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**A Study Exploring
Nurse Educators' Perceptions and Experiences of
Practice Related to Sexuality**

**Development of a Model
of Practice Related to Sexuality in
Nursing Education**

**A thesis presented in partial fulfilment
of the requirements for the degree of a**

Master of Education (Ad. Ed.)

**Massey University at Wellington
New Zealand**

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2004**

Abstract

Nursing literature identifies that sexuality is an integral part of holistic client care. However, research continues to indicate that nurses generally, *do not* address issues of sexuality with clients. While there is no absolute reason attributed to this deficit in client care, issues within undergraduate nursing education and the nurse educators have been implicated. While most of the literature is written by nurse educators, it appears to be their own views and/or anecdotal views of other nurse educators from reviews of the literature. I was unable to find research that is specifically focused on the perceptions and experiences of nurse educators in regard to practice related to sexuality in nursing education. Coupled with this, the literature is from overseas and is not necessarily the perceptions or experiences of lecturers within the New Zealand nursing curricula, and the literature is now somewhat dated. Before assumptions about sexuality-related practice in New Zealand undergraduate nursing education and nurse educators can be made, the current situation within the New Zealand nursing curricula needs to be explored. To my knowledge, a study of this nature has not been undertaken.

A descriptive qualitative research study was undertaken where six nurse educators from an undergraduate nursing programme in New Zealand were interviewed. From the analysis of the collected data, nursing lecturer's experiences and perceptions of practice related to sexuality were described. The analysis clearly suggests that further research and improvement is required in undergraduate nursing education, particularly sexuality assessment of the client in order to provide holistic care. A model for practice related to sexuality in nursing education has been developed and described.

Acknowledgements

It is my pleasure to acknowledge and thank those who have 'been there' for me, on this long and tortuous journey. Primarily, I wish to thank the six participants for their enthusiasm, honesty and willingness to reflect and share both personal and professional experiences with me. Without their contribution, this thesis would not have been possible.

I am indebted to my supervisors, Sue Purnell and marg gilling for their patience, guidance, academic challenges and reassurance that I was 'getting there.' Supervising a thesis is a remarkable challenge and thankfully, as a student, there are people willing to take on this role.

I would like to express my gratitude to family, friends and colleagues who have listened and provided support during the lows of this venture. My family eventually accepted that I am not 'superwoman' and that I cannot do everything. I have promised everyone that on completion of this thesis, I will get my life back and be a new person.

To the late Dr Shane Town – this thesis is dedicated to you and I hope I have done you justice. You will always be remembered for your part in this thesis. Without you, this thesis would not have been.

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Introduction To The Study

The major focus of this research is practice related to sexuality in undergraduate nursing education. Sexuality-related nursing practice can be described as nursing practice that relates to any aspect of a client's sexuality for example: biological sex, gender identity, gender orientation, self-concept, self-identity or sexual behaviour which may or may not be altered through illness, disease, disability and medical interventions or treatments.

After enrolling in the Master of Education Programme at Wellington Polytechnic, the first paper I chose to pursue was Special Topic: Sexuality in Adult Education Practice. At that time, I had been a practising nurse for 26 years, the latter years with an educational component, and during those years of practice and study, sexuality had not been a focus. Sexuality is so much a part of our everyday lives and also within nursing practice, and yet I had not had any formal education in this area. I looked forward to the challenge of learning something completely different from the topics I had covered in my undergraduate studies.

Meeting Dr Shane Town was an unexpected bonus. Shane coordinated the sexuality in adult education paper. Shane was a quiet, gentle, but strong and assertive man. He was inspirational. While studying the sexuality paper, the more I learned, the more I realised I did not know. I undertook a mini literature review on sexuality issues in nursing practice and memories of past nursing experiences flooded back.

I distinctly remember the first time I had to wash the genitals of a young male client, and how both he and I were acutely embarrassed. Embarrassment is infectious, difficult to conceal, typically unpleasant, often rescued by tact and wit and is out of proportion to the event (Meerabeau, 1999). How was I to react if a male client had an

erection while I was providing care for him? How was I to respond if a client asked me when they could resume sexual activity after discharge from hospital? What should I say when a client wants to discuss concerns related to their sexuality following body-image altering surgery? In the early stages of my career, I felt both embarrassed and inadequate. I was never prepared for sexuality-related nursing practice. I wonder how many clients have I said the wrong thing to, or have been left with unanswered questions 'after being in my care.' I shared my learning and concerns with colleagues who both 'listened' to me and shared issues and concerns that they could recall. From these informal discussions, it appeared that nurses are not well enough prepared for dealing with sexuality issues in nursing practice and many clients are receiving inadequate care in regard to issues of sexuality. At that point in my studies, I was busy learning about sexuality-related nursing practice from the literature and anecdotal evidence and had not seriously considered research in this area.

In early 2001, I heard of the death of Shane. I was both saddened and shocked at the loss of such a great person. I will always be grateful to Wellington Polytechnic and Shane for making the sexuality paper available to me. Shane's death and a change in employment to become a nurse educator in a Bachelor of Nursing Programme was the impetus that prompted my interest in researching practice related to sexuality in nursing education. It has been through my Master of Education studies that a course on sexuality was available to me, which I have applied to my nursing practice. This course enabled me to:

- critically examine the literature on sexuality issues in nursing practice
- increase my knowledge base about sexuality and the effect disease/illness and medical treatments have on clients
- critically reflect on my earlier clinical practice and current practice in education, including biases and attitudes

- make positive changes to the quantity and quality of teaching sexuality issues in nursing practice within the courses that I teach
- share my learning with friends and colleagues
- undertake research within the New Zealand setting

As a nurse educator, it is of personal interest and academic value to research issues that may affect undergraduate nursing education and therefore the knowledge and attitudes of nursing students, and ultimately, the quality of client care. I am not advocating that I am an expert on sexuality or that nurse educators are required to undertake sexuality education in the same way that I have. I do suggest though, that educators be adequately prepared for teaching practice related to sexuality.

Aims of this Study

The fundamental aim of any research in nursing practice or nursing education, is to improve client care and this research is concerned with nursing practice related to sexuality within nursing education.

The aim of this study was:

To explore nurse educators' perceptions and experiences of practice related to sexuality in nursing education, within one Bachelor of Nursing Programme in New Zealand, with a view to answering the following questions:

1. Do nurse educators have adequate knowledge and attitudes (preparation) for teaching nursing practice related to sexuality to nursing students?
2. Is there a lack of nursing practice related to sexuality within undergraduate nursing education?
3. Do nurse educators have a degree of discomfort or embarrassment while teaching nursing practice related to sexuality to nursing students?

Overview of the Chapters

Chapter One: Nursing Practice Related to Sexuality in Clinical Practice - A Review of the Literature

Chapter One provides a review of the literature of nursing practice related to sexuality in clinical practice, particularly the hospital setting. Most of the literature is from Britain or the United States of America. It is clearly evidenced that nurses are not meeting the needs of clients in regard to issues of sexuality. Chapter One lays the foundation for Chapter Two, which underpins the essence of this study.

Chapter Two: Nursing Practice Related to Sexuality in Undergraduate Nursing Education - A Review of the Literature

This second chapter details the results of a review of the literature of nursing practice related to sexuality within undergraduate nursing education, and this particularly pertains to this study. Most of the authors of this literature are nurse educators, and both nurse educators and nursing education are implicated in the deficit of client care in regard to issues of sexuality. Most of the evidence is from Britain or the United States of America.

Chapter Three: Research Design and Methodology

The methodological foundations of this study are presented. The methodology chapter differentiates between qualitative approaches commonly used in nursing research, and explains the rationale for the decision to conduct a non-experimental, descriptive or exploratory research study using a qualitative approach. The application of the methodology in this study is described including acknowledgement of the limitations and strengths of this research.

Chapter Four: Nurse Educators' Perceptions and Experiences of Practice Related to Sexuality in the Clinical Setting - Findings and Analysis

Findings from the study are presented in two chapters and Chapter Four is the first of two data chapters. It presents a description of the nurse educators' perceptions and experiences of client sexuality in clinical practice.

Chapter Five: Nurse Educators' Perceptions and Experiences of Practice Related to Sexuality in Undergraduate Nursing Education – Findings and Analysis

This chapter is the second of the two data chapters. This chapter presents a description of the perceptions and experiences of the nurse educators' teaching practice related to sexuality in undergraduate nursing education.

Chapter Six: A Model of Practice Related to Sexuality in Nursing Education

A discussion and integration of the findings from the literature with the findings of the study is presented in this chapter. As a result of these findings, a nursing model for practice related to sexuality has been developed and the findings are discussed within the framework of this model.

Chapter Seven: The Study in Conclusion

Chapter Seven draws the findings into a cohesive conclusion by addressing the aims of the study and the research questions. Recommendations for practice in nursing education are discussed and suggestions for further research are offered.

Chapter One

Nursing Practice Related to Sexuality in Clinical Practice

A Review of the Literature

Introduction

This review of the literature is in two sections. Chapter One explores trends in nursing practice related to sexuality in clinical practice. Chapter Two identifies issues in relation to sexuality in undergraduate nursing education. Nursing literature identifies that sexuality is an integral part of holistic client care, however, research continues to indicate that nurses generally, do not address issues of sexuality with clients, particularly during client assessment and are therefore not providing holistic care.

Holistic health care is defined by Anderson (Ed.) (2002) as a philosophy of care which is comprehensive or is total client care that considers the physical, emotional, social, economic, and spiritual needs of the person; their response to illness; the effect of illness on their ability to meet self-care needs. Holistic nursing has been described by Crisp and Taylor (2001) as "a comprehensive way of being, knowing and doing in the delivery of knowledgeable, skillful and human-centred nursing care, which relates to people as greater than the sum of their parts" (p. 969). Holism includes ways of interacting with clients on a personal level, not wholly reliant on objective information about the structure and function of the body (Crisp & Taylor) and this totality of care must include the client's sexuality.

While there are no absolute reasons attributed to this afore-mentioned deficit in client care, issues within undergraduate nursing education and nurse educators have been implicated.

Within this review, a number of researchers' names have appeared several times, either as authors of their own articles or being cited in the work of fellow authors. These include: Crouch, 1999; Kautz, Dickey and Stevens, 1990; Lewis & Bor, 1994; Morrissey, 1996; Ross, Channon-Little and Rosser, 2000; Van Ooijen and Charnock, 1994 & 1995; Warner, Rowe, and Whipple, 1999 and Waterhouse, 1996, all have proved to be rich sources of data. I have drawn heavily on the literature review by Waterhouse (1996), as it provides a comprehensive overview of sexuality issues in both nursing practice and nursing education. While some of the literature is somewhat dated, the content has been invaluable for this research. The literature spans 20 years and clearly shows that the issues of the past remain issues in the present.

Throughout the literature, there is little mention of specific ethnic cultural groups being included or excluded from the samples or populations. This is a significant limitation as sexuality is influenced by cultural/ethnic rules and norms and these underpin what is acceptable and unacceptable behaviour within a culture. Within different ethnic cultures, a diverse range of beliefs and values are presented (Crisp & Taylor, 2001), about both sexual activity and sex related discussion (Ross et al., 2000). Consequently, sexuality has different meanings for people within different societies and cultures other than Caucasian European. For example, in some cultures it maybe necessary for the client and nurse to be of the same gender to gain an accurate health history (Ross et al.). Nurses need to know the culture of their clients and the language and rules for assessing sexuality within their culture in order to avoid cultural insensitivities and to gain an accurate client history. The views of nurses and clients from other specific ethnic

cultures is likely to be different and as these issues were raised only briefly by the participants, they are not addressed in this study. As a Pakeha, I have chosen to talk primarily from a Pakeha/European perspective.

With the exception of Clear and Carryer (2001), Giddings and Wood (1998) and Parr (2002) whose research was undertaken in New Zealand, the literature is mostly American or British. The review of the literature demonstrates that research in this area is well established overseas and highlights the paucity in New Zealand literature.

In the first part of this review, I have described the findings from the literature in four sections.

- The Importance of Nursing Practice Related to Sexuality
- Sexuality Assessment of the Client
- Trends in Nursing Practice Related to Sexuality
- Factors That Influence Practice Related to Sexuality

Firstly though, what is sexuality? How is sexuality defined?

Definition of Sexuality

Sexuality is a powerful and emotional subject that belies simple definition. It means different things to different people and the meaning changes over time depending on external [and internal] influences (Rafferty 1995). Van Ooijen and Charnock (1995) support this view stating "that any history or definition of sexuality must be viewed with caution" (p. 26).

Taylor, Lillis and Le Mone (2001) suggest that sexuality encompasses the following:

Biological Sex – which denotes chromosomal sexual development and external and internal genitalia.

Gender Identity – the inner sense a person has of being female or male which may be the same or different from biological sex.

Gender Role Behaviour – the behaviour of a person related to being male or female which may or may not be the same as biological sex or gender identity.

Sexual Orientation – the preferred gender of the partner of an individual – heterosexual, homosexual, bisexual or transsexual. (p. 780)

Woods (1987) though, provides a succinct, yet encompassing definition of sexuality:

Human sexuality is a complex phenomenon that pervades the biological being, sense of self, and relationships with others. Sexual function, sexual self-concept, and sexual roles and relationships constitute important dimensions of sexuality. (p. 1)

Sexuality also includes aspects of a persons' self-identity, self-concept and body-image which, when combined, are an assessment of a person's social being and social worth (Taylor et al., 2001). Price (1990) states:

In a society that emphasizes body presentation as a guide to social worth, people are forced to take personal body image seriously. Failure to achieve a satisfactory image may affect self-respect and a number of life opportunities, and self-image is important for confidence, maturation and sense of achievement. (cited in Crouch, 1999a, p. 604)

It must also be remembered that understanding sexuality is not an exact science, but rather a continuous, life-long process (Van Ooijen & Charnock, 1994).

To gain an understanding of the role of sexuality in nursing it is helpful to have a working definition of sexuality from a health perspective. Sexual health was first defined by the World Health Organisation (WHO) in 1975 and was amended in 2002. WHO (2002) now defines sexual health as the following.

Sexual health as a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p. 2)

As well as defining sexual health, WHO (2002) has also defined sexual rights which are already recognized within human rights legislation, but include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services
- seek, receive and impart information in relation to sexuality
- sexuality education
- respect for bodily integrity
- choice of partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not and when to have children
- pursue a satisfying, safe and pleasurable sexual life. (p. 2)

The focus of sexual health within the WHO's (2002) definition is to maintain or enhance an individual's sexuality in the broadest sense. As a consequence, sexuality-related nursing practice should enable individuals toward optimal sexual health or fulfilment, in other words, the highest level of sexual health that an individual can achieve. For the purpose of this thesis, I have used the WHO (2002) definition as the basis for my discussion.

