issues about having warts and at the end she hardly had a wart but she was just absolutely beside herself about it. I mean, it's like I wasn't treating a wart in the end. I was um, you know dealing with the other issues of how she felt about having warts. Potential relationships and stuff ... (Emily, 1:427).

The meaning that herpes has for some clients is symbolically expressed as being an outcast and of expecting isolation and rejection. Some nurses used social support groups for people with genital herpes as a way of countering social isolation:

> ... Like a leper. Leper is a word that some of them use. Yeah they do use that. Like, I'm the only one. And that's why the support group is so good. You know, if they've got the courage to come back and find out from other people ... (Sam, 1: 345)

It is recognised that low self-esteem and poor self-efficacy increase individual vulnerability to sexually transmitted infections:

> The badness feeling is why they've ended up seeing you too. You know? Not making good choices and this whole feeling of undeserving and that sort of stuff. I find that a lot ... (Jane, 1:307).

Clients are anxious at the same time that their sexual behaviour is perceived as normal. Nurses discussed the sensitivity of sexual history in not excluding any possible sexual practices and on the other hand avoiding offending the client who may have conservative views about sexuality:

> ... the vaginal sex thing. Actually I had a girl this morning and I said do you have vaginal sex and she said "what?" and I said you have sexual intercourse don't you? She said "I've well I've just told you that we have sexual intercourse". And that way that I was saying it was telling her that she did, because everybody does and of course she did and luckily she thought it was funny that you know, we had this thing. But some people do feel "what do you mean" and I say plain old sexual intercourse and they say, oh yeah, yeah, yeah. But there's also an assumption that of course they do; it's like you wouldn't even ask it ... (April 1254).

The work of sexual health nurses is associated with the indecency of sexually transmitted infections, sex workers, homosexuals and the 'dirty work' of genitally examining such groups of people. The role of nurses as advocates for their clients is a professional and public alliance with social 'deviance'. The failure of nurses to shun or demean their clients attracts professional ostracism and public censure. In Goffman's words:

> The tendency for stigma to spread from a stigmatised individual to his close connections provides a reason why such relations

> tend to be either avoided or to be terminated (Goffman, 1963, p.30).

Lawler (1991, p. 90) suggests that sexuality "lies on the margins of what is considered dangerous and potentially polluting". Working with people who have sexual infections, homosexual relationships, inject drugs, are sex workers or frequent sex workers is considered to be one of the most dirty, diseased and dangerous areas of professional care. When nurses reject the labels, which the public and other health professionals attach to their clients, and publicise the commonness of STIs such as genital wart virus, it is socially challenging. As a public health issue STIs can no longer be discounted as a matter of 'dirty' people with sexually indiscriminate lives. Society has a choice to either label a sizeable proportion of the population 'dirty' or to normalise people who have sex and STIs.

THE STIGMATISATION OF SEXUAL HEALTH

It is implicit that anyone visiting a sexual health service is going to discuss sex and of the morally suspect variety. The stigma addressed in the current study relates to social attitudes towards the populations who visit sexual health services and to the staff who work there, to the personal impact of having to attend such a service and to having an STI. Sexual health nurses reveal in their interactions with clients their perceptions of the impact of multiple layers of sexual stigma in society. In this section the prevailing attitudes towards sex and gender, ethnicity, adolescence and prostitution will be discussed in the words of the participants in the study.

It is recognised by nurses that history and culture shape the social context and meaning of sexual health care. Sexualities are regulated through societal attitudes, behaviours and the mechanisms of state control (Tulloch, 1997). Sexually transmitted infections are the tangible evidence of the transgression of rules that govern standards of acceptable sexual behaviour. Sexual diseases have historically been used to divide people into clean and dirty (Tollerton, 1992). It is a product of the continuing sexual 'double standard' that womens' sexualities continue to be dichotomised into pure and impure. Women who enter sexual health services are stigmatised through inferred sexual

impropriety and expect a loss of reputation. Having a good reputation however, fails to protect women from adverse labelling. One nurse expressed the view that greater social and sexual freedom for women has changed societal attitudes about womens' sexuality. Women continue to be referred to sexually in ways that are derogatory and demeaning:

> And the boys at school talk to each other, you know, and she's got this reputation now. And she's not, you know, she doesn't deserve it at all. ... at the time she felt OK about doing it because she trusted the guy, but now it's all turned around and she's, yeah, feeling awful about herself and her self esteem is way down in her boots ... it was always a macho cool scene to be sexually active and it was always unfeminine to be sexually active if you're a woman. Which doesn't make sense at all. Because if the guy is going to be sexually active, he needs to have a woman most of the time ... (Sue, 1:720).

People gain a social reputation for their sexual lives that extends to the manner in which they are perceived in health care. In the current study sexual health nurses indicate that derogatory sexual labelling is so normalised that within the confines of a clinical interaction it is a difficult phenomenon to change. Mirroring language or ignoring negative sexual stereotyping are some of the strategies that are used in nurse/client interactions. While it is recognised that it is sexual stigma that is operating when clients are disrespectful about sexual partners there is also an awareness that the context of a sexual health check up may not be an appropriate time to challenge this:

> I guess I've had some difficulty with some terminology that has ... unexpectedly come out in conversations [with males] during consultations and things. I find that quite difficult, that derogatory tone about women...it depends what the terminology is I suppose and I tend not to be confrontational "she was a bit of a slag" or something like that ... I either ask them to clarify what they mean. You know, so that you can use some more appropriate language around that ... I mean I'd never say ... what does that mean? ... And occasionally um the time that I

> did nothing, I think probably was the best thing to do actually … (Jane, 1:409).

Women are not expected to be sexually independent and assertive although they are expected to be available. Women's achievements in public life can be readily undermined by a bad sexual reputation. The social system of the sexual labelling means that respect cannot be gained through sexual availability or celibacy. While female status has improved in the public arena, womens' sexualities continue to be marginalised and stigmatised. It is expected that women should be neither too chaste nor too available. Nurses in sexual health care are managing not only the health risks associated with unsafe sex but also the risks of sex itself. The risk for men and women is a loss of reputation. The effects of this loss are to fail to meet accepted standards of masculinity and femininity and to be stigmatised as a poor example of manhood or of decent woman hood. Derogatory labelling is a powerful means of social control. There are gender differences in the social taboos that surround talking about genitalia that are reflected in clinical practice. While talking about sex is socially unacceptable, men are generally more comfortable and open about their genitalia than are women. Colloquial terms for female body parts are often abusive. For women therefore openly naming genital anatomy is considered impolite and distasteful:

> … there are plenty of names for penises aren't there. If you think about it they're quite jolly, you know dick and cock and all that. Quite, they're OK they're not too revolting. But women tend to not go round talking about their vaginas the way that men might talk about their dicks or whatever. And they certainly don't talk about their cunts. And even in an interview with a woman, you'll find with a man you can say where's the lumps that you're talking about? They'll say oh it's on the head of my dick or it's on my penis or whatever. And you say to a woman, if she's well educated and she's confident and the rest she might say it's on my labia or it's on my arse or my lips or something like that but it's hard to get a woman to say. Yeah my vagina's been really itchy lately. They say "I've been itchy" or "it's been itchy". What's been itchy? You know you feel

> like almost sometimes stirring them up and saying "come on it's OK to say vagina". You know. It's not dirty ... (Emma, 1:278).

Women have few acceptable words to refer to genitalia and to symptoms without sounding 'dirty'. Women in society gain repute according to their perceived sexual decency and are therefore guarded about expression and identity. The most indecent women are considered to be sex workers. As sex work is criminalised and discriminated against, there are few agencies where sex workers can expect professional help. Women face hostility and rejection from health professionals and members of the community, if they disclose their work. Sexual health services provide not only clinical care but also social support for sex workers. As one nurse says:

> ... It's an underground thing because we are a small community. I'm not aware of a parlour in our small community. I certainly know that there are escort agencies that run out of houses and things and again it's looking at issues for commercial sex workers too, because we don't have a prostitutes' collective in our community and no person has identified themselves as being a representative ... (Patricia, 1:689).

While society criminalises and condemns sex work, in every community sex is commercially available. Sex workers are a hidden population as are their clients. Disclosing sex work or that one is a client risks withdrawal of care and discrimination from health professionals. People in health care reflect social values. Society acts strongly to protect community values and to exclude and discriminate against those who offend what is considered to be a decent, normal and acceptable lifestyle and sexual relationship. Family and fidelity are supposed to protect people from sexual diseases. Sex work, homosexuality and non-monogamy threaten the social institution of the family. At the same time for men there is strong pressure to maintain the perception of a predatory style of heterosexual sexuality (Connell, 1995). Constructions of mens' sexualities are problematic and contradictory. Men who do not conform to masculinist stereotypes of sexuality are labelled and stigmatised. For young men, failing to meet up to gender expectations of sexual behaviour and performance is a greater threat than the

health risks of unprotected sex (Connell, 1995). Using alcohol is a common means to become disinhibited and sexually successful. One nurse explained the pressures for young men to be a 'stud':

> ...We grow up in a country of "studs"... This is a country of urban myths and these kids, all of us I don't believe, we've never been told anything about sex, really go out and have it and these kids have got to be good at it. So they're terrified of not being good but they're going to try, they're going to get drunk ... You have to ask yourself where does that come from ... (William, 1:355).

Adolescent culture and the societal normalisation of female sexual passivity and male sexual aggression means that date rape is prevalent. Young women who have been date raped present commonly in sexual health services. Nurses have a significant influence on how this event will be interpreted by the client and in facilitating future coping skills, self protection and safety:

> ... I often say to young women, because I get that typical "I asked for this you know". And I say "asking for something means you open your mouth and you go I would like." That's asking for it, to put it back into the context. That what happened is inappropriate and it's not OK. That it happened and it isn't your fault. Because that invariably is what happens with young women ... Perhaps for the first time in their life they've drunk too much and they've done something and they're so whakama [shamed] about what's happened um and it's really trying to make them be OK about that and trying to look for the positives in a very negative environment. You know, I always say to them "hey it's great you came, what's happened may not make you feel OK about it now, but what's good about now is that you've come here and that's really neat because we can do something together you know and try to focus on that"... (Patricia, 1:539).

In one sexual health clinic teenage mothers were employed as educators. The experience of young women is that while schools supported continuing education during a teenage pregnancy and motherhood, peers did not. Such overt evidence of sexuality was punished with name calling and social rejection:

> There's two teenage mothers that help us to do some work or work with us and specifically educate on what it's like to be a teenage mother. Some of them have got some horror stories. But what some of them tell me is you know, once you get pregnant at school you get so ... what's the word for it? Um, is it discriminated against by your school mates? It's not an easy road for them often. They think everything is going to be cool but it's not ... It's a real name calling stuff. And even though some of the schools have been really supportive in encouraging the people to come back or to carry on through their pregnancy at school, it doesn't actually work so well (Harriet, 1:530).

Clients who present to sexual health services with a history of sexual abuse carry psychogenic stigma. The sexual abuse of women and increasingly of men is common (Gavey, 1991). Risky adult sexual behaviour, relationships and lifestyles are often related to childhood experiences of sexual abuse. The low self-esteem frequently referred to by nurses in the current study is identified by Briere (1992), as related to childhood abuse. Janes's statement of this participant is typical of the impressions given by others in the present study that many clients present with the social and psychological sequelae of childhood sexual abuse:

> ... I think issues related to women long term self-esteem wise, um violence, sexual abuse, all that kind of stuff, I find you see people in huge numbers with those issues ... (Jane, 1:126).

The nursing care of people who have been sexually abused is complex. In addition to the management of clinical symptoms, the psychopathology that results from childhood abuse can be permanently disempowering unless there is therapeutic intervention. Health care professionals have a good opportunity to identify the social and

psychological damage associated with trauma and to intervene to enable more healthy coping skills. Finkelhor and Browne (in Briere, 1992) list four destructive traumagenic dynamics: traumatic sexualisation, stigmatisation, betrayal and powerlessness. The three latter are cognitive psychological traumas integral to sexual abuse. Victim blaming is another form of stigmatisation. Victims of sexual coercion often blame themselves for the actions of the abuser. According to Briere (1992, p. 27):

> Abuse-related poor self-esteem can also result from ... *stigmatisation* – the messages that the victim directly received from the abuser (eg, "You deserved that." "You asked for it." "You're being punished for being bad.") or indirectly from a victim- blaming social system after the fact (eg, "You seduced him." "Why didn't you just say no?" "What did you do to deserve it?"). This internalisation of others' negative statements and judgments during or following child abuse frequently produces guilt, shame, and self-blame in adult survivors- responses that are difficult to alter short of extensive psychotherapy (Briere, 1992, p.27).

Health professionals have a significant role to play in reshaping this self-perception and in stopping the shaming and self-blame that fosters continued abusive sexual experiences. Nurses in the study moved to counter statements from clients that they deserved nothing better than getting an STD. Herman (1992, p. 103) refers to the tendency of children who are abused to develop an inner sense of badness in response to parental scapegoating:

> Survivors frequently describe being blamed, not only for their parents' violence or sexual misconduct, but also for numerous other family misfortunes. Family legends may include stories of the harm the child caused by being born or the disgrace for which she appears to be destined.

Childhood scapegoating continues to impact in adulthood, resulting in sexual behaviours, relationships and lifestyles that are frequently abusive. Nurses refer in this

study to picking up the cues and reading the signs of abuse from clients. They hear survivors say of themselves that they deserved nothing better than getting an STD and being treated badly. The caution and tentativeness with which nurses undertake routine sexual health checks are designed to overcome the shaming and trauma associated with genital touch and exposure. The time and care taken by nurses to build therapeutic alliance recognises the significance of this relationship to the process of healing the abuse. Through trust building, raising self-esteem and self worth, lives and health improve. The pacing of the professional client interaction, in this instance, the psychotherapist in the context of counselling, is defined by Briere (1992, p.98):

> ... the interaction between client and therapist becomes paramount, as does the ebb and flow of the therapy session.... Especially important are the following:
>
> - the role and timing of assessment
> - the balance between exploration of potentially distressing material and the need to provide support and consolidation
> - intensity control
> - decisions about when to focus on present concerns versus historical events
> - the negotiation of client "resistance"
> - the sequence in which problems are addressed in relation to "self" versus "trauma"
> - termination issues

The stages of the therapy session defined by Briere are a good description of the therapeutic decision making that sexual health nurses describe. There are however some important differences in the interactions between the therapist and client and the nurse and client. In the interaction between the nurse and client in sexual health settings therapeutic alliance and interventions must occur within the time limit of a thirty minute appointment and in a situation that has the emotional intensity related to genital examination. The nurse may have only one opportunity to obtain a history and to make interventions. Many sexual health nurses have training in counselling which they consider to be essential to effective therapeutic management. As this nurse describes, in

the context of a clinical service, every phase of the consultation from sexual history taking, through examination and diagnosis is an opportunity for brief therapy:

> ... you see them accepting what someone would consider as abnormal. So many of the clients who come here have had an abnormal history in terms of sexual abuse. Physical abuse, emotional abuse, emotional neglect. And this is how they get their love, is equating sex with love and affection. And so I can sometimes see why something has happened. And even though I might not agree with it in terms of my own values, I can see why it's happened. And that's when I sort of like to offer them the chance to work with me and maybe look at ways of changing that...[I use].a lot of brief therapy....Even just in the history taking. That can be therapeutic in itself because then they've got it then on pen and paper. Got it down. And um they think about it. Gives them time to reflect ... (Jill, 1: 455).

While Briere (1992) states that long term psychotherapy is needed to counter the effects of childhood sexual abuse, the findings of the present study are that nurses do make significant therapeutic interventions. Very few clients have access to long term psychotherapy; many will present to a health professional for issues related to sexual and reproductive health care. Nurses in the study detail intensive clinical, psychological and educational management strategies. The focus of strategic interventions is to facilitate examination without trauma, to raise self-esteem and to change patterns of behaviour harmful to the client. Genital examination is particularly threatening for people who have been sexually violated. The focus of care is therapeutic management to avoid triggering previous trauma and loss of control. The nurse acknowledges the difficulty of examination and uses strategies to enable the client to regain control by providing the client with choices:

> I think that's really important to be able to ... putting a client at ease is to be able to hear what they're saying. And, reflective listening basically. Not to patter back everything they've said but to be able to sort of succinctly say so, you've been sexually

> abused so some people who've been sexually abused aren't comfortable having internal examinations. How are you feeling at the moment with the thought of this? Just putting it out there. Going with the response. Some people might say, "you know I'd rather wait a couple of days" or "I'd rather wait until I can have a friend come with me". Well OK. That's a good idea. We'll rebook you ... (Jill, 1:171).

Sexual health nurses in this study describe well the importance of the therapeutic sequencing of an alliance with sexual abuse survivors in order to successfully interview and examine the client. The challenge for the nurse is to compress the process, which occurs in therapy over many sessions, to the timeframe and setting of a clinical appointment. Additionally the genital examination can be a triggering and threatening event for the client, requiring intensive efforts on the part of the nurse to establish safety. For clients, experiencing therapeutic treatment when they disclose sexual abuse, is an important step in the psychogenic destigmatisation process. While there is extensive psychological literature relating to the management of the psychotherapeutic relationship between the therapist and the client, the nursing literature on this subject is confined to managing the genital examination (Kitzinger, 1992a, 1992b). In the present study sexual health nurses describe the steps taken by to recognise and encourage personal resilience as an alternative to continued victimisation. The nurse engages with the client to stop abuse, shame and stigma.

SUMMARY

Nurses recognise the significant social barriers faced by clients who are attending a sexual health clinic. For clients, the experience is initially threatening whether or not an STI is diagnosed. Daily, nurses encounter people who feel ashamed, humiliated, defensive and frightened about their situation and the health care setting that they find themselves in. It is understood that stigma is attached to sexual health services, staff, and clients. Nurses develop ways of knowing about and responding to social, psychological and cultural reactions to sexuality and sexual health care based on their

experience in practice. Within the broader spectrum of sexual and reproductive health care nurses in sexual health settings are viewed by other health professionals and the community, as being involved with the 'dirty' aspects of sexuality. Nurses develop awareness that clients anticipate negative reactions from the staff who work in sexual health services. Accordingly strategies are adopted to convey humanity, safety and normality. In the next five chapters the process of *destigmatisation* will be presented in the stages that will form a theoretical framework for the work of sexual health nurses. From the data analysis five conceptual categories emerged *identifying with people, personalisation, respecting and dignifying, advocating and empowering* and a parallel process that attaches itself to the nurses who are *doing deviant work.*

CHAPTER FIVE

IDENTIFYING WITH PEOPLE

The conceptual category *identifying with people* is discussed in this chapter. The combined conceptual categories *identifying with people, personalisation, respecting and dignifying, advocating and empowering,* and *doing deviant work,* constitute the basic social process of *destigmatisation.* Professional disidentification with people who have STIs is a process of social distancing. *Identifying with people* describes nursing interactions that get close to people in sexual health settings. The sexual health nurse engages in an ongoing, organised and individualised set of strategies designed to counteract the stigma of attending a sexual health clinic and of having a sexually transmitted infection.

In this chapter sexual health nurses' experiences of entering the social reality of their clients is described. Nurses talked about the ways in which clients internalised negative social attitudes and the psychological impact of this. In this context '*identifying*' describes connections nurses make with their clients in the everyday practice of sexual health care. Understanding the other is fundamental to forming a therapeutic alliance with the client. '*Identifying*' refers to the nurse's ability to enter and engage with marginalised subcultures and people. This process involves meeting people in community settings and becoming known and accepted. Providing a safe, friendly, welcoming environment is the starting point in sexual health care. In the study, the three categories which combine to make up the category of *identifying with people* (See Figure Two) are *getting into marginalised social networks, creating open and accepting environments* and *making services safe.*

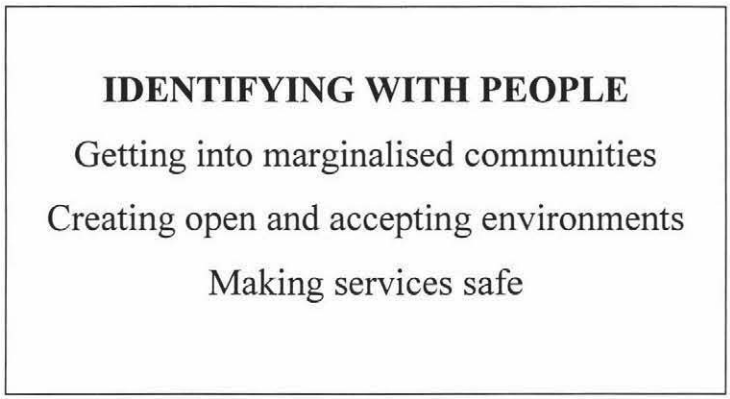

Figure Two: Identifying with People

IDENTIFYING WITH PEOPLE

The nature of the role of the health care professional is a position of power in which there is the potential to have a major impact on the positive self- identity of others. The New Zealand Nursing Council Guidelines for Cultural Safety in Nursing and Midwifery Education state that:

> Attitudes held by people in power have a major impact upon the identity of others. One of the more destructive elements of negative attitudes is the redefinition of other people's realities and the imposition of that definition (NZNC, 1996, p. 8).

Nurses and midwives combined are the largest group of health professionals in New Zealand (NZNC, 1996). Nurses reflect in professional practice the ideas, attitudes and behaviours that are socially acceptable. In a society that aims to protect individuals from "immoral" sexual behaviours and dangerous infections, health professionals are bound to distance themselves and to disidentify from the people who are considered to cause social trouble. For many health professionals, STIs and HIV are the deserved outcome of sexual profligacy (Brandt & Jones, 2000). Such people are not considered worthy of professional sympathy and understanding. In order to nurse in sexual health services, that is to care for and to support clients, professional attitudes must run counter to prevailing social attitudes. The idea that health professionals are immune from the

risks, infections, environments and histories of the clients who visit them is artificial. Nurses can identify with the lives, personal experience and feelings of their clients, as they are members of the same communities. The guidelines for cultural safety in nursing and midwifery in New Zealand outline a process to address marginalising professional practices (NCNZ, 1996). There is widespread recognition that it is Maori who are disproportionately affected by STIs and who have the poorest sexual and reproductive health statistics (Smyth, 2000). To treat people with STIs as less valuable or important health care clients, is culturally unsafe and is not nursing. As the guidelines for nursing and midwifery (NZNC, 1996, p. 8) state:

> Every interaction between health professionals and consumers is unique and powerful, and involves a convergence of experiences in what amounts to a relationship between social groups or cultures. These relationships have power and status imbalance and are influenced by the differences in the histories, social status, and educational and other realities of the two people in the relationship.

The status imbalance in sexual health care interactions is in relation to the powerlessness of the person who is disclosing information that could ruin their reputation and the powerfulness of the professional receiving information. Sexual health nurses must ensure that they take scrupulous care to be both private about their work and at the same time public enough to be an accepted part of the community.

GETTING INTO MARGINALISED SOCIAL NETWORKS

Sexual health nurses can gain acceptance with a range of marginalised groups who are otherwise inaccessible to community health care workers and agencies. Social groups who have the highest prevalence of STIs are the most difficult to get at. Nurses demonstrate innovative community approaches and extensive social networking in reaching at risk communities. Social custom is used as a means of breaking down barriers through the visiting of socially alienated communities, the offering of

hospitality and in using the safety of group rather than individual encounters. Such strategies are a means of reducing social threat and distance. They are the processes of *identifying with people.* Effective interpersonal skills and networking are the most effective way to get clients to attend clinics. Nurses in sexual health services are involved in a wide range of educational and promotional activity aimed at demystifying the people, work and settings of sexual health:

> … we're OK and half of my objective when I'm doing education sessions is that the people … know where we are and what we do and how to get there. If they, I don't expect them to know all the ins and outs of chlamydia and herpes. But if they need to come, they know where to go … you get that continuity of being in the teaching session with them and I can talk about my role and what I do and when they come, it's the same person … (Emily, 1:351).

For the client having someone to identify with is a persuasive factor in deciding to go to a clinic. In the words of a nurse who teaches in local secondary schools:

> I can do an education session and the next day there will be two or three people at the clinic. And for me, it's wonderful. Because I just think well that's the best evidence possible. Here they are. It's so, you know, somebody listened and they're at the clinic … (Emily, 1: 343).

In small communities sexual health clinics are identified as centres where youth can present for a range of issues. Drawing the boundaries presents difficulties when referral to other agencies results in failure to attend:

> ... We try to keep away from drawing that line bit. Even if it means that we have to try to set up some sort of referral stuff for these young people ... a young person comes in and they just want emergency contraceptive pill but that's not actually all they want, it's an ideal opportunity for them to be able to get all the other stuff out. And all their sexual health needs and what's happening in their sexual health bit ... but certainly that's how we started off here as sexual and reproductive health. But we're finding for young people, it's much more than that. I don't know whether we can just carry on seeing their sexual and reproductive health in isolation ... Whether we need to start addressing some of the other issues they have. Which I think we've been quite good about and referring them on. Like you need to go to your GP for this or a counsellor or take it to relationship services. But the failure to attend rate amongst that is enormous. They don't follow through with that stuff. They just do not attend. Or they might eventually end up at their don't actually end up telling the GP what they're there for. And it all gets wrong ... (Harriet, 1:402).

In the context of adolescent populations it is easier for sexual health nurses to get into marginalised communities if they are unknown. A Pakeha nurse providing a clinic for young Maori people felt that being an 'outsider' was important in gaining trust:

> I guess my advantage is I am not part of the community and I can slip in and slip out. And that makes it really appealing for people too because I'm not going to bump into them in the street or whatever. And so the confidentiality aspect of that is really huge ... (Jane, 1:154).

In close knit communities seeking sexual health care is particularly problematic. Often nurses work alone with little medical back up, as young people are often reluctant to go to a General Practitioner who knows their family. Adolescents identify nurses as safe and confidential people regardless of the limits of their professional practice. Sexual health nurses gain trust but may feel limited in terms of the level of clinical care they can offer:

> it's a very lonely clinic because I don't have any medical input at all and ultimately you know that if you refer somebody on to see a GP, they're more than likely not to access that service. So I'm often in a dilemma of. I think I'm pretty clear about my boundaries. I mean all I can do is do no harm I suppose … there are times when you know that that medical training is definitely lacking (Jane, 1:252).

Sexual Health services identify and meet gaps in sexual and reproductive health care in rural areas where there are few services available:

> In smaller rural New Zealand towns, it's so important … we don't have the city services and it is almost becoming about generic services. So it's not really about in a rural area so much boundaries. We can't say that's not us, I'll ring up such and such, he can come out and do it … (Harriet, 1:441).

For young women in small communities sexual health services were identified, as places were they could get reproductive health care. Combined services are popular with clients however, with funding cuts to sexual health services and fewer doctors, nurses maintain large case loads in order to keep services open. In order to survive, nurses discussed the innovative ways that they maintained contracts with health providers:

> ... we were worried that we'd lose sexual health altogether so we actually combined the under 25 contraception clinic and opened the sexual health clinic together. It made the attraction of a doctor to the service a little better but it also ensured that we were able to continue sexual health services in the region. Had we not been able to secure medical downgraded supervision, we would have had to have an education service only because we would have had no medical supervision for that ... Cause often sexual health issues can come up in a contraceptive consultation and vice versa and the ability to actually deal with those in one setting and at one appointment can be advantageous to the client, and certainly for us in terms of preventing infection spread if we get the symptoms from the client at the time ... (Patricia, 1:6).

Where contracts allowed the integration of sexual and reproductive health services was a successful way of getting into marginalised adolescent social networks. The combined clinics provided opportunities for testing, treating and preventing STIs:

> I think that's probably the unique thing about having the clinic together [sexual and contraceptive] is that sexual health has been given a broad focus, so that it encompasses contraception as well. So, part of my practice is anyone who comes in for contraception I tend to ask other questions as well. So I say "is everything OK in the vagina area?" or even take a shortened sexual history of how are things going. "Do you still have your regular partner or are you using condoms with people that are not a regular sexual partner of" and these sorts of things and that's when we got the telltale signs. When we had the separated clinics because they had a complete contraception focus, that's really all that was focused on. So they were very focused but having them together you can broaden that focus at

> any of the clinics which I think is probably one of the biggest things that has happened … (Patricia, 1:102).

The nurse's role is educative in explaining to clients that risk for pregnancy carries the risk of sexually transmitted infections:

> …we gave them the morning after pill but we also took a full sexual history and looked at contraception and any of their other needs and it was also a means of education and introducing them to us … it was practical to sort out all their sexual health needs in one hit … (Jackie, 1:34).

Specific strategies were engaged in working with adolescents that recognise the importance of peer group support and approval: As one nurse says young people often:

> Come as a group for support. Which is sometimes, I guess in terms of communicating, I acknowledge that they come as support but also acknowledge that sometimes those students that come with that support, they have issues that they won't actually talk about in front of those students ... They're not trusting their friends. And that's part of adolescent development. And what do they come for? It might just be a sexual encounter that really was not a comfortable experience for them and that they don't really want to talk about in front of their friends. And I think it's part of them to be sometimes want to be seen the same as their friends but also wanting to be acknowledged as being individual … (Milly, 1:48).

Being identified by peer groups as a safe and accepting adult is critical for young people who are starting to consider sexual health care. Sexual health nurses have evolved community based practice and community development models out of personal care

contracts. The nursing role in sexual health services involves negotiating funding where there are unmet community needs:

> in a small community ... that insight that you get into people's lives is reasonably comprehensive because of the nature of the size of the community and the frequency of which you see the people and the connections they have with others ... And to have a more comprehensive role that, because you're it rather than passing on things to clerical workers or doctors or whatever, you actually have that, fulfil that role ... So you're doing a blood pressure and helping out trying to get the money from the HFA [Health Funding Authority]. And everything in between ... (Jane, 1: 55).

Sex workers are one of the most marginalised groups in society. Sexual health nurses openly ask clients about sex work and are proactively engaged in ensuring their safe working conditions, human rights and access to support systems. Nurses work in partnership with the government funded New Zealand Prostitutes Collective to ensure that sex workers receive optimal sexual health care:

> that for me is quite frustrating in the sexual health clinic because again, it's a small community issue that can't be "out there" because their kids may be in the local school, so it's an element of sensitivity and I always try and have a sex worker time where they can come in unimpeded by the rest of the clinic ... (Patricia, 1:692).