The Importance of Nursing Practice Related to Sexuality

Sexuality and problems related to sexuality have been identified as components of nursing care by the nursing profession, nurse educators, other disciplines and clients (Gamel, Davis & Hengeveld, 1993), because "sexuality is an integral part of the individual, [and] any illness has the potential to impinge on it" (Guthrie, 1999, p. 314).

Examples of chronic illness include arthritis, asthma, diabetes, multiple sclerosis, vascular disease, chronic respiratory disease and renal disease. All of these have differing effects on an individual's sexuality, ranging from decreased libido to sexual dysfunction. Clients who are for example recovering from strokes or myocardial infarctions sometimes feel too lethargic for a sexual relationship (Ross et al., 2000).

Savage (1987, cited in Guthrie, 1999) suggests that drugs, surgery and radiotherapy are other examples of factors that affect sexuality. Changes in appearance following treatment of an illness, such as surgical removal of a body part (mastectomy), colectomy and formation of a colostomy, or hair loss following chemotherapy, can have major impacts on body-image and self-concept for the individual. Self-image can also be affected following a hysterectomy, and spinal cord injury

clients may have multiple sexuality issues including body-image, self-image, sensation and sexual dysfunction issues (Ross et al., 2000).

The effect of cancer will vary depending on which body parts are involved, the type and severity of the cancer, the treatment regime and also how the individual reacts physically, psychologically and emotionally (Van Ooijen & Charnock, 1994). Warner et al., (1999) explain that illness not only impacts on a person's physical being, but also on their self-image, erotic desires, emotional and sexual relationship and reproductive decisions.

The impact of psychiatric disorders on sexuality is made more difficult because of the effect that psychiatric medications can have on an individual's sexuality. Loss of libido is a classic symptom of depression and anti-depressants are known to compound this problem. Several other drugs may affect sexual functioning and may affect sexuality in a number of ways. Anti-hypertensives may cause sexual dysfunction, opioids have a sedative effect and may inhibit sexual function and some hormonal drugs will decrease libido, particularly in men (Ross et al., 2000).

According to Woods (1987), sexual health reflects the interrelationships of sexual function, sexual self-concept and sexual relationships, and any alterations in sexuality are multi-dimensional. Alterations in one dimension will produce changes in others. For example, an alteration in self-concept typically produces changes in sexual function and sexual relationships. Whatever the nature of the condition or illness, it is likely that some part of a person's sexuality is affected and often in ways that they do not expect. Whether we are sexually active or not, whatever our sexual orientation or age, our sexuality cannot be separated from who we are, including during disease and illness (Van Ooijen, 1995).

It is important to note that an alteration does not have to be major, to be significant to the client. As Van Ooijen and Charnock (1994) question, can Miss J. continue to wear shoes with four-inch heels after the removal of an ingrown toenail? If not, this may alter her self-concept. For some individuals, this may seem a trivial adjustment to make, but it may be a major issue for Miss J., particularly if she is of short stature.

Nurses have an important role to play in promoting holistic care and this must include the sexual health of clients. Holism is a theory based on wholes being greater than the sum of their parts (Deverson, (Ed.), 2003), and to exclude sexuality from care is to exclude parts from this sum, as people are sexual beings. Many believe that to ignore sexuality is to overlook a key factor in people's general well being and this can represent a failure to deliver holistic care for the client (Lamp, Alteneder & Lee, 2000; Parr, 1998; Van Ooijen & Charnock, 1994; Warner et al., 1999; Waterhouse, 1996; Weston, 1993; Woods, 1987). Many chronic illnesses and drug treatments have an effect on sexuality and it is important that clients know about this (Gamlin, 1999). However, clients generally are reluctant to discuss the issue unless it is raised by the health professional. It is therefore prudent that health practitioners introduce questions regarding the effect of illness on the client's sexuality (Ross et al., 2000).

Rafferty (1995) proposes that because nurses perform intimate procedures on clients' bodies, they commonly behave toward clients as being asexual beings (Weston, 1993). "The continued exposure to clinical procedures can make a nurse indifferent and insensitive to patients' needs. Nurses can operate on autopilot, repeatedly doing things without consideration or thought" (Van Ooijen & Charnock, 1995, p. 26).

Conversely, by virtue of the privileged and intimate nature of the nurse-client relationship (Fitzpatrick, 1998) many nurses are ideally placed to discuss sexuality with clients and, according to Green (20 years ago) (1983, cited in Lewis & Bor, 1994) 80% of nurses studied in 1983, felt that issues of sexuality were an appropriate role for the nurse. It has been suggested by Peate (2004) that because nurses care for people in a variety of settings and are more accessible than other healthcare professionals, the nurse may be the first person that a client turns toward, to discuss sexuality concerns or issues.

The importance of nursing practice related to sexuality has a greater emphasis now than ever before, particularly in view of informed consent issues and consumer rights related to the Health and Disabilities Act 1996. Informed consent is covered by the Health and Disability Act 1996.

Right 6 Right to be Fully Informed

- (1) Every consumer has the right to the information that a reasonable consumer, in the consumer's circumstances, would expect to receive, including -
 - (a) An explanation of his or her condition; and
 - (b) An explanation of the options available, including assessment of the expected risks, side effects, benefits ...
- (2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent
- (3) Every consumer has the right to honest and accurate answers to questions relating to services ... (Health and Disability Commissioner, 1996).

According to Crouch (1999a) the purpose of sexual health care should be the enhancement of life and personal relationships, not merely care

related to reproduction or the prevention of sexually transmitted infections. As Coughlan (1987) proposes, if maintaining sexuality [or enhancing an individual's sexuality in the broadest sense, WHO (2002)] can add to quality of life, then assisting clients with issues of sexuality must be part of the nurses' role.

Sexuality Assessment of the Client

In order for nurses to practise in a holistic manner, they are required to undertake a complete health assessment of the client. One assessment tool useful for the collection of data is Gordon's Functional Health Pattern assessment framework (1994). Gordon (1994) has defined 11 functional health patterns that are a sequence of related behaviours and can be used in any practice setting for clients of all ages. These 11 functional health patterns include self-care assessment of activities of daily living (Jarvis, 2004) and are as follows: health perception-management, nutritional-metabolic, elimination, activity-exercise, sexuality-reproduction, sleep-rest, cognitive-perceptual, role-relationship, self-perception-self-concept, coping-stress and value-belief patterns (Weber & Kelley, 2003).

A health assessment has been described by Milligan & Neville as "a systematic data collection method from which judgements about health can be made. It has the potential to provide the health professional with the information about current health as well as a means for predicting future health issues" (2003, p. 24). It is important for nurses to assess each functional health pattern with clients because any alteration in health can affect functioning in any of these areas (Weber, 2004).

The purpose of assessing the client's sexuality-reproduction pattern is to determine the client's fulfilment of sexual needs and perceived level of satisfaction ... perceived problems related to sexual activities, relationships, or self-concept are elicited. The physical

and psychological effects of the client's current health status on his or her sexuality or sexual expression are examined. (Weber, 2004, p. 22)

A recurring theme found in the literature by Waterhouse (1996) was the issue of initiating discussion about sexuality with clients – should the nurse or the client initiate this discussion? In several studies, most clients preferred that sexuality issues be raised by the nurse (Cort, 1998; Crisp & Taylor, 2001; Gamel et al., 1993; Steinke, 2000; Waterhouse, 1996; Weston, 1993) and many clients waited for the nurse to raise sexuality in the nurse-client discussion, however, as noted earlier, this may not be a reflection of all ethnic cultures.

Kautz et al. (1990) found that nurses felt addressing sexual concerns with clients increased client anxiety and were therefore unlikely to raise sexual issues with clients. Additionally, Wilson and Williams' study (1988, cited in Waterhouse, 1996) found that 92% of nurses were more comfortable discussing sexuality if the subject was raised by the client.

Bor and Watts (1993, cited in Grigg, 1997) explain, some clients are willing to answer very intimate questions as long as they are not judged or felt ridiculed. The initiating of a discussion by the nurse about sexuality sends a signal to the client that the nurse is interested and willing to listen, allowing the client an opportunity to talk about any problems they may currently have, or to feel comfortable to ask at a later time. Lewis and Bor (1994) support this view stating that a doctor or a nurse should feel comfortable in providing an opening for all clients to discuss sexual issues.

The results of an American survey by Matocha and Waterhouse (1993) in a variety of practice settings, found that 34% of nurses never assessed client's sexual needs. Nevertheless, 76% offered to discuss sexual concerns with up to 10% of clients, 71% offered information

about sexuality to 10% or less clients and 53% never made referrals for sexuality concerns. A British study by Lewis and Bor (1994) found similar results where only 35% sometimes or always, included questions about sexuality on admission of a client. "An invitation to talk is all that is required" (Parr, 2002, p. 91).

Merrill and Thornby (1990, cited in Lewis & Bor, 1994; Ross et al. 2000; Warner et al., 1999) found in studies of medical students, that while 93% believe that an accurate sexual history is an important part of understanding a patient's medical problem, inadequate sexual history assessment is due to: embarrassment, believing that a sexual history is not relevant to the presenting problem and that they feel inadequately trained. However, Warner et al. argue, a client assessment is not complete if a sexual history is not gained and vital information may be lacking, which may affect their recovery. Coleman (2000, cited in Ross et al., 2000) explains that every person, no matter what age, ethnicity, religion, gender, sexual orientation, physical condition, illness or disability will have questions on sexuality at some time in their lifetime.

When to Undertake a Sexuality Assessment

Since sexual health implies involvement with many other body systems, a sexual history should be included with the routine nursing assessment of the client. Nurses assess other bodily functions that are also considered private, for example body secretions, but they remain reluctant to ask questions about sexuality. Alterations in sexuality are as important to assess as all other human functions (Le Mone & Jones, 1997). According to Le Mone and Jones, "in a society where sexuality is openly illustrated, written about, and discussed, it seems paradoxical that such an integral component of personhood is neglected" (p. 9).

A sexual assessment is best undertaken at the initial interview with the client, as it then establishes that their sexual concerns are relevant and

they have been given 'permission' to discuss them. The client may be too embarrassed or overwhelmed to discuss their concerns at the assessment, but they may wish to raise the subject at a later time (Warner et al., 1999).

As context and timing of the interview are crucial, inadequate privacy and lack of opportunities to facilitate discussion have been cited as barriers to sexuality-related practice (Guthrie, 1999; Kautz et al., 1990; Lewis & Bor, 1994; Quinn, 2003). A question raised by a nurse cited in Guthrie "Where would I go to actually speak to someone about it? I don't think it's a good place to speak to someone if you've just got a curtain between you and the ward" (p.317) is fair and valid, particularly in public hospital settings, with four and six bedded rooms.

Lack of time and heavy workloads were identified as barriers to effective sexuality-related practice (Ashcroft, 2002; Guthrie, 1999; Kautz et al., 1990). With less nurses caring for more clients, time for a comprehensive health assessment is limited to the most urgent and obvious client needs and problems (Le Mone & Jones, 1997). One participant in Ashcroft's study stated that nursing has become "rush, rush, rush – patient in, procedure done, patient out [*sic*]" (p. 6). Warner et al. (1999), on the other hand, suggest that shorter length of stays strengthens the argument to address sexuality issues due to a scarcity of community resources that deal with human sexuality.

Other factors that must be considered when taking a sexual history include the age, gender and culture of the client as different approaches are required (Ross et al., 2000).

Additionally, Kautz et al. (1990) found that, collectively, nurses felt they needed written resources specific to their client population, (and according to Steinke, 2000, clients want written material), so they could use them when talking to clients about sexual concerns. An issue

raised by Ashcroft (2002) is that this may give nurses an excuse not to verbally address sexuality issues with clients. However, nurses may overlook the fact that not all clients read the information given to them, may be unable to read the information handouts, and therefore continue to feel reluctant to ask questions.

WHO (2002) state, "for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (p. 2). In relation to the sexual rights described by the WHO (2002), are nurses respecting, protecting and fulfilling these sexual rights? Are clients attaining the highest standard of health in relation to sexuality? Are clients receiving information and education on issues of sexuality?

Le Mone and Jones (1997) explain that nurses are not required to do, or adequately prepared for, in-depth sexual counselling, but they are responsible for: assessing and identifying needs and concerns, providing and promoting open communication and appropriate education to clients, and recognising and actioning required referrals. The next section is a review of the literature that identifies trends in practice related to sexuality.

Trends in Nursing Practice Related to Sexuality

Although issues of client sexuality have been deemed of paramount importance (by writers cited previously) for the individual's well being, they are generally marginalized within the healthcare setting (Crouch, 1999b). Ashcroft (2002) identified that client sexuality issues are not raised for constructive discussion at staff meetings or during shift handovers in the ward setting.

Waterhouse (1996) reveals that despite the increase in nurses' education about sexuality in the past 12 years, research reported predominately in American journals indicates that nurses continue to underestimate clients' sexual concerns and do not routinely address

sexuality in their practice. A review of the literature by Waterhouse provides examples of nursing practice where sexuality issues of the client are poorly addressed. The following examples are from this review.

Wilson and William's (1988) study involving oncology nurses' provision of sexual teaching, found that 90% of the nurses had offered sexual advice or education to only 10 or fewer clients (in the last six months) and 25% had never offered any. Jenkins (1988) reports that 59% of women who underwent surgery and radiotherapy for endometrial and cervical cancer did not receive any information from any health care professionals about their sexual functioning. Young (1987) reports after interviewing medical-surgical clients in hospital, that while 48% of them thought that their illness might impact on their sexual functioning, only 30% had been involved in any discussion on sexuality with healthcare professionals. Of these discussions, they only occurred once, lasted only for one minute, were poorly timed and involved words that they could not understand.

Kautz et al. (1990) report from their audit of nursing care of 302 clients, that nurses in obstetric, paediatrics, psychiatry, medical-surgical and intensive care units consistently failed to meet the hospital's nursing care standard for sexuality, despite several changes being made to the assessment form. In an American study in 1996 of client's experiences of sexual discussion in the acute care setting following myocardial infarction (MI), only 33% reported receiving information while still hospitalised (Steinke, 2000). In 2004, Crumlish reported that discussion on sexuality issues was an area of nursing practice that was neglected. Often MI clients are left with unanswered questions about resuming sexuality activity after this life-threatening event (Crumlish, 2004).

In a survey on clients' hysterectomy experiences in New Zealand by Giddings and Wood (cited in Coney & Potter, 1990) negative effects following surgery (less satisfactory sex life, difficulty reaching orgasm) were low on the list of possible negative effects discussed preoperatively with the client. However, these negative effects on sexuality were experienced by clients with increased significance postoperatively, compared to routine postoperative negative effects, for example, infection or haemorrhage that were discussed as having greater significance by the doctor. Additionally, clients who were not provided with any information regarding possible negative effects, reported experiencing more difficulties postoperatively, than those who had received this information. This suggests that, "providing information about possible negative effects does not necessarily encourage women to experience them" (Giddings & Wood, cited in Coney & Potter, 1990, p. 155). Of those clients who did experience negative effects in the area of sexuality, only three percent received any assistance to deal with the issue.

In a more recent study into hospice nursing in New Zealand by Parr (2002), clients were disappointed that none of the healthcare professionals, including nurses, felt comfortable talking about sexuality. One participant tried to discuss her difficulties following surgery and radiotherapy, but was met with embarrassment and felt dismissed. Parr (1998) adds:

If we say we provide quality of life care and we don't give people an opportunity to talk openly about sexuality and intimacy, then we have to question whether we are holding up the philosophy of what we stand for. (cited in Seymour, 2003, p. 8)

Jane Bissell recently launched her book *Welcome to the Amazon Club* (2004), which records her experiences of breast cancer from diagnosis to shortly after her first 'all clear.' In a personal conversation with Jane

on July 20, 2004, we discussed the sexuality aspects of breast cancer and Jane's experiences of health professionals in regard to issues of sexuality. The surgeon was uncomfortable talking about body image issues and the oncologist told her she would experience early menopause, but did not mention vaginal dryness or a decrease in libido. The oncology nurses were quite helpful and did discuss sexuality issues with Jane. Generally though, the healthcare professionals involved in Jane's care, discussed sexuality when it had been initiated by Jane.

These examples indicate that healthcare professionals both in New Zealand and overseas, including nurses are not adequately assisting clients with issues of sexuality and this is a predominant finding within this literature review. The literature has identified multiple factors that influence practice related to sexuality and a discussion of these factors follows.

Factors That Influence Practice Related to Sexuality

Based on a review of the literature by Gamel et al. (1993) and Waterhouse (1996), factors have been identified that influence nursing practice related to sexuality. These factors include: sexuality knowledge, attitudes about sexuality, degree of comfort in addressing sexuality issues and opinions on the professional responsibility of addressing sexuality issues with clients. While these factors have been identified separately, they are inter-related in regard to the nurses' role as providers of holistic client care.

These factors are discussed under the following headings.

- Adequate Knowledge
- Negative Attitudes
- Discomfort and Embarrassment
- Professional Responsibility

Adequate Knowledge

Grigg (1997) states that research over the past two decades concludes that nurses rarely have adequate theoretical knowledge to enable them to care for clients in the area of sexuality. Matocha and Waterhouse (1993), on the other hand found that it was a 'perceived' lack of knowledge by the nurse that significantly influences sexuality-related practice. In Kelly and Quinn's study (cited in Quinn, 2003) addressing sexuality and fertility issues with cancer clients, all nurses voiced concerns about giving the wrong information. Webb (1988) states that for nurses to be in a position to provide clients with information, they need to be knowledgeable themselves.

In experimental studies of groups of nurses and medical students, it has been reported that increased knowledge leads to more liberal attitudes towards sexuality (Mandel, 1983; Roy, 1983; Santo Pietro, 1980; West, 1983; cited in Webb, 1988), indicating a link between knowledge and attitudes.

Lewis and Bor (1994) conducted a survey to explore the relationship between knowledge and attitudes and sexuality-related nursing practice. Their findings suggest that while knowledge and attitudes about sexuality are related, it is not a significant relationship. Results from Lewis and Bors' study imply that one of the greatest obstacles to an increase in the openness of discussion about sexuality between clients and nurses is the influence of strongly held attitudes by nurses. These attitudes are influenced more by emotions rather than cognitive factors and "these emotions are particularly durable" (Lewis & Bor, p. 258).

Negative Attitudes

Negative attitudes in relation to issues of sexuality have been identified toward the following client groups: older clients, clients with human

immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS) and sexual minority clients. Further discussion on these client groups follows.

Palmer (1998) suggests that nurses are not immune from the social forces that create and reinforce negative stereotypes. Society is now recognizing the depth and breadth of human sexuality that is possible and it is therefore reasonable for nurses to accept each individual's description of themselves as valid – "stereotypes can seriously limit a person's understanding of an individual's expression of sexuality" (p. 15).

Older Clients

Sexuality in aging is an area that is often misunderstood by society, elders and healthcare providers. Nursing facility staff interact with older adults on a daily basis in caring for physical and psychosocial needs, yet many staff members have vague understandings of the sexual needs of older adults. Staff members may view residents' sexual interests as 'behavioural problems' rather than natural occurrences or expressions of needs for loving contact. (Butler & Lewis, 1987, cited in Steinke, 1997, p. 59)

According to Van Ooijen and Charnock (1994), older people are often regarded as asexual (or dirty and perverted, Peate, 2004) and yet, many people in their 7th, 8th and 9th decade enjoy fulfilling sexual relationships (Wallace, 2003). It is these stereotypical attitudes that "may lead to an unsympathetic reaction if the patient is caught masturbating" (Lewis & Bor, 1994, p. 252) and may also interfere with objective listening to a patient and thus compromise the nurse-patient relationship (Lewis & Bor, 1994).

However, as Ross et al. (2000) explain, with aging, there are physical and physiological changes and these can have a negative effect on sexuality, for example, reduced libido and slower sexual responses. Compounding the aging process is the increased development of medical conditions and the treatment for these medical conditions, which as discussed earlier, can affect sexuality (Peate, 2004; Wallace, 2003). The role of the nurse is to raise the topic of sexuality with the client in a calm and professional manner, but be prepared and respectful for the client who prefers to keep this part of their life private (Ross et al.).

Clients with HIV/AIDS

Negative attitudes toward clients with either HIV/AIDS, or who are 'under suspicion' of being HIV/AIDS positive have been reported by multiple authors (Adler, 1998; Hayter 1996; Taylor & Robertson, 1994; Van Ooijen & Charnock, 1995). McHaffie (1993) found in her study high levels of intolerance and discrimination from health professionals toward these clients. Negative attitudes have been evidenced by avoidance, ridicule and disapproving non-verbal behaviours (Taylor & Robertson, 1994). When HIV/AIDS first appeared:

... the concomitant fear of infection brought strong reactions to the fore. Being associated in the early days with allegedly 'excessive' sexual activity among homosexuals, [drug users and prostitutes, already stigmatised by society, p. 29] HIV carried connotations of stigma and disrepute. (McHaffie, 1993, p. 30)

Hayter (1996) proposed that the advent of HIV has legitimised the expression of negative attitudes toward homosexual clients. Conversely, other authors have stated that the emergence of HIV/AIDS places an expectation on nurses to examine their attitudes about sexuality and to recognize sexuality as an important component of client

care (Hayter, 1996; Weston, 1993). Additionally, Peate (2004) reports that the introduction of combination drug therapy means that clients with HIV are living longer and that healthcare professionals can no longer regard HIV/AIDS as a disorder of younger people.

Sexual Minority Clients

Although issues surrounding HIV and AIDS have highlighted the gender identity and sexual orientation aspects of sexuality within society, these aspects are not yet treated as holistic components of client care. British studies have shown that nurses are less willing to care for homosexual clients than heterosexual clients with the same illness (Kelly et al., 1988, cited in Morrissey, 1996). This may be because the general public and nurses associate HIV/AIDS with the gay community (McHaffie, 1993; Taylor & Robertson, 1994).

While lesbians have not been stigmatized with HIV/AIDS, Brogan (1997) found the following:

Lesbians fear a homophobic reaction from healthcare providers, are anxious about the consequences of revealing their sexual orientation, worried about breaches of confidentiality and concerned they may face hostility or physical harm. Negative experiences can also lead lesbians to delay seeking health care, which may adversely affect their health. (p. 39)

Walpin (1997) suggests that while ethical practice requires nurses to have an understanding of diverse cultures, the focus has historically been on racial and ethnic minorities, not on sexual minorities. Homophobia or the promotion of a heterosexual orientation has much the same effect as racism (Walpin).

Eliason (1998) reports, that the attitudes of student nurses, registered nurses and even some nurse educators, toward lesbian, gay and

bisexual people, were more negative than toward racial minorities. The students expressed that lack of knowledge, skill and exposure to groups of people different from themselves, was a primary factor in their discomfort (Eliason & Raheim, 2000). Student nurses reported more comfort in dealing with racial minorities than sexual minorities and the students' attitudes toward sexual minorities was related to parental attitudes toward sexual minorities.

Historically, the healthcare provided to sexual minorities has been less than adequate, partly because health providers did not receive adequate education to achieve an informed understanding of sexual orientation concerns; and partly because of negative physician attitudes towards homosexuality; and partly because until 1970, lesbian, gay and bisexual concerns were hidden and not well understood. (Ross et al., 2000, p. 161)

Hayter (1996) agrees that nurses do allow attitudes to negatively affect the care that they provide and are not able to give non-judgmental care in many instances. Nurses will encounter sexual minorities in all healthcare settings because gay, lesbian and bisexual people suffer the same health problems [as well as some unique to them] as heterosexuals, and nurses must be prepared to practice in an ethical manner (Walpin, 1997).

Goldsborough (1970, cited in Hayter, 1996) explains that being non-judgmental is not about giving up one's personal beliefs or changing them to mirror what others think is morally right, it is about being aware of one's own values and attitudes and how these may affect others (Weston, 1993). Adler (1998) reports that to impose one's own personal attitudes and values on clients, is bad manners and bad practice.

Lastly, Waterhouse (1996) suggests that from studies undertaken in the late 80s and early 90s, some nurses have conservative attitudes about sexuality because sexuality is both personal and private. These conservative attitudes could still be present today, which affects the nurses' level of comfort about sexuality and will in turn influence practice.

Discomfort and Embarrassment

"Sex is a topic that was long considered taboo for proper adult conversation" (Crisp & Taylor, 2001, p. 567) and "is bound up with secrecy, privacy, personal and moral codes ..." (Rafferty, 1995, p. 28). Dealing with sexuality "can make us feel embarrassed and uncomfortable ..." (Weston, 1993, p. 26). Comfort is described by Deverson (Ed.) (2003) as "a state of ease and contentment" (p. 96) and discomfort is described as "uneasiness of body and mind," (p. 145). For the purpose of this research, discomfort is defined as 'feeling ill at ease' or 'in a state of uneasiness.'

Embarrassment is infectious, difficult to conceal, typically unpleasant, often rescued by tact and wit and is out of proportion to the event (Meerabeau, 1999). Embarrassment deters staff from broaching topics such as sexuality (Kelleher & Oxenham, 1993 & Wiejts et al., 1993, cited in Meerabeau) and is seen as deterring clients from seeking treatment and adopting health protecting measures (M^cKie, 1993 & Weisse et al., 1995, cited in Meerabeau).

In "reflecting on sexual sensitivities:"

I was not prepared to deal with sexual matters when I started nursing ... We were instructed to wash patients as far as possible and then let them wash beyond 'possible' themselves, but no one proffered any serious advice on dealing with having to touch, wash

or discuss people's bodies in general, let alone their private parts.
(Anonymous, cited in Cort, 1998, p. 54)

Lawler (1991) suggests that techniques are "required by the nurse to construct a context in which it is permissible to see other people's nakedness and genitalia, to undress others and to handle other people's bodies" (p. 195). However, what are these techniques? As a colleague remarked, do we go back to the days when student nurses practiced bed sponging on each other naked? Would this reduce the embarrassment for the nurse in the clinical setting? From my own experience, I have difficulty accessing volunteers from the nursing class, to be showered and sponged or to practice head to toe assessment on each other, wearing bikinis or even a t-shirt and shorts.

Other common embarrassing moments cited by many nurses is the behaviour of male clients where they make sexually suggestive comments to nurses. Lawler (1991) has labelled orthopaedic clients as "stereotypically sexual harassers of nurses ... orthopaedic wards can resemble other male-dominated situations where sex-as-sport forms part of the local culture" (p. 211).

Meerabeau (1999) explains:

some men, rather than becoming embarrassed by inappropriate bodily reactions may attempt to impose their own definition of the situation as a sexual situation; young orthopaedic patients are notorious for this ploy, which maybe construed as sexual harassment. (p. 6)

However, Lawler (1991) proposes that nurses are cautious about 'speaking up' about these incidents in case it is thought that they are encouraging this type of behaviour.

Sometimes humour is employed during embarrassing moments to divert the attention away from the cause of the embarrassment (Guthrie, 1999). When nurses do not know how to respond to a client, some develop a 'professional manner,' (Miers, 2000), a 'matter of fact' (Meerabeau, 1999; Miers, 2000) approach to distance themselves, enabling them to cope with the situation. Valentine (1995, cited in Guthrie) claims that avoidance is the most common tactic employed by nurses to cope with embarrassment. Unfortunately, according to Sundeen et al. (1989, cited in Hayter, 1996) this emotional distancing is a primary factor that caused clients to feel emotionally excluded. However, whatever the nurse's response, "sometimes it is not what you say, it's how you say it" (Garber et al., 1997, cited in Warner et al., 1999, p. 35) [or what you didn't say] and this is what the client will remember.

Evans (2000) suggests that healthcare professionals' conservative approach to discussing issues of sexuality with clients is based on myths and fears about sexuality.

This fear of dealing with matters sexual, as opposed to other aspects of health care, can be seen to be a form of institutionalized erotophobia (fear of sex). It is more than shyness or embarrassment, it is a disproportionate condition which regularly prevents numerous healthcare professionals from addressing a most personal aspect of holistic care. (Crouch, 1999a & McHaffie, 1993, cited in Evans, 2000, p. 651)

Evans (2000) continues, many barriers to communication in healthcare are disguised by morals and taboos and also by silence (it's a private matter, it's none of our business, it's not clinically relevant, I'm not trained to deal with that) and medical jargon and terminology. Evans further explains that the 'language of sex' is a barrier to communication within healthcare. In all languages, there are a number of ways to

communicate and an example in terms of sexuality that Evans cites is the word genitals. For some, this word conjures up uncomfortable feelings and to deal with this discomfort, variations of the word are used. Genitals have been referred to in childhood terms and names, in embarrassed innuendos ('private parts' or 'down there'), technical medical terminology and lastly, 'street names,' which for some are too vulgar.

Ross et al. (2000) state that comfort comes from both practice and a sense of control over the subject matter and this comfort is then conveyed to the client. As professionals, nurses have a responsibility to be knowledgeable about issues discussed with clients.

Professional Responsibility

In a summary of the literature related to sexuality, Kautz et al. (1990) identified that varying opinions about their professional role prevent nurses from addressing sexuality issues with clients. These varying opinions include:

- some nurses may not perceive sexuality as a basic human need and therefore may not include it in their holistic approach to nursing care
- some nurses may perceive that most sexual problems are too complex to be within the role of the nurse
- the feeling that there is a lack of role models who discuss sexuality issues
- fear of rejection from other healthcare professionals for addressing sexuality issues. (p. 71)

Frenken et al. (1988, cited in Gamel et al., 1992) state that, opinions on professional roles of general practitioners in Holland accounted for the most variation in the provision of sexual healthcare to clients. Aylott (2000) agrees that because the nursing profession has not considered

sexuality as an element of nursing, a wide divergence of nursing practice related to sexuality has resulted, which does not always benefit the client.