Although going to a sexual health service is threatening, many in the community recognise the expertise and safety of staff:

> it's [sexual health services] separate. It's more expert in nature and it's free. Major difference. Which makes it accessible for people who wouldn't otherwise access services. It's also I think

> it's location in the community is really pivotal as well. Because you can walk in the front door and you wouldn't know where in fact you were going. And you occasionally see people who walk in the door just for a lookie and then they go away and might come back the following week and ask for a pamphlet and the next week they actually finally sit down and see someone … (Jane, 1; 106).

In rural areas sexual health clinics are identified as safe and private places to go for sexual health checks. Cervical screening services are well advertised, free and readily available, however there are cultural barriers to be overcome for Maori women. Community based approaches that respect cultural practices are critical to effective sexual health prevention work among Maori. One nurse discussed the strategies that she used working within her own community, to reach Maori women, in a remote rural area (See Appendix Ten):

> … there does need to be more consultation with these groups and knowing how to provide that appropriate service for them ... I know a couple of the Iwi health providers quite well and have built up a rapport with them. And but it actually took three months for all the consultation and setting the right time … for them and that wasn't easy because it usually was sort of at the drop of a hat. "We can have you next week." I had to cancel other appointments that I'd made to make sure I was to be there next week because they had set up the Marae specifically to be able to have this full presentation workshop on. And know that full well I could go all the way up there and have done all this preparation and there could be a Tangi tomorrow and the whole thing would have to be cancelled again. In actual fact it didn't work that way and look we had … I did the presentation and the education session one day and offered a smear clinic the next day. And I had about 50 women come through in those two days that had never had smears or were so outdated with their smears. And that to me was the most ... gratifying part of my

> work is being able to reach those people … they have once a week a GP service in T_____that they'll go to them for everything else other than anything to do with [genital examination] ... (Rose, 1:616).

Getting into marginalised communities, such as gay communities, relies on good reports of practitioner interactions. Sexual health services have established a reputation for safe and appropriate care for gay communities. People hear about services through word of mouth and will attend on the basis of the experience of friends:

> … yes we do provide a safe environment for gay men to come into the clinic and you know, they have the run of the clinic, they know that they can phone in or come in or tell us whatever they need to tell us … (Tony, 2:69)

The first visit to a sexual health service is often the hardest, however once clients overcome their fears and perceptions of what will happen second visits are less threatening. Nurses work within the parameters of what the client perceives their needs to be. Young Maori men are particularly reluctant to present. One nurse describes this:

> I think young Maori men can be very difficult in that they're usually pulled in rather than coming in voluntarily and because they're extremely shy and awkward and it's probably hardest of the barriers to get through. Although once you've cracked that they tend to come back but usually only when they've got the next problem … humour's probably the most important thing we've got. I just explain to them, probably keeping explanations a lot shorter. What they want is you to do what you have to do so that they can get out of there and I'm very much aware of that and I'll work on trying to do that and probably because they think that you're going to be absolutely horrendous and actually it's nothing much and now especially since we're not doing those nasty chlamydia tests and then

> getting the urine sample and its just, probably putting them through fairly quickly without too much in the way of education ... (Jackie, 1:495).

Experienced nurses learn to respond to signals from clients that they are gaining or losing rapport and to change their practice accordingly:

> I've got a very simple straightforward patter which is fairly clear and I've learnt that, that's evolved over time as well, for example, if you ask a person how many partners have you had in the past 3 months, they will tell you, especially young Maori men, they will tell you one, if you ask how many people have you had sex with in the last 3 months, they will tell you 10 and I've learnt. I probably vary the way I ask the questions really and the speed of going through the questions depending on the person and how they're feeling, and if they go through quickly and it hasn't been that bad and they've had some pills and whatever they've needed, you're far more likely to get them back ... (Jackie, 1:531).

Some sexual health services provided the only sexual assault care available for people over seventeen. Services offered support to clients deciding if and when to report abuse:

> Sexual abuse within families. Where the person being abused is over the age of 18. Doesn't want anyone to know about it. But quite disturbed. Doesn't want counsellors involved. Doesn't want anyone involved ... too old to be referred to CYPS and if you were to tell anyone, you're breaking your confidentiality and ruining that relationship ... they might be quite happy coming to you for three or four months, just coming to have a chat before they're ready to move on ... So sometimes sort of in those cases that can be quite hard ... we have a 24 hour hot line so they know they can contact you at any time and they will be

> contacting you and there's not a lot that you can do until they are ready to do it ... (Grace, 1:227).

The boundaries between nursing and social work blur when in small towns there are no other services to refer the client for professional help. Sexual health nurses often provide support for sexual abuse survivors while decisions are being made. Some services operate as part of a community drop in service for young people. Getting students familiar with sexual health services is a direct approach to encouraging young people to test. Nurses found that they could attract more young men to attend by inviting work skills groups into clinics:

> ... those kids from school will come over here and have a formal tour around the clinic, have a look. And then of course what happened is that there's this huge amount of people in this district that aren't in high school, of young people. And so a lot of them ended up in the TOPS training programmes and there's a school, an alternative school here for children that have been suspended I guess, or not fitting into the mainstream. There's been a lot of work done with them. And they too come here a lot for their education sessions. So they can see the layout of the place and the clinic and that we're here and meet us and a lot of the TOPS groups that we've had there's a lot of males in them. Especially some of the ones if we do some like agricultural, the bush TOPS groups ... I think there's engineering and a motors group and pre-apprenticeship training – they all come ... we have a high percentage of males come here and higher numbers of younger people compared to the rest of the country's STD figures ... (Harriet, 1:118).

Inviting young men in employment training schemes is one way that nurses developed to get into marginalised male communities. Sexual health services are one of the few places young men identify as a place where they can go for care. Teaching healthy lifestyles is part of the strategy used by one sexual health clinic to improve mens' sexual health. In the context of an informal and relaxed atmosphere nurses can introduce

discussion about safer sex. For young men the idea of talking about sex to a health professional becomes less threatening and there is a greater willingness to agree to a check up:

> … a lot of the groups that have come here, we also give them lunch … sometimes they don't like the food we give them. They'd like it to be fish and chips and stuff like that. And a lot of it's not so formal, it's about what they want to hear about … so then while you're here, why don't you go and see one of our nurses and she'll give you condoms and she can also give you an STD check if you want … and it's worked quite well … So when they come into the clinic and then we can get the opportunity to do the full sexual health history. And some of the people that come into the clinic – and I have seen someone in recent times that haven't actually had sex yet. So it's a really good opportunity to take that talking then and to prepare them. And even though all the rest of their mates would think they've come for an STD check, we don't actually need to do that in private. It's just the talk and then there's the others that come that really do need an STD checkup ... it's establishing that relationship … (Harriet, 1:162).

In most services there are no male nurses available and male clients are seen by female nurses. There is varying opinion among sexual health nurses about whether this presents a barrier to men attending for an STI screen. One nurse expressed the view that male nurses were more appropriate to work with some groups of men:

> … he's got an incredibly good relationship with the a white gang in A___And there's no way that those guys would be seeing me. I'd see their girlfriends. (Emily, 1:599).

The gender, sexuality and ethnicity of the practitioners will influence their acceptability to some marginalised people and individuals. Essentially however, it is the ability of the nurse to relate to people in the context of a shared humanity that creates alliance. The professional ability to be inclusive characterises the social interactions of sexual health nurses. This work is the essence of client and cultural safety. In contrast, Gilmore and Somerville (1994, p.1343) explain that " Marginalisation through stigmatisation of some members of the community can define the boundaries of the community, and their exclusion can enhance homogeneity by eliminating differences.

Sexual health nurses reach people in a variety of settings. The concept of 'the clinic' is applied flexibly to suit the needs of different populations, communities, and cultures. The evidence of the study is that nurses form partnership with poorly served health populations that make sexual health care acceptable.

CREATING AN OPEN AND ACCEPTING ENVIRONMENT

Going to a sexual health service is not perceived to be a positive health care experience. In the words of one nurse:

> What we try to do is to set the scene to make a pleasant experience out of a maybe not so pleasant experience (William, 2:21).

Clients indicate that they need reassurance when they attend for sexual health care. Signs and gestures that demonstrate acceptance are of particular importance when people feel marginalised and stigmatised. One nurse talked about a philosophy of welcome in the clinic in which she worked:

> I think we're lovely people. I think the philosophy we have … is very welcoming and … we're not only sexual health, we're pretty much youth health … we have a nice atmosphere for them

> just to come and at the moment we do have a great bunch of people that I think most people feel quite comfortable in popping in and talking to. And we do get a lot of feedback saying "I don't want to go there because, you know, they'll whip you in, do some tests and send you out again but you'll give me a coffee."... I think we have a little bit more maybe empathy or caring or ... And it's not that we have more time. (Grace, 1:108).

The key to overcoming the significant social and psychological problems inherent in attending a sexual health clinic is the attitude of the practitioners who work in the clinics. Personal comfort with sexuality and sexual difference is essential to be able to manage the work in a functional way:

> I guess in the first place we're comfortable with our own sexuality and how we are in our skin. And if we're comfortable about who we are in our skin, then we're going to be OK about anyone else. We're not going to feel challenged, threatened or whatever by someone else and so we're at ease with difference, we're at ease with men helping women, women helping men. I think it's about being comfortable and I think it shows if you're not comfortable in your skin ... (Jill, 1:89).

Creating client comfort and safety depends on an ability to perceive the events of clinical consultation from the perspective of the client and to recognise discomfort and resistance:

> It's making it safe and it's making it OK at any point for them to say stop ... it's about not being rigid in your examination like we do a urethral swab for chlamydia and telling people about that and then them saying "no I don't want that". OK we won't do it. Fine. And it's the same as a man. You know we've had

> men come in and say "look I just will not have that urethral swab. I hate it." OK, we'll do a urine. We won't worry about it. It's not worth upsetting people, we'd rather them do a little bit of the examination, rather than being too rigid. So it's about keeping open, putting yourself in the client's shoes, like saying how would I feel coming to this total stranger? But you're very aware when you're meeting people for the first time, you've basically got to be a top notch hostess … or host (Jill, 1:136).

Nurses worked on engagement from the first point of contact with the client. The process of rapport building has to be rapid as time is limited and the client often feels extremely anxious while waiting to be seen. Feeling relaxed, using humour and actively liking people is described in this situation:

> I think it's the whole attitude all the way through. I think it works very quickly from the moment that you're going out to the waiting room and calling them in and the way you're even doing that. You know with the smile. You know how often do you get to a hospital and not a single person smiles at you … and I've just got to be very relaxed in myself and at times use humour, but never at the person, and everything has to be explained. I like that for myself but how often do we ever have anyone else explaining what's happening and right from the word go, in bringing them in and talking to them I'm working on making them feel more relaxed and a lot of that is because I'm not a doctor and when you're not a doctor, you don't have that barrier of being someone a bit further up the ladder I guess, and it's the way you're speaking with them. It actually happens quite quickly, quite steadily and especially if they laugh anywhere along the way. The minute there's laughter is the minute that they've relaxed a weeny bit … (Jackie, 1:194).

The basis of identification as a health care professional is getting to know and understand the client as a person and is the basis of maintaining an ongoing therapeutic relationship. In the long term more effective sexual health care is maintained by first establishing the trust and cooperation of the client. Emphasising safe sex and behaviour change before rapport has been established can sound censorious and may in the words of this nurse deter the client from reattending:

> … it's establishing a relationship I think so they will just keep coming back. I don't want them to feel that they can't come back so it's really hard not ... to challenge them on that [getting so drunk that they can't remember who they had sex with]. And I know that I can't do that, I can't challenge them too bad, you know, too much because they won't to come back (Harriet, 1:246).

Going out to schools and educating students about safe sex and sexual health is an important preparatory step to getting young people to present at a clinic. Changing attitudes towards self care and sexuality is part of the framework of providing sexual health care. Nurses as health educators recognise that getting a check up is mostly about having the social confidence to enter a clinic. Nurses emphasised the importance to start with actively welcoming the client:

> I do a clinic sometimes up at the school and lots of boys started presenting at the clinic. And, you know, put the hand through the door "Come in" … it's amazing what they know actually. I was really impressed by … the knowledge that they've got about sexual health … And it's quite a broad spectrum of adolescent boys that we're talking about too … our wonderful health educators ... it's making a big impact … they're using condoms… And there's the younger client that presents to a sexual health clinic seems to be much more comfortable. And entitled to sexual health services than somebody who is a bit

> older too. And that's got a lot to do with attitude changing from education in school … Normalise it … (Jane, 1:706).

The reputation of the nurse and the clinic depends on favourable experiences being reported from a young person to their peers. As one nurse says:

> … it can be quite difficult and sometimes you have to be quite direct and say, you know is there a reason that you're here and do you think we should do something about that. But often I find in my school that … word of mouth is the best advertising and it gets around that oh no she's OK and you can say what you like to her and kids will listen to that and they feel quite comfortable with that. But yeah a couple of times I've had to be direct and say "well you know, this is happening and this is what I think might be happening and we need to do something about that"… Like I always try and remember that it's a drop in clinic and they've come of their own free will. And without trying to scare them away ... (Sue 1:120).

It is not always easy to empathise with or relate to clients however, in a situation where this occurs the nurse would not convey any negative feelings:

> Jolly well don't show any. I mean every now and then you do have someone that comes in … I don't know but I do sometimes think oh God, really? … (Emma, 1:367).

In participant statements there is continual concern for the well being of the client rather than making judgements about them. Nurses report that clients sometimes arrive having experienced punitive care from other health care providers:

> … it's the non judgmental stuff too I think. Because you do hear of stories of people in other situations being made to feel as

> if they've really done a bad thing. Whereas I think that people who come into Sexual Health don't have that experience ... even though they've had chlamydia five times and they've had two terminations and … they still come back. So and at the end of the day I prefer them back there than not coming back at all even if they are coming back with chlamydia. I mean I know it's not ideal but it happens, you know that's the way it is … (Emily, 1:486).

Hearing sexual health stories in a way that is honourable is the context of the interaction between the nurse and client, as described by one nurse:

> … there's something about story telling in these settings too that seems particularly important and maybe that's related to some issues around sexuality. And how people have got to where they are now, like explaining how come these things that I'm telling you about my sexuality, some of which are risky and quite shocking, how I got to there, you need to hear that. I think that just the whole step of walking into the sexual health clinic and maybe it's the first time and you know that the people who work here … And a lot of the clients assume and I think rightly assume here the people, we are going to listen to them, we're not going to be shocked, we're not going say to be really judgmental, we're not going to make them feel bad about anything that's happened sexually or whatever to them … seize the opportunity to tell their stories because of the environment, because of what we are, you know it's sexual health and it's sexual health nurses … (April, 1508).

Learning how to talk to people with sexuality issues evolves with time and practice and in an environment where this activity is supported:

> Maybe it's a trust thing here or it's having confidence in the staff from a client's perspective. I don't know, they just know the information is going to be dealt with appropriately and ... it's also working within the speciality as well. Like this is what you do all day, every day at Sexual Health ... so it's constantly, you're constantly exposed to it. Whereas in general practice ... (Emily, 1:148).

The social process of identifying with people is uncovered in the present study in the taken for granted skills that nurses have in conveying to the client the sense that they will be cared for appropriately. Sexual health practice is a matter of learned skills and behaviours. The learning of such skills depends on a culture and environment in the health care setting that makes sexuality an acceptable, appropriate and professional topic of discussion. Prejudiced and judgemental professional attitudes towards people can be reframed and relearned as respecting and dignifying if the culture of health care is conducive.

MAKING SERVICES SAFE

One of the biggest fears clients have is that they can be identified as having attended a sexual health service and that the consequences of this would be a personal disaster. Sexual health clinics therefore protect client identity from other health care providers, laboratory services and from hospital databases. To ensure total secrecy the client will only be contacted if they wish. Nurses give full explanations of the level to which the client's name will be protected and anonymised:

> I would explain to her that they're all going to the lab, we don't use names here, and we use numbers. So it's all anonymous. That it will go to the lab, how many days it will take to come back and then we'll sort out how she wants to get the results.

> Whether she wants to come in or she wants to phone us or whether we can phone her ... (Grace, 1: 299).

This nurse also explains a number of other personal safety issues. Patients are vulnerable during examination so that questioning and information giving is provided when the patient is fully clothed. As part of informed consent, the nurse assesses the impact that results may have on the client before proceeding with tests. The client is given an opportunity to review the consultation process:

> as we're going through the tests ... and afterwards once we've finished and she's, clothes back on and sitting down, I'll just give her an opportunity to let me know how it was. Let me know if there were any things that she would have liked to have done differently ... anything that she thinks I should have told her before she started ... (Grace, 1: 301).

In the above and other cases client safety is frequently referred to as a balance of power between the nurse and the client. In the following case female nurses talk about their own and their client's safety in 'managing men'. Female clients are not referred to as having to be 'managed' in the same manner. It is the gender power relationship implicit in the nature of women discussing sex with men, which is referred to. Nurses new to sexual health care overcome their own nervousness about how this interaction will be interpreted by male clients when they are 'out of the box' of the protection of a hospital bed. In this case the nurse recognises her own power which is that it is the client's embarrassment which is greater than hers. In turn picking up on the client's reaction to the nurse's gender and responding is a way of minimising discomfort and gives the client the power to decline examination if it is not appropriate:

> Well just managing men really. Yeah I mean it is interesting. Because you can tell sometimes when they first come into the room that it's like not wanting to talk to this woman … but I'm surprised at how many men that it's not an issue. I ask them, I say to them "you know you look a bit surprised, do you mind talking to woman? I hope you realise the doctor is a woman today. If you're not OK with that well you can come back on a Wednesday." I mean I get that all out in the open to start with … I just think they're often far more embarrassed than I am. And initially that was my thing, I thought I don't really, you know I've nursed men in hospital but somehow they're in their client box in hospital, and when you're in this sort of place they're not in a box … (Emma, 1:425).

Female nurses identify with male clients. This nurse went on to explain that managing men was a 'pleasant surprise', indicating that she had expected that caring for men in a sexual health setting would be difficult. Taking people's concerns seriously however clinically minor is emphasised. Nurses reflected that men are often direct and uninhibited about revealing problems. This sexual health nurse indicates an understanding of the symbolic social value of genital perfection:

> And I guess initially it was harder for me. I mean it doesn't worry me at all now. Because I do quite a bit in the male clinics. In fact I think that the men are easier to talk to quite often and they've come straight out with stuff, no beating around the bush, incredibly honest about you know their symptoms are quite distinctive. In terms of actual treatment it astonishes me, like we were saying about penises and it's out there, they'll just grab their penis, pull back the foreskin and say, "there's the wart. Oh yeah I think it's got smaller" or whatever … There may be a small amount of initial embarrassment but once they've had one treatment, they're quite relaxed (Emma, 1:425).

Identifying with people who attend sexual health services is dependent on a degree of social distance from clients. For sexual health care, clients will avoid services with health care providers who are related, socially connected, or who know their families. Clients separate their health care seeking behaviour into common and public and special and private events. For unstigmatised health problems it is safe for the client to go to a setting where they may be known by others. For stigmatised health problems such as STIs they will go to a setting where privacy and anonymity is available. This leads to the separation by many, of sexual health from other health care. Sexual life therefore represents a private and hidden self, unless connected to acceptable events such as childbirth. Maori clients will attend for sexual health problems according to the safety for them of the provider. Although Iwi providers offer sexual health services for Maori, many continue to use sexual health clinics. Adolescents prefer not to take the risk of encountering a relative, as one nurse stated (see Appendix Ten):

> They've got a big health service [Iwi health services], which is looking at all the things like well child services, and Youth Health ... we seem to be more of a clinical service here, that they're still coming here. A lot of that is about the confidentiality thing … we go in and we come out again. And they quite like that. And we quite like it because it's a real safety issue for us. We're not there after hours for them to ring us up. And even though we have a 24 hour phone line ... and that we're not going to break their confidentiality. We're not their aunty and it's a very small community … (Harriet, 1:492).

With experience nurses learn a repertoire of strategies that will make the potentially difficult encounter easier for the client. In this case the nurse talks about assessing each individual case and engaging in a personalised care approach:

> And that's about setting the scene when you're actually doing the history. And setting the scene and explaining to people what the examination is. And saying things that might help them feel at ease. Like, you know, a young woman saying " Oh God, this

> is so embarrassing, you've got no idea what it's like." And I sometimes say "just imagine us having to have this. We've all had to have internal examinations". And they just laugh. And it's just somehow working out ways to make the individual client at ease … (Jill, 1:113).

One nurse used adolescent social networks as a way of informing others of sexual risks and the need for testing. Young men had particular fears about testing and were offered non-invasive testing procedures:

> when it comes to anything happening, girls tend to be proactive and do something about it, boys will pretend it's not there or hope that it will go away so young men are very difficult to get them in. They're petrified ... First of all they don't want a test because they don't want to know if they've got chlamydia, that would be terrible, absolutely devastating and kids don't believe that it will happen to them anyway … So the sexual histories is a key to the whole thing. You're looking at their needs and you're also going through symptoms and the symptoms may be very mild … and when you're actually asking them and they are giving you answers, they're starting to see a picture for themselves about what may be happening and for some of them it's a bit of a shock especially if they're a friend or a support person and they're listening in and thinking gosh. I've got some of that happening to me and they will but in and have their weird three or four way conversations in the middle of trying to get a single sexual history. And I think that they come to that conclusion themselves. And now if they're not keen for the full examination we have the urine test which we can at least offer so it's better than nothing, it's looking for the most common of the nasty infections that will do them harm, and you don't have to take your pants off. And I think that's a starting point. If they've got other symptoms such as discharge, we can often talk

> them into it or sow the seed of having an examination … (Jackie, 1:57).

Limiting nursing care for young people in trouble to clinical concerns is inadequate and unsafe. Setting boundaries is difficult when trust and safety have been established and there are few social or family supports available to young people. Nurses, in small communities often took on social work responsibilities:

> And there's all those issues of someone quite foreign to her taking her to Auckland for an abortion. But actually it was quite successful … she came back into our service and saw us and fed back and carried on getting some support until she shifted. She was a very transient person – I think she's 14 now – shifting, just running away basically all the time. And it was unfortunate that she was actually under CYPS through the whole thing … We weren't very happy about it though. Because we knew as nurses that it was about the caring and the holistic bit but I could see other people ... you know counsellors and such that … you know, where are your boundaries around this kind of thing? But I just find the nursing thing is just the total caring and that's what happens in a service like this … (Harriet, 1:369).

Keeping clients who have been traumatised, psychologically safe when painful and threatening issues have been raised was discussed by one nurse. The issue of safety is raised as a matter of professional responsibility:

> … Because I felt that I had a sense of responsibility to this woman. That in some respect I'd pushed her button. And I'd made her start thinking about what had gone on in her past and I just didn't feel that I could leave her with that because, I mean that's what you'd think yourself really ... (Emily, 1:95).

Often young people are reluctant or unable to tell parents about their sexual activity. Students felt safest using services during school hours and know that visits will be kept confidential:

> The girls can come to the clinic during school hours. And so there's a confidence thing there for them that they know where to go and they're safe ... they don't have to sort of go after school hours and things like that ... (Emily, 1:331).

Sexual health work is secretive and private. In order to ensure that nurses kept safe as practitioners debrief and clinical supervision processes are used. In small communities nurses who worked alone prevented burnout by offloading with an appropriate health professional:

> ... I think in sexual health you do a lot of things that are specific and sometimes challenging and emotive and often as the only clinical nurse, I feel weighted down by that and have a need to go yadda, yadda ... to somebody that actually has had that similar experience to me. I have negotiated with a person off sight to off load onto her and it's not ideal but it keeps me to some degree safe ... (Patricia, 1: 230).

Identifying with clients and relating to the experiences of marginalised communities makes effective interactions in sexual health services possible. The danger is over identification with clients, which would become professionally and personally unsafe. In small communities it is essential to develop collegial support networks with people who can identify with the nature of sexual health work.

SUMMARY

The categories outlined in this chapter are the processes by which nurses are able to identify with the people who visit sexual health services and are identified by those

populations as non threatening and confidential. In the first category *getting into marginalised communities* nurses recognise the significant social barriers faced by clients who are attending a sexual health clinic. For clients, the experience is initially threatening whether or not an STI is diagnosed. Daily, nurses encounter people who feel ashamed, humiliated, defensive and frightened about their situation and the health care setting that they find themselves in. Nurses emphasised the stigma attached to their clients and the service that they worked for. In the second category *creating open and accepting environments* nurses develop ways of knowing about and responding to social, psychological and cultural reactions to sexuality and sexual health care based on their experience in practice. Within the broader spectrum of sexual and reproductive health care nurses in sexual health settings felt that they were perceived by other health professionals and the community, as being involved with the 'dirty' aspects of sexuality. Nurses had awareness that clients therefore anticipated negative reactions from the staff who work in sexual health services. In the third category *making services safe* nurses adopt strategies to convey humanity, safety and normality.

CHAPTER SIX

PERSONALISATION

As discussed in the previous chapter *identifying with people* who attend sexual health services is a matter of overcoming stigma and marginalisation and the social and psychological impact on individuals and groups. Sexual health services and sexually transmitted infections have derogatory implications for people. Nurses recognise that stress reducing and non threatening approaches enable *getting into marginalised networks.* People with sexual health problems are reluctant health care clients therefore *creating open and accepting environments* is part of the psychological atmosphere provided. To put clients at ease considerable attention is given to *making services safe* enough to enter. The attitudes and behaviours of the nurses who work in sexual health services are as important as anonymity, confidentiality and privacy to the client.

When clients arrive at a sexual health service they are apprehensive about how they will be received. The theoretical codes which were identified during the study were *getting close to people, making it a positive experience, finding the right empathic approach* and *minimising threats and fears* (See Figure Three). Nurses work with clients who have high levels of anxiety and a fear of being judged and therefore actively engage in demonstrating liking and acceptance. Nurses learn different patterns of interactions in the climate and culture of sexual health services The process is described as *personalisation* as it specifically counters the social distancing and impersonalisation that may be used to reinforce the clients unacceptability in other health care contexts. The nurse develops an empathic recognition of the client's psychological condition. *Getting close to people* when they are vulnerable and threatened is the challenge nurses face in the limited time frame and setting of the clinical consultation. Health care professionals have the power to make sexual health care a stigmatising experience. As people often perceive themselves to be in a bad situation having to seek sexual health care, nurses intend *making it a positive experience* to minimise any psychological harm and to ensure that the client will return if they need to. Making the experience constructive and therapeutic depends on the nurse *finding the right empathic approach* for each individual client. *Minimising threats and fears* is a matter of reassuring and

preparing the client for sensitive history taking, tests and procedures, and ensuring that the process is not experienced as one of being physically and emotionally exposed or demeaned.

Figure Three: Personalisation

GETTING CLOSE TO PEOPLE

Getting close to people is the primary task that nurses describe in undertaking sexual health care. Intensive rapport building must take place quickly before the nurse enters the more sensitive aspects of the consultation, sexual history taking and genital examination. Building rapport involves communication, relationship and connection (Fowler & Fowler, 1964). It is the therapeutic alliance between the nurse and the client that is significant if there is to be any impact on risk behaviour. The importance of 'knowing' the client before proceeding is emphasised by this nurse:

> ... the biggest thing probably for me is just to be able to have that rapport with them first. Of knowing who you are and just being able to talk to you face to face here for a while and that sort of tends to break down some barriers ... (Rose, 1:449).

Hearing the client's personal story is considered to be a key to therapeutic intervention As one nurse says testing for sexually transmitted infections is secondary to demonstrating interest in the client's life:

> ... the clinical stuff like doing the swabs or whatever, it's almost secondary you know and it's more listening to stories ... (April, 1:13).

The patient's story is the essence of the fact finding that is the basis of a good clinical assessment. In the context of discussing sex a number of studies promote the concept of professional distancing in health care in which sensitive issues and intimate examination is involved (Emerson, 1970; Lawler, 1991; Meerabeau, 1999). Browne and Minichiello (1998) however, emphasise that the client's story is the most important aspect of sexual history taking. Hearing stories is interactive and negotiated between the clinician and the client. Clinicians facilitate a process of 'unpacking' in which the client is able to disclose relevant information regarding risk in addition to symptoms and sexual practices (Browne & Minichiello, 1998). The interaction is one of *getting close to people* rather than one of professional distancing. Conversations with clients are purposefully directed towards gaining the client's confidence and cooperation. A dual process is occurring in which a comprehensive clinical and psychosexual assessment is being made along with conveying a sense of professional competence. As this nurse states 'detective work' is a matter of developing communication and advanced clinical expertise:

> ... I've also evolved it for myself and worked out my own ways of talking to people. And I think too that being a nurse is part of the break down of the barriers but I don't have any problems. I

> think it's first of all to give the information that we do, you have to have a huge knowledge to draw on and a huge knowledge gives you confidence and if you know exactly why you're doing it and what you're looking for and when you're talking to people you can tie up all these loose ends and say like the reason we've asked this is because … which makes people start to have a lot of confidence in you because you seem to know what you're talking about here and I think that's the key to really getting a sexual history and it's like really painting a picture isn't it. You've got to have enough parts of that picture to get what the picture's all about, it's a bit of detective work really … (Jackie, 1:471).

Getting to know the nurse may involve a number of interactions over a period of time. Adolescents often need the safety of a group of peers before they will attend. In this instance the nurse manages group dynamics as part of the clinical interaction:

> … one of the issues that came to me the other day, a group of girls came. One girl spoke on behalf of another student. This student couldn't speak for herself … so the friend actually had the knowledge of what they'd come there for and spoke on behalf of the student. And then they all sort of sat around, the whole group, the four of them just talking. And then they got up to move out of the room to go and make themselves a drink and I'd already said, I think I'd gone down the process of saying "Well, you know, are there any other issues? Do you want to stay, you know, one at a time? Do you want to have space" "No no no no". They all said "no". But as they all got up to move off, one girl lagged behind and stayed … (Milly, 1:73).