The practice of registered nurses in New Zealand is governed and guided by a number of professional codes, standards and legislative documents. Nursing Council of New Zealand (n.d.) provide registered nurses with a Code of Conduct with four guiding principles. Two of these principles that can be related to sexuality-related practice are:

Principle Two – the nurse or midwife acts ethically and maintains standards of practice.

Principle Three – the nurse or midwife respects the rights of patients/clients.

The New Zealand Nurses Organisation (1998) have Standards of Nursing Practice with five guiding standards and the standards that can be related to sexuality-related practice include:

Standard One – nurses are accountable for their practice.

Standard Two – within their scope of practice, nurses are responsible for the safety and well-being of their client group.

Standard Three – nurses are responsible for entering into and maintaining a partnership with clients, iwi/community, colleagues and employers.

Standard Four – nurses are committed to professional development.

As professional practitioners, a registered nurses' responsibility is to ensure that they practice within and maintain the standard required by these documents.

In 2000, the Royal College of Nurses in England (cited in Aylott, 2000) proactively developed guidelines aimed at improving nurses'

understanding of the impact of sexuality-related practice. Three of these aims were to:

- raise the awareness of the professional role that nurses can develop in the area of sexuality and sexual health.
 - highlight some of the professional development issues that will need to be considered.
 - provide professional, ethical and legal guidance on best practice.
- (p. 609)

During the development of these guidelines, feedback from different specialties, "confirmed that sexuality and sexual health is an issue that permeates throughout all spheres of nursing practice" (Aylott, 2000, p. 609). If nurses are to make a real difference to the lives of clients, "we must put their needs before our own personal and moral judgments" (Aylott, p. 609).

Summary

Sexuality is clearly described in the literature as an appropriate topic for nurses to address with clients. A search of the literature conclusively demonstrates that health professionals are currently not meeting the needs of their clients in relation to sexuality. There is strong evidence that most clients prefer to have discussion about sexuality initiated by health-care professionals and that most nurses do not initiate these discussions.

There are no absolute reasons why so many nurses fail to address sexuality in their practice, but several factors have been identified as barriers to sexuality-related practice. These include:

- practising nurses claim that they lack the knowledge and preparation required for sexuality-related practice

- strongly held attitudes of some nurses which reinforce negative stereotypes, particularly issues concerned with sexual minorities
- many nurses express levels of discomfort/embarrassment when discussing issues of sexuality
- some nurses do not perceive that sexuality is a basic human need and/or that it is not their role to discuss issues of sexuality with clients. Some even consider that issues of sexuality are too complex for nurses to deal with
- environmental factors were also cited as barriers to sexuality-related practice – lack of privacy in the ward setting, lack of time due to heavy workloads and clients having a shorter length of stay.

Seemingly, these barriers could be overcome through education and experiential learning opportunities. Palmer (1998) states that it has been suggested by many authors, that nurse education should be targeted in order to initiate changes in practice.

However, what education is currently provided for nurses in regard to sexuality-related practice? In the next chapter, I have reviewed the available literature around sexuality in undergraduate nursing education, to assess what role undergraduate education is having in the preparation of student nurses in regard to practice related to sexuality.

Chapter Two

Nursing Practice Related to Sexuality in Undergraduate Nursing Education

A Review of the Literature

Introduction

All nurses should be adequately prepared for assisting clients with issues relating to sexuality. It is crucial that nurses have sufficient knowledge, confidence and awareness of their own sexual attitudes in order to provide information in a non-judgemental manner, make suggestions, or refer clients to other professionals for specialized assistance.

This quote is from an article by Giddings and Wood (1998, p. 11) reporting on the results of their longitudinal descriptive study of knowledge and attitudes of pre and post-registration nursing students regarding sexuality. Their data was gathered using surveys by questionnaire and interviews from participants in four New Zealand Schools of Nursing between 1988 and 1991. "The study found that 55% of pre-registration students and 88% of registration nurse participants, felt that nurses were inadequately prepared for helping clients with concerns about sexual matters" (Giddings & Wood, 1998, p. 11).

They acknowledge in their conclusion that as their research is over ten years old, further research in this area would be timely, especially as students' knowledge and attitudes were changing during the period of the research project, along with the changes in society.

It is clear from Chapter One of this thesis that preparation for sexuality-related practice includes an emphasis on increasing nurses' comfort when providing sexuality-related care to clients. To achieve a realistic level of comfort, the acquisition of knowledge, understanding of attitudes and acquisition of assessment skills could be productive in preparing nurses for addressing issues of sexuality with clients. According to Grigg (1997), "sexuality is one area in which nurse educators must pay full attention as part of the process of accountability for the quality of care which learners give which patients receive" (p. 63).

In the section that follows, I discuss sexuality in nursing education under the following headings.

- Knowledge and Attitudes
- Discomfort and Embarrassment
- Sexuality Assessment of the Client
- Curriculum/Programme Content

Knowledge and Attitudes

Waterhouse (1996) reports that research studies provide conflicting conclusions about the effect that sexuality education has on sexuality knowledge and attitudes of the nurse, or whether sexuality education enhances sexuality-related practice with clients. Baird and Beardslee (1990) found that more knowledge about AIDS related to more positive beliefs about care of clients with AIDS. Matocha and Waterhouse (1993) found only a small positive correlation between education and practice, and Kautz et al. (1993) did not find any relationship.

Conversely, Lewis and Bor's (1994) study found that there was a correlation between knowledge and practice. Nurses who asked clients questions about sexuality on admission of the client were those who had been taught specifically how to take a sexual history. In addition to

this correlation though, the relationship between knowledge and practice is complicated by other factors, in particular, strongly held attitudes of nurses. This implies that even if knowledge about sexuality is increased through education, emotive attitudes or personal beliefs can continue to negatively affect practice. However, because aspects of sexuality are frequently implicit rather than explicit, it is difficult to assess the true impact of sexuality education in nursing (Rafferty, 1995).

Attitudes toward sexual minorities were identified as an area to be addressed in nursing education. Morrissey (1996), reports that issues relating to sexuality are rarely addressed in schools of nursing, therefore the awareness of sexual minorities is limited and nurses are inadequately prepared to deal with the sexual and psychological aspects of the lesbian, gay and/or bisexual client. Teaching cultural competence to nursing students has commonly focused on ethnic beliefs, values and practice, rather than issues of gender and sexual orientation (Abrums & Leppa, 2001). Nurse educators have the responsibility to prepare nurses for meeting the needs of people of various cultures and lifestyles, through educational experiences.

While research has demonstrated that homophobic attitudes can be changed through education (Lewis & Bor, 1994; Serdahely & Ziemba, 1984, & Young, 1988, cited in Richmond & McKenna, 1998) they also propose that the place of education is not to alter personal beliefs, but to teach nurses how and why personal beliefs must be separated from professional practice when they are in conflict with those of the client. This view is supported by the Nursing Council of New Zealand (NCNZ, 2002) and is reflected in the Nursing Council's standards through their Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health and in Nursing and Midwifery Education and Practice (2002) document. NCNZ (2002) state that culture refers to the beliefs and practices common to any particular group of people including age, gender, sexual

orientation, socioeconomic status, ethnicity, religion and disability. One of the learning outcomes of the NCNZ (2002) Cultural Safety Guidelines is for the students "to examine their own realities and attitudes they bring to each new person they encounter in their practice," (p.12). "One cannot provide culturally competent care unless underlying issues of discrimination are examined and confronted" (Abrums & Leppa, 2001, p. 270). Nurse educators should encourage students to have a high level of tolerance towards sexuality and how it is expressed (Weston, 1993) by raising the awareness and expanding on the issues of sexuality that are taught in order to achieve this outcome.

This will enable the student nurse to:

have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans and disempowers the cultural identity and well-being of an individual. (NCNZ, 2002 p. 7)

It is the role of the nurse educator to facilitate this reflection, however, is the nurse educator prepared for this role? A basic requirement of nurse educators is the need to be adequately prepared for teaching sexuality (Crouch, 1999b; Grigg, 1997; Hayter, 1998; Rafferty, 1995). Nurse educators require research-based knowledge of sexuality, as accurate information can lead to positive attitudinal changes in the right environment and nurses need to act as positive role models and as client advocates (Rose & Platzer, 1993). Peate (1995) and Randall (1989) further suggest, that educators should analyse and challenge their own biases, as students are sensitive to the attitudes of the teacher. These views have been promoted by Brookfield (1995), when he suggests that educators recognize the effects of their practice on

students and address poor teaching practices through reflective practice.

Rose and Platzer (1993) provide an example where a nursing lecturer presented homosexuality as a perversion alongside bestiality and sadomasochism and treated it as a joke. When one student challenged the lecturer, the lecturer played on the prejudice of the others in the class, which humiliated the student, who was then asked to leave by the lecturer. While this example is 10 years old, some recent examples of inappropriate nurse educator comments in relation to gender identity and orientation were cited in Ashcroft (2002).

As Clear and Carryer (2001) explain, "if we neglect issues such as diversity in cultural identity and sexual expression within education, we are in no position to calmly lay claim to such attributes as culturally competent care ..." (p. 35). Weston (1993) states that nurse educators "must educate themselves thoroughly about sexual health matters before attempting to pass on their knowledge to learners" (p. 28). Grigg (1997) also states that it is the responsibility of the nurse educator to be trained and qualified, as sexuality should be taught by 'experts.' Nurse educators are required to be involved in formal courses or inservice training programmes otherwise "it will not be sufficient to give specific teaching sessions on sexuality" (Webb, 1988, p. 242).

If the participants were interested in formal education around issues of sexuality in nursing practice, where would they go? While I had not actively sought out courses on sexuality in New Zealand, I have not seen them advertised in the New Zealand nursing journals, as is the custom for other courses for nurses. In a recent telephone conversation to a newly established sex therapist in this province, I asked her where she gained her knowledge for this role. She has a Bachelors Degree in Psychology and a Masters Degree in Social Work and then undertook private tuition in Auckland. However, there are modular courses on

sexuality provided by Sex Therapy New Zealand Ltd (STNZ). According to STNZ, this is the only course of this nature in New Zealand and is available to psychologists, counsellors and medical professionals. The pre-requisite two day foundation course with STNZ, which is available to anyone, covers the following: information on human sexuality, sexual problems and their treatments, and development of the therapist's self-awareness and confidence as a sexual being is highly recommended. Since providing STNZ with contact details for New Zealand nursing journals, STNZ are likely to advertise their courses to nurses.

While Rafferty (1995) suggests that teachers who have a special interest in sexuality issues require the opportunity to enhance and develop their knowledge, Grigg (1997) quotes "at this point there are very few tutors who are 'willing' – let alone expert enough" (p. 63).

According to Walker (1971):

.... the aims of a sexuality-integrated teaching programme, would be for all people in direct patient care to be comfortable with sexual topics and be able to put the patient at ease, be able consistently to be concerned for the patient's feelings and do nothing to increase the patient's shame and embarrassment, and listen well while learning to ask questions about patient sexuality. (cited in Keane, 1982, p. 44)

If a sexuality teaching programme can prepare nurses to practice as Walker (1971) suggested 30 years ago, they would be respecting the sexual rights of clients as defined by the World Health Organisation (2002) discussed in the previous chapter.

Discomfort and Embarrassment

Webb (1988) proposes that the lack of adequate training within the curriculum, in regard to knowledge or skills required to share

information on sexuality with clients, may in part be due to the discomfort that nurse educators themselves feel about sexuality. Supporting this view are Grigg (1997; Van Ooijen & Charnock, 1994; Weston, 1993) who state that nurse teachers are uncomfortable and anxious about highlighting sexual matters and this may be why sexuality is given a low priority or is overlooked in many nursing programmes.

Crouch (1999b) suggests that sexuality, for some, is a very fragile entity which can easily be affected or damaged by inappropriate or ill informed interventions and because student nurses have their own sexual history, attitudes and perceptions, conflicts within the group could easily develop. Any conflicts need to be defused quickly, highlighting the need for 'expert' facilitators when dealing with sexuality education (Crouch, 1999b; Eliason, 1996; Grigg, 1997).

While Crouch (1999b) and (Grigg, 1997) suggest that having a sexual knowledge base is essential for teaching sexuality, having a sexual health knowledge base is not enough. Only when nurse educators are comfortable with their own sexuality are they better able to integrate sexuality within the curriculum and develop sensitive and perceptive communication skills about sexuality with the students (Crouch, 1999b; Grigg, 1997). McHaffie (1993) states, that "the skills of the nurse educator will be taxed by dealing with powerful emotions generated by this kind of work and they will require thorough preparation and support" (p. 28).

Rafferty (1995) adds, those who are uncomfortable with the topic should not be expected to teach or facilitate sexuality topics, however, differing opinions were expressed in Ashcroft's (2002) findings. One participant in particular was adamant that 'buy in' was required from *all* nurse educators in regard to teaching sexuality issues in nursing education, to avoid compartmentalization and to ensure that sexuality is

integrated throughout the curriculum, commencing in year one and included in all courses. This participant felt that all nurse educators should be prepared to teach practice related to sexuality.

Sexuality Assessment of the Client

Sexuality assessment of the client refers to obtaining data about the client from Gordon's (1994) sexuality-reproductive functional health pattern, one of Gordon's 11 functional health patterns. Obtaining a nursing health history is through a nursing interview with the client where professional interpersonal and interviewing skills are required (Weber, 2004).

Ross et al. (2000) found that prior to writing the first edition of their book in 1991, they were surprised at the lack of nursing and medical texts available on sexual history taking and counselling. They were further disturbed when writing the second edition (2000), where they identified that the gap had widened between the client's awareness of issues of sexuality, and the ability of the practitioner to address issues of sexuality. Has society's knowledge and attitudes towards issues of sexuality surpassed that of the nursing and medical profession? At least one current text used in the nursing programme taught by the participants in this study (Crisp & Taylor, 2001) has a chapter on sexuality, which includes sexuality assessment of the client.

Palmer (1998) states that nurse education in relation to sexuality has tended to focus on knowledge and attitudes, rather than a skills component, and needs to include communication and teaching skills (Lewis & Bor, 1994). Eliason (1996) and Warner et al. (1999) suggest that sexuality education requires two major components – a cognitive (theory and research) component, an affective (feelings and attitudes) component, and Warner et al. and Guthrie (1999), suggest the addition of a communicative component. Baraitser, Elliot and Bigrigg (1998)

add, while nurses require education in general communication skills for a therapeutic nurse-client relationship, sensitive issues such as sexuality require additional, specific communication skills, for example, the ability to choose the appropriate language. The communicative component comprises of practice in talking directly about sexuality, sexuality assessment or sexual history taking and may include being paired with a practitioner to act as a role model. To the surprise of Baraitser et al. students' discomfort about discussing sexuality decreased after only one two-hour session in the communication skills course. The aim is for the students to gain confidence in using language that previously was not familiar to them and these should be practised both in the clinical setting and the classroom (Baraitser et al.). Introducing sexuality as part of the nursing curriculum is of little value if nurses do not have the skills to integrate the theory into practice (Guthrie).

Some authors have suggested cues that nurses could use to initiate discussion on issues of sexuality that are sensitive to the needs of clients and non threatening to both the nurse and client:

- sex is an important part of life and can be affected by your health status and vice versa. To better understand your health, it is useful to know ...
- have you noticed any changes in the way you feel about yourself as a man, woman, husband, wife, [partner]?
- how do you feel about the sexual part of your life? (Crisp & Taylor, 2002, p. 578)
- how has your illness affected the way you feel about yourself?
- sometimes people with your condition worry whether it is okay to have sexual relations; is there anything you would like to ask me?
- people sometimes worry about the fact that they do not seem to have much interest in sex, how about you? (Van Ooijen & Charnock, 1994, p. 137).

- many people with your illness find that they have some sexual problems. Have you noticed any difficulties since your illness began? (Ross et al., 2000, p. 120).
- I always try to talk to patients about concerns that they may have about sex. Is it okay for me to ask you some questions? (Warner et al., 1999, p. 39).

This type of questioning is equivalent to the limited information level of the P-LI-SS-IT model (discussed in the next section) that Waterhouse (1996) suggests most nurses should be practising. Responses to these types of questions varies enormously according to Ross et al. (2000), from being told to “mind our own business” to a young married man who had had multiple consultations with a broad range of health professionals and was moved to tears in his response “that’s the very worst thing going wrong in my life and no one’s ever asked me about it before” (p. 120).

To learn these communication/assessment skills, an experiential approach with learning activities such as role-play using realistic practice and rehearsal opportunities is required (Baraitser et al., 1998; Crouch, 1999b; Palmer, 1998; Savage, 1998; Warner et al., 1999; Waterhouse, 1996; Webb, 1988). Role play is a learning tool used to encourage participation by improvising behaviours that may be encountered in the nurse-client relationship and has been found to be more effective than lectures (Shearer & Davidhizar, 2003).

Coleman (1999, cited in Ross et al., 2000), states that after more than 20 years teaching, the most difficult task in teaching medical students, is to develop the comfort and ability of the health care professional to discuss issues of sexuality with clients. Green (1979, cited in Ross et al.) noted that practitioners displayed discomfort during role-play/practice sessions in taking a sexual history. Practitioners performed role-play with fellow students, asking each other questions

about their sexuality. Audio or video taping of the session is recommended as valuable for assessing their own performance. Within these role-plays, it is important that the students develop a self-awareness of their own views on sexuality and also what may be issues for clients. According to Lowenstein (2001), role play:

... may address practice of skills and techniques or changes in understanding, feelings, and attitudes. When role play is used to practice skills and techniques, instructors design the role play with emphasis on acquisition of skills and overcoming problems. When role play is used to address changes in understanding, feelings, and attitudes, problem solving and relationships are emphasised. Instructors are responsible for guiding students and helping them cope with the emotions and negative feelings that may be generated in the role play. (cited in Shearer & Davidhizar, 2003, p. 274)

As these teaching techniques are successful for medical students, it could be fair to assume that they may be just as successful for nursing students.

Curriculum/Programme Content

Nursing Council New Zealand (2004) provide an overview of the content which is to be included within nursing curricula and all curricula documents from schools of nursing in New Zealand must be approved by NCNZ prior to the commencement of a nursing programme. "The accreditation and audit process ... for undergraduate programmes provides a very sound process for monitoring education standards and ... assessment processes" (NCNZ, 2004, p. 2). This overview includes the specialties (child health, mental health, medical/surgical, etc), but is not prescriptive as to the content to be included within these specialties. Sexuality is therefore not overtly identifiable in the NCNZ Nursing

Schools/Departments Handbook for Pre-registration Nursing Programmes (2004).

The NCNZ Cultural Safety Guidelines (2002), on the other hand, are more directive and practice related to sexuality is within the umbrella of cultural safety. Issues of cultural safety must be included within the curriculum documentation of each school of nursing.

The literature however, indicates that despite the increasing complexity of nursing education and practice, many nurses may not have adequate knowledge and skill in educating clients about issues of sexuality (Lamp et al., 2000). Rafferty (1995) suggests that sexuality within nurse education and practice is often neglected or inadequately covered due to social forces and factors within [and outside] the profession that support the maxim that sexuality is a taboo subject.

The topic of sexuality is insufficiently addressed in nursing education and practice and therefore becomes a daunting area for nurses in clinical practice (Jolley, 2002; Kautz et al., 1993; Lewis & Bor, 1994; Van Ooijen & Charnock, 1995). Additionally, Ross et al., (2000) state that sexuality is not taught or is taught with severe time restrictions or minimal practice to develop the skills required in assessment of the sexuality of a client.

Abraham Maslow (1962, cited in Crisp & Taylor, 2001; Taylor et al., 2001) placed sex as a basic physiological need in his Hierarchy of Human Needs. He incorporated aspects of sexuality into the basic physiological level, love and belonging level and in the self-esteem level of needs for all human beings. As Maslow's Hierarchy of Human Needs is still taught in nursing programmes as a humanistic theory, it is pertinent to ask why sexuality is seemingly given a low priority in nursing education? As nursing care is based on meeting the needs of the client, any assessment that excludes sexuality is not moving a client toward sexual fulfilment.

If sexuality is to be included in nursing curriculum it should not be trivialized, but rather have a more overt approach (Crouch, 1999b). Rafferty (1995) states that sexuality should be explicitly identified in the curriculum documentation and also referred to in the learning outcomes, just as cultural safety is now required by the NCNZ (2002). Sexuality requires a planned progressive model that has positive benefits and which acknowledges sexuality as diverse and individual (Crouch, 1999b).

Several articles have discussed the introduction of sexual health models to guide the teaching and learning of sexuality-related practice. Crouch (1999b; Jolley, 2002; Morrissey, 1996; Weston, 1993) suggest the use of the P-LI-SS-IT model (Anon, 1976, cited in Crouch, 1999b; Morrissey, 1996; Ross et al., 2000; Wallace, 2003), which provides a framework for self-assessment, interventions and planning of sexuality education. P-LI-SS-IT is an acronym for Permission, Limited Information, Specific Suggestions and Intensive Therapy and is frequently used to describe levels of nursing intervention. P-LI-SS-IT is described by Waterhouse (1996) as follows.

Permission – involves conveying to the client that sexuality is a suitable subject for discussion and providing assurance that concerns and practices are normal. Waterhouse considers that all nurses should be able to function at this level, but according to the literature, this is not the case. Nurses are not conveying to clients that sexuality is suitable for discussion.

Limited Information Level – where factual information relevant to the client's concern or problem is given and general sexual concerns, questions, myths and misconceptions maybe addressed. Waterhouse suggests that most nurses can intervene at this level, however, again, the literature challenges whether this is happening.

Specific Suggestions – are made to clients about sexual concerns at this level, but many nurses do not have the special knowledge and skills needed to intervene.

Intensive Therapy - is required for long-standing sexual problems or severely stressed relationships and should be provided by specially trained professionals. (Waterhouse, 1996, p. 413)

The P-LI-SS-IT model includes suggested questions for initiating and maintaining discussion of sexuality and has been used to assess and manage the sexuality of adults (Anon, 1979, cited in Wallace, 2003).

An alternative sexual health model is the Mims-Swenson model (1980, cited in Crouch, 1999b; Morrissey, 1996; Morrissey & Rivers, 1998), which has been adapted from the P-LI-SS-IT model. While these models have demonstrated some positive outcomes, further research as to their effectiveness is required (Crouch, 1999b). Both these models provide a guiding framework as to the level educators should be teaching student nurses and also the level of practice that an educator should be, to be an effective teacher. Morrissey and Rivers (1998) suggest that for these courses to be effective, the nurse educators are required to have undergone training at an advanced level with relevant practice experience. Stenhouse (1975, cited in Grigg, 1997) adds, "the quality of the teacher, in a process model curriculum (on which sexuality education is usually based) is the greatest strength of that curriculum" (p. 63).

Webb (1988) summarises:

Like many other topics in nursing, sexuality is not a neat, self-contained area but overlaps with many others. Therefore an approach must be adopted throughout the curriculum which acknowledges the importance of sexuality, in the same way that nurses are in the process of incorporating themes such as

communications and problem-solving skills at all stages in their work. (p. 244)

Summary

These two literature review chapters have demonstrated that there is a vast amount of literature relating to sexuality-related practice (or lack of) in the clinical setting compared with the literature on sexuality in nursing education. However, nursing education seems to be the area which, given a greater focus, has the potential to improve the quality of nursing practice related to sexuality and holistic client care which nurses believe they should provide. Research suggests that emphasis on increasing nurses' comfort when providing sexuality-related care would be helpful and it appears that increasing nurses' knowledge, acknowledging and addressing negative attitudes toward sexuality, and learning effective communication/assessment skills when discussing sensitive issues like sexuality with clients, could be of some value in changing practice.

Nurses learn to apply nursing practice experientially and therefore client care related to sexuality issues needs to be learned in this way. Nursing students require multiple experiences of addressing sexuality issues in role-play and practice situations to become more familiar and comfortable. Nurses also require time to reflect on their own sexuality beliefs and values, to become comfortable with their own sexuality and have the ability to partition any conflicting personal views from their professional practice. The less uncomfortable or embarrassed the nurse is in addressing sexuality issues with the client, the more comfortable the client will be, because as Meerabeau (1999) explains, embarrassment is contagious.

Findings from the overseas literature suggest that changes are required in nursing education and with the preparation of nurse educators. For

example, there is a lack of sexuality education with the nursing curriculum, nurse educators may not have the knowledge or have negative attitudes about sexuality and nurse educators are uncomfortable teaching aspects of sexuality. There is no evidence to suggest that the issues raised are the perceptions or experiences of nurse educators in New Zealand. What are the perceptions and experiences of nurse educators within the New Zealand nursing curricula? The current situation with nurse educators and undergraduate nursing education requires exploration and a search of the literature confirms that this has not been examined previously. It is this area of nursing education in New Zealand that I am exploring in this thesis.

Chapter Three

Research Design and Methodology

Introduction

This chapter will explain the use of a descriptive/exploratory research design, its applicability to nursing (education) and its application to this research study in particular. The research methodology for this study is discussed in detail including participant selection, ethical considerations and data analysis processes. Limitations and strengths of the research are also acknowledged.

Research Design

For this study I chose an exploratory, descriptive research design using a qualitative approach.

Qualitative methods should be used when little is known about a phenomenon, when the investigator suspects that the present knowledge or theories may be biased, or inaccurate, or when the research question pertains to understanding or describing a particular phenomenon or event about which little is known. (Morse & Field, 1995, p. 10)

In regard to my research, I saw a perfect 'fit' [*sic*] between this quote and my research. Little is known about nurse educators' perceptions and experiences of practice related to sexuality in undergraduate nursing education in New Zealand or internationally and there is no evidence to confirm that what is suggested in the literature, is the opinion of nurse educators in the New Zealand setting. Therefore, my research is exploring a phenomenon about which little is known. My intention is to undertake an exploratory study that provides a base on

which other studies can develop and to make recommendations for change in nurse educator practice if deficits are identified.

Qualitative research is aimed at the discovery of meaning rather than cause and effect and where the ideas are collected and analysed as words, as opposed to being analysed as numbers (Miles & Huberman, 1984, cited in Roberts & Burke, 1989). The emphasis is on achieving understanding from the data that will open up new options and perspectives with a view to changing people's worlds (Schneider & Elliot, 2003). If this study confirms what is suggested in the literature, then recommendations will be made with a view to changing the 'world' of nurse educators, practicing nurses and clients in relation to issues of sexuality.

Before noticeable changes occur in the 'world's' of nurse educators, nurses or client care, further research will be required following the completion of my study. With such slow developments in improving client care, as identified in the literature, and the paucity of research in New Zealand in regard to issues of sexuality, a more extensive assessment of nursing practice and education in New Zealand will be required before strategies can be identified and formulated which will improve nursing practice related to sexuality to the benefit of the client.

Prior to choosing an exploratory, descriptive methodology, I carefully examined other qualitative approaches that are commonly used in nursing research: phenomenology, ethnography and grounded theory, before deciding on a descriptive/exploratory design. In order to weight my choice, I briefly discuss these other options.

Phenomenology

Phenomenology comes from a philosophical and psychological background and its focus is on the lived experiences of human beings (Polit, Beck & Hungler, 2001). Beanland and Schneider (2000) describe

phenomenology as “a process of learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience,” (p. 245) or the day-to-day existence of a particular group or the life world of individuals. However, sexuality education within the curriculum is not necessarily a daily or even weekly event for some nurse educators. For some educators, it may not be a ‘lived experience.’ Examples of the day-to-day existence of a nurse educator is, nursing education and for the hospice nurse, caring for dying clients. Sexuality-related education can be a planned, timetabled event, or a sporadic and unpredictable event, depending on what is being taught at the time and depending on what questions are raised by the nursing students. The experiences are not ‘lived’ often enough to capture the data that I require for this study using a phenomenological approach.

As the primary data using a phenomenological approach is gained through dialogue from those ‘experiencing’ the phenomenon to ensure that the data is both “rich and descriptive” (Holloway & Wheeler, 1996, p. 123), this would have had to be part of the inclusion criteria for selection into this study. To gain the participants for a phenomenological approach, the criteria for the sample would require that the participants currently teach practice related to sexuality, which would have restricted the size of the sample. As I prepared the proposal for this research, I had private concerns that I may not access the four or five participants that I had aimed for. By using a phenomenological approach with a more restrictive selection criteria, my concerns may have been confirmed, in that I may have been unable to recruit an adequate number of participants.

While I am focusing on the nurse educators’ experiences of sexuality-related practice in nursing education, I also wished to gain insight into their ‘perceptions of practice’ related to sexuality in nursing education. An educator does not need to have ‘lived the experience’ to have these

perceptions. Nurse educators do have perceptions, attitudes and opinions on practice related to sexuality in nursing education, without having 'experienced' it, or with minimal experience in teaching sexuality issues, and it is these perceptions that I also wished to capture and include in this study.

Ethnography

Ethnography is associated with the field of anthropology and focuses on the culture of a group of people in an attempt to understand human behaviour from the perspectives of the individuals in the culture being studied (Beanland & Schneider, 2000). Holloway and Wheeler (1996) define culture as the total way of life of a group and the learned behaviour within the group, for example, gestures, mime or language and values that they have learned from within the group. While nurse educators are themselves a culture, practice related to sexuality in nursing education is a small part of our roles and I am not certain that such a culture exists.