While support people are welcome client privacy is paramount when personal details are being shared. Making decisions about the involvement of the client's partner in the consultation is a matter of clinical judgement. To represent the interests of the client

some nurses avoid having a third person in the consultation, as the client may be unable to disclose important information:

> It robs the client of a chance to tell their story. Occasionally men want to bring their wife or girlfriend and that changes my whole approach to the interview that I have with them. I don't want to replicate that schoolroom situation. People can't disclose things if they have other people in the room. Often if the support person leaves the room for 5 minutes, they'll say, "this is what really happened" so I thought after all this time that I'm just going to cut through that. I say thank you for coming, we may need you to hold the patient's hand and so we will call you when we need you and we really appreciate that you're here for that ... (Mia, 2:37).

Meerabeau (1999) discussing the management of sexuality in fertility clinics observes that the practitioner's conversation with the client is kept strictly to 'relevant' medically related issues. By comparison sexual health nurses give great importance to allowing the client to discuss their general concerns. Sexual health nurses are unconventional and appear to be resocialised in a manner of interaction that is intensely 'personal'. Nurses like their clients. It is the personal closeness that the work brings which nurses find particularly rewarding:

> ... you don't make it overnight but you know over a couple of months as you get to know people ... I like it ... I like the personalness of it ... (Grace, 1:367).

Client populations are not homogenous. People interact differently with health care professionals according to the characteristic behaviours of culture, gender, age group and rural or urban locations. The process of gaining trust is paced according to the level of self disclosure that is comfortable and safe for the client. Often it is the most marginalised and at risk people who are protective of their personal information:

> … Very at risk. Huge numbers of young Maori women mostly. Those are the people I would mostly see. And pardon the turn of phrase but the hit rate is amazing compared to here. As far as positive results, if you're talking purely STD wise … you're very aware that people come in with a specific need and may divulge other areas to you in that consultation. But basically they're generally really clear about what they want and it may not be what you think they need at all … (Jane, 1:164).

Nurses are not a homogenous group either and will relate better with some sexual health populations than with others. Adolescent clients choose whom they will relate to. Being young, having an open door policy and an understanding of youth culture closes the professional gap in the view of this nurse:

> … I guess that's where like my counselling comes in and I do discuss a lot of other things that aren't directly related to sexual health. But, you know, if it's affecting their sexual health in the end, then that's all got to come into it. And the school actually, they have a counsellor for drug and alcohol and they have a public health nurse that I work quite closely with as well. So yeah, it is very diverse. But at the same time the kids sort of identify who they like going to talk to. And if you say, "well that's not my area" then you've lost them in a lot of ways. I guess well I'm young… And I, you know, I'm very informal I think. I go and I don't just sit behind a desk. I've made my clinic as a drop in clinic. They can just drop in and talk about anything … and I've never sort of put anyone off. I've never said "no I don't want to talk to you about that" or "that's inappropriate" or whatever. I've often said, "I can't answer your question"… I'm just very informal and approachable and make them feel that I'm more than happy for them to be there ... (Sue 1:82).

Distance in the health professional conveys to experienced practitioners the tentativeness of nurses new to sexual health practice. It is an interpersonal behaviour that will change with clinical confidence and with competent genital examination skills:

> I pick up on distance. I think that they maintain the person. In terms of like just sitting in the room with them. But also distance in the examination room. Like when someone's actually examining someone, you know you've got to get up close. You can't examine someone from an arms length away. So getting up close I think it's just, it's body language. That's what I detect it as, as body language. And being happy to even just touch someone else. Yes I know it's an intimate examination, yeah and you're wearing gloves and everything like that, but you've still got be OK about touching that person … (Jill, 1:100).

In this case the nurse reflects on her initial anxiety about looking and knowing how to distinguish clinically normal from abnormal clinical presentations:

> I guess feeling comfortable with examining a woman and feeling really OK about that … and not being afraid to look. And to touch and to see. I think when I first started doing that I was really tentative ... I think it was my anxiety for the woman and ... so I guess it's a confidence thing and just looking and seeing what you're seeing and touching and feeling OK about that. And also knowing what's normal and what's not … (Emily, 1:183).

Clients present with issues and behaviours that are challenging at times. Bracketing judgemental feelings is the way that nurses maintain a regard for the client. The rationale for suspending judgement is that the nurse does not know the client's situation and is therefore unprepared to draw any negative conclusions:

> ... I mean, you know, I can't judge you. I can't say you shouldn't have done that. I mean, who knows what's happening at home? ... I'm not saying that these things are OK, I'm not condoning it but I can't say well you're shocking and therefore I can't even talk to you any more. No I do put it aside. I do bracket it and I guess it depends if he was completely arrogant ... I mean it could be for any reason. (Emma, 1:410).

Discussing sexuality and sexual health problems rather than a professionally distant experience is intensely intimate and offers a greater level of interpersonal sharing than many other health settings:

> I think you get to develop relationships with people much more quickly ... So that you know if I see somebody one week and say for instance it's not appropriate to do the genital examination for whatever reason, I can book out a longer slot for next time. And particularly moving from doing the education counselling sort of contact tracing stuff, into clinical. because it's so intimate, yet you're seeing people repeatedly, you do develop relationships quite quickly. Like wart treatments for instance, I mean you could be seeing somebody once a week for ten weeks ... it's not because I would be any better than anybody else at all, but people certainly asked to come back and see you and it's just a comfort thing really ... (Emily, 1:398).

Setting boundaries once rapport has been established is a particular difficulty in smaller centres where sexual health services are seen as youth drop in centres and there are few available referral agencies:

> it's quite hard to draw a boundary there because it's a case of well if I refuse to help them deal with this issue then it's not going to be dealt with. If it's not in my role ... it comes with

> knowing where everybody else's boundaries are and what they will accept. And how appropriate they are for our clients as well. And whether or not we can have a working relationship with them. At the moment, yeah boundaries are very difficult … (Grace, 1:197).

One nurse contrasted her experience of client disclosure in a general practice setting with her work in a sexual health clinic. The issues raised in sexual health settings open up relationship problems and past abusive experiences:

> The issues are so much more complex. That's what it seems to me. That somebody just comes in to have their wart sprayed with a bit of liquid nitrogen on their hand. I mean that's sort of in and out but somebody comes in to have a smear and then discloses sexual abuse or suddenly you find chlamydia that's unexpected and the woman's married or whatever, you know, some of the issues around sexual health seem to be so much more complex than your standard sort of bit of asthma ... (Emily, 1: 42).

Client stories may also trigger painful experiences of relationships in the nurse's life. The nurse understands her client's situation as a shared women's predicament. This nurse explains that this can make it difficult to work with men as clients:

> … like because we've all had some sort of personal experience of one issue or another around sexual health that you can relate to it. And that might be a bit of difference of when, you know if you're dealing with somebody with asthma. If you've never really had that experience stuff, you'd just think oh you've got asthma. But you know somebody comes in and they talk about their partner being unfaithful and you're sitting there thinking God I know what that's like. Because that happened to me last

> year and maybe it's a more personal sort of experience that you have. Though it's to be completely honest. I don't really want to see men anyway and I'm not sure what that's really about. But I prefer not to see men … (Emily, 1:556).

In the case of clients who have been sexually abused the process of *getting close to people* may be protracted. Nurses will postpone examination until sufficient safety has been established. The nursing intervention in this case focuses on building a therapeutic alliance with the client:

> … don't even do the examination. Because it's just not safe. And the person's just out of touch with reality and yeah you're just going to leave it. Or an abuse sort of situation. I've had quite a few situations like that where the person at some stage needs to have a genital examination but doesn't need to be today. And that, I guess, you hope that at the initial visit, that you develop some sort of relationship that that person will come back. And it might be on their fifth visit that they have a genital examination but you need to have all of that time before you can get there. And that's certainly what you don't get in general practice really is that luxury of time. And building relationships … (Emily, 1:225).

Gender has a strong influence on how much or how little personal detail is discussed in the consultation. This nurse demonstrates the view that men and women have different levels of expectation about the purpose of the sexual health visit. Women frequently took the opportunity to discuss a variety of issues whereas men wanted a quick consultation. This example may reflect differences in men's and women's health care seeking behaviours:

> … female clients take on average, on a first visit, take about three quarters of an hour, whereas men take about half an hour,

> so there's a lot less history and a lot less complications to deal with, with men than with women, women are much much more complicated and women also, tend to have a lot more questions and lot more things stored away inside, if they're comfortable, they tend to let out [more] than what men do. I suppose it's the role women play in life really. Where often their needs seem less important than everybody else's needs maybe and I think when you sort of delve into it, there's a lot of little issues I guess like sexual abuse for a start, asking about that, but there's also maybe date rapes which they wouldn't put into the category of sexual abuse. There are sexual hang ups and difficulties, like you get a lot more vestibulitis and obscure sort of symptoms from what men do, I think women are a bit more demanding in what they're going to get as well in a way especially when they feel a bit more comfortable whereas men tend to want to get things sorted out and off they go again … (Jackie, 1:305).

The gender and ethnicity of the health practitioner and the client may be a significant factor in *getting close to people* in the setting of sexual health services. Most importantly nurses detail how it is that a therapeutic alliance is established with the client.

MAKING IT A POSITIVE EXPERIENCE

Clients experience a visit to a sexual health service as a negative experience in which they are likely to receive bad news. Sexual health nurses take the approach that through personal alignment, reflective listening and a reframing of events, the outcome for the client can be positive. During the assessment phase of the consultation nurses obtain information from the client about the meaning for them of visiting a sexual health service, of having a sexually transmitted infection and of being examined. Nurses will engage a variety of personalised interventions based on the nature and extent of client fears and anxieties. Through interviewing techniques the significance and severity of the event for the client is determined. Nursing interventions and interactions are of critical

importance in the adjustment the client will make to a sexually transmitted infection. Ensuring that the client has had a positive experience is part of the destigmatising process. The client's expectation is that they will be made to feel bad and that they will be distanced in some way from the health professional and from significant others in their life. The nurse in this instance wants clients to have a good enough experience that her frank comments about the need for behaviour change are not interpreted as denigrating:

> I think making sure that they go away from it feeling good. And well informed. That they know, and if they don't feel informed, that they know that they can you know access further information. I just think the main thing is I want people to know that it's an OK place to come ... it's funny though you want them to think it's an OK place to come but you don't want them to think it's so OK that they can keep coming back for full checks every 3 months ... And they're just reinfecting themselves. And you just say, "look, you know, you came in because you want treatment" I mean sometimes you've got to be quite firm with people and say, and just remind them of what they're actually doing here and that they must be here because they want treatment. Do they want to get better ...? And it's quite good to throw it back in their court and say, "what do you perceive you can do? You know, what do you think you can do to stop this cycle?" And they'll come up with something ... (Emma, 1:480).

The experience of good service is feeling valued. In this environment clients are more receptive to messages about self protection:

> ... at some point there is a sense where people have to take some sort of responsibility for themselves and you know, my job is to support and give the information, and make the experience for the person as, you know, as good as possible ... (Emily, 1:308).

Unless the interaction is carefully constructed women may experience female genital examination as invasive. In this case the nurse is educating Maori women about cervical screening. The symbolic 'mind set' referred to is that speculum examination is immodest, demeaning and exposing for Maori women. The nurse is reducing the cultural impact of the experience in educationally reframing the significance of screening procedures:

> ... Usually if they've come along to one of my education sessions first and they've understood the importance of screening and that it's not such an invasive procedure as they have that mind set about but that it is, that it's not quite as painful and uncomfortable as what they feel it might, initially they might have felt it would be. So usually when they've got ... that in their mind that ... this is not quite so bad, it makes it a lot easier for them to come in ... More than often they'll turn round and say "Oh well that was easy." (Rose, 1:432).

While procedures are routine each individual case is personalised. Nurses define good experiences for clients as those in which the genital examination is negotiated and co-managed between nurse and client. Nurses place importance on operating in a relaxed and happy atmosphere. The client gains a sense of control in being made aware of procedures and giving the nurse permission to proceed:

> ... the biggest thing is giving them control. If you give them the control, they're a lot happier ... I've had people who have had negative experiences in the past who don't want to have it done ... and I think if you give the person that control, it just changes the whole atmosphere. And really I've only heard comments that say, "it's not as bad as I thought it would be." Some people like to be shown what instruments they're going to use. Some people say "did you have to show me the speculum, I'd rather you didn't." But that's me personally, I'd rather personalise what I'm doing than that I didn't ... (Grace, 1:320).

Nurses continually engage in strategies that will increase client comfort. Care is designed to enhance effective client coping skills. Nurses develop ways of knowing about potential areas of difficulty and offer clients options about their care:

> … I find out what their experience is of internal examinations in the past. Like have they been to another sexual health clinic. Have they been to us before. By the time I get to that stage I know … strategies for making them comfortable are explaining the examination, talking about being able to stop it at any time. Is it OK to have the examination today, particularly like a woman who's menstruating. Or if it's a man who's going to have me doing the examination or a female doctor – checking out that it's OK that it's a female and that there's an opportunity to see a male two days later … (Jill, 1:125).

Noticing a lack of self esteem, low self confidence and shame is a signal to the nurse that interactions need to focus on a positive therapeutic alliance in which the nurse and client engage equally at a social level. Shame is a dehumanising experience; the individual becomes unworthy of regard and respect. Body language that is inconsistent with verbal language communicates ambivalence and discomfort. To proceed with clinical tests when there are indications that the client is submitting rather than choosing will reinforce the experience of abuse. The health professional is in danger of being experienced as threatening and over powering if the client is not sufficiently empowered. Aiming for assertive rather than compliant responses from clients is effective behaviour change and enhances future self efficacy:

> … Like maybe at that initial visit, they're really submissive and head hung and sort of saying "yes" but you're thinking no, no, no, no, no, and maybe on that fifth visit they've got the control. … they're trusting you and they're much more confident in the way that they're speaking and holding themselves … you're reading the signs I guess from the person. And having another person in the room as well is helpful. Another colleague or

> friend or something is helpful to allay their anxiety and make it a better experience … (Emily, 1:239)

Each consultation entered into is a process of negotiation, cooperation, and compromise with the client. Sexual health nurses implement informed consent as an agreement with the client that care is a mutual undertaking that can be adjusted and altered according to individual comfort. Client consent for procedures continues to be negotiated throughout the examination. In some cases genital examination is barely tolerable. There may be little that the nurse can do to make screening procedures a better experience, however it is important to meet the needs of the individual:

> Oh she just said I hate being examined. But I'll lie there and tolerate it. And I said well you know what can we do to make it better for you? Oh nothing she said. Just do it really fast. And actually yeah, what can you do other than at least you acknowledged it I suppose ... (Emma, 1:756).

Lawler (1991) indicates that distancing has a role when nursing care may place the client in an embarrassing position. Embarrassment is the central concern of the literature about sexual health care however to nurses in the current study this is not the predominant issue. The central preoccupation of sexual health nurses is tension reduction and the development of strategies that will allow the nurse to get close enough to the client to provide physical and emotional care, and make it a positive experience.

FINDING THE RIGHT EMPATHIC APPROACH

Sexual health nurses use therapeutic alliance as a means of repairing and interrupting the psychologically damaging effects of having a sexually transmitted infection. Evidence is provided that nurses in sexual health settings engage in a process of reconstructing social meanings and interpretations with clients. Client affect concerning the event of a sexual health check is an indicator of the impact of stigma. A range of counteracting therapeutic interventions is utilised according to the practitioner's training

and experience and their psychosocial assessment of the client. Psychological adjustment varies according to the meanings attributed to sexually transmitted infections. Nursing interventions vary in levels of interactive intensity and involvement, including one to one counselling, crisis intervention and group work. Clients can react to news of viral STIs such as genital herpes with extreme distress:

> … counselling for genital herpes. And that brings a lot of stuff, to see them sit there and come there and be so ashamed and wanting to cry and hide away … And it's quite a lot you can do. We can refer them. We've got people in our support group … some young people, you can just bounce it right off them … the diagnosis of herpes. "So what?" "Yeah. OK." On with their lives … and others are devastated. It's a very interesting range … (Sam, 1:282).

Nurses contract sexually transmitted infections. Having had a personal experience of visiting a sexual health clinic and being diagnosed is a basis for understanding and empathy with clients. Self disclosure used appropriately can decrease the client's sense of inadequacy:

> … I have to say when I applied for the job, yeah I had some experiences in my past as a background which gave me, I thought, good empathy, good understanding, been there done some of that. And in fact I will sometimes self disclose if I think it's necessary. Like I can say "I know how it is to go into a clinic. I actually went in balling my eyes out. You're braver than me." And I actually got a big shot in the bum in those days way back with penicillin say. I mean I don't mind talking about it, that's fine. And sometimes I'll use that if it's appropriate … (Sam, 1:394).

The interviewing that takes place during sexual health history taking is an opportunity to reflect, interpret and challenge inconsistencies between client verbal and physical

responses. Some nurses use counselling interventions such as neuro linguistic programming (NLP) to gain a more complex understanding of client feelings:

> Well basically looking at the body language. Particularly looking at the eyes and what's going on with the eyes. So like instead of saying, "what are you thinking now?" or "what's going on inside your head now?" I sometimes say that or sometimes I just say, "what's that about?" When I can see that there's something going on in their head. They're seeing something, playing something on audio, or visualising it or looking to the past or the future. Or actually feeling something. So I tend to use the NLP skills there ... If you say how you're feeling, when they're actually seeing a picture, you've missed the boat. So I, if I think they're seeing something or I'm not sure if it's seeing or audio, I'll say, "what's going on now for you?"... (Jill, 1:207).

Undergoing sexual health care with a past experience of sexual abuse and rape can be particularly traumatic. Nursing management includes assisting the client to report to the police. In this case the nurse uses knowledge of Rape Trauma Syndrome to normalise the client's reactions and to comfort her:

> ... she didn't want to lay charges. No. I always ask them ... it was really just about, you know, empathising with her about how she felt afterwards and did she scrub herself more, and she'd done all those things. You know it was just doing that kind of thing and letting her know that I had, well hoped that she picked up I had that empathy for [her] ... (Sam, 1:94).

Women feel vulnerable and exposed during genital examination. Stress reducing and relaxation techniques are used to make the procedure as comfortable as possible. This nurse has a variety of approaches to reduce tension, beginning with distraction:

> ... quite often we'll talk about something that might interest them. Like maybe hairstyles or the latest trend in clothing and that sort of thing. And that tends to help them relax and if not, if they're so, if they're not just in to making light conversation or they feel really tense and that, I usually take them through some deep breathing exercises and just making them relax. And explain to them different ways that they can make themselves more comfortable and relaxed in going through that procedure. And particularly if they like, you know you might experience a little discomfort and that but it's not a frightening thing to be afraid of, it's not going to hurt. And the more that they can relax the more comfortable it's going to be for them ... (Rose, 1:376).

Another form of distraction is humour. A way to alleviate the client's sense of being in trouble is to make light of the situation. Nurses describe their social role as one of being an entertainer, contradicting the expected role of the judge. As indicated in this example humour must be appropriate and acceptable:

> ... you've got to be able to kind of like not be deadly serious about it. Like you can tell a joke. It's helpful to be able to have a bit of laugh about it. Without any sexual innuendo either. I mean you've got to find that fine line ... Well you've got to be an entertainer ... (Jill, 1:150).

While getting into personal lives, nurses are aware of the risks to the client of emotional over exposure. Managing disclosure is a matter of knowing the limits of personal skills and of the support systems available. Agencies and resources for sexual assault care are extremely limited in rural areas and often an onward referral is not available or appropriate:

> I don't feel that I should tap on things that I can't actually deal with or at least refer on. At the same time, if people offer

> information in that sort of area, certainly I will stay with them and talk as much through as they were wanting to. One of my real difficulties comes when you suspect something is actually going on and what to actually do about that, one, because I feel completely inadequate to deal with it, two, I don't think I have any right to open that if I can't actually help them with that or at least refer them on to somewhere appropriate. In a small community even referring can be difficult. There may be a relative, friend, family person, someone known to the family who actually may be in the service itself. So that makes referral difficult ... (Patricia, 1:140).

The danger of empathy is over identification and rescuing. There is an emphasis on supporting healthy coping behaviours and self responsibility in clients:

> ... I think that sometimes the danger, the mental health stuff, when they talk about empathy and that there's a real danger of taking over and everybody has a right to their story and a right to their suffering for it and in the end, it's their responsibility, not my responsibility. I can sit and listen and say it's bloody awful and it's not fair that that happened, but it happened; you know. And it's not my responsibility to deal with it ... (April, 1: 199).

To maintain functional client relationships the health professional needs to have resolved personal issues and experiences related to sexual health work:

> I certainly think it helps [if the nurse has some life experience]. Although I was always not an advocate for [using sexual health work to deal with personal issues] ... I mean I always remember sitting in groups and you know you share all round. And it might be on counselling for rape. And ... you'd get these people

> say "well I know how to help. You know I've been there and I know what it's like." ...and you'd think "yeah but you haven't healed yourself first." ... just because you've been there doesn't necessarily mean you can help ... (Sam, 1:547).

An approach to avoiding appearing censorious is to make genuine but naive inquiry about at risk behaviour. This may appear simplistic but it is however, an effective way of starting discussion about personal safety:

> I was truly interested in why they wanted to be trashed every weekend. Truly. And I think they knew that I was being really genuine ... so they were really honest about their responses. But it turned out that they didn't really enjoy it and maybe they'd never talked about it in that way before, it was just something that happened ... (Jane, 1:638).

Each nurse works out a personal style of approach to clients that is comfortable and natural. In the therapeutic alliance genuine empathy, warmth and compassion takes many forms. Witnessing another's pain is a powerful way to acknowledge resilience and survival:

> ... I think that I've got past empathy. I know that sounds weird ... I think it's because like I've had, you know, some big yukky hassles in my life and it's just the way I've dealt with stuff to get to a point where in the end it's your responsibility, my responsibility, my life is my responsibility ... but at the same time I'm quite happy to listen to peoples' stories ... just to, to listen really ... (April, 1:424).

Allowing the client to explain is demythologising. It stops the categorising of individuals into types of people who can then be labelled and distanced. Sexual health nurses demonstrate *personalisation* behaviours in managing interviews and procedures

with clients. Hearing the client's sexual history in the context of their lives rather than as primarily a gathering of medical evidence is a more effective approach to intervening in lifestyle risks. The health professional forms a relationship with the client in which self disclosures can be made which break the isolation of privacy and secrecy. By comparison Meerabeau (1999) discusses gynaecological examination as a series of stages of depersonalisation and describes the purpose as the minimisation of embarrassment and any overtones of sexual intent. The indications of the present study are that clients can construct an otherwise stigmatising experience, as safe and positive, when health professional behaviours involve *getting close to people* and not of distancing them.

MINIMISING THREATS AND FEARS

Consultations progress through a number of carefully negotiated phases. An intensive phase of rapport building allows the nurse to get close enough to provide physical and emotional care. Nurses faced with anxious clients engage a variety of distress reducing behaviours such as reassuring, humour and non-procedural talk. To gain client cooperation with sensitive questioning and examination, the focus of the interaction is maximising safety and minimising resistance and personal discomfort. Therapeutic engagement, clinical and psychosocial assessment occur concurrently. As the assessment becomes more sensitive the nurse continues to check client comfort and to alter the interaction accordingly. Each stage of the interaction is prefaced with explanation and choices, lessening the client sense of resignation and increasing self-efficacy. The skill is in talking non threateningly with people about their sexuality in a way that is therapeutic and has clinical significance.

Embarrassment can be avoided if the health professional demonstrates consideration and anticipates questions and procedures that are exposing and shocking. People can cope with the intrusiveness and unconventionality of direct sexual questioning if they are confident in the professionalism of the nurse. Questioning about a range of sexual practice is important but needs to occur in such a way that the client is not offended. People will respond well to the sexual health interview if they understand the purpose for questions, procedures and practices.

> … following the actual form itself and having warned her what was coming, I think that helps. She actually told me quite a lot as I was running through what I was going to ask her. Even before I asked the question she said, "oh, oh, I've never had anal sex". And I wasn't asking her but she was telling me and I quickly wrote it down … and then I didn't need to ask it again, I mean you know I just breezed over it at the end. And said oh you said you never had anal sex so I'll put never for that, is that OK? I always say to people "if you leave the room and you know you haven't asked me something, there's opportunity to and if the whole appointment's gone by and you still haven't asked, you can ring up or you can come back. Don't hesitate." And I think they do by the time you've got to the clinic room, they're actually feeling quite comfortable with you ... (Emma, 1: 195).

Nurses make a distinction between interviewing which is intrusive and voyeuristic and asking challenging questions because it is important to making an accurate risk assessment:

> … and I didn't even think to ask did they have a partner at home, you know and what was happening at home and stuff. And it was almost like I didn't want to get too nosy … The biggest thing is asking those perhaps what might be seen as hard questions … maybe I didn't ask that question and it was there waiting for me to ask it ... (April 1 159).

Making clients relaxed is important, as many are tense and anxious on arrival. Humorous distractions in good taste are used to break the ice with clients. The social threat is acknowledged and a zone of safety constructed through confidentiality, negotiated power and the nurse's therapeutic use of self:

> ... Oh it's just a 3D-baby orangutang. They look up at this mirror and see this stupid looking monkey peering down at them. And that's the main icebreaker that works for everybody. I never ever make jokes at people. I use myself, I use my husband, but never at the person there and it's always the words you use and language ... (Jackie, 1:527).

Folklore has it that male STI testing is painful and embarrassing. In order to get men to test, historically rooted ideas about the treatment of men in sexually transmitted disease clinics need to be modernised. Young men scare each other with stories about painful urethral instruments and it is this belief that is a major barrier to men attending sexual health clinics. Non invasive testing procedures such as urine testing are available and widely used. Sexual health nurses use the opportunity to coach clients about giving their partners messages about the safety of the service and the testing:

> ... They're just going to state the fact that there is an infection that can be treated, make it quite clear that it's two tablets and it can be sorted out and that the only thing we want from the guys is a urine sample. That they need to hang on, not to have a nervous pee for a couple of hours beforehand and by keeping to a very non threatening urine sample we can actually get a lot of them in ... (Jackie, 1:105)

In general settings there is concern in the nursing literature about inappropriate male sexual behaviour when intimate care is involved. It is claimed that female nurses are the target of sexual harassment by male clients (Meerabeau, 1999). It is stated that some men rather than becoming embarrassed by genital exposure and therapeutic touch may interpret nursing interactions as a sexual event. Nursing care of male bodies by nurses specifies sexuality as a central concern and caution (Lawler, 1997). Discussing male sexual health care is assumed to be an area of difficulty as nurses are attempting to make their work respectable and to shed public perceptions that they are involved in dirty work. In sexual health settings nurses manage male genital examination therapeutically and without sexualised overtones. Opportunistic sexualisation of nursing

activities by clients is not a central difficulty in sexual health settings. The interchange between the nurse and the client is primarily concerned with minimising client vulnerability and discomfort. The process of examination is one of control, gaining permission, information giving, managed touch and reassurance:

> ... You're building a picture of a problem so that they are actually seeing and being aware of what you're looking for, because they're learning from that as well. And in doing that there has never been a problem with that [inappropriate behaviour] ... (Jackie, 1:367).

Sexual health interviewing may uncover sexual coercion and rape. In sexual health services in New Zealand questions about sexual abuse and assault are a routine part of history taking. The question is important as increased lifestyle and sexual risks are often the sequelae of sexual abuse (Briere, 1992; Herman, 1992). Preparation, timing and sensitivity are essential to maintain client safety and to avoid the experience of disclosure and of examination as retraumatising. While support is offered the client's right to privacy is respected:

> I always mention it before I launch into the whole thing. Like I run through the questions and if that's the last question so I say "the last question will be a question about sexual abuse so you've got time to think about how you want to respond. And if you want to have counselling". And I always talk about just that counselling is available, that it's free, they don't need to say yes now, and they can change their mind any time. They may remember something that they think is valuable to talk about at a later stage. It's amazing how many people just want to push that away. You know they don't want it brought up again, in fact they get quite, almost angry that you've mentioned it. But it intrigues me that they'll say yes. You know you always think it's surprising they don't just say no. They're bracketing it away

> but they will say yes I have been but I don't talk about it ... (Emma, 1:706).

Nurse's perceptions that the client has been sexually coerced may differ from the client. The client may deny that sex is non consenting, however nurses report a pattern of interviews with young women in which sexual pressure has resulted in date rape. In order to avoid alienating the client questions are phrased to minimise threat, denial and confrontation:

> … and how much is the sex that young females are having is consenting sex … I really like the way our sexual health form flows on … we get down to the question about sexual abuse but we don't actually ask it in that way. We have to feel around … we have to word it about sexual concerns and like that and they ask what we mean and go through that kind of process … that it's better reworded or they can get it out in a better way than saying the 'abuse' word. And the other word of course is rape that just, young people just do not very rarely anyway that I see, sort of acquaint with being raped. They don't see it as rape even though we might … so that's a big issue for us because so many people are saying yes they've had a problem with sexual abuse … and a lot of it's when they were younger too, the girls. But as far as teenagers go, yeah they're often not seeing some of the sex that they're having as – I might be seeing it sort of as non consensual sex or pressure. They're not seeing it as that … and they do not want me to see it as that either. So that's really hard … (Harriet, 1:255).

In preparation for STI screening conversation turns to information about genital examination. Appropriate levels of information and explanation are gauged for each client. In the case of the first examination nurses give a detailed explanation of the genital and reproductive anatomy and procedures. Giving the client permission to stop

reduces vulnerability and powerlessness. The talk during examination is focused on reassurance and on normalising findings:

> … what's helpful for me and the client is to do a lot of explaining beforehand. A lot of talking about what's going to happen and particularly if it's a woman whose having a checkup for the first time. I'll show the speculum if it's appropriate. Use a pelvic organ thing. Show what I'm looking for. Open up the speculum and give them permission to stop me. And I all, I know that I always say you know "please stop me if you're uncomfortable." And explaining to them as I'm going. "This is what I'm doing now, this is what I'm seeing, everything looks fine. You're OK." Just taking it step by step like that…(Emily, 1:198).