Data collection in ethnographic studies is through in-depth interviews, studying documents and participant observation where the behaviour of the participants is observed in the setting of the culture (Holloway & Wheeler, 1996). As Beanland and Schneider (2000) explain, the ethnographic researcher is required to "enter the world of the study participants to watch what happens, listen to what is said, ask questions and collect what ever data is available" (p.250).

However, as a subject, sexuality-related nursing practice is not necessarily taught in a stand-alone situation, like for example pharmacology or anatomy and physiology. The nurse educator cannot always predict when the topic is to be addressed within nursing education, questions can be raised from students at any time and multiple hours of observation would be required to capture relevant

data. It would therefore be unrealistic to gather data by observing educators in this role, which is a main feature of data collection in ethnography.

Grounded Theory

Grounded theory as a research methodology is described as a qualitative, inductive method of inquiry. I spent considerable time reading, analyzing and considering both grounded theory and exploratory/descriptive research design, before deciding on the later. Grounded theory was first developed by Glaser and Strauss in their book, *The Discovery of Grounded Theory* (1967). In this approach, theory is constructed inductively from the observations of the world that is lived by a selected group of people. The emergent theory is discovered and developed based on observations and perceptions of the social scene and evolves through data collection and analysis during the actual research process (Beanland & Schneider, 2000; Strauss & Corbin, 1990), in other words, data collection and analysis occur simultaneously. The aim is to construct theory where no theory exists.

Simms (1981) states, that grounded theory "is particularly suitable for nursing studies because often the literature has a scarcity of information on the topic, which precludes the generation of hypothesis on the bases [*sic*] of previous work" (p. 356). However, in this study, would a theory or hypothesis derived from only one Bachelor of Nursing Programme in New Zealand have credibility? On the contrary, as it is not apparent that research in this area has been undertaken, particularly in New Zealand, preliminary research exploring the perceptions and experiences of nurse educators is appropriate. One purpose of data from exploratory research is to provide direction for future research.

I felt that the development of a theory directly from the data would have been too great a challenge for a beginner researcher and

colleagues who have completed their own theses guided me away from the grounded theory approach, as 'it is too complex, difficult, complicated.' After much deliberation, I elected not to use the grounded theory approach and I am comfortable with my decision to undertake this study using an exploratory, descriptive design with a qualitative approach.

At the early stages of this study, I was not considering developing a theory. However, I have since developed a model for practice related to sexuality through analysis of the findings from the literature and analysis of the data from this study.

Exploratory/Descriptive Research

The purpose of my study was to both explore and describe the perceptions and experiences of nurse educators of sexuality-related practice in nursing education. The research texts present slightly differing views on exploratory and descriptive research designs. Brink and Wood (1994) state that exploratory studies provide an in-depth exploration of a single process, variable or concept where little is known and the researcher's intention is to develop new knowledge. The data from exploratory studies may lead to suggestion for further study. While the aim of my study was broader than a single process, variable or concept, it otherwise meets Brink and Wood's description of an exploratory design.

Descriptive designs, however, differ from the exploratory designs in that they study known variables in unknown populations (Brink & Wood, 1994) "there may be literature on the variables, but the variables have not been studied in a population" (p. 108) ie; there are variables about nurse educators in the literature, but I am not aware that the nurse educators in New Zealand have been studied as a population. My study is a combination of these two designs. Little is known of nurse

educators' perceptions and experiences of sexuality-related practice in nursing education in New Zealand and while variables have been identified in the literature, to my knowledge, nurse educators in New Zealand are an unstudied population in relation to sexuality.

Alternatively, Davidson and Tolich (1999), describe exploratory research as the discovery of whether something actually exists and/or the extent of an issue. Using this approach, I could have posed the question 'Do nurse educators feel inadequately prepared for teaching sexuality-related practice?' or 'Do nurse educators feel uncomfortable teaching sexuality-related practice?', these being two of the issues raised in the literature. However, in asking these questions in this manner, preconceived ideas may have biased the data within the study. I wanted to know the perceptions and experiences of nurse educators without mention of the findings from the literature in the research question, as there is no evidence suggesting that the findings in the literature are the current perceptions and experiences of nurse educators in New Zealand.

Descriptive research, as described by Davidson and Tolich (1999), is to describe a social phenomenon in detail endeavoring to gain insight into the nature of the phenomenon. Again, I could have asked similar questions, 'Why do nurse educators feel inadequately prepared for teaching sexuality-related practice?' or 'Why do nurse educators feel uncomfortable teaching sexuality-related practice to nursing students?', again, preconceived ideas are still implied. I therefore used an exploratory, descriptive method of inquiry described by Roberts and Burke (1989) and Beanland and Schneider (2000) where exploratory, descriptive studies are described as one.

Exploratory or descriptive research has been described by Roberts and Burke (1989) as a non-experimental design used to observe and

measure a variable when little conceptual background has been developed in regard to specific aspects about the variables under study.

Non-experimental designs are used when the desire of the researcher is to construct a picture of a phenomenon or to explore events, people or situations in their natural state where there is no manipulation or control of the variables (Beanland & Schneider, 2000). This approach is used to describe variables (Roberts & Burke, 1989), (for example, in my study, nurse educator comfort/discomfort or nurse educator knowledge), or to explore relationships between variables or differences between variables, rather than test a predicted relationship between variables (Beanland & Schneider).

Brink and Wood (1994) state that no matter what method is chosen to collect data in a descriptive design, it must provide descriptions of the variables in order to answer the research question.

In this study, I explored the data to identify variables and then described them as they developed into concepts. I did not intend to explore relationships between the variables, however, relationships have emerged while describing the data and in relation to the literature, and these have been discussed in Chapter Six.

Choosing the Methodology

Having explored these four approaches, a decision on one had to be made.

A phenomenological approach would involve interviewing participants who are 'living the experience,' thus having a more restrictive inclusion criteria, and the study may have been jeopardized through a lack of eligible participants. It was not just the 'lived experience' that I was exploring. I was also seeking the perceptions of nurse educators

regardless of whether they have 'lived the experience' of teaching sexuality issues in undergraduate education.

Entering the world of the nurse educator in ethnography to observe their behaviour to gain insight into their experiences and perceptions of practice related to sexuality in nursing education would have been unrealistic. Teaching sexuality can be a timetabled, sporadic and unpredictable event and multiple hours of observations would be required to capture relevant data.

Grounded theory would generate much relevant information, but my intent was not to generate theory, particularly as only one undergraduate nursing programme is included in this study, but to gain insight into the experiences and perceptions of the nurse educators with a view to providing a 'spring board' for further research.

Exploratory, descriptive survey studies collect detailed descriptions of existing variables (opinions, attitudes or facts) and use the data to justify and assess current conditions or practices, or to make suggestions for improvements in current conditions or practice (Beanland & Schneider, 2000). While opinions and attitudes of practice related to sexuality in nursing education have emerged from the literature, there is no evidence to suggest that these are the current opinions and attitudes of nurse educators in New Zealand. Primarily, I was interested in the current perceptions and experiences of a group of nurse educators in New Zealand, with a view to making recommendations for improvement in practice if a need is identified. To this end, an exploratory, descriptive study provides the best option that is achievable for a beginning researcher and attainable within the available time frame for this study.

Methods

In exploratory, descriptive survey studies, data is either collected by questionnaire or interview and the sample can be either small or large, but is generally from a defined population. While large populations can provide a great deal of information economically, the information is superficial, giving breadth rather than depth. If however, the sample is representative of the population, a small sample can provide an accurate picture of the population (Beanland & Schneider, 2000). While I sampled 50% of a specific population, I am not suggesting that the sample is representative of the population. Due to the sensitive nature of the subject, I am mindful that those who chose not to participate in the study may have diverse perceptions and experiences from those who did participate and this could be seen as a significant limitation of the study. This also confirms that the credibility of developing a theory from this study could have been dubious.

In qualitative research, research participants are viewed as having the knowledge that the researcher gains (Schneider & Elliot, 2003). The participants were nurse educators from one Bachelor of Nursing Programme in New Zealand. For this study, I undertook in-depth interviews using a small population. Data collection via interview "permits an exploration of a person's feelings, ideas, attitudes and thoughts in words of the individual and not the words of the researcher," (Beanland & Schneider, 2000, p. 294) which is the type of data I gained to answer the research questions. I had considered bringing the participants together (as a focus group) after the individual interviews, but decided against this, due to the personal and sensitive nature of the topic. My feeling was that participants within a focus group may feel pressured to say what they feel is expected of them, rather than express their own perceptions/opinions.

I selected convenience sampling as the sampling technique for this study. Convenience sampling is a non-probability method that takes advantage of a group of subjects that fall within the population of interest and are conveniently located or readily accessible to the researcher (Polit et al., 2001; Roberts & Burke, 1989; Schneider & Elliot, 2003). For convenience, I interviewed nurse educators from only one organization in New Zealand.

My intentions were to interview four or five participants from a relatively small population of 12. In the event that more than six agreed to participate, I planned to select the participants using a range of ages, gender and teaching experience, to avoid repetition and an unwieldy amount of data. As only six agreed to participate, further selection was not required.

Ethical Considerations

Qualitative methods of research involve a direct relationship with the participants and this raises ethical concerns (Schneider & Elliot, 2003). Ethical approval was gained from the Massey University Human Ethics Committee, (MUHEC) Wellington, (Appendix Five) which was also accepted by the organization who employ the nurse educators, and approval was given.

Informed consent

Informed consent was gained from all participants following an introductory letter and an information sheet (Appendix One and Two) about the nature of the research and their involvement in the study. An opportunity to ask questions prior to commencement was provided and written informed consent was gained (Appendix Three). Participants were given a copy of the information sheet and the consent form to retain. The participants were informed that they had a right to withdraw from the study at any time, that the audio-tape tape could be

stopped at any time at their request and that they could refuse to answer any questions, particularly due to the sensitivity of the subject – sexuality education.

Anonymity and Confidentiality

The participants were assured that anonymity would be maintained at all times. Each participant chose a pseudonym; Binty, Edith, Fay, Jane, Sunny and Tory. These pseudonyms are only known to myself, and the participants real names were not recorded at all. Every effort was made to suppress the identity of the participants by using their pseudonym and omitting geographical details and names of any identifying institutions. Where one quote had the potential to identify a participant, I clarified the use of this quote with the participant and was assured that the quote could be used.

The raw data was seen only by the transcriber, one research supervisor and myself. The transcriber signed a confidentiality agreement (Appendix Four) and the participants were informed of this. The participants were given the opportunity to edit the transcribed data prior to any data analysis. All data was stored in a locked filing cabinet at my home. All participants were given the option of having the audio-tapes returned to them or wiped on completion of the study. All disks and transcripts will be stored with the research supervisors for five years on completion of the study.

The possible uses for the research were outlined, including anonymous verbatim extracts from interviews being published and/or used in educational forums. A copy of the completed thesis will be available to the participants through the usual channels.

Maori Issues

As all of the participants were non-Maori, perceptions and experiences of Maori nurse educators in regard to sexuality-related practice in nursing education was not investigated. Two other issues around sexuality in regard to Maori are that non-Maori nurse educators teach Maori students and that all nurses care for Maori clients. I do not know how Maori nurses or Maori clients' perceive sexuality-related nursing practice and this is an area that warrants further research. These issues are outside the scope of my study and have not been explored or represented in this research. Where possible, I believe that research concerned with Maori, should be undertaken by Maori. If Maori issues or concerns had been raised within the course of my research I had permission to seek advice from a Maori nurse educator, as this is not an area of my expertise. However, there were no issues or concerns raised during this study.

Potential Harm to Participants

Due to the nature of this research it was unlikely that participants would suffer harm during this study, particularly as participation was voluntary and they were fully informed of the nature of the study. No situations arose where the researcher considered that the interview was causing discomfort to a participant whereby it was deemed necessary to 'stop' the interview. On the contrary, participants were delighted to be part of this study and it provided them with an opportunity for reflection on their own practice. In fact, 'time out' or cessation of the interview occurred once, which was at my discretion. It involved a very reflective, emotional and private episode between the participant and the researcher.

Participant Selection

All 12 nurse educators, who teach on one Bachelor of Nursing Programme in New Zealand were provided with a letter of introduction (Appendix One). Six educators expressed interest in participating in the study and they were provided with the information sheet (Appendix Two). All six agreed to participate in this study and written consent was gained from each participant (Appendix Three). As I prepared the proposal for this research, I had private concerns that I may not access the four or five participants that I had aimed for. However, my fears were soon allayed, for within a week, I had gained six willing participants, a response rate of 50%.

Demographic Data

The participants range in age from mid 30's to 60. All are female and their clinical nursing experience ranges from 4 to 27 years. Their clinical practice includes a variety of settings – public health/health visiting, operating theatre, orthopaedics, emergency department, general surgical, general medical, palliative care, mental health – acute and community, neonatal intensive care, paediatrics, intellectually disabled, physically disabled, care of the elderly and rehabilitation, nursing management, obstetrics and midwifery, and pain management. With the exception of one, all participants have worked in clinical practice within New Zealand and with the exception of one, all participants have worked in clinical practice outside of New Zealand including England, the United States of America and Australia.

The participants' experience in teaching undergraduate education ranges from 1 to 30 years. The courses taught, or that have recently (the last two years) been taught by the participants within the Bachelor of Nursing curriculum include: communication, human growth and development, child health, older client health, health promotion,

sociology, psychology, obstetrics, cultural safety, law and ethics, research, medical/surgical, fundamentals of nursing practice, with client assessment being incorporated into several of these papers.

Data Collection

After gaining written consent from each participant, interviews were scheduled at a time and place convenient to the participant and were conducted over a period of five weeks. Participants were interviewed by myself on one occasion for 1- 1 ¹/₂ hours, with only one second interview required, this being a follow up interview from the first interview undertaken. The first interview did not flow as well as I had hoped and I required clarification on aspects of the data that I had gained. I began each interview with a general and broad open-ended question, "what does the word sexuality mean to you?" to set the scene of the topic. Other questions included the following, but were asked within the context of the discussion, not in any order or structure and not all questions were asked of every participant as often the information was provided spontaneously (Appendix Six).

How do you think sexuality relates to nursing practice?

How do you think sexuality-related practice relates to nursing education?

What are your feelings on teaching sexuality-related practice to student nurses?

Would you like to share some of your experiences of teaching sexuality-related practice with me?

What preparation did you receive to enable you to teach sexuality-related practice?

While interviewing the first participant, other issues arose that were worthy of exploration and these were then included in the interviews with the remaining participants.

What are your feelings on the amount of sexuality content within the programme/curriculum?

Do you think that all nurse educators should teach sexuality within the programme?

Do you teach students how to take a sexual history and/or how to broach the subject of sexuality with clients?

Probing questions were asked to elicit further details or to seek clarification on aspects of the data. Each participant was thanked for their participation and permission was sought to make further contact for clarification during the data analysis phase, if required.

The first interview was a steep learning curve. It did not flow well and in an attempt to promote discussion, I was asking questions which were not related to the data that I was seeking. Interviews with the remaining five participants went well, with some follow up queries to clarify aspects of the data.

The audio-tapes were transcribed by an independent person with experience in medical typing and research data transcribing and a confidentiality contract (Appendix Four) was signed by the typist. The transcribed data was returned both on disk and hard copy. On return of the transcribed data, I listened to each audio-tape for accuracy of the transcription and made minor corrections to the hard copy. The 'corrected' hard copy was offered to each participant to check for accuracy of the data and to delete as they deemed necessary. Three participants declined the offer to view the transcribed data and only one of the three who did view the data, made any changes. In this instance, I gave the participant the disk to make the alterations required. Both the original and altered transcripts were on the returned disk.

Data Analysis

The audio-taped interviews were transcribed to include all pauses in conversation and laughter etc to assist in maintaining the context of the discussion and my words were typed in italics.

During the analysis phase, I began with two copies of the transcript, one for filing purposes and the second to write on. While reading the transcripts, I scrutinised the data carefully and became extraordinarily familiar with the data, deliberately searching for meaning and a deep understanding. What is going on in the data? What are these people telling me? The early phase of qualitative data analysis has been described by Morse and Field (1995) as comprehending. Comprehension is complete when new data does not add much to the description of the phenomenon under study, which in this case had probably occurred by the fifth interview.

Morse and Field (1995) describe the next step of the analysis as synthesis, which involves 'sifting' of the data and putting pieces together. As I became familiar with the data, themes, patterns and variations emerged and these were colour coded into categories for easy identification, for example: a definition, sexuality and nursing, clients and sexuality, sexuality-related practice, educators, students, comfort, discomfort, cultural safety, client assessment and curriculum etc. These categories were initially linked into two broad themes, clinical practice and education. As the analysis progressed, these broad themes merged within the categories and as the analysis further continued, the categories were collapsed and merged into larger and broader categories. It was during this part of the analysis, where I had to refocus on the research questions and remove valuable, but irrelevant data.

As the data was synthesised I began to make some generalised statements about the phenomenon and study participants (Morse & Field, 1995). In other words, I was able to describe concepts in relation to nurse educators and sexuality in nursing education, based on their perceptions and experiences. Examples of these generalised statements include: sexuality is difficult to define, teaching sexuality is related to an educator's clinical experience, educators comfort/discomfort with sexuality will affect the teaching of sexuality, teaching of sexuality is linked to maturity and experience as a teacher and sexuality should be integrated throughout the curriculum/programme. These generalised statements are supported by quotes from the participants in the next chapter.

From the generalized statements from the data and the literature review, links were made between the two. The links from both the data and literature were later developed into a model for practice related to sexuality. The framework of the model is described in Chapter Six.

Limitations and Strengths of the Study

While this study has explored the perceptions and experiences of a group of nurse educators, there are limitations to this study that must be acknowledged. As this research has been undertaken as partial fulfilment of a Masters Degree, time constrictions govern the geographical sites available for obtaining participants. Although there was evidence that saturation of the data was beginning, it would have been helpful to explore the perceptions and experiences of nurse educators from other schools of nursing in New Zealand. Due to the localisation of this study and the number of participants, the interpretations of this research cannot be generalised to other populations of nurse educators. While the results must be viewed with caution, the importance of this research should not be discounted as these results may cause other nurse educators to reflect on their

practice. Consequently, this caution draws attention to the need for further research.

Due to the sensitive nature of sexuality for many people, I was heartened to have a response rate of 50%, however, I am aware that input from those who did not accept my invitation to participate may well have altered the outcomes of this study.

The views of Maori educators are not represented in this study in regard to sexuality, sexuality and the client, sexuality in nursing practice and sexuality in nursing education, which is a significant limitation of any research in the New Zealand setting.

On a positive note, two changes have been implemented as a result of this study. Firstly, sexuality is now included on the nursing care plan teaching/learning document and in one course descriptor. Secondly, during the interview, one participant accepted that she would be making changes in her teaching of sexuality assessment of the client. This participant stated that she will be encouraging a proactive rather than passive approach when discussing client sexuality issues with the students with a view to fostering a generation of nurses who are comfortable discussing sexuality with clients.

How have my personal interests and experiences of sexuality in nursing practice and education influenced this research? Having practiced in the clinical setting for many years and having been one of the many nurses who was not prepared for practice related to sexuality I have contributed to this deficit in nursing care. Now that I teach nursing practice to undergraduate students, I have an opportunity to better prepare students for practice related to sexuality and to facilitate holistic care that clients are entitled to. I am therefore aware that I have a personal, professional and academic agenda, which has shaped this research. However, the focus of this research was to 'explore with an

open mind' the perceptions and experiences of nurse educators, and not necessarily accept what is stated in the literature. It is through this 'exploration' that issues in the literature have been both confirmed and challenged, and also other issues have emerged from the data that have not been identified in the literature. As these patterns emerged, I was constantly reflecting on my own stance, questioning the literature, the data and my own experiences. I therefore believe that my perceptions and experiences have enabled this research, rather than directed this research. Rather, this research has directed me. As a nurse educator, I have implemented changes within my own teaching practice, specifically focusing on sexuality assessment of the client during the general health assessment process.

Summary

This chapter has described the rationale for implementing an exploratory/descriptive research design for this study. The process of this research has been outlined, including how ethical considerations, participants were selected and data analysis was managed. Limitations and strengths of the research have been acknowledged. The following two chapters present the findings and analysis of the data.

Chapter Four

Nurse Educators' Perceptions and Experiences of Practice Related to Sexuality in the Clinical Setting.

Findings and Analysis

Introduction

This chapter will provide insight into a number of nurse educators' perceptions and experiences of sexuality in the clinical setting, and provides the foundation for the next chapter, which explores practice related to sexuality in undergraduate nursing education.

The first step in this data collection process, was to assess the nurse educators' perceptual knowledge and understanding of the term sexuality. The second step was to gauge if they perceived that clients may have alterations to their sexuality and if so, could they describe these perceptions to me. The third step was to establish if the educators perceived a link between altered sexuality of the client and nursing practice, thus completing a loop.

Comments from the participants related to sexuality in nursing practise therefore emerged under the following headings.

- Definition of Sexuality
- Sexuality and the Client
- Nursing Practice Related to Sexuality

Although there was a diverse range of specialty experience and number of years of experience within the clinical setting among the participants,

there were many similarities within their definitions of sexuality, in their descriptions of how client sexuality can be affected by illness/disease, disability and medical interventions, and the implications of these effects for nursing practice. This indicates that despite the varied clinical experiences of the participant, all were aware of sexuality issues for the client outside their own nursing specialty. Coupled with this was consensus on what nursing practice related to sexuality is, or perhaps more accurately, what it could or should be.

At the commencement of each initial interview, the participants were asked what the word sexuality meant to them and as each interview was completed, the words of Rafferty (1995) came to mind. Rafferty states that sexuality means different things to different people and the meaning changes over time depending on external [and internal] influences. Similar trends evolved as each participant described sexuality in their own terms, keywords were identified which illustrate the diverse nature of sexuality, and each participant added an aspect of sexuality that was unique to them.

For the purpose of this study, the six participants chose their own pseudonym and these are Binty, Edith, Fay, Jane, Sunny and Tory.

Definition of Sexuality

Keywords identified: female/male, he/she, feminine/masculine, physical/psyche, gender, identity, sexual expression, sexual preference, sexual practices, body-image, self-concept, behaviour and relationships.

Fay initially gave a succinct description of sexuality and later linked sexuality to other aspects of a person's being.

Sexuality is the sum total of the physical and psyche of the individual ... sexuality is not just the physical body, I mean sex is everything that makes up whether you are a he or a she, but it's

*the psyche that makes up whether you're feminine or masculine
An individual's sexuality is just part of that individual, the same as
their age, their race, their religion and their socio-economic status
.... (Fay)*

Fay described sexual expression as how an individual chooses to express their sexuality and sexual preference, being heterosexual, homosexual, bisexual or asexual. Most participants referred to gender identity or preference when they described sexuality in their own words.

Sunny, on the other hand viewed sexuality from a holistic perspective and she described sexuality from within, her soul.

It means to me everything, my body, how I see my body, how I feel about my body. I guess it's all part of me. I don't think I can isolate it. It's how I am, the way I dress, the way I walk, the way I talk, it's all representative of this word 'sexuality.' ... so it's a mind thing, it's a body thing, it's a spirit thing, I wanted to say it's a soul thing. (Sunny)

Edith also described sexuality from a 'within' perspective and in addition described how a person 'externalises' their sexuality.

It's to do with how somebody sees themselves and understands themselves ... how the body alters ... how I behave and how I would like to be treated ... it's about how you dress and then probably the sorts of things you like to have around you. Maybe the things you like to do, things that you enjoy ... (Edith)

While Binty described sexuality in the third person, she was expressing sexuality in personal terms. At the time of the interview, Binty explained that she was moving through a rediscovery phase within herself, getting in touch with her feminine side, and this is reflected in her quote.

I think sexuality ... it's how or what encompasses a person and I think their sexuality can be part of their personality, I think what drives them in life ... what their sexual preference is, in a person's life, I suppose what role it plays, how they see themselves as a person, what that sexuality means to them as well. (Binty)

For Binty, sexuality is about finding a balance within who you are:

like the ying and yang. (Binty)

Tory presented another multifocal picture.

Sexuality means lots of things. It means your gender, it also means your sexual practices and preferences and it also means your body image ... how you perceive your own sexuality and it's also how you present that in a sexual and gratifying way ... (Tory)

Jane's definition of sexuality was significant as she was the only participant who discussed the influence of society on a person's sexuality.

... Sexuality begins very, very early in our life and it's moulded, I think, mostly by our parents to start with and very, very much by society. We're put in categories from the moment we are born and for the most part we stay in that category of whether you're male or female or what ... (Jane)

Participants agreed that "sex [the sexual act] is only an aspect of sexuality" (Sunny) and sexuality is "not just about bonking" (Edith), "it can be as simple as touching and it can be as complex as intercourse" ...(Jane). Jane further explained that some people confuse reproduction with sexuality and gender, however, while reproduction is a part of sexuality, sexuality is more concerned with self-concept and how we interrelate with other people.

Edith feels that "... *sexuality for some is not 'conscious' but for others it is 'all conscious.'*" In other words, some people have a stronger sexuality focus in their lives than others and for the most part this is not constant. For those who have a stronger sexuality focus than others, this too fluctuates.

According to Jane, sexuality "*is the most normal fundamental thing really ... it is probably the one of the most powerful, maybe tool, ... things in our lives ... it is charged with emotion.*" Jane's words mirror those of Rafferty (1995) "Sexuality is a powerful and emotive [*sic*] subject which belies simple definition" (p. 28).

It is evident from these descriptions and the variety of keywords identified that sexuality can be a difficult subject to define or to find a singular definition. An individual's description of sexuality possibly reflects where sexuality 'fits' for that person at that time in their life. One cannot assume that a person will always describe sexuality in the same way at a different time or place in their life, because sexuality is fluid. This supports Van Ooijen and Charnock's (1995) opinion "that any history or definition of sexuality must be viewed with caution" (p. 26).

For the purpose of this research, it is imperative that sexuality is discussed in context and to facilitate this, either a 'working definition' or a description of sexuality is required and the WHO (2002, p. 2) definition, refer page 11 of this thesis, provides the framework for this study.

Nursing practice related to sexuality includes having knowledge of the impact that illness or disease and/or medical interventions or treatments may have on an individual's (client's) sexuality, and the skills required to assess, address and discuss sexuality issues and concerns with the client.

Sexuality and the Client

Disease Processes and Medical Interventions

When I asked the participants if they thought sexuality related to nursing practice, all participants identified examples of diseases and medical interventions as factors that may affect the sexuality of a client.

... that's the sexuality of the patient and how their condition or illness affects their sexuality ... (Edith)

The list of examples provided by the participants is by no means comprehensive, and I did not seek this at the interview. As discussed earlier, I was seeking a link between a client's sexuality and factors that may affect the sexuality of the client, and then later, if there was a link between alterations to a client's sexuality and nursing practice.

Generally, when people think about alterations to sexuality through disease and medical interventions, surgical removal of organs or body parts are the most obvious and dramatic. They are the common examples that spring to mind. Body-image and self concept issues are affected by the removal of body organs or parts and the most common examples raised by the participants were the removal of the breast (mastectomy) and uterus (hysterectomy), both of which are female defining organs.

... somebody gets their uterus torn out [sic], particularly if they are young, the first thing you'd think about is their ability to reproduce and how that affects you as a female ... I would feel really unwomanly ... and certainly if I lost a breast it would be hugely disfiguring to me because I like my boobs ... that's what makes me a girl ... (Tory)

... a woman losing her breast is part of her sexuality, it's a huge part, because it is part of the female organs, but to lose a finger or thumb is also part of your sexuality, you feel something is not right. It's your body image that is affected ... (Sunny)

As Woods (1987) explains, any alteration in one dimension of a person's sexuality will produce alterations in another dimension, for example, a change in body-image will produce changes in self-concept. In other words, the multi-dimensions of sexuality are interrelated and any single dimensional change will cause changes in a person's total sexuality.

A less dramatic, but very familiar example of an alteration in sexuality is the common cold, was shared by Sunny:

... you have a cold, you have a runny nose ... and somebody has knocked at your front door ... this is part of your sexuality, just not looking good, not feeling good and your neighbour appears and the last thing you want is them to see you the way you are ... (Sunny)

Paralysis following a stroke or trauma was also discussed in relation to clients not being able to meet their own health needs. In nursing practice, a health needs analysis is a problem identification/solving approach that nurses use to assess the client's functional health patterns. Functional health patterns are a sequence of related behaviours that assist nurses in collecting and categorising data about a person's self-care of activities of daily living. These functional health patterns include: health perception-management, nutritional-metabolic, elimination, activity-exercise, sexuality-reproduction, sleep-rest, cognitive-perceptual, role-relationship, self-perception-self-concept, coping-stress and value-belief patterns (Weber & Kelley, 2003).

Like you've got people who have got strokes [sic] and paralysis and things like that, well that's an unmet need, so it needs to be dealt with in the same way. (Jane)

Jane added another dimension that is vital to the client undergoing alterations to their sexuality, particularly alterations to body image. As a nurse:

it's not easy to put yourself in that person's situation. And you don't know how, and I've seen this happen, the partner will react, and I've seen both positive and negative reactions from partners ... (Jane)

The paralysed client following trauma, while not suffering from a disease process, is significantly affected in regard to issues of sexuality.

... family friends of ours, he was cycling in the United States and was hit by a drunk driver, made a paraplegic. Two little children under the age of five, and him and his wife had wanted more children ... (Fay)

Myocardial infarction (M.I.) was discussed by most participants in relation to the client not physically overexerting themselves during the rehabilitation phase of their recovery. Edith added that part of the current education to male clients post M.I. is to use positions during intercourse where less energy is required and the example suggested was for his wife to go on top.