Nurses reduce the objectification of the client by asking them to communicate difficulties and to stop procedures if necessary. By contrast Emerson (1970) found disengagement in a study of practitioner interactions during gynaecological examination. Women were managed as a pelvic object under scrutiny and not as a person in possession of a pelvis. Rather than disengage with the person while looking at the client's body, sexual health nurses continue to communicate, relate and respond. The client is not considered to be a passive recipient of procedures having given informed consent:

> … and that they're in control really too. That it's not that I'm just taking completely over and they don't actually have a choice here, that they just need to sit back and grit their teeth, it's like well it's OK if this is not OK for me and I know exactly what's happening. I find that really helpful ... (Emily, 1:211).

As nurses are explaining procedures they are also assessing client reactions to vaginal examination. It must be recognised that any entrance to a woman's body, whether instrumental or human, has symbolic meaning. For some women the experience is terrifying, and mutually agreed safety strategies need to be put in place before the nurse

begins the procedure. Nurses are alert to fear and anxiety regarding genital examination as it may indicate a past history of sexual assault and rape and will require appropriate management:

> ... I guess by starting off I just run through what I'm going to do and gauge their reaction for a start ... Initially she sat there with her legs crossed and looked very nervous and I said to her "you look a bit worried. That's OK. It's OK to be worried". So I reaffirmed how she was feeling and she said, "yes I am. I'm terrified". I said "That's OK. What I'll do is I'll just tell you what we're going to do today and then you can stop me at any point and say I actually don't feel very happy about this ... no I don't want to answer that question. I don't want to do this anymore, I want to go home". And because I said that I think she probably relaxed a little bit more just because I nailed her ... to feel nervous ... (Emma, 1:171).

Attempting to minimise and normalise genital examination is not a successful approach to a situation that may exceed the limits of client coping skills. Emerson (1970), in an article entitled 'Behaviour in private places' states that the procedure represents for the client a problem of maintaining physical decorum. It is suggested that the issue for the female client is the breach of behavioural decorum in expressing the unappealing nature of her body, such as discharges or odours (Meerabeau, 1999). The findings of the present study indicate that all genital exposure is deeply threatening to a sense of social propriety and dignity. In American studies of gynaecological examination nurses made jokes about vaginal odour with clients in order to defuse tension (Ragan, 1990). The interactions of New Zealand sexual health nurses show progressive and timely phasing of therapeutic interventions, to improve coping behaviour, and to maintain client safety and integrity.

SUMMARY

Recognising a community climate that is hostile to people with sexually transmitted infections has a strong influence on sexual health nurse's empathic alignment with their

clients. A process of *personalisation,* emphasising humanity in client interactions, counteracts the dehumanising fears and stigma that faces clients who are attending a sexual health clinic. Consultations with clients are intent on *getting close to people* who otherwise feel alienated in health care contexts. Sexual health care interventions are constructed to destigmatise by *making it a better experience* than the distancing treatment commonly designated for people with STIs. Sexual health care has different meanings for clients based on gender, previous experience of sexual abuse, past treatment for STIs and cultural context. Nurses individualise strategies for *minimising threats and fears* according to a social and psychological assessment of the client that is concurrent with a clinical history. Having an STI is a health event and it is also a social event. To understand the complete clinical picture involves the social details of people's sexual lives. It is the context of their personal stories that clients want to be heard and situated. Knowing personal stories is essential to the therapeutic relationship and the discussion of future prevention strategies. Safer sex information is frequently ineffective if little account is taken of the personal circumstances of the client.

In sexual health services while clinical practices and procedures are routine, interactions with clients are close, highly personalised and individualised. The nature of the intensive attention given by nurses to the client is *respecting and dignifying* the encounter. This will be discussed in the next chapter.

CHAPTER SEVEN

RESPECTING AND DIGNIFYING

In this chapter the conceptual category *respecting and dignifying* will be explored (see Figure Four). Sexual health clinics and STIs are the ultimate indignity and antithetical to the concept of respectability. The work of the nurse is not only to meet required standards of professional codes of conduct but also to reconstruct the negative meanings given societally to sexual health clinics and to sexual infection. When people are unwell those close to them can generally be relied on to provide comfort, understanding and support. The case of sexual ill health cannot be shared with others and becomes a solitary experience. It is therefore the sexual health nurse who provides not only the professional role of caring but also the social role of *treating people with care.* Nurses are treating stigma as much as they are infection. The nature of *treating people with respect* is concerned not only with acceptable codes of professional conduct but with therapeutically counteracting societal disrespect. Additionally *treating people with dignity* is part of the process of interrupting the shaming and punishing of sexual health clients and of *restoring self worth.*

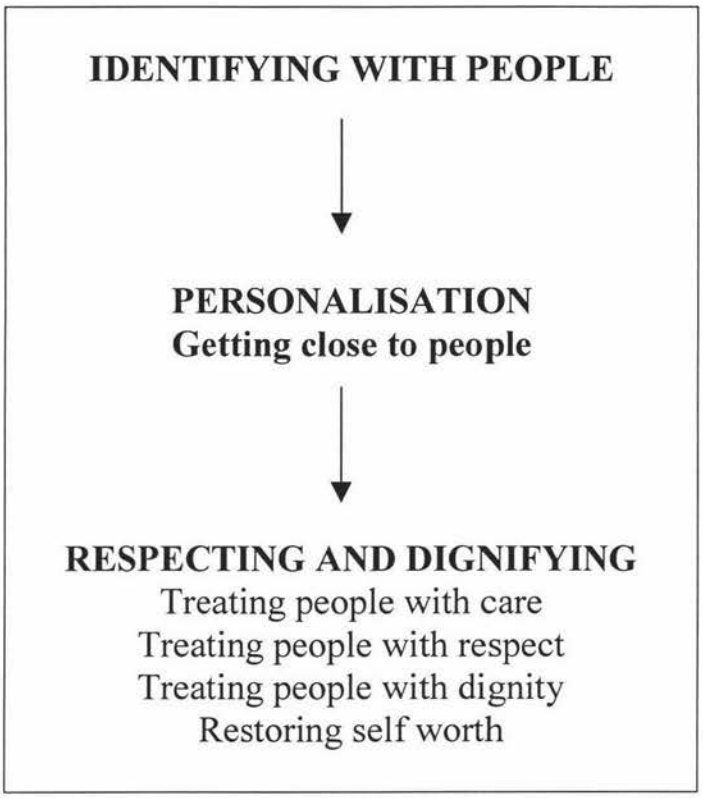

Figure Four: Respecting and Dignifying

Clients are treated in the health care system in hierarchies of worthiness and deservedness. Underpinning the attitudes and behaviours of health professionals is a public discourse of blame and individual responsibility in relation to sexually transmitted diseases. In general health care settings, people labelled as sexually indiscriminate and lacking in moral self control, are often punished by experiencing a lack of care and respect, which creates a feeling of indignity. Sexual health nurses operate within a discriminatory health care environment in which sexual infections are singled out as the lowest form of communicable disease. In common with other transmissible infections such as tuberculosis and meningitis sexual infections have shared population characteristics. Sexually transmitted infections disproportionately affect people in low socioeconomic groups, ethnic minorities, and marginalised subcultures. The highest prevalence of STIs is in women and predominantly those with a history of sexual assault and rape (Eng & Butler, 1997; Ehrhardt et al., 1999; Shew & Hurst, 1993). The prevalence of sexually transmitted infections is not mentioned in the publicising of the poor health statistics that receive political attention and subsequent funding. Complications such as pelvic inflammatory disease, male and female

infertility, and chronic genital conditions are preventable but ignored in public health strategies. The sexually acquired health problems that do receive public attention, such as cervical cancer and chronic hepatitis B are carefully distanced from sexual activity to avoid the stigmatisation of clients. The shaming of sexual health clients occurs professionally, publicly and privately.

TREATING PEOPLE WITH CARE

Being sexually unprotected is a state of social as well as physical vulnerability. There is a useful Maori concept called 'awhi', which is to embrace, aid, help or to cuddle (Ryan, 1995). It is the level of personal support for clients that sexual health nurses describe. In the view of sexual health nurses encouraging personal safety involves modelling a caring relationship. The nurse is assessing not only risk and physical symptoms but also the psychological symptoms of neglect and abuse, low self-esteem and poor self-efficacy:

> ... if they decline to be examined at that interview, I would certainly encourage them strongly to have a follow up appointment before they left the clinic and in that session time would be made, if they've never had an exam before, about what is actually involved in that exam. Why we do the exam, the sorts of things that we're looking for, the sorts of tests, how they can prevent getting other infections, and it's all that sort of what I call awhi. I don't know another word for it. You get people along. They feel cared for. I wonder if that's what puts people off sexually caring for themselves is that they don't feel cared for, you know, they go to the doctor and that doctor might say "oh you silly girl" or they feel that anyway because they've got this discharge or they've got this thing going on down below ... (Patricia, 1:83).

Nurses describe a lack of sexual care as an emotional problem. Poor self-concept and a lack of self-esteem are predictors of behavioural risk for STIs and therefore therapeutic

interventions focus on strengthening self-efficacy. The nursing qualities of empathic understanding, warmth and genuine concern bring about constructive change in client functioning. Sexual health nurses assess client coping skills and make decisions about the timing and appropriateness of interventions. The immediate problem for the client with an acute primary presentation of genital herpes is symptom relief and recovery. Often clients are in a state of psychological shock when they are given a positive diagnosis. Until the client is well enough, health information and counselling is postponed. The interaction is transitioned from the immediate treatment of symptoms to the later needs of psychological adjustment:

> I think making sure that they go away from it feeling good. And well informed. That they know, and if they don't feel informed, that they know that they can, you know, access further information. Because sometimes, like say with herpes, I mean you're sending them away and you can say to them "I haven't told you everything there is to know and the reason is because you are symptomatic and you're uncomfortable and I can't, I mean this isn't the time while you're sitting there in pain. You're possibly not going to absorb the information anyway. We'll deal with what you think you need to know for now and go away and come back" (Emma, 1:480).

Sexual health nurses underpin their practice with the acknowledgment that often the events that surround sexual health care are distressing and therefore interactions with clients are necessarily psychotherapeutic in nature. During sexual health history taking specific questions are raised about previous sexual abuse. With clinical experience judgements are made about the timeliness and intensity of questioning, information, support and closure:

> … the last question is about sexual abuse and that can be a hard one and it's like do I, sometimes, it seems like it doesn't seem right to ask it because it doesn't …sound as important as it actually is for the person. If they have been sexually abused. It's just like a question we tag on the end … And then what do

> you say when they say yes. It's like well, oh, and that has been something that I've really had to think about. And then what do I say, you just don't say, you know have you dealt with it, how have you dealt with it and leave it at that. It just didn't seem right so I kind of had to think, well, where do I go with it if they say yes ... (April, 1: 173).

The responsibility of exploring potentially distressing material is to provide safety and to access support for the client. Talking about sexual abuse uncovers trauma and vulnerability. Skilled history taking in the context of sexual health nursing is an accurate clinical and psychosocial assessment. In order to assess the client safely, the nurse needs to be practiced in managing disclosures and in crisis intervention:

> ... Because I felt that I had a sense of responsibility to this woman. That in some respect I'd pushed her button. And I'd made her start thinking about what had gone on in her past and I just didn't feel that I could leave her with that [sexual abuse disclosure] ... (Emily, 1:95).

There are time and resource constraints that impact on delivery of service and practice. Nurses develop styles of interaction that are tension reducing, will gain client cooperation quickly and with minimal discomfort. To maintain a quality of care workloads and stress must be managed as well:

> Because if you do it [increase client discomfort] you make your work harder for yourself ... That doesn't sound very compassionate. If you compound anxiety then you're going to have to compound what you have to unravel. The goal somewhat cuts across the story that they feel that they're going to be accepted ... (Mia, 2: 14).

Occasionally nurses encounter clients who behave in ways that are disrespectful and inappropriate. These behaviours are challenging as nurses act to both desexualise the interaction and to maintain self respect and psychological safety for themselves and the

client. With experience and skilful management, potential conflict and confrontation can be averted. The experience of sexual health nursing is both caring for and protecting oneself and the client. When the encounter is threatening for either the health professional or the client there will need to be a negotiation of power to enable safety for both. Clients exhibit a range of psychological counter reactions:

> It must be some sort of power thing I suppose ... three [men] that I said were problem clients … I would just not give them the attention which means they're missing out which isn't very fair. That would be my way of thinking. So I would be very brief and do the least I needed to … But also be thorough and do the basics, do whatever's needed. But not take any notice of the behaviour. But probably I wouldn't address it. I might say to someone 'you seem particularly angry'. But I wouldn't like say 'I don't appreciate the way you're behaving'. Or something that sort of instigates something more to it ...Well its allowing them to …Whereas often it diffuses it if you just don't buy into it … I never did feel unsafe. Those have been uncomfortable things that might happen but nothing unsafe ... (Merryl, 1:360).

To return the client to a sense of social equilibrium the health professional acknowledges that the visit is socially difficult. Interactions that value the client, however brief have a powerful impact on client self acceptance:

> … even if you're going through it fairly quickly and that's the only way to go really and "look thanks for coming" and that's the main thing. It seems to work anyway … (Jackie, 1:541).

For most clients the setting, circumstances and events of sexual health care are mysterious and threatening. Nurses are challenged to develop models of comfort and care that are protective for themselves and clients in sexual health care. Nurses learn to manage a range of people, behaviours and clinical and psychosocial presentations in an environment that is underpinned by a culture of respect and treats people with care.

TREATING PEOPLE WITH RESPECT

Dignity and respect for clients is an ethical responsibility and a human right in health care. In New Zealand the Human Rights Act (1993), identifies the obligation of health care organisations to the consumer in respect of their rights and entitlements (Health and Disability Commissioner, 1993). According to the 1996 code of Health and Disability Services, consumers' have rights to services that are provided in a manner that is consistent with his or her needs and with reasonable practitioner care and skill. Further, services should be provided in a manner that minimises any potential harm and optimises the client's quality of life (Health and Disability Commissioner, 1993). The health professions and the public sanction the social shaming of sexual heath clients and it is in this environment that complaint is difficult even when care is discriminatory and inadequate. People expect, therefore, that the consequences of an STI will be that they are treated with less respect and dignity from health professionals than they would expect in other health care contexts. As one sexual health nurse states:

> A lot of people experience an STD as a punishment. You know, I shouldn't have gone and had sex or I shouldn't have done this. You know, I shouldn't have had sex before marriage ... And experience us as punishers. So we're going to tell them off for having unprotected sex. We're going to tell them off for losing their pills. We're going to tell them off for being here or something. It's not until they've actually been here and got to trust us and seen what you're like as an individual, that they know they're not going to get that (Jill, 1:253).

There is an understanding among sexual health nurses that there is a great deal of folklore about the sexual health screening of men that is associated with painful and invasive procedures. Nurses involved in the speciality of sexual health care continually encounter public perceptions that the work is punitive and this is demonstrated by the client's fear of the practitioner on arrival. Not only do people expect demeaning procedures, but also to be shamed. In the client's mind they are now in a marginal social category of people. The group of people who go to sexual health clinics are, in the

public mind, unusual, deviant and undesirable. Sexual health nurses experience however, the client as ordinary and likeable. In sexual health services, health professionals recognise that their attitudes have social power and a definitive significance:

> … I treat people in this room as I would want to be treated myself, so therefore, if someone trusts people in here enough to [come in here], the things that they think are going to happen which generally don't, you know, that we're going to shove these things into their penis, they've actually taken a huge amount of trust in coming in here. I think you need to just treat people with respect, that's the bottom line, I think for me. It doesn't matter who they are. Ninety nine, point nine per cent of the people I really like. There's a couple of real creepers that come but I still believe that they deserve respect … (William, 1:102).

Sexual health nurses are aware of the social meaning of being a sexual health client. In general, it is considered that people who attend an overtly sex related health care setting have forfeited the right to respectability. Clients will withhold important information until they are sure that they are safe from moral scrutiny and from rejection. Just as nurses are cautious about the intensity and timing of questioning, the client is cautious about the degree to which they are willing to disclose information to a stranger:

> I take what they give me and you'll find that the odd time when they feel more comfortable like on their way out the door, they'll drop a change of information and that's OK. They'll probably be back if they've given you that bit of information, they'll come back and if necessary you can always take it from that point but it's often not that urgent that you have to say, look come and sit down here, we need to talk. You've still done all your checks and you're going to be giving them some results at some stage and you can always bring them back and do it then … (Jackie, 1:550).

Sexual health nurses understand the tentativeness and awkwardness of the initial interactions with clients. They avoid forcing the relationship and respect the client's right to silence and privacy. Interventions are based on the client's readiness and willingness to disclose, and their perceived needs:

> So you've got pick your moments and you can't just put everybody in the same box and say "right, everyone's going to walk out of here with condoms"... (Emma, 1:632).

There is considerable resistance by clients to the health professional's insistence on protected sex. While the purpose of the professional is to assist the client to move away from self harm, it is counterproductive to convey the sense that the client is being critiqued, evaluated and corrected. Nurses learn from experience to work at establishing a relationship of mutual liking and trust and to work within the framework of client interests and issues. Sex for most people is relational and is not primarily about their health. Sexual health nurses are aware that people live in multiple realities. Conceptual understandings of sexual lives have some similarity to descriptions of relating sensitively to client cultural differences. There is however a different process of 'hearing'. Where sexuality is concerned, it is a matter of desensitising socially conditioned negative responses to lifestyles and relationships that are outside the nurse's personal and sexual experience. In general, being culturally sensitive is to sanction the social taboos and judgements about 'foreign' sexualities. Sexual health nurses however, contradict the cultural value placed on social conceptions of sexual normality and acceptability by refusing to disrespect, distance or marginalise clients who would be considered outside the norm:

> we're going into areas that are really foreign ... I think in terms of hearing what people say and then using it appropriately, that's one of the big challenges. It's where we are coming from around it, and that we're treating it with respect you know ... (Mia, 1:532).

In the clinical encounter respect is shown to the client, however in private conversations between sexual health professionals, the prevalent attitudes and beliefs parallel those in general society. For example, there is a conflict of interest in sexual health care between the protection of individual sexual freedom and the rights of third parties to safety and honesty within a sexual relationship. Health professionals do make judgements. Remaining respectful of the client when a partner is being disrespected is a professional challenge:

> ... But I think among ourselves we don't always have, we've not always reached that point. And the same thing with something incredibly basic where a heterosexual man comes in and says that he went to a bar on a Friday night, got drunk and had unprotected sex with somebody he met there. But he is already, he is married and he has not exposed or told his partner that ... and that absolute repulsion and disgust that is shared among staff members, nurses and doctors alike about how dare he do such a thing. And yes I do agree that you know it was irresponsible but just the way in which it's almost maliciously shared ... (Tony, I: 213).

A succession of similar histories may lead to a hardening of social attitudes rather than a liberalisation in some instances. In general nurses will shape the interaction to avoid casting the client in a sexually indiscriminate or irresponsible light. Enough history is taken to be relevant to the diagnosis of the presenting problem but not so much that the client will feel labelled and categorised. Nurses have an ongoing sensitivity to the meanings that are implicit in lines of questioning about the sexual life of the individual. While clinical accuracy is essential to accurate screening and diagnosis, it will be counter productive if the interview is offensive to the client:

:

> I hardly ever ask them how old they were when they started having sex or how old they were ... Like the total number. Sometimes I just don't think that fits. I don't need to know. You have to gauge it ... (April, 1: 218).

Treating people with respect where sexuality is concerned involves not only the suspension of judgements about people's lifestyles and relationships, but also the practical management of history taking and clinical examination. Clients are respected in the subtle and sensitive shifts made in questioning and procedures according to individual needs, cultures and life circumstances.

TREATING PEOPLE WITH DIGNITY

Although clients present for the treatment of infection, emotionally aware practitioners are as much concerned with signs of poor affect. To change sexual behaviour it is as important to address the underlying adverse social conditioning that has contributed to poor self-care. It is helpful to reframe the event of going to a sexual health clinic as a positive step in taking care of oneself and not as a punishment for bad behaviour:

> … I mean it's an area that really needs people to feel dignified. Yeah dignity is really important … The badness feeling is why they've ended up seeing you too. Not making good choices and this whole feeling of undeserving and that sort of stuff. I find that a lot ... (Jane, 1:277).

It is critical that the staff who work in sexual health services do not reinforce the client's sense of social failure or marginalisation. Attending a sexual health clinic is a state of social demarcation that is intended to shame and stigmatise. The attitude of sexual health practitioners will determine how clients evaluate themselves and the meanings they give to the visit:

> But I think when you're talking about dignity … that includes anybody and everybody who accesses the service … like the alienation factor. Part of your dignity isn't it still? The

> welcomeness and the whoever you are kind of stance … (Jane, 1:463).

Some client groups face cultural barriers to seeking sexual health care. The shame associated with explicit discussion of sex and with genital examination is a significant deterrent for young Maori men who need health care. Using strategies that will divert attention away from shame, minimise personal exposure and acknowledge the difficulty of the event, are a means of maintaining integrity:

> I do show them how to put on a condom because most young Maori men don't know, they've never used one. I think the humour first, the thing is when you're getting them in and you can tell right from the moment they drag in. They drag right from the waiting room. Their feet seem to drag, they look around and they have this trying to be cool smile but thinking what am I doing here and right from the moment then you've got to work fairly quickly, so you say "right now you're for it" (laughs) and then they start loosening up a bit from there and I've got my mirror on the ceiling. Its a 3D monkey. Lie on the bed here. You can drop your britches there and cover up with this, this is dignity. I always pull the curtains and then they can lie there and cover up before I go in and they see the mirror on the ceiling, they laugh as well. It works, it works brilliantly … (Jackie, 1:512).

Events in the clinical consultation with male clients, which could be interpreted in some contexts as harassment, need to be understood in terms of situational vulnerability. Male clients occasionally have erections when genital examination is taking place. This is not regarded as sexual arousal or inappropriate sexual behaviour but as a physiological response to the anxiety of the situation. This is managed in a way that does not embarrass the client:

> … You get, occasionally, men getting erections but I don't consider that inappropriate in that they can't help it and they're

> often quite horrified as well but on the whole not a problem at all ... (Jackie, 1:357).

There are many instances in the settings of sexual health care where there is potential for the client to feel out of control. Each nursing interaction is different depending on the concerns of the client and the perceptions of the nurse. Some client histories are painful and shocking. In some cases nurses are working with people who have been violated as children. Sexual health nursing is more than a matter of respecting difference and lifestyle choice. What society sees as deviant sexual behaviour may be the result of childhood sexual victimisation that has been incorporated into the adult identity. Nurses understand the effects of childhood abuse and recognise, in personal stories, individual resilience and survival:

> ... there's a huge range ... such diversity, like you get, the girl I saw this morning who was fifteen or sixteen. Such a dreadful life, you know she'd just gone to live with her auntie who's a prostitute and who works from home. She's been under CYPs care and how can you be fifteen or sixteen and already so jaded and then you get other people who are like just, are just amazing, like one woman I saw last week or the week before, she'd had nine pregnancies and she was my age and she'd had six kids, one of her kids, her first baby was had through rape and he was adopted out and then he died with all his adopted family when he was seven, and she was a sex worker. But she was as bright as a button ... (April, 1: 69).

Sexual health nurses recognise that they are hearing stories of resilience and that it is a privilege:

> ... it's the more you see people, they'll just start talking and then you know, you'll hear stuff. I actually feel really privileged to hear ... (April, 183).

It is recognised that the information expected of clients would be viewed as indignity in any other context:

> … the questions about sexual practices, some of those are … most of the time. I wouldn't think twice about asking them, you know people are kind. But the first time I did a history … a woman who was older. I think she was 48 or something which isn't very old. But it's like oh, I can't ask her these and I think that you know, it just didn't seem right … (April, 1: 226).

Sexual health nurses show respect in the tentative, cautious and careful manner in which client interviews, examination and health interventions proceed. Nurses recognise that it is on the basis of the nature of the health care interaction that clients will interpret the encounter. By dignifying the individual and the processes and procedures of sexual health care the client maintains self worth in a situation which is potentially shameful.

RESTORING SELF WORTH

Sexually transmitted infections have symbolic social meaning. People understand themselves in relation to the meanings given to the kinds of sexuality presumed to be related to STIs. For women, the meaning associated with STIs, indiscriminate sex, multiple partners and sexual availability is a matter of disrepute. For men however, the event may be associated with sexual prowess and virility when opportunities for a sense of masculine self worth are limited:

> … it's a psychological thing that when guys come in and they're diagnosed as having chlamydia for example, that they actually feel quite proud of that because to them it means that at least they're being ... Sometimes even just the whole promiscuousness of it can be ... quite possibly with the girls as well. Maybe they've not – their self esteem is so low and they haven't got a lot going for them and it's just having a connectedness with something that they feel, like within that

> very sexually active promiscuous group that you know teenagers seem to get into ... (Rose, 1:242).

Masculine identification is depicted in terms of sexual conquest and power. Male sexual risk-taking, however, in the experience of sexual health nurses is related to poor self-confidence and low self-esteem. The connection between sexual safety and self worth is important to understand in therapeutic interventions:

> ... people with quite a low self-esteem. They know all about it and they're willing to come in and have check ups. But when it comes to the crunch ... they don't have the confidence in themselves to say, "please use a condom" or you know "this is on my terms" or anything ... (Grace, 1:55).

People are generally well informed about safe sex, however, having the confidence and communication skills to insist on condom use is a difficulty. Being safe is about valuing and protecting oneself and one's body and is connected to social power. People who are socially disempowered will need to be given opportunities to improve self-efficacy. It is important that the interactions of the nurse and the client do not in any way replicate the characteristics of the coercion that is the context of some sexual experiences. Giving the client control is a therapeutic strategy that is designed to counteract the association of genital exposure with vulnerability and a loss of control:

> ... I always ... say before ... an examination, one, if it hurts, two, if you want it stopped at any stage you can stop. You don't have to go through with this. And sometimes you say that twice. Sometimes you say it before that. I mean I often say it in this room and I often say it in there as well. So they surely must know that, I guess they feel they've given consent by walking in the door as well to a certain extent. So they think they haven't got the choice to back out half way through ... (Emma, 1:764).

Nurses indicate to the client that examination is a matter of a cooperative partnership and not merely a matter of patient compliance. The offering of choices and alternatives

is a way of increasing client skills of self-efficacy and self worth that are essential for future safe sex behaviour:

> I often, I mean I always ask if they've talked to anybody previously about it. That's what I'd like to know. And I guess I always, well like I do emphasise that it is OK not to talk about it now. Because maybe they just don't like me, maybe they just don't want to talk to me about it. You know maybe they want to talk to someone else ... I do mention that it can be helpful, you know, I do emphasise that other people have initially said "no" but have found it helpful ... (Emma, 1:736).

The phenomenon of sexual health care is breaking the strict social taboos about discussing sexuality and sexual violation. People internalise the prohibition about talking about sex and remain silent and isolated. It is the ability of the nurse to transcend the social directive and to enable disclosure that is alleviating:

> ... when you start working you discover that you're actually seeing ordinary everyday people. And it's a very useful job, where you're actually lifting somebody else's load off their shoulders in a way and you can actually do something very practical about it ... (Jackie, 1:288).

While STIs are common, the people who have them enter the category of 'outsider'. There is so much societal blaming attached to infection that is sexual in nature, that people are surprised to be treated caringly and with worth by health professionals. The populations that nurses 'comfort' in general settings are worthy of public sympathy, however, sexual health clients are 'uncomfortable' people to care for, for many nurses. Sexual health clients become identified as less ordinary, special and respectable.

SUMMARY

Professional attitudes have a major impact on the self- identity of clients when society gives physical health problems a moral meaning. The expectation is that health

professionals will enforce acceptable social and moral codes through distancing, distaste and disapproval for clients who act outside conventional behavioural norms. Sexual health clients expect that they will be reminded of social transgression. *Respecting and dignifying* is an outcome of sexual health nursing that enables safe services for those considered to be socially unsafe. In the next chapter the next process of *destigmatisation,* that of *advocacy and empowerment, is* discussed.

CHAPTER EIGHT

ADVOCATING AND EMPOWERING

In the previous chapter the *respecting and dignifying* of clients was discussed as a nursing strategy that counters the societal disrespect for people with a sexually transmitted infection and the indignity of a visit to a sexual health service. While the work of the nurse involves clinical assessment and treatment for sexually transmitted infections, building self esteem and self efficacy is a central characteristic of interactions with clients. The nurse integrates into clinical work the social task of *advocating and empowering* for marginalised communities and people who have STIs. When lifestyles compromise the health and safety of the client, strategies to reduce future risk depend on *teaching survival skills*. Interventions are contextualised to the norms and values of the social networks, communities and subcultures in which individual sexual lives take place. Sexual health nursing is a matter of *working in the context of sociocultural realities* in which patterns of sexuality and sexual lifestyles are dynamic and changing in New Zealand. As the age of first sexual experience progressively declines, rates of sexually transmitted infections increase along high teenage pregnancy and abortion rates. Nurses are continually *reframing stigmatising experiences*. Populations with the poorest sexual health are the young, women, Maori and Pacific Island communities, low school achievers and those with a history abuse (Davis & Lay-Yee, 1999; Dickson, Paul & Herbison, 1996). Sexual health nurses have a critical role in presenting opportunities for *rebuilding futures* on the basis of improved life skills and effective self protection behaviours. This chapter will explore the conceptual category of *advocacy and empowerment* which is underpinned by *teaching survival skills, working in the context of sociocultural realities, reframing stigmatising experiences* and *rebuilding futures* (See Figure Five).

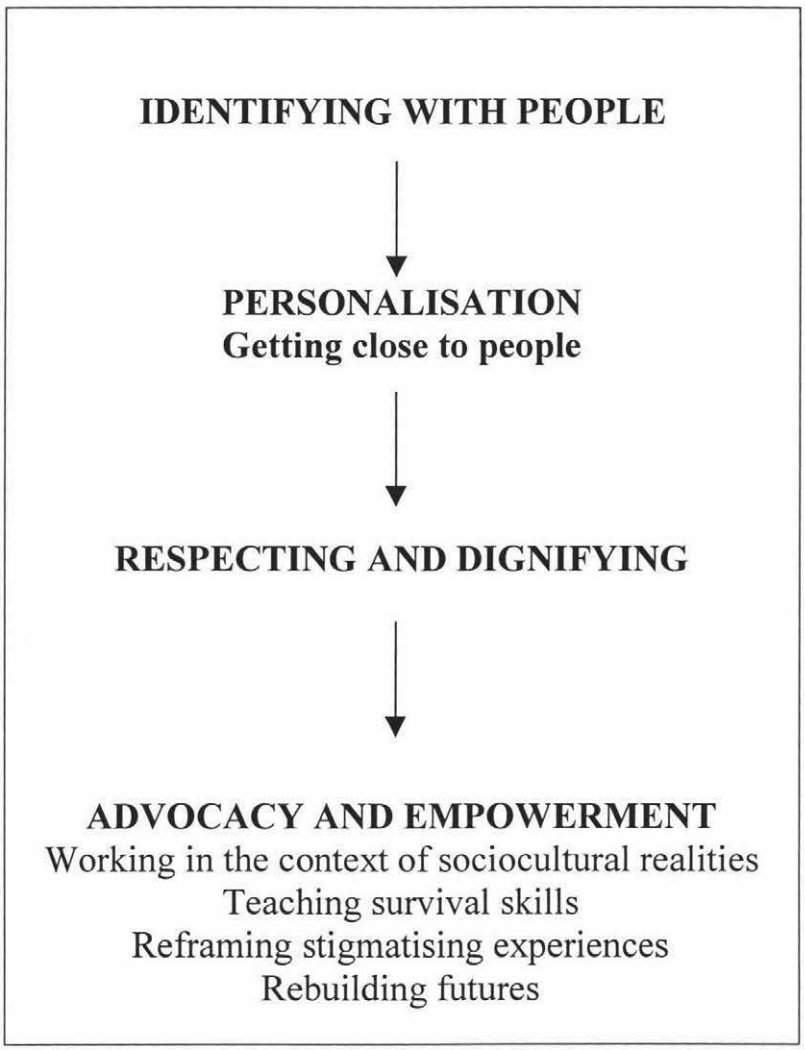

Figure Five: Advocacy and Empowerment

Working to improve sexual health involves social advocacy. Protecting human rights such as freedom from violence and coercion, the right to reproductive control and the right to sexual preference are professional responsibilities in health care. Sexual health nursing practice is underpinned by emancipatory philosophies of the social agency of the health professional. In the words of this nurse:

> … A protector of those basic rights as a sexual being. I suppose that would form a huge basis of my nursing role here. Protecting that on an individual level … (Jane 1:27).

The concept of nurses protecting the human rights of people as sexual beings is double edged because society has double, if not multiple standards of sexuality. The social meanings and consequences of interpretations of sexual standards are the professional concern of sexual health nurses. Sexual health nurses continually contextualise sex work, sexual behaviour and relationships to the social, cultural and economic conditions of their clients. The perspective that emerges is that sexuality should be enjoyed and at the same time protected so that reproductive and sexual health is not damaged. There is an acknowledgment also that in some cases nurses are dealing with coercive rather than consenting sexualities. Individual sexual health problems are related to the context of being female, gay, poor, Maori, young or unemployed in a society that restricts status and opportunity for each of these groups. Sexuality is an expression of social oppression or of social empowerment. Sexual health nurses experience in day to day practice that poor sexual and reproductive health statistics in client populations say much about high unemployment, dysfunctional families, educational failure, racial and gender discrimination. Health care workers are powerfully placed to make changes as will be demonstrated in the following experiences of sexual health nurses.

WORKING IN THE CONTEXT OF SOCIOCULTURAL REALITIES

Patterns of sexuality have changed in New Zealand in the last twenty years (Davis & Lay-Yee, 1999; Pool et al., 1999). There is a direct relationship between social life and sexual and reproductive behaviours and health. Individual cases of STIs occur in the context of the epidemiological trends, the lifestyle and sexual norms of social networks and communities. Sexual health nursing management therefore is concerned as much with individual clinical management as with social change and community interventions. The poorest sexual and reproductive health statistics in New Zealand are among young Maori women (Smyth, 2000). The sociocultural climate in which sexual health services operate is one in which the age of first sexual activity is decreasing and opposition to safer sex education from conservative lobbies is increasing. Sexual health nurses demonstrate that effective management is a matter of clinical expertise and of an applied social analysis of the sexual, cultural and gender behaviours of particular

subcultures in New Zealand. In practice understanding the social and cultural context of sexual lifestyles allows a greater understanding of the client's perspective:

> … Some of those children … want to be a mother … It's the way that they get acknowledgment in their big family and having some self worth because they've actually reproduced ... And in rural communities, and I can see how there is wanting to have children … it's very complex. Where there is limited employment and often for these youth there is no employment they may well have been low achievers academically at school. There may be limited life skill programmes going out of school where they can actually achieve something … so sometimes I think that they often maybe only see the achievable thing for them is to reproduce … it provides a sense of income. It provides a means to identify their own individuality … (Milly, 1: 473).

Sexual behaviour patterns are established in social networks. Where sexual risk taking is the norm, there are correlations with limited educational, social and employment opportunities (Davis & Lay-Yee, 1999). Nurses in sexual health clinics in rural areas understand the relationship between community norms of sexual activity and pregnancy in adolescence and high unemployment:

> It's the risk taking behaviour amongst our young people … we'll go into school there and talk about their sexual health and, you know, wag our finger about – don't get pregnant. We don't do it like that but. What else are we offering them? Some of those people have hardly been out of their town … They're going to carry on having babies and historically here, we've had high teenage pregnancy rates forever … I just think we need to be a lot more positive about teenage pregnancy and give them a lot more help. Health care. Social work care (Harriet, 1:525).

Teenagers make sexual decisions on the basis of socioeconomic conditions and future expectations. Access to education, employment, income and housing is strongly related to health. A review of these indicators for the past decade shows that Maori are relatively worse off compared to non-Maori in all social index indicators (Smyth, 2000). Rates of unplanned pregnancy, STIs, poor mental health and substance abuse for Maori adolescents is among some of the worst in the developed world. Sexual health nurses are increasingly involved in adolescent protection through education, community and state intervention:

> ... Well in the rural areas, the kids their social network is very limited. Like they have parties on the weekends and they don't have access to town, they don't go to the movies, so they go to parties. They tend to get drunk and that's where their sexual experiences are coming in. We've got quite a large number of unprotected sex happening. We do a lot of morning after pills ... just lack of access to facilities is probably the biggest issue ... (Sue, 1:70).

Educational achievement delays the age of first sexual intercourse and of parenthood (Dickson et al., 1996; Pool at al., 1999). Some rural communities show signs of the social stress of poor social and economic conditions. In a survey of 981 Hawke's Bay teenagers forty per cent of fourteen-year-olds had had their first sexual experience (Fenwicke, 1999, cited in Ministry of Youth Affairs Report, July, 2000). At the time a third were drunk and ten percent of those surveyed experienced their first sexual experience as abuse. Nine percent had had their first sexual experience by age twelve and of sexually active fourteen-year-olds seventy five percent were Maori. Binge drinking and unprotected sex is a common behaviour described:

> ... a group get trashed every weekend and suffer the consequences, whatever it is. It might just be a hangover or it might be unprotected sex and whatever or unconsenting sex ... (Jane, 1:586).

The poorest sexual and reproductive health outcomes in New Zealand are for Maori. The findings of the Population Studies Centre, University of Waikato shows a significant difference in patterns of sexuality for young Maori women compared to other ethnic groups (Pool et al., 1999). In the study of fertility patterns it was found that the majority of Maori women aged 20 to 24 years surveyed, experienced first intercourse at 16 years or younger. It was likely that Maori women in this age group had had twice the number of sexual partners and twice the number of pregnancies than non-Maori.

Research on the views of young men in regard to responsibility for safe sex reflects the attitude that it is young women being provocative and promiscuous that is the reason for STIs and pregnancy (Ministry of Youth Affairs, 2000). A significant number of young men interviewed in research on male condom use did not take any responsibility for the prevention of pregnancy or sexually transmitted infections. The interviewees were aged between fifteen and twenty. They believed that girls in this age group and younger could effectively insist on condom use. While young men considered that safe sex is a female responsibility there are significant social and psychological barriers to young women controlling sexual protection:

> ... a lot of the young women they don't have a lot of control over their life I guess in a big way. But then down to specifics over their fertility and over their sexual health ... (Harriet, 1:568).

When there are no other options for self and child support women do sex work. Prostitution is prevalent in New Zealand (Ministry of Women's Affairs, 1991). Poverty is a major reason for women deciding to sex work. Sexual health nurses often account for sex work as a consequence of women's unemployment, low rates of pay and an inadequate social welfare system. Nurses develop a social analysis of sex work as an indicator of poor social and economic conditions:

> ... one of the things that probably distresses me a great deal is that a number of our commercial sex workers have done so because of poverty and I'm alarmed at that. Certainly some of them are single mums or young women who have got into debt and then lost a job and unemployment in our area, being what it is, and the dole being what it isn't, they have felt that this is the only option that they have in dealing with their financial situations, and that brings up lots of issues like they need to do this but they don't want to be there. I have to do these things to pay my debt ... (Patricia, 1: 656).

Nurses are aware of the health problems associated with early sexual activity, in particular in Maori and Pacific Island communities, and adopt realistic perspectives in relation to protecting young people. In the community, nurses work towards improving parental communication and support for children and adolescents. As this nurse explains it is important that there are forums where parents can express their anxieties and fears about adolescent sexuality and pregnancy and learn to discuss these issues:

> ... the biggest thing I find when doing education and working with groups, particularly we're talking about with Maori groups, I think it's more like they can understand about the young people being sexually active from a very young age. And the thing that I found more than anything and I did a, just thinking back to doing an education session, a sexual health session with a Pacific Island group of women, and they were really interested and they were very keen to learn how they could cope with the adolescents and their sexual activity. And how they should keep themselves safe. But the thing that I found more disturbing for them was the fact that their young daughters or their young 13 and 14 year olds can come in and have the termination pregnancy without them even being aware of it ... (Rose, 1:115).

Mothers are concerned to protect their daughters and feel that their role is undermined when health professionals are able to, without their authority, refer a minor for a termination of pregnancy. Nurses work with parents, most commonly mothers, on creating a safe and accepting environment at home for the discussion of relationships, safer sex and contraception. In a number of cases young women are making decisions without any parental guidance and support. Where girls are making a decision about continuing a pregnancy without adequate care, nurses take responsibility for finding suitable adult support:

> pregnancy counselling ... I think it's always quite difficult when you're a young girl ... 13 or 14 year old ... in the counselling process, I would, I sus out what their relationship is with their parents. Their mother perhaps more than their father but certainly either parent, and if it's appropriate, would encourage those girls to be speaking, talking to their mother or father about it. Particularly their mother. If not their mother if it's inappropriate, then a responsible adult. Maybe an aunt or someone that they go to. But sometimes that's not possible and it has to be a school counsellor or something like that. I guess part of me thinks it's hard for a 14 year old ... it's a big decision for anyone to make. (Sam, 1: 12).

In families there is some evidence that indicates that communication between parents and children has an impact on birth control and contraceptive practices (Hutchinson, 1999). Parental communication and disapproval of teenage sexual activity can influence the delay of sexual intercourse. Family norms about teenage pregnancy and family size shape adolescent sexual behaviours and practices. Early motherhood is encouraged, supported and welcomed in some cultural and family contexts. One nurse talks about discussing pregnancy choices with young Maori women:

> So I've always been mindful of those cultural dynamics that are going on there ... I sit there and ask them "What do you want? What do you want in your life? What do you see for yourself? If you had the wildest dream in your life to be able to be

> whatever you wanted to be, what would it be?" And I try to … And everybody has a dream somewhere along the line. There might be sometimes when you get… "I just really would like to be a mother." ... our banner is reduce teenage pregnancy … (Milly, 1: 605).

For nurses protecting sexual freedom and rights to reproductive control is complex when the client is a child. Explaining to the mothers of children and young adolescents that nurses are ethically bound to protect the privacy and the confidentiality of clients of all ages is difficult. Parents are often naive and unaware about the early sexual activity of their children and children in turn, aware of objection, will avoid discussing safe sex and sexual health with parents. New Zealand has one of the highest rates of teenage births of any industrialised country. As well, New Zealand has a high abortion rate with 2962 terminations carried out on eleven to nineteen year old women during 1997 (Minister of Youth Affairs, 2000). Sexual health nurses understand that familial, cultural and social pressures on young people have the biggest impact on pregnancy choices. The role of the health professional is to ensure and facilitate informed choices:

> … we're a teeny tiny slice in the broader, huge broad life of somebody else so we can think that what we say is the most important thing, but it isn't. She's within the huge context of her friends and her family and all this kind of thing so I can give her a little bit of information and what I basically say is again offer them choice around their (pregnancy) decision making… that's really the case for young Maori women. To think that they're making an individual decision is absolutely naive … (Mia, 1:255)

Poor parenting and socially dysfunctional families have an impact on teenage pregnancy (Hutchinson, 1999). Nurses commented on the absence of positive father figures in the lives of many 'at risk' young people:

> … but the lack of empowerment for women, girls is really hard to understand. Well I suppose it's the whole society thing. You

> know, about fathers. If they're absent. Yeah. Good fathers. And especially it seems to be like that in the – I often ask these young women when they come, well I do often about their family. Who they live with and a lot of them, I even saw someone yesterday and she was pregnant, teenager, and had a mother and father and so I explored who she'd told about the pregnancy and she'd told her mother. And she lived with them and her partner. And I said you know "do you have a father?" who lived with her and she said yeah but you know she wouldn't tell him. He wasn't even in the picture ... (Harriet, 1:614).

Nurses working with school leavers who are poor school achievers noted an almost universal absence of good parenting models. New Zealand studies indicate that low educational achievement is associated with early sexual activity, an increasing number of sexual partners and an increase in the incidence of STIs (Davis & Lay-Yee, 1999).

> ... a lot of the boys I guess in TOPS groups [Employment Training Programmes] when you're talking to them about their father, there's not one, or "no I wouldn't have anything to do with him" ... (Harriet, 1:616).

Sexual health nurses target health promotion in identified high risk groups, for example, young men who leave school with few qualifications and limited opportunities for employment, such as those in TOPs (Employment Training Programmes). The population based incidence of chlamydia in New Zealand is three times that reported in Canada, and the US and is particularly common in subcultures with poor social indices (Ministry of Youth Affairs, 2000):

> ... with these TOPS groups ... we are getting a high chlamydia positive rate from some of these young men. So they're a really good target group (Harriet, 1:203).

When health professionals establish a relationship of openness and availability to adolescents, safer sex interventions can be introduced that suggest changes in peer culture (Elliot & Lambourn, 1999). To some young women intimacy, partnership and relationship with men is socially validating. Drugs, alcohol and the rules of 'mateship', in combination with female lack of control, are strongly linked to unsafe sexual behaviour and sexual coercion (Hiltabiddle, 1996). Nurses utilise peer group loyalties as a means of socially promoting the safety of young men and young women:

> … in the school that I work in, the majority of the population is Maori, and what really intrigues me is that … that they can actually come and say, "Yeah miss, went out to a party. Four or five of us. Oh and I did it." And so what I will actually do is talk with students too as part of that whole process. "Hey, when you guys go to a party, do you have a party plan it ... You know, do any of you sort of work it out who's going to look after who?"…"Who's going to drive, you know?" ... And it really surprises me that often I ask this – "Oh yeah miss we always watch out for our mates. You know, we make sure that we're all you know, if one has gone missing we make sure that we find out where they are."… Oh the party pack. It's the whole thing that goes with that scene. It's the drinking, the driving, the sexuality stuff … I go down the track of condoms and contraception, drinking/driving, the sex with alcohol and they become quite laid back, and things happen … (Milly, 1:594).

Encouraging planned sexual activity is socially responsible. An emphasis on choosing when, and with whom to be sexually active is a strategic intervention. Establishing patterns of controlled and safe limits of drinking can influence sexual safety. It is more likely that protection will be used and that sexual coercion will be avoided. Adolescents need confidence to initiate sex. Potts (2000, p.21) states that, "While men may construct

first intercourse as a major milestone of masculine identity, there are no doubt, various anxieties and vulnerability associated with achieving this change in male sexual status". Contemporary studies of sexual behaviour support the view that social and cultural pressures are internalised by men and women as sexual scripts or roles. Mostly, for women, sex is only acceptable in terms of achieving emotional and psychological intimacy within certain prescribed relationships (Hynie, et al., 1998). The study undertaken by Davis and Lay-Yee (1999) indicates that young women regard sex as a mechanism for establishing an intimate relationship. For young women, older male approval is highly valued and usually means complying with sexual pressure:

> And then there's the other thing that I have with a lot of women having sex with older people. And they're feeling really -. Even though they didn't particularly like the sex that they had, and it was unprotected so they're having to come here for the morning after pill or emergency contraceptive and an STD check, and they didn't particularly like the sex but they're feeling good about the fact that someone older wanted them, someone wanted to have sex with them. So they're agreeing in that respect … (Harriet, 1:295).

Some nurses acknowledged that they have a personal issue with the uneasy coexistence of differing cultural norms and sexual standards for men and women. Others think that men may be uncomfortable with a female practitioner, as women would automatically judge male sexual activity as antisocial:

> … Men can be more maybe disrespectful to women … you often hear women saying things like that about men … he puts me down and he slept around. I know women do it the same but I don't know it does seem a little bit different ... And maybe I'm just a bit more sensitive to it as well. I've dealt with men who have been married and had other partners and had chlamydia will tell their other partners but won't tell their wife … it really pushes my buttons. I'm sure it's probably the same for women

> but you know, reverse situation but. I sort of feel like I feel that more with men ... (Emily, 1:541).

Womens' social scripts for sexual lives are predominantly about faithfulness, love and trust (Kippax et al., 1990). Nurse's note that women tend to agonise over sexual relationships outside their primary partnership, whereas men generally regard the sexual risks involved as inconvenient:

> I probably have seen more males who have been unfaithful rather than the other way round. The woman I'm thinking of, it was kind of like it was just a huge mistake. Got drunk, slept with this ex boyfriend, shouldn't have done it ... And she spent a long time talking about her guilt whereas the guys just think Oh God this is a pain! What a nuisance! (Emma, 1:393).

Gender power relations are the sociocultural context of interactions with clients and the meanings given to sexual histories. Men expect that women in general disapprove of male sexual behaviour and are therefore secretive. Such responses are also expected of female sexual health nurses. Practitioners are more concerned with understanding sexuality from the perspective of the opposite gender than with imposing their own gender based values:

> ... Sometimes I find men very indirect ... I find it difficult seeing men because I'm not a man. So I can't be in a man's skin. And that's often said around here ... a male doctor saying, " I don't know what it's like for a woman". I find men actually, I find that men would prefer not to tell the whole truth whereas women generally come out with it. Whereas a man ... you have to pull it out of him ... I think it's that they fear that they're going to be judged. And so they prefer not to. They feel they're going to get told off. You know I'm the naughty boy sort of thing ... (Jill, 1:240).

Finding an approach to positive sexual behaviour when gender interests are in conflict is a challenge in sexual health nursing practice and exemplifies the wider gender power inequalities:

> ... Like I think sometimes perhaps if they [male clients] had a male doctor they might tell him something different. You see they might perceive me as being on the side of women ... I do get angry about the people who aren't telling their partners and continue to have sex and aren't treating their partners fairly. But I would get the same sort of feeling about a woman who did that to a man ... if a guy's got NSU [non specific urethritis] and he says if I tell my partner that I've got an STD and she's going to leave and you can understand that that's a very good reason to break a relationship up ... Well I generally would always say like you could have had this for years. Because I think that and just rule out blaming whoever might have given it to you completely. Because it really gets nowhere does it ... (Merryl, 1:422).

Sexual health nurses recognise the social difficulties of social sexual relations. Nurses are able to work with individuals and their sexual health problems, but for many changing the wider social context of sexuality is unresolvable:

> I think I have a very skewed view probably on sexuality and sexual health issues through being here ... I just accept it ... I don't set out to change the world ... through counselling I do get people to accept problems with herpes and things like that ... in terms of my own self ... it's unresolved ... (Jill, 1:342).

Sexual health nurses do have attitudes about sexual behaviours. Nurses value the principles of social justice, openness and fairness in all sexual relationships. The impact of personal experiences is acknowledged in individual nurse's opinions and responses, however the intrusion of any negative perception of client behaviour is avoided. While many draw conclusions of a pattern of female naivety and male sexual opportunism,

there is also an acceptance that genders are deeply embedded and invested in their respective roles. For many nurses the social issues related to sexuality were unresolvable in a broader sense. Nurses therefore focused on *teaching survival skills* to young men and women in a dysfunctional society.

TEACHING SURVIVAL SKILLS

Sexual health nurses understand that they are working with vulnerable individuals and in communities in which patterns of sexual behaviour are often indicative of social disempowerment. Frequently unsafe and non-consenting sex happens when people are drunk or drugged. Safer sex interventions include controlling drug and alcohol use in social situations:

> I think a party starts off with a few beers in a back yard and the next thing you know is a swirling mass of oozing hormonal activity with alcohol and drugs and all of a sudden you've got something that's quite different and so it's really just trying to help them to develop life skills to deal with those sorts of situations and I consider it very much part of sexuality safety … (Patricia, 1: 613).

In its broadest context sexual health care is about *teaching survival skills* for people and groups who have poor health statistics in a range of indicators:

> Well I find that most of the kids are coming to me before they become sexually active anyway. Because they're interested and they want to know how does it happen? What does it feel like? And does it hurt? And I have the models, I've got model cervixes and model this and model that and they just love looking at them and playing with them and asking questions. And if they can actually hold something in their hand. And you know we do condom demonstrations way before they become sexually active. And if, yeah, the more familiar they become,

> then the easier it is to talk about those things when they actually do arise. And I find that by the time they are sexually active, which might be months and months down the track, that they are quite comfortable and they can come out and ask some quite, you know, just straight forward questions ... (Sue 1:146).

Many women and some men report sexual abuse during sexual health history taking. Often the health professional is the first person that the client has told. Clients need considerable professional support before reporting a sexual offender. Nurses emphasis that it is the client who decides on the appropriate action and timing to protect the themselves and who will be involved in this process:

> So we tend to work with them to see how much confidence they have got in dealing with it and just the way they want to. And recommend that it does go through the Police and that it's stopped … take them through what might be involved there, that they may have to go to court and things like that. And we'll go to court with them if they want us to. Generally by the time they're confident enough to tell other family members, parents or whoever, it sort of seems to sort itself out, the family members back them a lot more. But everyone is so different … some people just want to go and do something about it now and don't know how to go about it ... (Grace, 1:249).

Counselling new sex workers focuses on the rights of women to decline unwanted sex from clients and the exploration of assertiveness skills:

> … telling new sex workers that they have a right to their own bodies, they are going to say what they want, that just because a man's paid for them doesn't mean they've paid for whatever they want … So empowering people about their own choices is probably the biggest part and seeing what alternatives there are … (Merryl, 1:180).

Sometimes nurses use provocative and challenging interventions when the client has repeated infections and an educative approach has not been effective. Clients who have insight into the lifestyle behaviours that are contributing to their poor sexual health can find realistic strategies for change:

> … and they're just reinfecting themselves. And you just say, "look, you know, you came in because you want treatment" I mean sometimes you've got to be quite firm with people and say, and just remind them of what they're actually doing here and that they must be here because they want treatment … "what do you perceive you can do? You know, what do you think you can do to stop this cycle?" And they'll come up with something … Oh just won't have sex … And you have to keep going. "Have you had any thoughts on how you might stop having sex for two or three weeks or a month?" "Oh I don't know really". "You know, when do you most likely have sex?" "Oh when I get drunk". "So you're gonna not drink and not have sex for a month?" "Oh yeah that's a bit tough isn't it?" … and sus out what they have said about their lifestyle in terms of drinking and smoking or whatever they're doing that might be a weakness in their ability to have safe sex or no sex ... (Emma, 1: 480).

The event of an STI can be turned into a learning situation. Developing strategies for future behaviour change will rely on personal self-efficacy:

> … now if you'd been given that situation again what are the things do you think you could have or what do you think you might do if you found yourself in the same situation?" So they leave not feeling downhearted about the fact that they've had to come here … (Patricia, 1:553).

Demystifying sexual and reproductive physiology and anatomy is an important part of improving knowledge and understanding of body functioning and encouraging self care:

> There's lots of that [education] and it's just impromptu stuff like the girls who come in and say "what is this" [picks up the model of uterus and vagina] and they've never seen anything like it and they're really fascinated by it and then you talk about ovulation which they don't know anything about. And I really like that part of it ... which is very empowering ... (April, 1: 314).

Young people have limited options for learning about how to protect themselves. Skills and information need to be relevant to the client. Nurses avoid overloading the client with clinical detail and focus on skills that reduce personal risk. In the limited timeframe of the consultation the nurse identifies the information that is most important to the client:

> It's vital and … and how do you do it. I mean I saw someone today who was 15. Not using any form of contraception so therefore not using condoms … the clinic was running late and I had to think right what do I have to get across to this girl, you know. So what I did was found out where she was at and what she knew already as quickly as I could. And luckily she'd just had an education session at school so she was able to put on a condom for instance. So I didn't have to spend 10 minutes teaching her how to put on a condom. I mean there are so many potential things that they need to know. And I didn't scare her by talking about every STD on the planet. But I mentioned a few and mentioned the risk of oral sex as well as intercourse for transmission because that's hugely missed in what they know. And I just, I guess I tried to really ascertain where she was at, at her level … (Emma, 1:154).

Although clients are most often concerned with testing for HIV, chlamydia is one of the common infections in young people in New Zealand. The infection is often

asymptomatic and if untreated may lead to complications such as pelvic inflammatory disease, epididymitis and impaired fertility:

> … most think, oh well they're doing blood tests and they're checking for HIV, it's like we'll eliminate that but there's no way I'm going to have it you know, you just know that that's just the way they think, and you know I think it too and … I probably could take it a little bit more seriously but I just don't think there's that huge a risk and I would be more concerned about the stuff like chlamydia and stuff. Which is so everywhere and these girls, they're at far more risk of it and need more education about that … (April, 1: 297).

Women may present for cervical screening and be unaware of other sexual risks. The nurse however, may become aware of clinical signs of infection and will have to manage this information diplomatically. In the experience of sexual health nurses women would rather be tested and treated than to be kept in ignorance:

> and there has been the odd occasion when I've gone to do a smear and I've noticed a discharge or some inflammation and I've said to them "Look do you mind, I will take a further swab because you've obviously got something there, there might be something simple as thrush, it could be an STD, and do you mind?" And more than often they say "Oh no, please, you know, do that." If it's come back as a positive at least they've been a little bit prepared because they've been – I've actually picked up something that's been there … And I think too, probably because being another female and I can usually feel comfortable about talking to them about that, they feel a little bit more relieved than if they'd gone along to their own GP and had it picked up ... (Rose, 1:531).

Suggesting further screening may not only result in informing the client that they have an STI but also raise questions about fidelity and how the infection was transmitted. The

psychological impact of STIs often outweighs their clinical significance. Nurses make therapeutic interventions to improve adjustment to the event of having an STI. Nursing management is a matter of individually *reframing stigmatising experiences.*

REFRAMING STIGMATISING EXPERIENCES

The received view of having an STI is that you have to be bad. An STI is therefore a social condition brought on by unworthiness. Individuals interpret a sexual infection as part of a negative personal script in which this is one of a continuing series of bad experiences. Such histories may be an indicator for anxiety and depression. Psychosocial nursing intervention is needed when clients convey a sense of powerlessness over their lives:

> … It's a self esteem thing. Confidence thing. Or a person's point of view too, like often people don't … I'm not good enough and so I only deserve to get chlamydia five times and …You know it's just a whole snowball sort of thing really … just listening to the stories are pretty horrendous sometimes … (Emily, 1:295).

Sexually transmitted infections such as gonorrhoea and chlamydia disproportionately affect marginalised social groups. The prevalence of the genital wart virus means that more sexually active people have an STI than do not, although this may not be clinically obvious:

> I think if you address some of those things just by saying "look, before we start, I'll just run over the wart virus with you … warts are really common, you know up to 80% of people have the wart virus". I mean that's a really good statistic … there's times when I don't think the sentence has meant a thing to them, you know you have to tailor it a bit but a lot of people are students and they're not stupid and I think you've got to credit

> that they're informed ... I mean I do say that it's not a disease, not dirty or wicked ... It's all that shame stuff that's tied up with it ... (Emma, 1:224).

Differing reframing strategies are observed according to the nature of the STI. In the case of bacterial STIs personal efficacy is strengthened so that clients take control of their future sexual health. In the case of wart and herpes viruses nurses tend to focus on the normality of living with an STI. The emphasis in the latter case is constructive management strategies:

> The opportunity is also provided by mentioning and normalising HPV [Human Papilloma Virus] to help put it in perspective, face to face, for the women. As Mic Campion said in a conference address in the early 80's: "If you do something as natural as breathing, you risk getting the influenza virus, and if you do something as natural as having sex, you risk getting human papilloma virus." (Pia, 2: 13).

Social stigma exerts a far stronger influence than epidemiological knowledge. Some people feel permanently tainted and that they should isolate themselves from future sexual relationships:

> ... you know a young woman I saw time and time and time again who had huge issues about having warts. And at the end she hardly had a wart but she was just absolutely beside herself about it. I mean, it's like I wasn't treating a wart in the end. I was dealing with the other issues of how she felt about having warts. Potential relationships and stuff ... (Emily, 1:427).

The effects of internalised stigma can continue even after the clinical signs of STIs have gone. It is often social issues that are most distressing for clients and the reason for continued therapeutic intervention. Clients are commonly concerned that they are no longer a desirable partner and that a disclosure of a viral STI to a new partner will result

in social and sexual rejection. Nurses encourage self affirming attitudes rather than self punishment:

> ... I always encourage people to tell their new partners ... one way of handling things too, you know you talk about them and you're saying "this may be a really tricky situation but, you know, choose the right time, the right moment that you think is going to be right. And you've got to look for the positives and look, hey if this partner turns round and runs a mile, you're probably going to be really upset but look you're probably better off without that kind of person. You know and if they're going to stick with you well hey that's a bonus and they think a lot of you and that looks good for a future relationship." So I sort of work on the positives certainly. That seems to help ... (Sam, 1:325).

Exploring the meaning of the event of sexual health for individuals and offering alternative perspectives is important. Although many people have STIs the impact that this will have on future relationships is a major concern. Clients rehearse future scenarios in which they may face rejection as a carrier of infection. Client counselling focuses on destigmatising the individual and in reassuring people that this does not have to be a negatively definitive life event. Nurses recognise that strategies that raise self-esteem are central to the development of healthy coping behaviours.

REBUILDING FUTURES

Improving sexual and reproductive health is about public policy, adequate and appropriate service provision and relevant health promotion. Sexual health nurses develop their own social and public health policies. Nurses work in and represent the marginalised communities that continue to have worsening sexual health statistics in spite of the Public Health Commission policy on the prevention and control of sexually transmitted diseases in 1997 (PHC, 1997). While personal health and health promotion services are funded separately, sexual health nurses innovate and integrate clinical care

with community interventions. Individual sexual behaviour change involves communities taking responsibility for establishing norms of sexual safety in social networks. This nurse discusses facilitating a process of changing lifestyle patterns in adolescent cultures (See Appendix Ten):

> I won't initiate doing an education session or workshop or providing a sexual health or cervical screening service without consulting with my Maori colleagues first and saying "Look you're the ones that are involved with these kids more. You're the ones that work with their Whanau and their Hapus in this area and that. And how do you want me to do this presentation? How do you see me as being arbitor, to provide this service appropriately and comfortable for them? ... if it means having to go off to the local wool shearing shed so be it ... and particularly working in [areas] ... which are really quite isolated ... we've just had to go out there and be prepared and strut around in our gumboots (Rose, 1:595).

Communities have knowledge and resources for resolving social and health difficulties. Nurses see themselves as catalysts for changing health standards and behaviours. Engaging key people in communities in promoting sexual health gives value and acceptability to the concept. Sexual health nurses understand the social imperatives that can be of significance in promoting healthy sexual lifestyles and cultural futures. For Maori, fertility is therefore more than an individual capacity, it is as well a matter of cultural connectedness and continuance. In Maori women fertility represents, "The energy arising from Papatuanuku ... this is their driving force, they are the whare-tangata, providing the first environment of the human being. Maori women are the land, they are Papatuanuku. This history alone gives Maori women their status, their mana, and their direction", (Kuini Jenkins, cited in Manihera &Turnbull, 1990, p. 458). Understanding issues from a Maori perspective is a matter of cultural safety. More Maori nurses are needed to work with young Maori people and communities. Maori nurses talk about restoring mana as a complex of improving life chances, fulfilling the role of women in Maori society and gaining the respect of significant people in the community (See Appendix Ten):

> … I've certainly seen some radical – I mean I can remember one girl in particular who sticks right out in my brain. She was notorious, she was just dreadful, you know, multiple partners, no condoms, falling over every fortnight … we were talking one day and I ... talked about her ancestors and her mokopuna's to come and I said "You may not have that opportunity if you continue with this lifestyle that you have got because you are putting yourself at risk." You know she'd been in hospital for PID ... [after] … a four week period she came into the clinic, she hadn't had any intercourse and she wanted to go on contraception and she wanted to do the right thing and she wanted to be HIV tested. All of a sudden all of this stuff. The noticeable difference was the fact that she went from unemployment to a job … She's a peer model. And they look at her and say what happened, the girl's got something … and it's wonderful and there is this mana that has been restored to her and I think that in itself says something in contextualising sexuality as bigger than ourselves in the fact and particularly for people … who have got whanau in the area, who have kuia, kaumatua and a lot of their friends have got babies … (Patricia, 1:478).

Invoking symbols of cultural strength and pride is a powerful approach to women who feel socially undervalued. Giving Maori women status, mana and direction in communities where there are few educational opportunities and high unemployment is complex and skilful (See Appendix Ten):

> … sexuality from a Maori perspective and certainly that's where I got a lot of that perception of sexuality for some culture as being broad. That I'm here because someone was sexually safe and ensured that their fertility was good and the fact that Rangi and Papatuanuku are very much tied up with fertility and reproducing and being healthy and to some degree that has been

> lost I suspect with some urban Maori and certainly some rural areas too, there's elements of the culture that actually have truly been lost, because when I see what young people do to their bodies, one of my first questions is why do you do this when it hurts you physically, spiritually and emotionally, why keep doing it yourself? … (Patricia, 1:508).

Being careful is a matter of self esteem. Therapeutic interventions focus on positive cultural identification and self perceptions. Improving cultural status means transitioning to behaviours that will gain community acceptance and responsibilities (See Appendix Ten):

> … one thing that I've found that works really well is I talk about their families, particularly among Maori clientele, I say to them, I talk about their nanny, or their kuias or their kaumatua and I get them to remember being a mokopuna, being a young wahine, being a tane, what do these things mean, do you remember? Oh yeah, I remember being with a kuia and she did this and this and I remember the kaumatua … And I say well now, there's going to come a day when you'll be a kuia or a kaumatua and you're going to want to have mokopuna's and be able to say "oh isn't that wonderful that you know that here is my seed that will go on", because you know that is the perception, "that here is my seed that will go on when I'm no longer here. The tangata whenua will go on but I say how are you going to have mokopuna's if you can't have your own children and suddenly it's like wow, this is actually not about me, my sexuality is not confined to me, but it's my ancestors, and it's my mokopunas too, and sometimes I find when you contextualise it for some of the clients on that perception, it's like a lightbulb goes on in their head. They want that all and I find that works very well … (Patricia, 1:430).

Maori women are sensitive to being labelled and stereotyped because of poor sexual and reproductive health status, including high teenage pregnancy rates. Maori women are

over represented in rates of cervical cancer which are almost three times that of non-Maori women (Smyth, 2000). Reducing cervical cancers in Maori women is connected to overcoming the stigma that is associated with populations considered to be at higher risk (Manihera & Turnbull, 1990, p. 458). Maori nurses understand why it is that Maori women are reluctant to seek health care when sexual health issues are involved. Overcoming fears of specialists and procedures is a critical step. Additional professional support is needed if women are to follow through treatment when an abnormality is found:

> … and also I think it's important too when you're being a smear taker and doing their smear and particularly if it's a first time, like I know from a particular woman who was in her late 50s and never ever had a smear … she'd been to an education session and she decided OK she really needed to start looking after herself. And she ended up with … grade 3 … so the next hurdle for her was like we talked about what that meant … what her options were, that there was treatment available and it was really good that … we'd managed to pick that up before it had got any worse… and the next hurdle was having to go to somebody else, like having to go to an gynaecologist and go through that whole colposcopy thing … (Rose, 1:477).

Counselling clients to reduce sexual risk often leads to discussion of other harmful patterns of behaviour. Nurses have considerable social agency. History taking is not only about sex but also a broader picture of the clients lifestyle, past and relationships. The skills of safer sex are decision-making, negotiating condom use, and resisting peer pressure. Being able to conceptualise a future in which there is some control is therapeutically significant to behaviour change:

> ... it's because of drug and alcohol problems that they're in here in the first place. You know, it's quite related ... I would have a discussion with them about their own situation, whether they've got the money to do that. Who their close personal friends and family are and how it affects them … their behaviour when they

> are drunk or high or whatever, how that affects their friends and then how it affects them. How it affects … what happens to them the next day, the next week. if they happen to have sex with someone that they get a disease from, how that's going to affect them. How they could perceive it might affect them and the changes they might want to make it a little bit safer. Yes, I just sound them out a little bit about what they think and kind of prompt them in the direction that it's a little bit risk taking and that they could be safer. And then I leave it up to them. If they want to know more, fine, if they don't, fine. If they say they've got a problem and they're happy to be referred, fine ... (Grace, 1:16).

For some clients unsafe sexual activity is connected to drug and alcohol addiction, and further support is offered through counselling agencies. Nurses worked at interrupting patterns of teenage drug and alcohol abuse before this became an established pattern. Recognising the bonding between young women can be utilised to keep parties safe. Engaging young people in problem-solving issues of safety strengthens group cohesion and mutual responsibility:

> And you know talking about tiny little strategies about, just things like food and water and – they were amazed! You know they got quite excited about those little strategies, try not to get quite so out of it on the weekend ... But I mean the group thing, girls are really good at groupy stuff so they look after each other. But just things like taking food and taking water … in between times … just little things like that … I thought they'd be like "oh give me a break"… Well I didn't actually, I don't think I even offered the ideas. I think most of them they thought of on their own. So those moments when you feel like you've made a difference rather than you've just, you know, slogging on ... (Jane, 1:593).

Planned parenthood is associated with the life choices and options available to women. In general in New Zealand there is a trend towards an overall rising maternal age and to the later timing and wider spacing of children (Pool et al., 1999). For some however, poor socioeconomic conditions and limited educational and employment opportunities influence deciding on early motherhood. Early school leavers have often missed sexuality education programmes. As this nurse states young people are often subsequently misinformed about their risk of pregnancy:

> … All I can do is give them the information and give them a little bit of education about their sexual health because some of them they haven't been part of the school programme … they don't actually realise how easy it is to get pregnant. And have all these excuses and wives tales like, they'll be right. They'll be safe … specifically it's … do you want a baby or don't you? If you don't then you have to do something about it … (Harriet, 1:578).

Women who have been victimised as children are often without the skills of self protection. Successfully negotiating sexual safety is a powerful milestone in enabling future assertiveness. Once a pattern of self care has been established it tends to be resistant to change:

> … a young women, I think she's probably about 18, no contraception, her third episode of chlamydia in her short life. You know a history of some domestic violence and sexual abuse … Never really even heard of a condom I don't think. And I don't know how it happened but she was just so excited about using condoms … And so coming into the clinic and especially being able to get some flavoured ones has been like Christmas ... I think a lot of it had to do with deserving. A lot of it had to do with her sexual abuse history and how she felt about herself, particularly sexually. But she's really celebrating that. I mean just in a small way without actually addressing any of the abuse on it's own. Well, you know, it was a long time ago and she'd

> seen a counsellor and it wasn't seen as a huge issue in her life … (Jane, 1:316).

Nurses take personal satisfaction from the knowledge that they can make a significant difference to individual lives. An STI is an opportunity to intervene. Sexual health history taking is about the past and therefore the interaction focuses on changes for the future. In many instances clients learn how to manage their sexuality safely:

> … I like it because you're a lot more personal. They're not just another person that comes and goes you get to know them quite well, quite intimately. I mean you hear a lot of stories when you're in that personal setting. I like the personal contact. I like to be involved with a person's health. I like to be involved with their primary health, with keeping them healthy, with preventing things rather than patching up at the other end. Obviously we do some patching up at the other end. but it gives you quite a sense of achievement when you have seen a client come in and you get to help retrain their ways of thinking and their habits and you see them at one end of the scale and you see them at the other. And then you get to keep them in that healthy cycle. And it really makes you feel like you've done something worthwhile … (Grace, 1:352).

While there has been considerable attention given to the implementation of public health and educational strategies to improve sexual and reproductive health in the last decade, STIs are increasing. Nurses understand that socioeconomic conditions have a significant role to play in the patterns of lifestyle that cause high rates of infection. Nurses can shift attitudes of failure. The interventions outlined demonstrate a complex understanding of the sexual cultures of young people, of men and of women and of Maori.

SUMMARY

This chapter has considered the role of the nurse in social change. A*dvocating and empowering* individuals and communities involves a complex negotiation of community requirements and affirming individual rights to make choices. The experience of *working in the context of sociocultural realities* of poverty, dysfunctional families and abused adolescents leads to social advocacy. Understanding the relationship between socioeconomic conditions and the state of sexual health is incorporated into clinical and health promotion practice. Sexuality in this context is unsafe and nurses perceive their role as *teaching survival skills* in social networks, communities and subcultures that have a high prevalence of infections. Nurses work with clients in *reframing stigmatising experiences* and making opportunities for life change through raising self-esteem. Populations who are most at risk for poor sexual and reproductive health have generally poor social health indices, such as income, housing and education. In the next chapter public and professional attitudes to the work of sexual health services are explored.

CHAPTER NINE

DOING DEVIANT WORK

Being identified with sexual health clinics and sexually transmitted diseases carries the stigma of indecent work. Jokes and distasteful comments from other health professionals and social acquaintances are a universal and continuing experience. Nurses are positioned in communities as sexual liberals, defending homosexuality, young people's rights to express their sexuality and women's rights to termination of pregnancy. Nurses are challenged to defend their endorsement of sexual diversity, pregnancy choice and safer sex health promotion by moral conservatives. Maintaining the wish of a young person to decide on a termination of pregnancy without family involvement is a contentious issue for Maori and Pacific Island communities.

Being identified as different is one of three theoretical codes shown in Figure Six to make up the conceptual category *doing deviant work.* In each of the conceptual categories there are positive and negative aspects in being visible as a sexual health worker. Sexual health nurses commonly are *experiencing professional marginalisation.* Often they are treated derisively by other health professionals, personal acquaintances and the public. Nurses overcome their marginalisation through increasing the public visibility of their work by taking opportunities for *speaking out* on behalf of their clients. In this way nurses are identified as community health educators. In the last decade sexual health nurses have emerged as spokespeople about sexuality in our society.

Doing deviant work describes the dual process of being tainted by 'dirty work' and of being visible as an advocate for the rights of marginalised people and communities. In both respects the nurse experiences separation and alienation on a personal, community and professional level. Working with sexuality means an atmosphere of closely guarded privacy, secrecy, confidentiality, boundaries and barriers. Clinic staff subsequently form close, collegial bonds. Supervision and debrief processes are essential to cope with the social role and work of sexual health nursing. Black humour is used to avoid becoming

too intense, serious and overwhelmed. Nurses struggle with the conundrum of, on the one hand encouraging sexuality and on the other hand discouraging risk, in a social context where there is an imbalance of power between men and women. Coping with sexual abuse, the double standard and the powerlessness of women is a daily reality in practice. Nurses work out multiple strategies to counter sexual pressure, for example, getting together with adolescent peer groups, working with parents, boards of trustees, on marae and in the media, to change patterns of peer pressure. Gaining a sense of the bigger picture of sexuality develops with a composite of sexual histories. Nurse's come to know what is going on by asking and listening. Having a sense of the importance of the sexual health nursing role in raising public awareness and changing social attitudes becomes critical to professional survival.

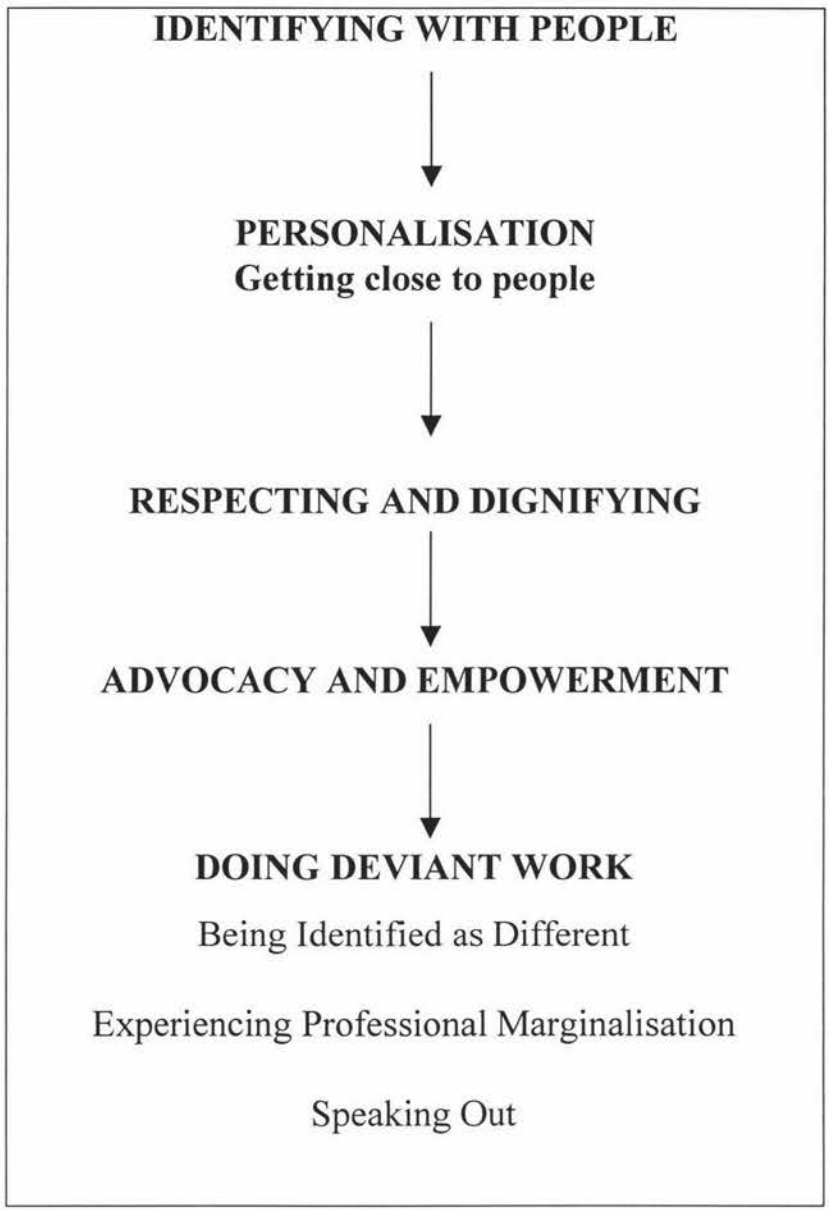

Figure Six: Doing Deviant Work

BEING IDENTIFIED AS DIFFERENT

Knowing that someone works with sexually transmitted diseases, talks about sex and has clients who are HIV positive, gay or are sex working, makes people uncomfortable. Nurses confront the public and other health professionals with issues they would rather remain hidden and private. Talking about people's sex lives and examining genitalia all day are unorthodox health activities.

> ... I remember coming here feeling so frightened about all that sort of stuff. It's just being exposed to it I think, constantly. Like it's there all the time. The support of the people that you work within. Why is it different? And there's other people that have been there and done that and so you can bounce ideas off. Supervision stuffs very very helpful in dealing with those sort of issues. You certainly don't have that out in general practice ... (Emily, 1:131).

Sexual health nurses hold a lot of secrets. Unlike other areas of health care little of the work can be shared with friends, family or other health professionals. It is private and frequently distasteful to people outside sexual health services. Nurses hear about the issues that other people cannot be told or do not want to hear about. Nurses know about the prevalence of rape, abuse, infidelity, sex work, and the complications of sexual lives.

> Sometimes I feel like "Oh God" they've kind of dumped it all on you. They've got rid of it and you have to deal with it ... (William, 2:48).

Some nurses draw parallels between the social issues that they encounter when working with male clients and the social issues of sex work. There are occasions where male clients use the interaction in an abusive way. Sexual health nurses have a right to professional respect and will protect themselves from undermining behaviours.

> ... the parallels between nursing and prostitution and about image and selling our wares, you know, what we will do for money and what we won't do as nurses, that is very much a part of this whole process as well. Recently I had a male client and there was something about the dynamic there about exposing himself and his release that he gained through that. He wouldn't

> tell me anything about his sexual history. I was trying to get a human touch to his inner self. Yet it felt like I had to use something that was outside what I'm willing to get paid to do to bring his comfort level. Because I didn't get what I felt in terms of rights and responsibilities of our contractual relationship as client and nurse. I felt that he didn't give as much as I gave. There wasn't a balance. He didn't play the game. There has to be give and take (Mia, 2: 56).

There were very few examples given in the study of opportunistic harassment. Where this did occur the behaviour of male clients was directed at both male and female nurses. Occasionally nurses encountered behaviours from male clients such as inappropriate genital exposure, ambiguous behaviours that were sexual in nature, excessive discussion of sexual matters for erotic gratification and acting out. The public and professional perception is that these behaviours are the norm for sexual health nurses rather than the exception and that the work entails an expectation of harassment behaviours (Lawler, 1991). The public identifies the client who visits a sexual health clinic as deviant. Services are provided for people considered to be outside the range of sexual normality, homosexuals, sex workers and the sexually depraved. It is therefore assumed that sexual health nurses will dissociate with their clients, treating them as outsiders, abnormal and definitely different from themselves:

> … I was queuing in a queue … and I was talking to this woman next to me and she said, oh you're a nurse. I told her where I worked. She said something like ooh or something like that and then as we got further up in the queue she was ... Some older guy, she said something about him being a deviant coming to buy a school uniform and she said you'd know all about deviants from where you work and I said "what?", assuming that because I worked in sexual health that we saw sexual deviants, what's a sexual deviant anyway? And it's just people don't, a lot of people think that we see, I don't know, sex workers, gay

> men and sluts, basically which is so far from you know what we, what people see ... (April, 1: 350).

When nurses reject the labels which the public and other health professionals attach to their clients and normalise difference, they themselves are identified as different and stigmatised. Mythologising preconceptions surround the work of the sexual health nurse. Popular perceptions of sexual health work generally focus on the extraordinariness of procedure of genital examination. It is not recognised that nurses spend the majority of their time with clients taking histories, counselling and educating:

> ... I think they think I burn off warts and look at vaginas and penises all day. I mean I think that's honestly what they think. Or I stand there handing things to a doctor. And clean the room afterwards. I don't really think they know there's a lot of talking that gets done and a lot of teaching and, yeah. There definitely is, when people don't want to admit because you work there ... a few people I know go "oh what's that like?" I feel like going "well what's it like working in a bank?" (Emma, 1:461).

Maintaining a normal social existence can present difficulties, when in small communities it is likely that the nurse will meet clients frequently. Unless the client acknowledges the nurse, it is not appropriate to make social contact. Many clients pass through sexual health clinics. The need to maintain an appropriate social distance outside the clinical setting can be isolating:

> ... going out socially ... what [is] my role is out there, because I went out with my partner and there were three sex workers in this little wee small bar where we were and it made me feel uncomfortable because I didn't know whether to say hi to them or ignore the fact that I knew them and yet I knew So that's what's uncomfortable about this job where any other job you see

> somebody and you say hi as you do. But in this job you don't say hi to your clients ... It is isolating (Merryl, 1: 583).

Because genital examination is highly personal and exposing, some clients are very embarrassed by encountering the nurse in a public situation:

> ... I don't like going out to the pub at night and seeing someone I've done a cervical smear on that day ... More often than not I will actually have people coming up to me saying, "oh it's good to see you out" and they don't seem embarrassed. I've had the odd person that walks the other way. You know, especially if they're a bit young and they've been in for an STD screen and I know that they're not supposed to be at the pub ... you get the odd person sort of slide out the door that way. I think I've had a fairly good response really ... (Grace, 1:368).

Nurses expect to be people who are avoided in public. To be recognised talking to some one identified in the community as the sexual health nurse has social meaning. Being a sexual health nurse means remaining separate from aspects of normal public social interaction and exchange:

> You notice when you're walking around town if you see somebody you know they actually don't see you or happen to cross the road at that point or they don't want to see you. No matter how well you've got on with them in the clinic, they don't want to see you. I also find that if I've seen somebody around town, I quite often get a visit a week or so later. There's no acknowledgment that they actually saw you in town and I just tell people, look if they ever mention that "I saw you in town" my mind said hello to you ... (Jackie, 1:217).

The lives of sexual health nurses are carefully socially managed. Being involved with the details of people's sexual lives makes people different. The discretion, privacy and confidentiality that surround work in sexual health clinics permeates everyday social interactions. The social consequences of work which is involved in treating STIs is social constraint and distancing:

> what's also unresolved kind of related is being in a small community … walking down the street and someone seeing you and them knowing who you are and you not even remembering. Or them knowing members of your family or even members of your own family coming in here. And having to get involved, with their permission, getting involved in their care as well … So how I deal with that is that I've got a little bubble. I come in, the bubble goes down and everything stays here … I find it quite hard. So I don't tend to socialise so much … if I do ... I just am very careful about how much I drink … (Jill, 1:345).

Generally there is community support for the work of sexual health clinics. Being identified in public as a sexual health educator is generally a positive experience however when the community member has been a client the interaction changes:

> So some of the parents are really pro, you know, that and we get a lot of positive feed back too. You know, a lot of parents or friends that we might see at other things out in the community say "well you know my child was part of your programme last week and they came home talking about this really positive." So there is all that positive stuff. And we had a few GPs that we've worked with all along … they were being so helpful and supportive … They often see the end result … and that's why they help set up the education and the promotion, they were … finding it really hard all the time to see all these unplanned

> pregnancies, STDs and stuff … And, you know, trying to prevent that bottom of the cliff stuff ... (Harriet, 1:688).

There are few places that clients can go to where there is an overt acceptance of the need to talk about sexual problems. In general health care many practitioners will avoid hearing and knowing about sexual health issues. Sexuality is too difficult for people to deal with:

> In private practice … it's like it's too scary ... You know and other people don't want to know about it, it's too much to have to deal with. Whereas working within the area of sexual health, you have such a lot of team, well this is what I found, a lot of team support. Because other people have worked within that area and they have experienced the same thing within. Yeah so it's more supportive I think … (Emily, 1:107).

Not only must sexual health nurses feel comfortable talking to clients but also colleagues about sexuality. Giving case histories means discussing frankly sexual practice, genital symptomatology, and presentations of sexual violence and abuse. Working in a professional culture in which it is acceptable to address the social as well as the health issues of sex and sexuality is critical to the well being of the staff who manage sexual health care. The personal support of colleagues is essential to professional survival.

EXPERIENCING PROFESSIONAL MARGINALISATION

Sexual health services are provided to treat and prevent sexually transmitted infections with the aim of controlling threats to public health. Sexual health nurses do the work that people want done but do not want to know about. Work that involves public morality is dangerous. Within the health professions there is still evidence of the historical ambivalence to seeing sexual health as a fully legitimate, mainstream health

care activity. For the most part, sexual health continues to be seen as a private or lifestyle issue and primarily concerned with managing the diseased and deviant:

> ... it's stepping back. You actually have nurses and other people that step back from you when you announce what you do. Especially in the early days. These days they all probably know what I do anyway. But they used to step back or step back and make jokes about "I hope you double glove" and stuff like that. You know ridiculous stupid things ... I had a specialist, an orthopaedic specialist, in one of the clinics who was using the room in the afternoons and I was using it in the morning and he was majorly concerned about that because he could get wart virus floating around in the air and he was giving steroid injections into joints and that's pretty typical. Gynaecologists who constantly ask me how the pox clinic is ... (Jackie, 1:251).

Sexual health nurses are symbolically the unclean. Other health professionals treat them as if they are contaminated. What is communicated is excessive and irrational concern about infection control in relation to sexual health clients. It seems that sexual infections are considered to be outside the standard infection control procedures and therefore staff who work in sexual health clinics become a health hazard:

> ... Actually I've had that (jokes). You see I find it difficult to deal with because I'm quite passionate about all these areas of work. And I mean I got all those jokes when I first started here. You know, I'd go dinner and people would say, "I hope you washed your hands" and all that. I thought oh get off the grass, you know. Yeah and I've had nurses say "oh God, I couldn't think of anything worse. I don't know how you could bear it." And I don't know where they're coming from. And I just don't understand ... (Sam, 1:389).

The social threat of overt sex and sexuality is expresses in terms of a concern with hygiene. The sexual health nurse is close to 'sinners and 'deviants' and must therefore be involved in dirty and dangerous work which is beyond the domain of 'normal nursing practice', however normal sexuality is claimed to be:

> all the interns get together and have study days and of course ... they're always fascinated ... I think it's the same not just with the nurses, but people in general. When you say where you're working, and sometimes they say it must be really good ... I'm really jealous and other people go ooh yuck ... You know you poor thing and it's the same with the interns that they, some of them think it's great and often think that's not really nursing either ... and some really weird ideas about what goes on and about the people that we see ... (April, 1:330).

Some kinds of people are not worthy of health care and of the proper attention of the health professional. Nurses find themselves in a position where they are defending the moral character of their clients and not the right of the individual to decent care:

> Most people I think the attitude is ooh yuck fancy doing that. And every now and then you have the odd person come up and say, gosh that sounds a neat job and you know darn well that they would be perfect in the job, just the whole attitude and the way they see it. And I can't understand this other attitude really because it's a wonderful job I tell people, look I can gossip away all day. You see nice people ... (Jackie, 1:241).

Undermining and dismissive attitudes from other health professionals are common:

> ... I think, that often the work in sexual health is trivialised, you know, it's about "well what do they do anyway?"... And it's probably something that people still feel uncomfortable about.

> They sort of have this sexuality thing happening from the navel down and not much else. People's perception, I've found, other nursing colleagues who are not in sexual health, they perceive sexual health as vaginal exams and looking at penises and that's about it ... But not much about up here. What people are thinking and feeling ... or ...? how it impacts on us personally ... (Patricia, 1: 240).

The personal impact that sexual health nurses describe is the experience of personal, professional and public isolation.

SPEAKING OUT

The health professionals who work with people with STIs are often the only public voice to represent the interests of populations who have poor reproductive health statistics. For issues such as reproductive health, HIV and fertility there has been organised political pressure to raise public awareness and to provide adequate health services. The stigma associated with STIs and sexual health clinics is so embedded that although STIs rank highest among communicable diseases in New Zealand, there is little public pressure to improve and expand services or to target prevention campaigns at those most at risk. People with STIs are socially unable to form political lobbies to challenge the discrimination and stigmatisation that they experience and therefore the phenomenon of STIs remains a secret and shameful experience. This is well illustrated in the words of an experienced nurse:

> ... here it's even more refined marginalisations, where you see ... prejudice against sexual practice, or lifestyle or people that are quote, unquote peculiar ... refinement into even people on the dark shadowy fringe and I use those words quite deliberately ... here the women didn't have a voice because people wouldn't raise their hand and say I went to the STD clinic and so they're just forgotten people ... And men who have sex with men have led the way around HIV and formed politically active, vocal

> people around what services are given ... it's the power group within the marginalised group (Mia, 1:96).

While people with STIs are ostracised, the public maintains an interest in information about trends in STIs and in those who have them. The information available from sexual health nurses is practice based, local and topical. The use of the media is a way of maintaining public and political awareness of sexual health problems and prevention:

> ... I have quite a bit to say. I generally have got something every quarter to go in the newspaper. About STDs, about us moving, and there was stuff on the radio yesterday ... But yes a press release went out. So generally, and like World Aids Day, Aids Candlelight Memorial ... but yes there's that as well. The added stuff. I'm visible in a small community ... (Jill, 1:369).

Being a sexual health nurse means being involving in debating public health and education policy about sexuality. Nurses are proacatively involved in changing community attitudes. Working with local schools to introduce sexuality education before young people are sexually active is an important prevention strategy:

> I really like the new physical and health education curriculum. And I'm heavily involved in one of the primary schools in our town. And they really are trying to implement the puberty stuff a lot earlier than at intermediate. Back at primary school level. And whether that's going to be successful or not, I don't know but the whole thing needs to be much more consistent, sexual education, but everybody doing the same thing ... and right through the same messages through from primary school. Building blocks have got to be made right back to preschool basically. I mean we still have the boys in the – I suppose you'll get that sort of, you know when you go and talk about vaginas

> and breasts – like laughing, you know, and just not listening. … And I really like the primary school curriculum how it's integrated. They do their health sort of cross curriculum. But also once you get to high school in New Zealand, it's just you have an hour of health. That's it ... it makes much more sense to me still at the high school and intermediate level for cross curriculum stuff … health can be talked about in social studies surely ... (Harriet, 1:584).

Sexual health nurses take the opportunity to maximise the potential impact of the sexuality components of the health and physical education curriculum on young people. Unless important elements of sexuality education such as safe sex and contraception are included in a school's curriculum young people may not receive information about protection. The law requires school principals to consult communities about sexuality education. This is the only area of the curriculum where the law requires consultation, and where the principal does not have the final say over what is taught. The community can restrict the content of the sexuality programme in schools and parents can withdraw their children from such a programme, there is no parental consent required however, if a young person chooses to access sexual and reproductive health information and services from health professionals:

> a young girl who is 14, got brought in by her 23 year old boyfriend and I was incredibly uncomfortable about that professionally ... he did all the talking and he was doing all the directing of the questions and I thought "hang on a minute mate." You know, and so I was quite up front with him and I'm not happy or I'm not comfortable with this situation, you need to be aware that actually what's partaking here is actually illegal. OK, so you're making yourself vulnerable for prosecution by what you're doing. Now whether that was deemed professionally appropriate is probably quite a debatable thing, but I wanted to be up front with these people that in actual fact

> what was occurring was a legal issue. And a power issue … (Patricia, 1:265).

In spite of parental concerns about early sexual activity, withdrawing children from sexuality information is not an effective prevention strategy:

> … how we evolved was that a group of people got together and they decided in this town that we needed an alternative place to provide sexual and reproductive health. Whereas a lot of people weren't happy with the service that was being offered which was the GP service … And it was specifically about the young people too who weren't getting their sexual and reproductive health needs met in this town. We were having this high pregnancy rate, high STD rate. And so this group of people got together. There were a few doctors and public health nurses and parents and counsellors, and developed this model that we are now ... And we started off by just providing education at the high schools. We had a trained educator that did some family planning and education work. And then they decided that they needed a clinic backup for education. So funding was always a problem. But they set up this little clinic which just grew and grew and grew. And now most of our clients are young people. And then we managed to get the funding on the statistics that we had … to prove what we were doing first before we got official HFA funding rather than having to scramble round for all the grants … the people that we get then evolved from all the high school students … we see the four high schools. And we actually go in and educate ourselves, one to one. It's not promotion, it's education that we do here ... (Harriet, 1:87).

The collaboration and collective knowledge of people in social and health agencies has developed into innovative, integrated community based models of care. Local

knowledge of this kind is essential in making targeted interventions. In New Zealand an integration of sexual health nurse's community knowledge with public policy, could lead to considerable sexual health gains. A climate of sexual and reproductive health policy without adequate funding for specific services has rendered such policy ineffective. The approaches of health prevention and health promotion advanced by successive Ministries of Health have been unsuccessful in reducing rates of STIs, abortion and teenage pregnancy. Moral conservatives utilise these statistics in demonstrating the failure of sexuality education and of safer sex promotion and the culpability of sexual and reproductive health professionals for a decline in moral standards. Opposition to the work of sexual health nurses is based on the view that parental rights to establish moral guidelines for their children and adolescents is being undermined by irresponsible and 'anti family' health professionals (Thompson, 2000). There is strong moral opposition to the work of sexual health nurses. The work that nurses are contracted to do, that of supplying contraception and condoms to minors without parental consent brings sexual health nurses into conflict with some parental interests. Nurses are obliged to put the interests of the young people who are their clients, first. Research suggests that parent-child communication and disapproval of teen sex can delay the onset of sexual intercourse (Hutchinson, 1999). Not all parents however, are willing or able to talk openly to their children about sexuality issues. As this nurse states *speaking out* as sexual health educators and advocates for the safety and protection of young people attracts criticism from some parents who maintain that parental rights are being undermined:

> … But then you probably get a lot of, some flak too particularly from groups like the church, as to are we condoning sex, you know. And there's always the thing about … I've said we give out lots of condoms. And the most common complaint we have is parents finding condoms in their young people's bedrooms or bags … that's the most common complaint we have from parents. "You gave my child condoms. What do they need them for?"… we really have to follow a pretty strict sort of complaints concerns policy there. But we also have to point out

> to the parent about the law. And the confidentiality as well. A lot of parents have no idea, most of the parents I'd say have no idea what the Contraception and Sterilisation Act actually says. And they're horrified. Absolutely horrified when we tell them. And they can't believe it and a lot of parents will go to really long lengths of checking to see what we told them was correct. And the printed information that we can even give them ... (Harriet, 1: 650).

Nurses work with multiple communities. Maori communities are the worst affected by poor sexual and reproductive health statistics. Relating to people in communities is a matter of cultural appropriateness and acceptance. Furthermore, respecting community leaders and protocols is critical. Pakeha nurses are culturally sensitive but may need to learn cultural skills in order to achieve partnership with Iwi. One Maori nurse observed the difficulty of attempting to deliver services and to negotiate with community leaders from a Pakeha cultural perspective:

> I tend to actually be a little bit radical because ... I actually come up against a few ... different aspects about the way that things are done [in regard to Maori protocol] ... And I think that there's been certain issues that have come up like [pakeha} sexual health nurses that are ... finding it really really difficult to get into the different schools like R____ College ... And they find that there's a real barrier there and they're predominantly Maori populated schools ... I've just tried to pull them back and just say "Hey listen, are you the right person for doing the job? Are you having consultation with ... the Maori health workers out there, or are you doing it your way and expecting ?" And more than often they'll say "Yes, yes, we've always consulted with our Maori, our colleagues". You know, a lot of the Iwi health providers now are involved in sexual health and cervical screening and I've worked very very closely with them,

> particularly with cervical screening. I have a really good rapport with those. And I think because they know where I'm coming from as well. And I probably offer more support to them than I do my own colleagues ...We want to do things our way because we see that as being the best way which is not necessarily the right way how Maori health providers want to do things." And it needs to be a lot more consultation ... (Rose, 1:562).

The connection between, sexual activity, genital wart virus (HPV) and cervical cancer have been professionally downplayed. Such an association would highlight the risks of sexuality. In many cases when in general practice there is a finding of HPV on a cervical smear, the information is withheld from the client and an onward referral is made to a sexual health clinic. Sexual health nurses are critical of the protectionist stance taken by health professionals and advocate for women's right to know the findings of their cervical smear and the connection with sexual activity (Braun & Gavey, 1998). Nurses are vocal in professional forums about the failure to fully inform women of the causative relationship between the genital wart virus and cervical cancer:

> "those [women] I have dealt with who have not been told of the presence of HPV on previous smears [taken at their GP], have expressed incomprehension, anxiety, anger and resentment. They often feel let down and misled ... it is my firm conviction that women are in fact not giving informed consent to having a smear test unless they are aware that in many instances HPV will be picked up and will be reported ... My hunch is that where women are reluctant to have a smear it is the very procedure that puts them off. The relationship with sex, or with something sexually transmissible, may add to that of course, but it seems that to downplay the association with sex is, after all dishonest ... (Pia, 2: 10).

Sexual health professionals speaking honestly about the prevalence of HPV and the increasing likelihood of contracting the virus with any sexual contact is socially threatening. If it is only 'bad' girls who contract STIs, the eighty percent prevalence of HPV means that a considerable proportion of sexually active women will be labelled negatively unless social attitudes to sexuality change. It is no longer acceptable to perpetuate myths that people invite STIs through indiscriminate sex, multiple partners, and non-monogamy.

Doing deviant work is a personal, professional and social challenge. Guidelines for cultural safety (NZNC, 1996), the principles that underpin health promotion practice (Health Promotion Forum of New Zealand, 2000) and theories of social emancipation (Bevis, 1989; Bevis & Murray, 1990; Bevis & Watson, 1989; Moccia, 1988) do not fully encompass the phenomena and realities of sexual health nursing care.

SUMMARY

This chapter has considered the social implications of *doing deviant work.* The stigma associated with STIs is not only attached to the people who have them and the places in which they are treated, but also the people who work with them. For nurses, the experience is of *being identified as different* from any other health professional. The barriers of their 'carnal knowledge' and improper association with the sexually infected impede nurse's social relationships. Nurses encounter in the community mythologising attitudes and beliefs about their work. As a group of health care workers sexual health nurses are *experiencing professional marginalisation.*

CHAPTER TEN

DISCUSSION OF FINDINGS

In the previous six chapters the findings of this study have been presented with a focus on the conceptual categories and codes to emerge from the study of the work of nurses who work in sexual health services in New Zealand. The five conceptual categories generated from the data- *identifying with people, personalisation, respecting and dignifying, advocacy and empowerment* and *doing deviant work* – reveal a complex process of *destigmatisation.* Sexual health nurses have an in depth understanding of the stigmatisation of sexual health clients and of the process of counteracting that stigma in clinical practice. The study reflects the dynamic process of responding to changing sociopolitical climates in health care, societal attitudes and conditions and sociosexual patterns in New Zealand in the 1990s and the new century. The findings of the present study are integrated and interpreted in the theoretical framework of *destigmatisation,* presented diagrammatically in Figure One (Chapter Four).

In the first section of the final chapter the core category, the process of *destigmatisation,* will be examined. In the theoretical framework, the analysis of nurse's counter reactions to stigma is compared to Gilmore and Somerville's (1994) model of stigmatised reactions towards people with sexually transmitted diseases. The model describes the processes that characterise stigmatised reactions: disidentification, depersonalisation, scapegoating, and discrimination. *Destigmatising* in the context of the present study means that sexual health nurses engage in a process to counteract prejudice and negative social attitudes towards people who attend sexual health clinics and who have sexually transmitted infections. The *destigmatising* process that occurs is individual, professional and societal. In the discussion that follows, the findings of the study are reviewed. The implications of the study for nursing, education, practice, and further research are considered, and the limitations of the present study are noted.

THE PROCESS OF *DESTIGMATISATION*

The process of *destigmatisation* is proposed as a theoretical framework for nurse's management of sexual health care. Through interactions with clients, colleagues and communities, sexual health nurses learn the symbolic meaning of work that is involved with sexuality. Grounded theory studies derive from symbolic interactionism, based on the assumption that people inhabit pre-existing systems of meanings. As the present study indicates the meanings that are given to STIs are set within historical and cultural contexts. Through cultural beliefs and attitudes the world is interpreted in a meaningful way and communities behave accordingly. In interactionist terms, the practice of stigmatising people is symbolic of embedded social meanings.

Sexually transmitted infections are a social attribute as much as they are health problem. The experience of an STI is feeling socially and physically contaminated. The management of sexual health involves the treatment of infection and of the social impact of such infections. In the present study nurse's processes of *destigmatising* are described. This is a conscious process of the reversal of the negative cultural messages about STIs, which are internalised by people. Nurses daily are engaged in counteracting the shame, fear and anxiety among sexual health clients. Assessment is made of client psychological reactions to the event of sexual risk and STIs. *Destigmatising* is a concept for care that is based on the human rights and dignity of each individual in health care. A positive experience of health care with a stigmatised disease can alter client self-perception. As Braun and Gavey say (1998, p.356):

> Stigmatised illnesses carry 'moral' meanings that lead to prejudice and even exclusion from medical services. If the cause of a disease is perceived to be preventable, stigmatisation can be increased. However the stigma that people *feel,* rather than how stigmatised they are by others, is also crucial and causes most distress.

Health care practitioners have a powerful role in improving client self-concept. If the health care environment for people with STIs is to change, it is important that the wider context of social attitude is understood and that professional responsibility is taken to change the secrecy, stigma and silence around sexuality. The commonness and normalisation of prejudice and discrimination against sexual health populations requires sexual health nurses to work through *destigmatising* processes. In general there is a lack of sympathy for those considered sexually careless and irresponsible. Although there is a general awareness that marginalisation is an indicator for poor sexual health status, the issue is generally viewed as a matter of individual risk and lifestyle. Sexual health is itself a marginalised area of health care. Being a sexual health nurse is professionally *doing deviant work* and is a stigmatised social phenomenon. With the increasingly public profile that sexual health nurses are adopting there is the potential for changing the concept of deviance work to *destigmatising* work, over time.

DISCUSSION OF THE THEORETICAL FRAMEWORK

Intensive self-reflection is an outcome of daily encounters with the difficult and paradoxical phenomena of sexuality. Sexual health nurses conclude that the matter is unresolved. One realisation that is clear is that society stigmatises people with sexual infections. Sexual health nurses understand stigma in depth. Participants in the present study describe clearly the social mechanisms of the shaming of sexual health clients through blaming, isolation, labelling and rejection. Care occurs in the context of societal sexual operations that stigmatise and violate some, and pleasure others. Nurses in sexual health services develop an ethos of care and protection that is based on the principles of social justice and of human rights. Discriminatory practices towards sexual minorities, at risk social groups and people with sexually transmitted infections are societally unjust. *Destigmatisation* is a process in which there are progressive and integrated stages of counteracting stigma by *identifying with people, personalisation, respecting and dignifying* and *advocacy and empowerment* (Chapters Five to Eight). While the categories have distinctive characteristics, they also overlap and combine as processes. Additionally the processes relate to a complex of factors affected by the gender, culture, and sexuality of both the practitioner and the client. The processes of d*estigmatisation* occur in the context of sexual health nurses' work that is underpinned with an

understanding of the impact of socioeconomic conditions and of broader gender/power relations in society. Additionally the data suggests that sexual health nurses are *doing deviant work* (Chapter Nine) which is considered to be publicly and professionally distasteful.

The process of *destigmatisation* begins with *identifying with people.* As presented in Chapter Five, the sexual health nurse learns that the acceptance of clinical services by people in the community is dependent on a reputation of social and personal safety and an ability to relate to people who are marginalised and vulnerable. The groups at highest risk of STIs: adolescents, Maori and Pacific peoples, sex workers, gay people and sexual abuse survivors, show social indices reflective of stress (PHC, 1997). In general, many of the populations who visit sexual health services are uncomfortable in health care settings and even more so when sexuality is involved. In particular, sexual health nursing is concerned with concepts, principles and the ethics of caring for people who are stigmatised and marginalised. A nurse who is *getting into marginalised social networks* is also, in promoting the need for sexual health care, implicitly giving communities a bad moral name. Effective STI prevention and control strategies that target risk groups confirm social prejudices. Attending a sexual health clinic is further evidence of being an outsider, for people already socially marginalised. Others are reluctant to attend as, by association they become stereotyped with the dubious reputation of deviant social networks. Sexual health nurses engage processes of *creating open and accepting environments* out of hostile and difficult social contexts. People are primarily concerned about staff attitudes when they enter a sexual health clinic and *making services safe* enough to reduce anxiety and fear, is central to client management.

Identifying with people and *personalisation* are purposefully constructed processes to humanise interactions intended to be uncomfortable and awkward. A process of social disarming is taking place as nurses strategise *getting close to people* to enable personal information to be shared and an examination to take place with minimal discomfort and embarrassment. The process of conveying acceptance of the client and of their story must be genuine, convincing and quick. The skill in *finding the right empathic approach* is the development of a range of nursing strategies and interventions based on a comprehensive client history, and on nonverbal cues. Wanting clients to leave feeling better than when they arrived is an obvious objective in any health care setting. The

significance of *making it a better experience* in sexual health care is to counteract the shame that puts people in danger of not caring adequately for themselves. Having an STI is a psychological as well as a physical problem. Nurses, while providing prevention, information and counselling, are *minimising threats and fears* that are embedded in the meanings of events and associations of sexual infections.

Health care consumers' rights to dignity, respect, support and freedom from discrimination are humanistically based. The Health and Disability Services consumers' rights codes (1993) are human, social and professional codes of conduct. There are clear procedures for complaint and advocacy where rights have been breached however, people with STIs and groups such as sex workers are unlikely to complain to a commissioner about poor, demeaning or inadequate treatment. Some groups of health care consumers receive more humanity than others. Sexual health nursing care is a process of not 'making the person the other'. It is a process of *treating people with care.* In other words, the nursing interaction is based on an understanding of human vulnerability.

The ritualised customs that sexual health nurses extend to clients are those of welcome, comfort, and social belonging. *Treating people with respect* is showing friendly social customs to convey that the person is likeable. People feel less acceptable when faced with having to verbalise the sexual activity that they have with others. Deep, close and intimate aspects of lives are in danger of sounding profane. The possibility of a misrepresentation of self to a health professional is potentially distressing. Nurses develop ways of hearing and of responding that are in accord with the customs of *treating people with dignity.* Over time nurses relate to experiences which others would find degraded or tragic, in the context of a societal condition which they are committed to changing. Nurses find that it is the resilience of clients that is remarkable. The social process of sexual health nurses is noticing opportunities for turning points. If interpersonal dynamics are close enough the nurse is instrumental in *restoring self worth.*

Sexual health nurses contradict the social sanctioned distancing from people with STIs, and from communities considered deviant. Human sexual behaviour is a terse subject in the public arena in which individuals and linked health professionals are scrutinised and

made problematic, rather than social patterns and epidemiologies of groups. Sexual health nurses present the problem of non-conformity to norms of moral conservatism and of professional sexophobia. They are instead, actively *advocating* and *empowering* individuals and communities to change the social realities of people who have, and are at risk of STIs. It is an act of resistance not to stigmatise, withdraw from, or to label people who have or may be at risk of sexual infections. Sexual health nurses develop concepts of marginalisation in relation to *working in the context of sociocultural realities* that are impoverished and unsafe. Sexual victimisation is a common consequence of the dysfunctional social roles accorded men and women in our society. The sociodynamics of gender relationships discourage negotiated and safe sex. It takes the *teaching of survival skills,* to reshape patterns of individual and group behaviours that jeopardise future sexual and reproductive health. Nurses understand that their psychological interventions make a critical difference to the adaptation that individuals will make to having an STI and to recovery from non-consenting sex. Nurses develop a range of assessment skills and of psychotherapeutic interventions in *reframing stigmatising experiences* with clients. The frontline work of sexual health nurses engenders a social analysis of individual sexual behaviours and risks in the context of group norms. Complex understandings of the culture, locale, family dynamics and socioeconomic conditions of people are in evidence in the targeted group and individual prevention strategies.

Paradoxically, being an effective and committed sexual health professional is considered to be socially dangerous. Sexual health nursing is considered a necessary but unwanted social function. Some individuals and groups in society perform the necessary role of the dirty work that others would avoid. In some cases, participants raised the issue of the similarity between popular perceptions of their role and that of sex workers. The mythologising that surrounds sexual health work has similarity with societal attitudes towards the role of the sex worker. Both the role of the sexual health nurse and the sex worker remain invisible and are viewed as socially necessary as the result of undesirable sexual activity. In the case of sexual health nursing and of sex work the taboos about explicitly discussing sex and of the non-exposure of the genital area to a stranger are contravened. Being involved with sex as health care worker results in *experiencing professional marginalisation* and workers have been viewed as scapegoats. Scapegoating is a recognised social phenomenon whereby threatening social

characteristics are transferred to designated people and those to whom they are closely associated (Alonzo & Reynolds, 1995). The social and professional shunning of sexual health work is a social phenomenon akin to the historic rituals of scapegoating. According to Cooper and Sullivan (1994) the scapegoating of people involved with social and sexual sins is evident in Celtic traditions of 'sin-eating' The purpose of this ancient custom was to digest, through a funeral meal the transgressions of the deceased by an official sin-eater. Usually this task fell to a poor woman who was without the means to feed herself. To allow the soul of the departed to float to heaven, free from sin, food would be passed to the sin-eater over the corpse, along with a coin for her services. The women thus burdened with the sins of the departed would then be hounded out of the village.

Far from being hounded out the activities of sexual health nurses in New Zealand today demonstrate a high degree of social agency. The media, cultural, professional and community forums are utilised for *speaking out* on the right of people to an acceptable and accepting level of sexual health care. An awareness of the marginalisation and stigma that attach to the people, the work and the setting of sexual health services underpins the processes of sexual health nursing interactions.

INTEGRATION OF FINDINGS WITH THE LITERATURE

The processes of *destigmatisation* discovered in the present study are complex and add a deeper significance to the existing literature relating to sexual health care management. The evidence is that sex and sexuality are deeply problematic issues in nursing care, however there is a paucity of literature informed by sexual health nurses in everyday practice. The present study confirms that the secrecy and silence that continue to surround sexual infection and sexual lives is culturally embedded in New Zealand society and within health care.

In other studies that relate to sexuality care, embarrassment emerges as an antecedent to the coping strategies employed by nurses (Guthrie, 1999). Such studies conclude that all nurses experience high levels of embarrassment when performing intimate and invasive procedures such as genital examination. In the present study nurses rarely alluded to either their own or the client's embarrassment as the central difficulty of sexual health

care. In discussing the social phenomenon of embarrassment, Meerabeau (1999) cites Lawler's (1991) Australian ethnographic study of nurses in medical settings, as probably the key work in the area of the social difficulty of intimate care:

> Lawler claims that nurses use embarrassment in a richer, more inclusive way than its 'lay' usage, to denote vulnerability, dependence, social discomfort and physical changes. Nurses were protective of patients' privacy; two of the rules for providing care were that the nurse only comments on the body where this is relevant, and the body is only exposed where clinically necessary. Nurses learn to manage their own embarrassment early in their career, often by discussion with others, and thereby give patients permission not to be embarrassed. Nurse tactics included a 'clinical' matter of fact manner, and many thought that the uniform was important. Nurses used what Lawler terms 'minifisms', verbally minimizing the significance or severity of an event (Meerabeau, 1999, p. 1511).

Drawing on Goffman's (1963) dramaturgic perspective, embarrassment is public and unintentional. The 'actor' violates a taken for granted social rule, creating an undesired impression of the image that they are trying to project. Models of embarrassment identify five central aspects: knowledge of social rules, protective self-presentation, self-awareness, labelling, and dealing with embarrassment (Meerabeau, 1999). Lawler (1991) discusses the intimacy involved in routine nursing cares, emphasising the importance of the management of embarrassment as part of socialisation into nursing. Nurses expect to minimise embarrassment and to take measures to repair situations where client dignity is compromised during routine cares such as washing. Lawler has theorised the 'somological' approach to deal with the daily encounters that nurses have with clients that could be embarrassing. The behaviours of reduced eye contact, increasing body movements, speech disturbances and blushing are well recognised. Nurses do not however expect that their role will specifically include sexuality and are not well socialised in this context of care. The literature on genital examination advises

distancing to minimise embarrassment and clarify the meaning of the event as clinical. Meerabeau (1999, p.4) describes this process as depersonalisation:

> the patient is depersonalized by a series of rituals, so that the vagina is just another organ, and the patient another co-operative object. Phases include the waiting room stage (pre-patient), the personalized stage, the depersonalizing stage, the depersonalized stage ('the person as pelvic'). In this stage, distancing is achieved by the use of gloves, no eye contact, and the nurse as chaperone, who signals that there is no sexual intent. The patient is then repersonalized. In Goffman's (1974) phrase, the rituals act as a frame which makes the definition of the situation, that of a medical examination, clear.

It is evident in the words and behaviours of the participants in the present study that the main social difficulty inherent in the work of sexual health nurses is not embarrassment, but stigma. The coping strategies described are close and personal rather than 'clinical' and matter of fact. Informality in sexual health settings and casual clothing are important in creating a welcoming and relaxed environment for anxious clients. Additionally, nurses specifically acknowledge the severity of the events of visiting a sexual health service with clients and discuss client coping mechanisms. The social processes of sexual health nurses are focused on *destigmatising.* Meerabeau (1999) concludes that the data on the management of sexuality is limited and that more attention in particular, needs to be given to the gender of the participants in such studies:

> It would, for example, be very useful to look systematically at male and female nurses and their interactions with both male and female patients, particularly in settings where embarrassment may be most apparent, such as gynaecological or urological services. Partly because of this, the implications for professional practice are not clear (Meerabeau, 1999, p.1512).

The findings of the present study help to clarify some of the questions raised about specifically 'embarrassing' settings and the nature of gender interactions in the context

of sexuality care. It is evident in the practice of sexual health nurses that there is considerable therapeutic use of self in the care of both men and women. Interactions are characterised by empathy, closeness and comfort. Meerabeau (1999, p. 1512) suggests that, in the case of embarrassing care therapeutic disengagement and distancing 'although out of professional favour at least in nursing, may have its uses'. The study undertaken offers insight into the importance of therapeutic identification with and closeness to clients in situations of care that are specifically related to sexuality, personal questioning and of genital exposure. It is 'profoundness of feeling rather than its absence' that is the basis of the care of clients who are stigmatised (Reynolds, Scott & Austin 2000, p.2). Reynolds, Scott and Austin (2000), suggest that an understanding of the client's experiences, meanings, and choices is the knowledge needed for ethical care. *Destigmatising* is about a need to know the client. Reynolds et al., refer to existential advocacy, accurate perceptions and understandings of the client, as the proper philosophical foundation of nursing. Sexual health nurses reveal a detailed and accurate understanding and empathy with the human predicaments of their clients and with marginalised groups in society. It is suggested that to be therapeutically effective empathy needs to be cognitive and behavioural. It is the ability to convey understanding to the client that is the foundation of effective sexual health nursing practice.

Shame, in contrast to embarrassment, is a more devastating experience 'since it involves a comparison with what it is to be a worthy human being, whereas embarrassment relates to one's own idiosyncratic conception of the self' (Meerabeau, 1999). Sexual health differs in practice from other areas of intimate care such as gynaecology and urology, in respect to the shame attached to the nature of the care. Historically, nursing has readily embraced conservative societal norms about sex and sexuality and the stigmatisation of STIs. Reynolds, Scott and Austin (2000), suggest that professional and clinical environments mitigate against nurses offering empathy to some categories of clients. The findings of the study of the management of sexual health nurses indicates that a supportive clinical environment enables care that is *destigmatising.*

Guthrie, (1999) discusses some common strategies that nurses use in order to cope with embarrassment. It is suggested that because of the professional duty of care of nurses, means of coping with embarrassment are limited, and that avoidance and distancing are two options that are available. Studies claim that routinising difficult procedures helps

both patients and nurses cope with intimate and invasive care (Guthrie, 1999). A further coping mechanism identified by Guthrie (1999, p. 9) was the use of humour:

> Sometimes this was at the expense of the patient, as demonstrated below, where a nurse describes the reaction of nursing staff to comments made by patients when filling in the 'Expressing Sexuality' component of the admission sheet used in her clinical area:
> "If the patient writes anything we'll look at it and say 'Look at that, they're still doing it at their age!' You laugh about it ..."

In the current study humour was shared with clients to divert attention away from shame and discomfort. In the care of sexual health nurses the client becomes an equal participant in the interaction, rather than the victim of a potentially stigmatising event. Nurses in the present study demonstrate a remarkable level of dignity and respect for clients compared with the blatant contempt and disregard shown by nurses to clients who disclose sexuality issues in a number of studies (Guthrie, 1999, p.9). The overall conclusion made by Guthrie (1999) is that the nurses studied find it problematic to provide nursing care relating to sexuality. They are unwilling to introduce sexuality as a facet of client care for a variety of reasons, some contextual, some residual:

> Nurses need to examine the reasons why they are so reluctant to talk about sexuality with patients. It would be extremely difficult to change societal attitudes towards homosexuality. However, nurses must be encouraged to examine their attitudes, both individually and collectively, and to gain insight into their own behaviour and that of their peers. This could be achieved through the organization of discussion forums within clinical areas (Guthrie, 1999, p.9).

The basis of attitude change in relation to the care of clients with sexual health needs is the development of a social analysis of stigma and marginalisation (Joachim & Acorn, 2000). Discovering commonalities in the human condition is the basis for therapeutic engagement with sexual health clients. In the literature it is claimed that sexuality

should be included as part of holistic nursing care. The holistic approach has not succeeded however, in improving nurses' willingness to manage sexual health care as claimed in the literature:

> The more holistic and individualistic approaches to care will increase the importance of nurses' attitudes to sexuality as an important part of the caring relationship. Given the complex nature of nursing and the plethora of situations and contexts, in which nurses operate, it seems inevitable that nurses will involve their own attitudes and values in the caring relationship. An exploration of the literature on this topic clearly shows that nurses are not able to give non-judgemental care in many instances, and do allow attitudes to negatively affect the care they give (Hayter, 1996, p.665).

The theoretical framework for the management of sexual health care that emerges from the present study demonstrates that nurses are able to provide non-judgemental care. The study also reveals that there is a social and professional cost to being involved in such care. The finding contradicts the frequent assertion in the nursing literature that sexuality is a normal natural topic of health care. Sexuality is manageable in a supportive clinical environment, however, in most health care settings it is avoided because it is considered to be neither normal, natural nor safe.

Stigma and marginalisation are treated in nursing literature as conceptually linked (Hall, Stevens, & Meleis, 1994). They are different but related concepts used by nursing academics in developing knowledge that values diversity. The present study makes explicit the connections and differences between the social stigmatisation of sexuality and the marginalisation of cultural and sexual minorities. In practice, encountering the phenomenon of sexuality means managing distinctive social taboos for which diversity theories can offer only a partial explanation. Conceptual accuracy is significant in professionally recognising how it is that nursing interventions are *destigmatising* or stigmatising when clients present with sexual problems.

Concepts that explore the relationship between marginalisation and vulnerability are applicable to the management of clients in sexual health services. A growing body of nursing literature recognises that dominant cultural practices in health care marginalise the most at risk health care populations (Canales, 1998; NZNC, 1996). Cultural pluralism is a key concept in developing nursing knowledge and practice that values and respects a diversity of client ethnicity, culture, sexual orientation, and class (Hall, Stevens, & Meleis, 1994). Theorising marginalisation and its processes has had a considerable impact on the development of safe and accepting services for the people who have the poorest sexual and reproductive health status: adolescents, Maori and Pacific peoples. However, while the cultural environment and sensitivity of general health care settings has improved, attitudes towards sex and sexuality in New Zealand health care settings remain conservative. In the literature, the concept of marginalisation in relation to sexual health care has focused on the impact of homophobic attitudes (Hayter, 1996). The present study shows that the concept of stigmatisation has significance in explaining the marginalisation of all sexual health populations. Little attention has been focused on theoretical frameworks that explain the social processes engaged by nurses to destigmatise sexual health populations.

Client and community interventions undertaken by sexual health nurses in the present study have considerable future potential for improvements in public health. The findings of a study of early sex and its behavioural consequences in New Zealand correlates strongly with the clinical impressions formed by sexual health nurses (Davis & Lay-Yee, 1999). The study indicates that sexual activity is embedded within a broader socio-cultural context, with precursors such as socio-demographic factors, linked to subsequent sexual practices and outcomes. The study found that reporting an STD, a greater number of partners and failure to use condoms correlated with males, the young, non-Europeans and the less educated. Those from ethnic minority social groups in which there are patterns of sexual conservatism were more likely to report early sex. In the study by Davis and Lay-Yee the diverse, experimental, and 'risky' pattern of sexual behaviours is most marked for those reporting early pre-intercourse sexual experiences. This finding is consistent with the practice experience of sexual health nurses in New Zealand and suggests that programmes of intervention need to be aimed at younger age groups and at broader correlates of behaviour.

The results of the research by Davis and Lay-Yee (1999) are largely in conformity with the literature on patterns of early sexual activity and partnership in Western Europe and North America and the United Kingdom for young people. On most measures the New Zealand data indicate that for first heterosexual intercourse the median age eighteen for both males and females is the same as other western countries. However, young people in New Zealand appear to have poor sexual and reproductive health compared to other similar countries. If the trend towards earlier onset of sexual activity continues, then we are likely to see increases over time in reported levels of numbers of partners, teen pregnancy and abortion and STIs. New Zealand's history of secrecy, suppression and silence around sexuality and STIs provides some explanation for a poor comparison of sexual and reproductive health with other western countries. Social attitudes and government policies make a difference to sexual behaviours:

> A study of adolescent pregnancy in thirty seven countries found that countries with low rates of adolescent pregnancy, had in common an acceptance that adolescent sexual behaviour occurred and a willingness to provide education and health services that would support young people in reducing sexual risk-taking compared to countries where the approach was only to advise young people to abstain from sexual behaviour (Jones et al., 1985 cited in PHC, 1997).

In New Zealand the level of adolescent sexual activity is being ignored as a health problem. Frontline workers in sexual health therefore develop and implement 'social policy' that is informed by an in depth knowledge of the realities and culture of people in high risk groups while a national strategic approach is absent (Franklin, 2000). Sexual health nurses have developed individual and group interventions that acknowledge the social impact of poor socioeconomic conditions on Maori health. Establishing safe behaviours early, changing lifestyle factors such as drug and alcohol abuse and acting to protect people from sexual violation are sexual health nursing interventions. Traditionally sexual and reproductive health strategy has come from the Ministry of Health (1997) and has focused on womens' sexual and reproductive health. More recently the Ministry of Youth Affairs (2000) has taken the initiative in promoting

healthy public policy that addresses mens' and womens' sexualities and sexual and reproductive health.

The present study indicates the need for a review of public policy on sexual health in New Zealand. In the last decade there has been considerable attention given to the implementation of public health and educational strategies to improve sexual and reproductive health for women (Ministry of Health, 1997). Currently ministerial attention is shifting to changing men's attitudes and sexual behaviours as a more effective approach to improving sexual and reproductive health. Laila Harré, Minister for Youth Affairs released a campaign to improve young people's sexual and reproductive health through increasing condom use by young men saying that:

> "If we can increase the number of young men taking responsibility for safe sex then, in turn, we will improve the sexual and reproductive health of young women," (Laila Harre, Minister of Youth Affairs, media release, 10 July, 2000, cited in Ministry of Youth Affairs, 2000).

Nurses in the study undertaken have been pro-actively implementing social policy based on practice experience and cultural information. The participants demonstrate praxis, which is knowledge and action, in this context in relation to sexual health and the complexities of gender, sexualities and sociocultural conditions. As the findings indicate sexual health nurses have approached health prevention and promotion from a social reform perspective. The Ministry of Youth Affairs (2000) claims that there are a lack of initiatives that focus on the particular needs of young men however, there is ample evidence in the present study of projects undertaken by sexual health nurses that emphasise youth development work. The key initiatives outlined by the Ministry of Youth Affairs are already being implemented by sexual health nurses, including:

- developing key messages to encourage young men to delay the onset of intercourse and for sexually active young men to use condoms
- investigating mechanisms to improve condom availability

- maximising the potential impact of the sexuality components of the Health and Physical Education Curriculum on young men (Ministry of Youth Affairs, 2000, p. 3).

In spite of the importance of the work within public health there is still evidence of the historical ambivalence to seeing sexual health as a priority health issue. Sexual health continues to be viewed as an individual lifestyle issue, however, sexual health nurses understand the public health impact of stigma and marginalisation in relation to client populations. The basic social process uncovered in the present study is *destigmatisation,* the therapeutic management of the negative perceptions of people who visit sexual health services. Nurses develop an experiential knowledge, linking family background, abuse, culture and socioeconomic factors to sexual risk, and making strategic interventions to promote sexual self-care, self-esteem, self-efficacy and assertiveness.

LIMITATIONS OF THE STUDY

The scope of the present study is wider than initially intended. The number of participants sampled is representative of the majority of sexual health nurses in New Zealand. The size of the sample extended the depth, saturation and the wider applicability of the study, but time restraints limited the study to participant interviews. Through methodological triangulation there is potential for further data for comparative analysis and substantiation of theory. In the initial research design proposal, it was intended that a supplementary anonymous questionnaire would be added to the study to further develop theoretical points. The design of the questions would have derived from data analysis of the interviews. The questionnaire would have allowed the anonymous inclusion of the perspectives of nurses not able to be included in the study. However this plan was altered as the numbers of participants volunteering for the study doubled from the intended nine. The increased number allowed a greater degree of saturation than was initially anticipated. A further level of critical analysis was added in consultation with an expert panel of experienced sexual health nurses.

The study reflects a wide range of the experiences of sexual health nurses generally. The sample was inclusive of rural and urban settings, Maori, Pakeha and other

ethnicities, a range of ages and experience, sexual orientation, and men and women. Three quarters of the sexual health nurses employed nationally were interviewed. Some geographic locations were excluded for reasons of cost, time, and distance. More extensive theoretical sampling would have further substantiated the findings of the study. Extending the study to comparison groups would greatly enhance theory development. Decisions regarding the scope and extent of the study had to take into consideration the time and resource limits of a study at Master's level. Research time had to be balanced against the demands of full-time work.

The researcher's familiarity with the area under study may have limited researcher neutrality to some degree, in terms of the questions and the opportunities in interviews for participants to debrief. Due to the researcher's closeness and involvement with the area under study it is inevitable that at times the analysis of data may have been overly sensitised. The role of my thesis supervisor served to maintain an objective approach to the data. Considerable time and effort was involved in ensuring that the study was representative of the range and scope of work undertaken by sexual health nurses in New Zealand.

IMPLICATIONS FOR PRACTICE

At the time that the research proposal was written, the Health Funding Authority was conducting a national review of sexual health services. This followed extensive cuts in sexual health services between 1997 and 1999 and the progressive contracting out to private primary care providers. Sexual health nursing has not been recognised as an area of specialty practice. The trend towards primary health care gave considerable impetus to the project to record the experiences of sexual health nurses, which would have significance for the practice of others who had a similar professional interest. The 1999 Labour government is committed to specialised publicly funded sexual health services and nurses have a leading role in care. It is recognised that young people in New Zealand have poor sexual and reproductive health compared to other similar countries. There is a continuing trend towards earlier onset of sexual activity and a correlated increase in teenage pregnancy, abortion and STIs (Smyth, 2000). In planning health services it is essential that patterns and trends in sexual behaviours and in sexually transmitted infections are addressed if we are to avert the impact of continued risk

taking behaviours on future generations. The psychosocial aspects of managing client interaction have importance for improving personal and public sexual and reproductive health care.

The daily practice of sexual health nurses includes the complex and subtle social skills developed to deal with situations that are embarrassing, threatening and shaming. The discovery of the social methods of *destigmatisation* used, have significance for teaching nurses how to structure care situations in other settings where social shaming is an issue of care. Of particular importance to nurses in all settings is the management of client interactions that involve intimate questioning about sex and sexuality. In the context of sexual and reproductive health, the present study describes the interactions that may significantly improve client care during the procedures of genital examination. The research is of particular value in the management of client distress, anxiety and embarrassment. The discovery of specialised sexual health nursing expertise and management has significance for the development of a national strategy of sexual and reproductive health care. The knowledge accumulated by experienced and expert sexual health nurses raises awareness of stigmatising practices towards sexual health populations in health care. The information shared by nurses in the present study demonstrates the attitudes and interventions that will prevent or change potentially anxiety provoking situations for clients seeking sexual health care. This cultural knowledge will help nurses, new to sexual health care, develop sensitivity to the difficulties clients encounter when visiting clinics. The practical knowledge of experienced nurses is needed to enable recognition of opportunities to intervene in potentially stressful situations for both practitioner and client.

Introducing sexuality as part of the nursing curriculum is of little value if health environments are hostile to the practice of such care. Education should be geared not only towards providing nurses with knowledge about sexuality, but also to equipping them with the communication skills necessary to operationalise that knowledge. Sexuality issues will only be discussed openly if the setting is conducive. Private areas need to be set aside where nurses and patients can discuss sexuality without fear of being interrupted or overheard.

IMPLICATIONS FOR EDUCATION

Sexual and reproductive health nurses are currently seeking inclusion in the extension of prescribing rights to nurses under the 1999 amendment to the Nurses Act (1977). There is a growing recognition in nursing education that it is an area of specialised practice, however, little is understood about the social reality of the work. While the nature of the work is little known there is a great deal of media and public interest in the health services delivering sexual health, HIV/AIDS, abortion, fertility, contraception, sexual abuse and rape care. There is a concern within the profession to improve values, attitudes and beliefs about sexuality and the practice of sexual health care. Teaching strategies that raise awareness and desensitise nurses to the discomfort of discussing sex, need also to incorporate an examination of the social and cultural context in which sexual health care takes place. An understanding of the cultural operation of stigma is essential to nurses who work with peoples with sexual health care needs.

Understanding the relationship between poor socioeconomic and cultural conditions and poor patterns of sexual and reproductive self care is significant in future health prevention and promotion strategies. The practices of sexual health nurses model brief individualised harm minimisation strategies that can be used in the time available in a busy clinical setting. Sexual health nursing presents an opportunity for the teaching of community based care of marginalised peoples. Future graduate and postgraduate nursing education needs to include concepts of shame, stigma and disgrace as issues of social ill health and dis-ease. Progressively sexual health care is being presented as a part of the holistic care of the client, however the implications of the present study are that the practices are not considered professionally normal, natural or healthy. For nurses new to the area of sexual health, the findings of *destigmatisation* represent the processes of coming to terms with sex and sexuality. Finding meaning in sexual health work is balancing the social problems encountered with the rewards of social agency. New practitioners need to consider that the work involves a professional commitment to the rights of women to reproductive choice, to sexual diversity and to sexual health care for minors. It needs to be professionally recognised that being involved in work which is contentious and controversial over a long period of time has a personal impact. The study reinforces the need for the teaching and incorporation of nursing debrief and supervision processes.

The secretiveness and silence that impedes sexual health care and stigmatises both clients and practitioners needs recognition as a social system which health services continue to perpetuate. The study presents a model for the treatment of stigma that can be applied in other areas of health care. The codes of human rights for health consumers in relation to sexual health care populations need to be re-evaluated. It is evident that individual nursing practice is reflective of the social norms and attitudes of the workplace, which in turn reflect a wider social context. Setting standards of dignity, decency and respect for sexual health care populations is an environmental issue that requires interdisciplinary workplace consensus. There are few models of care based on the knowledge and experience of nurses in sexual health practice that are available to inform the social management of clients. It is recommended that nursing care is re-examined from the perspective of the theoretical framework of *destigmatisation* and in particular the role of advocacy and social empowerment in nursing.

It is time for the difficult work of sexual health nurses to be professionally supported, encouraged and recognised. The social methods developed by sexual health nurses are applicable to other areas of practice including midwifery, obstetrics and gynaecology and family planning services. The contribution of this project to an understanding of the nursing processes involved in sexual and reproductive care has wide implications for other health professionals, including doctors, social workers, counsellors and educators.

IMPLICATIONS FOR RESEARCH

In New Zealand there is a growing interest in the field of sexual health from ethicists, researchers, social scientists, historians and educators but not however, from nursing. The conceptual framework presented in the study is a beginning theory of the nurses' experience of sexual health care. The conceptual framework that emerges from the data as the process of *destigmatisation,* is grounded in the experiences of sexual health nurses, and has not yet been tested in other settings. There is a need to extend similar studies to other populations in health care and to other countries. It would be informative to compare the conceptual framework of *destigmatisation* to the practice of cultural safety in New Zealand. It would be interesting to discover if similar processes are or are not occurring in related fields of practice. Further research into sexual health

care by male nurses is indicated, as this is a predominantly female group of nurses. Lastly, questions are raised regarding the differences between the management of mens' and womens' sexual health and the influence of the gender of the nurse in relation to this. The impact on attitude and values of sexuality education that is informed by the experiences of nurses in practice is a potential area of future research.

There has been a rapid growth of inquiry into sexuality in the social sciences in the last decade. The potential for qualitative studies to complement the existing quantitative studies of nurse's values, attitudes and beliefs offers an expansion of nursing knowledge about sexuality. The use of a standardised series of questions concerning sexual health nurses' attitudes to sexuality would expand the range of available data. The collection of qualitative data of this nature would enable comparisons to other studies conducted in settings other than sexual health.

Statistical knowledge of the difficulty nurses have in approaching sexuality is broadened with a theoretical elaboration of the phenomenon of sexual health care. This study demonstrates that Grounded Theory is a suitable methodology for probing the hidden social issues in caring for people's sexual well being. The theoretical model of *destigmatisation* that has emerged from the study is grounded in the data taken from nurses' interactions in sexual health settings. The framework provides practical information, which derives from professional experiences of the sensitive and intimate care of the client. The discoveries in this study provide a starting point for continuing research on the management of social stigma by nurses in a variety of settings. The approach taken to sensitive interviewing techniques has specific relevance to areas of work, which are professionally protected, private and hidden. In future studies, interpretations of data from a macrocontext as well as a microcontext would explore more broadly the wider social processes and contexts of managing sexual health care.

CONCLUDING STATEMENT

Grounded theory methodology is a suitable approach to the social issues of sexuality care of interest to this study. At the core of this research were the social/psychological processes and meanings attached to nurses encountering client sexuality. It is significant

that the academic disciplines of the health and social sciences are addressing sexuality as a central concern of social life, yet many health professionals would prefer to avoid care involved with sex. While there has been considerable opinion expressed about the homophobic attitudes of health professionals towards clients of marginalised sexual orientations, negative reactions towards managing heterosexual sex have been ignored. Although studies have confirmed that sexual health practice is problematic for nurses, there has been an absence of adequate explanation for this. The basis for nurses' negative underlying values, attitudes and beliefs towards sexuality has been poorly accounted for. The professional prejudice described in this study, towards those involved in managing sexual health, may provide a more authentic view of nurses' reluctance to be associated with care related to client sexuality. The focus of explanations of nurses' behaviours has been personal discomfort, embarrassment and moral conservatism.

Sexual health nurses' *understanding stigmatisation* has formed the basis of client care designed to *reframe stigmatising experiences.* In this study nurses demonstrate that clinical care is more than examination, testing and treating for sexually transmitted diseases. Complex personal and professional social issues are faced, as clients as well as nurses are *being identified as different* when in sexual health settings. Nurses in this study exemplify their role as social change agents in client encounters, aimed at *advocating and empowering* through *teaching survival skills.* Nurses identify with a permissive attitude towards sexuality and regard challenging professional and community moral conservatism a matter for *speaking out.* The satisfaction nurses find in *rebuilding futures* in work with vulnerable clients overrides their *experiencing professional marginalisation* as a sexual healthcare worker. While nursing studies have addressed the concepts of cultural diversity and marginalisation as guiding concepts for new nursing knowledge, stigmatisation in the context of sexual health clients has not been analysed.

The understanding of client fears and anxieties, of underlying social attitudes and of the problems of marginalised subcultures and individuals is important information for practicing sexual and reproductive health nursing care. As well, nurses in this study encountered professional stigma. The practice of sexual health care results in *experiencing professional marginalisation,* suggesting that sexuality lies outside that

which is considered normal, natural and holistic. The implications of this study for nursing education show that programmes designed to improve sexual and reproductive health nursing care need to go further than changing nurse's values, attitudes and beliefs towards sexuality. A deeper exploration of the operation of social shaming and stigmatisation towards sexual health services, their practitioners and clients needs to be understood in order to improve practice

The present study maps the processes that sexual health nurses have developed to successfully provide holistic sexual health care. The findings show a conceptual framework for countering stigmatisation as the basis for managing sexual health care, at a clinical and a community level. The model may provide a framework for *destigmatising* other marginalised areas of nursing care.

APPENDICES

APPENDIX ONE

LETTER TO MANAGERS OF SEXUAL HEALTH SERVICES

20 April 1999

Title
To The Manager,
Sexual Health Service
«Address1»
«City»

Dear «Title» «LastName»

I am Nurse Manager at Auckland Sexual Health Service. I am writing to you in my capacity as a masterate student of Nursing Studies at Massey University. This year I am writing my thesis and am seeking access to various sexual health services to research the nurses' experience of the management of sexual health nursing care. I will be using a qualitative methodology.

A summary of the research proposal is enclosed. This has been approved by the Human Ethics Committee at Massey University, an accredited ethics committee with the Health Research Council and by the Auckland Healthcare Research and Development Unit. I would like your permission to approach the nurses who work in your service, to discuss their experience as sexual health nurses. This letter has been sent to a number of Sexual Health Services.

I would be grateful if you would consider my proposal and would very much appreciate support in my research if this is possible. If you agree to your organisation taking part in this research could you please forward the enclosed letters of introduction and information to the sexual health clinic nurses in your area. I look forward to hearing from you.

My contact details are:
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Yours faithfully

Annette Mortensen
M.Phil Thesis student

APPENDIX TWO

Letter of Introduction

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

REQUEST FOR POTENTIAL VOLUNTEERS

My name is Annette Mortensen. This year I am completing a Master of Philosophy in Nursing by undertaking research in sexual health nursing practice. The supervisor of this project is Dr Gillian White of Massey University. I am currently employed by Auckland Sexual Health Service, Auckland Healthcare Services Ltd as Nurse Manager.

I would like to invite you to consider participation in this research. I am seeking registered nurses who have current or recent experience working in sexual health services in New Zealand. Your input into the research would be in the form of taped interview of 1 to 2 hours at a suitable time from April to July 1999. This letter has been sent to a number of Sexual Health services. Interviews will take place in your hometown at a time and place selected by you for your convenience. If you wish to consider taking part in this research, or would like to hear more about it, please contact me or my supervisor, Dr Gillian White, preferably by telephone:

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☎ 09 307-4949 ext 7211 or 8288178
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APPENDIX THREE

Information Sheet for Research Participants Undertaking an Interview

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

INFORMATION SHEET

Thank you for your interest in the proposed research project which will examine the ways in which nurses manage sexual health care in practice settings. This part of the study will involve separate taped interviews with up to ten nurses about their experiences of sexual health nursing practice. This letter has been sent to a number of sexual health nurses. Interviews will take place in your hometown at a time and place selected by you for your convenience.

Typical questions that you may be asked will include:

"Tell me about problems you have encountered in the practice of sexual health care?"
"Tell me about managing genital examination?"
"Tell me about managing the patient's discomfort?"
"Tell me about any problems which you may have had with inappropriate sexual behaviour?"
"Tell me about the perceptions that others in the nursing profession and in society in general have towards your work?"

If you decide to take part in this study, you will be invited to ask any further questions you may have, about your input in the project, and to sign a Consent Form. If you then wish to proceed a taped interview with the researcher, of between 1 and 2 hours in duration will then be arranged. The initial interview may be followed up in order to verify my interpretation of the data collected. At this subsequent interview you will be welcome to add or to delete comments. Each interview will be audio taped, with your

permission, to allow transcription of the data at a later time. It is expected that interviews will be conducted between May and July 1999.

The research data gathered from you will be treated with confidentiality. Your name or other identifiable material will not be available to anyone other than the researcher and the transcriber of the tapes. The transcriber of the cassette tapes will sign a separate confidentiality agreement before commencing. Every effort will be made by the researcher to maintain your anonymity throughout the research project. Each participant will be referred to only by a pseudonym or a number. Patient names or any other identifying information will not be used during interviews.

If you decide to take part in this research, then you are reminded that:

a) You have the right to decline to take part or to withdraw from the research at any time.

b) You have the right at any time during your participation
   - to ask any questions about the research
   - to refuse to answer any question
   - to ask that the cassette recorder be turned off
   - to examine any notes taken
   - to read your own subsequent transcriptions
   - to terminate the meeting at any time
   - to be informed of the results (on completion of the research).

c) The proposed research may be of benefit to you, in that it might assist you to reflect on your practice. Should material discussed in regard to sexual health nursing practice cause distress, measures will be suggested to help you cope with this. If you require support in this regard, it will be given or sought on your behalf with your permission.

d) Any cassette tapes, notes or other material relating to you will be stored for the duration of the research in a secure place. On completion of the research, the cassette tapes will be returned to you, or, if you desire, will be destroyed. All

other materials used in data gathering, such as transcripts or notes, will be stored in a safe place and either returned to you or destroyed following the usual requirements of research protocol.

e) A summary of the research will be made available to you at the end of the study.

f) A thesis will be prepared from the completed research, and academic papers, journal articles and conference material based upon this research may follow this.

If you wish to consider taking part in this research, or would like to hear more about it, please contact me, preferably by telephone:

Annette Mortensen
Auckland Sexual Health Service
Building 16
Auckland Hospital
Private Bag 92024
Auckland

☎ 09 307-4949 ext 7211
fax 09 307 2884
email AMortensen@ahsl.co.nz

You may contact the following supervisor regarding this research:

Dr Gillian White
Albany Group Coordinator
School of Health Sciences
Albany Campus
Massey University
Private Bag 102 904
North Shore Mail Centre

☎ 09 443 9700
fax 09 443 9372
email G.White@massey.ac.nz

Thank you for your interest in this project and for taking the time to read this information. Massey University Human Ethics Committee has approved this protocol.

Yours sincerely

Annette Mortensen

M.Phil Thesis student

APPENDIX FOUR

Consent Form

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

1. I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

2. I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions.

3. I agree to provide information to the researcher, her supervisor and the transcriber of audiotapes on the understanding that my name will not be used without my permission. The information will be used only for this research and publication arising from this research study.

4. I agree to maintain confidentiality regarding the interview and the study.

5. I understand that the anonymity and confidentiality of my participation in the research cannot be guaranteed as it may prove difficult keeping this knowledge from other sexual health nurses in New Zealand.

6. I agree that my consent form will be lodged with Dr Gillian White, Supervisor, who will take all steps to ensure that participant anonymity is protected.

7. I agree / do not agree to being audiotaped.

8. I also understand that I have the right to ask for the audiotape to be turned off at any time during the session.

9. I agree to participate in this study under the conditions set out in the Information Sheet.

Signed _____ Date _____

APPENDIX FIVE

Confidentiality Agreement

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

I, ... have accepted the task of word processing the research data collected by Annette Mortensen in order to complete an M. Phil. (Nursing) at Massey University.

I understand that the data gathered for this research is confidential, and agree to take all necessary steps to ensure that any material on cassette tapes or computer disk containing data from interviews relating to the research will be:

a) Heard only by me, and transcribed to disk in private
b) Stored safely until return to the researcher
c) Treated as confidential in all respects

Signed _____

Witnessed _____

Date _____

APPENDIX SIX

LETTER TO PARTICIPANTS

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

Massey University letterhead

Researcher's address

Telephone Number

Dear

Further to our telephone conversation this letter confirms the details which we discussed. I am inviting voluntary participation in this research project, which is part of my M. Phil (Nursing) at Massey University. The focus of the study will be sexual health nursing practice.

I would like to interview you in your hometown and to discuss with you your experiences as a sexual health nurse. The interview with you, which will be an informal conversation, will be taped. We may meet for one to two hours. Questions may become more specific in follow up interviews, as I collect more data .The number of times I interview you will depend on your willingness to continue to participate, which will be renegotiated with you. It will also depend on my ability to travel to meet you. At times phone follow up may be necessary. If you live outside the Auckland area it is unlikely that I would visit you more than twice. If you live in Auckland I may ask to interview you three or four times. I will contact you in regard to a convenient time and place to meet with you.

To protect your privacy your name will not be used in the research. Your true identity will be known only to me and to my supervisor, who will retain your consent form for

security purposes. I will ask you to choose a pseudonym that you will be known by. Your place of work will also be anonymous.

The information you share with me will remain confidential.

Only my thesis supervisor Dr Gillian White and the confidential typist will have access to this information. All taped interviews will be stored securely. There will be no direct benefit to you from participation in this project. It is hoped however that this work will make an important contribution to documenting the value of sexual health nursing practice. It is possible that sensitive issues may be raised during the process of interviewing. To address this possibility and any other issues that may arise, time for debriefing will be included in every session. Should you encounter any emotional distress through this process I would offer support at the time. Counselling at your place of work would be arranged if it was needed.

The information that you share with me for this study will be used in the publication of a thesis that will be kept on file at Massey University. I would anticipate publication of the findings in a professional journal. Opportunities to present this material at conferences, workshops and seminars would also be sought. A summarised report of the research findings will be sent to you on completion.

Thankyou for your interest in this project. I enclose two copies of the consent form. If you would like to work with me on this project could you please return the signed copy of your consent to participate, to me at the above address. If you have any further questions, please do not hesitate to telephone me on 093072885 daytime or evenings collect on 09 8288178.

Yours sincerely,

Annette Mortensen.

M.Phil Thesis student

APPENDIX SEVEN

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

Initial interviews

The interviews were minimally structured. A general theme was introduced for each interview with an open-ended question. This was intended to focus participant's thoughts and to minimise the researcher's interference with the natural flow of the conversation. In some interviews more probes and prompts were required than in others. The content and direction of each interview was varied with participant's responses.

General theme

The internal and external experience of the sexual health nurse.

Initiating Question *"Tell me about your role"*

Probes:
The every day work of the sexual health nurse
Patient encounters
Nursing interventions

Secondary theme

The personal impact of this work on the nurse. The nature and consequences of the problems encountered.

Initiating Question *"How do you manage difficult situations. Reflect for a moment on some recent examples and how you managed them"*

Probes:
Managing difficult situations.
Attitudes to patients, male/female
Attitudes towards sexuality
Self care

APPENDIX EIGHT

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

INTERVIEW GUIDE

Second interview

Following analysis of the first three interviews some initial themes began to emerge. Subsequent interviews, which were semi-structured, explored preliminary theoretical leads.

General theme

The nurse's experience of patient interaction. The experience of listening to the patient. Verbal and non-verbal cues.

Initiating Question *"Tell me about how you know when you have built trust and rapport With your patient and when you have not "*

Probes

Knowing what you need to know: Asking, timing, judging
Listening to female patients
Listening to male patients
Noticing and listening: Knowing how to hear histories
Theorising about sexuality

Secondary theme

Nurses experiences of maintaining professional boundaries. Encountering sexual vulnerability and sexualising behaviour from patients.

Initiating Question *"How do you decide on the direction and detail of history taking. Reflect for a moment on some recent patient interviews and you managed them"*

Probes

Understanding sexuality

Giving and maintaining dignity and respect

Normalising conversations with patients to overcome stigmatisation

Coping strategies

Patient empowerment

Professional safety

APPENDIX NINE

RESEARCH INTO THE MANAGEMENT OF SEXUAL HEALTH NURSING PRACTICE

INTERVIEW PROBES

Derived from Swanson (1986).

Generality statements

Some nurses express concerns about … What are your concerns in this area?

Ubiquity statements

When did you

Where did you

How did you

Probes

The use of silence. Pausing and allowing time for the participant to respond in his or her own words.

Neutral Probes

Umm, hmm, I see.

Chronology

And then?

Detail

Tell me more about that, That's very interesting

Clarification/Inconsistency

I don't quite understand? But you said earlier….

Explanation

Why? , How come?

Non verbal

Non verbal cues such as facial expressions, gestures, body position and auditory cues were recorded.

APPENDIX TEN

Glossary of Maori Terms

Some of the words listed below have multiple meanings. The ones given are those used in the text.

Awhi	embrace, foster, cherish, draw near to, aid, help, cuddle
Hapu	pregnant, sub-tribe, clan, conceive
Iwi	tribe, nation, people, strength
Kuia	old woman, mother, grandmother, or other elderly female relative
Kaumatua	old man, elder, adult, become adult
Mana	integrity, charisma, prestige, formal, jurisdiction
Marae	meeting area of whanau or iwi
Mokopuna	grandchild, child of a son, daughter, nephew, niece, etc.
Pakeha	foreigner, especially European
Papatuanuku	Mother Earth
Tipuna	ancestor, grandparent
Tangata whenua	local people, aborigine, native
Tangi	mourn
Tane	husband, male, man, manful
Wahine	woman, wife, female
Whakama	shame, abasement, shy, ashamed, feel ignominious, loss of mana
Whakapapa	genealogy, cultural identity, Book of chronicles, family tree, recite genealogy
Whanau	family group, family
Whare tangata	relation by marriage, womb, uterus

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