Jane gave an example while teaching students in the ward setting:

... I remember a lady saying, ... her husband had a coronary, he was 44 or something, and she said to me "when will he be able to do the lawns" and it was quite priceless, but I used it as a good example when I later spoke to one of the students ... but underneath it I don't think the lawns were bothering her ... I would

have told the student, that to me was a way that she was saying "look, he's had a heart attack, when is he going to be back to sort of normal with everything. When are we going to be able to resume our life", you know, so sometimes patients will ask you, or say something in a different way and you have to just be cued in sometimes ... (Jane)

From this one client-nurse interaction, two learning opportunities were identified and utilised, for the 'wife' and the student nurses and this incident highlights the need for finely tuned assessment skills. Jane was the only participant who recommended that sexuality education for nurses be addressed in the clinical setting.

... one of your best places to teach it is when it happens. I think sometimes just broaching it cold in a classroom it sometimes doesn't come together ... (Jane)

Medications were also cited as affecting a person's sexuality.

... drugs affect your whole being, sex life or your sexuality. (Sunny)

Antidepressants can decrease the libido of some clients, which accentuates the already decreased libido from depression. Mental health drugs are discussed later in this chapter by Binty in relation to addressing these issues with clients.

Chemotherapy drugs (anti-cancer) were described as altering a client's sexuality in a variety of ways, particularly referring to loss of hair from the body and head.

The extremes that occur with some of the chemotherapy drugs ... huge changes to sexuality and there's your sexual appearance for a start, can actually be changed. (Jane)

To conclude this section on the impact of disease on a client's sexuality, I will use the following quote from Tory.

You know, about sexuality, because there's pretty much not one disease I can think about that your sexuality isn't affected by. When you really think about it, like asthma, have you got the puff to actually engage in sex, ... and you know emphysema and all those respiratory diseases, and then you think cardiac, well the same thing is the exertion on the heart, and then you think abdominal, you know, anybody with irritable bowel syndrome, you know sex could affect the pressure on your gut, arthritis, you know, pain ... I am wondering if that is why old people stop having sex [laughter]. (Tory)

While the last sentence was said in jest, it was genuinely acknowledging that as we age and/or disease processes and/or treatments take over our bodies (and our minds), for some elderly people, a sexual relationship is just too 'difficult.' Alex Comfort (a noted gerontologist, cited in Duffy, 1998)

once said that old people stop having sex for the same reasons they stop riding a bicycle: poor health, fear of appearing ridiculous, or not having a bicycle to ride. The biggest obstacle to sexuality for aging individuals is the lack of a partner, especially for women. (p. 3)

Older Clients

Issues of cultural safety were raised where the nurse's values and beliefs are incongruent with those of the client. Cultural safety, as defined by Nursing Council New Zealand (NCNZ, 2002), is a broad concept which expresses the diversity that exists within cultural groups. These cultural groups can be as diverse as age, social, religious, and gender groups, which are additional to ethnicity.

All participants, either directly or indirectly, expressed concern with the general attitude of many nurses that the older person does not have sexual needs or desires. Fay explains that when she is teaching the care of the elderly course within the programme, she deliberately discusses issues of sexuality related to older clients.

A rest home manager is a guest speaker on the care of the elderly course and she talks to the students about one of their residents who didn't have a relationship with a woman, but masturbated frequently. The rest home arranged for him to place a pot plant outside his door when he is masturbating, to ensure privacy. According to Fay:

... he was being recognised as a human being with sexual needs, being allowed to express his needs, but doing it in private and doing it discretely. (Fay)

The student responses to these discussions ranged from:

"oh, dirty people," through to 'great, let's encourage it, let's facilitate it." (Fay)

This allowed for further discussion and reflection in the classroom which is valuable in an attempt to dispel the myths that the older person does not have sexual needs and feelings. Nurses must be aware that issues of sexuality can be very much be on the older person's agenda.

Sexual Minority Clients

It is clear in the literature (Brogan, 1997; Clear & Carryer, 2001; Morrissey 1996; Ross et al. 2000; Walpin, 1997) that gay and lesbian clients fear negative attitudes from health providers, and as Fay suggests, this should not occur.

If a nurse is homophobic, how will this impact on the care they provide to homosexual or lesbian clients?

For instance, the rampant homophobe, an avowed homophobe will go and request to get away from being assigned 'Miss Brown' who is an open lesbian and who's lesbian girlfriend sits with her and holds her hand and the nurse is disgusted by all this ... She [the nurse] will either request to be removed from caring for the individual ... act in totally substandard nursing care actions ... or act in total indifference and ignore the patient when she wants help in those sorts of issues. (Fay)

Fay suggests that it is okay to be homophobic so long as the nurse recognizes it and take steps to avoid compromising the client's care by asking the nurse manager to remove the client from that nurse's care. However, as Ron Patterson, the Health and Disability Commissioner, stated at a Ministry of Health Forum on Friday 7 May, 2004, in relation to caring for victims of severe acute respiratory syndrome (SARS), firemen do not choose which fire they go to and police do not choose which dark alley they enter. In other words, unless the healthcare professionals' own lives are particularly at risk, they should not be choosing which clients they care for or not care for.

Male Clients

Stories of how male clients 'flaunt' their sexuality were shared.

And I can remember a guy that was in hospital ... for many months. And he would almost be able to have a erection at an opportune moment and do it deliberately, or at least attempt to do it deliberately, when there was a new nurse ... (Jane)

As Tory asked:

... men get erections in ... orthopaedic wards, so what do we do as a nurse? I know in the old days they used to say 'hit it with a spoon,' but I can't imagine us doing that. (Tory)

And another nurse, I remember the first time she was in the ward, a male had an erection, he asked her for a bottle and when she got there with it he said he was having difficulty managing, could she help him. (Jane)

On the other hand, there are clients who feel embarrassed about a nurse having to place their penis in the bottle if they genuinely are not able to manage it and this is going to affect their self-image, their self-concept.

... a man having to urinate post op. [operative] surgery and having some unknown nurse holding his penis into a bottle. (Tory)

Fay who has worked in orthopaedic wards is familiar with the behaviour of young male clients with a fractured femur, 'trussed' in traction for 12 weeks, which was the standard treatment in previous years. Fay describes:

... Rampant hormones running, they see a reasonably attractive nurse ... and they make her life hell, because they can't contemplate life without a kiss, a touch, a fondle for the next six-eight weeks, maybe 12 weeks ... It's the worst thing we can do is to stick a junior nurse into these situations. (Fay)

It is important to acknowledge that not all nurses are female and this behaviour may be quite different with a male nurse. Alternatively, Fay further explained that she has never seen this reaction from female clients who are in traction for 12 weeks.

I have never seen females who also can spend up to 12 weeks in a Thomas splint in traction, I've never seen them react in the same

way. They seem to somehow more accept the situation with magnanimity and not express themselves so voyantly [sic]. (Fay)

A situation that young nurses will remember (usually with acute embarrassment) is when they are required to wash the genitals of a young male who has both hands incapacitated, perhaps following a traumatic injury. Edith recalled the following:

I remember a young man who was about my age who was in a car accident who had both hands, you know [out of action] and we got around that because the girlfriend came and did his cares 'down there.' I remember thinking that would be a hard one to do. He wasn't sick, he was perfectly with it ... but I didn't do it. It was hard. (Edith)

These types of incidents have been described as part of the job, but do we prepare student nurses with strategies in how to deal with them? As Jane explained, she remembers talking to the students about comments and snide remarks that young male clients may make because they are in a nurse's uniform, but

it was almost saying 'oh, you have got to expect that, just deal with it, ... it might happen to you,' but I don't know if we told them how to actually deal with it. (Jane)

Should student nurses be provided with strategies to assist them in these situations? Fay suggests they should because:

... sex/sexuality is very much a part of the interactions that a nursing student and then of course on to being a registered nurse, would have with the patients. (Fay)

In terms of NCNZ Cultural Safety Guidelines (2002), ethnicity was not raised by the participants. It is significant that issues around Maori nurses or clients were not discussed by any of the participants in

relation to clinical practice. As sexuality is influenced by ethnic values and norms, a diverse range of values and norms are presented, for example, how people find partners, who they choose as partners, how they relate to one another, how often they have sex and what they do when they have sex (Crisp & Taylor, 2001), however, there is a lack of ethnic influence reflected in the literature in regards to nursing practice related to sexuality. This is a major limitation, as the views of Maori/Pasifika clients and nurses remain silent.

The complexity of client sexuality is clearly demonstrated by the effect that age, sex/gender, disease/illness and medical interventions have on the client, their behaviour and their relationships with others. In regard to nursing practice, nurses need to be aware of these issues and develop attitudes and communication strategies that effectively deal with situations related to sexuality and client care. It is advisable for health care providers to have an open-ended definition of sexuality in the context of client care (Warner et al., 1999). Fay states that:

the patient/nurse interaction is the key to good or bad nursing practice. So your views [the nurse's views] on sexuality indeed can greatly influence nursing practice. (Fay)

Nursing Practice Related to Sexuality

Nursing practice related to sexuality can be described as nursing practice that relates to any aspect of a client's sexuality, which may or may not be altered through disability, illness, disease and medical interventions. The participants were asked if or how the sexuality of a client relates to nursing practice and the following are examples of the comments.

... I think it affects nursing because there are so many things that actually affect people's body image for a start in nursing, and it can

be simple things as, you know, defaecating yourself in a bed and that can affect your sexuality ... (Tory)

If you are going to nurse somebody, you're nursing the person as a whole, ... this is what they are, sexual beings. ... they're not minus their sexuality because they are coming to a care setting ... (Sunny)

In the same sentence or simultaneously, all participants commented that nurses have neglected sexuality-related nursing practice or failed to incorporate the sexuality aspects of the client into nursing care.

... that is something that is not very well addressed by nurses. (Edith)

I think nursing over the years and nurses over the years, has [sic] neglected perhaps a little of it. (Jane)

... I can't recall really making a big thing about people's sexuality in my clinical practice. (Tory)

Reasons suggested by the participants as to why sexuality is not well addressed in nursing practice revolved around: knowledge and attitudes, discomfort and professional responsibilities:

... there are issues these days that relate to sexuality which ... nursing, practicing people may not be aware of. (Sunny)

... even though I say it might be more embarrassing for the younger ones, it may also be a little bit embarrassing and uncomfortable for the older ones as well. (Binty)

... discomfort on the part of the nurse, it's taboo. (Fay)

... if somebody's sexuality is different from you own. (Edith)

... it used to be the doctor's responsibility to tell them ... [about sexuality issues] it was an 'out' for the nurse really. (Jane)

Of the six participants, it seems that only three have actively discussed sexuality with clients in their nursing practice, two when the issues have been raised by the client and only one, who raised the issue with the client.

Jane addressed sexuality with a client while out on clinical placements with nursing students, as discussed earlier within this chapter, and she shared this as a learning experience with the students.

Edith was a public health nurse who used to visit high schools and talk to fourth formers about:

STDs [sexually transmitted disease] and condoms and family planning ... we did talk about feelings and relationships. (Edith)

Edith has also worked as a health visitor with mothers and babies and she visited them in their own home.

... we would talk about when you have a baby and you're tired and run down and we would talk about their relationship with their partner and heaps of things, and I would talk about getting the mother help with the baby and about doing something for yourself ... we wouldn't talk about sex [sexual act] very much, but sometimes it would come in, but I wouldn't really go into it much about how often you do it, because that's when you are looking at the whole relationship thing. (Edith)

In essence, Edith addressed sexuality with this client in a holistic manner, as there is more to sexuality than the physical act of sex. Edith has discussed relationships, behaviour and self-concept issues, which are all part of a person's sexuality, however, she failed to address

the more intimate aspects of the sexual relationship or the physical act of sex, as she does not feel comfortable discussing this aspect of sexuality.

Binty was the only participant who has actively raised issues of sexuality with clients in the clinical setting, rather than wait for the client to raise issues, and this was particularly in relation to mental health medications. Binty's quote emphasises the importance of raising sexuality issues with clients pertaining to medical interventions.

... other medications also impacted on people's sexual libido. But we would say to them, "can we ask you some personal questions? Are you experiencing any sexual dysfunction?" For women, it was also part of the education, "look, for women, you may find you are going to get breast enlargement and tenderness, maybe weight gain." I had another women who, mood stabilisers, it upset her sexual activity patterns. She was very open anyway but felt quite comfortable coming to me saying "look, this medication is really impacting on my relationship. We're having real problems with it ... (Binty)

Factors Effecting Practice Related to Sexuality

While sexuality-related practice has been identified as a deficit in nursing care, it has also been acknowledged that changes in nursing practice provide less opportunity for nurses to address personal aspects of a client's care with them. Some participants questioned whether nurses have time to sit down and discuss sexuality with the client, particularly in the hospital setting and with shorter lengths of stay.

But are we able to give it the time and how do you bring it into all aspects of nursing? ... In so many areas of nursing we are so focused on achieving the task and it comes back to time. (Binty)

... when people are very, very busy and nowadays we are in a very busy working environment, I don't mean in Nursing Education, I mean we can prepare the students certainly, ... I'm only talking about hospital type things at the moment, I don't know if people have time to give that time to that person [the client]. (Sunny)

Jane explained that nurses are aware of sexuality and the sexual needs of clients when they are hospitalised for long periods of time, 6-8 weeks, however:

... I think now the patients are not in there long enough for us to become too aware of where they are sexually. They don't necessarily miss out on that interaction with their partner or with whoever else, because they are not in there long enough, and because the procedures and things that we do for clients in the hospital, the way they are cared for in the hospital, ... I think for the patient, they are out of hospital so much quicker ... (Jane)

Jane suggested that sexuality issues should be discussed within the discharge planning process, as part of informed consent, right at the beginning; prior to admission to hospital for planned admissions (outpatients) and as early as possible for non-planned admissions.

And now what is happening is the moment they step into a hospital they are talking about discharge planning and I think that to me is the part where it should be in, right at the very beginning. (Jane)

While time has been raised as a potential barrier to addressing issues of sexuality, the participants recognised the importance of practice related to sexuality and that time should be made available to discuss aspects of sexuality with clients.

... there are more and more issues these days that relate to sexuality which ... nursing, practicing people may not be aware of

... you can get so bogged down in looking after people and meeting whatever their needs are that you always forget that there is this aspect of it ... you need to remind yourself continually, that there is this other aspect that this person has brought with them ... as nurses we should be able to explore these issues with the person ... We can't just discharge people, and say yes, these are your things and you will be all right, because there is much more to it. That is one side that we don't talk about. (Sunny)

Despite the fact that nursing practice has changed and the demands on the nurse are far greater, meeting the needs of clients does not alter, whatever they may be. In fact, clients are more aware of their rights as a client and ensuring that their needs are met, than ever before. It is vital that all healthcare professionals comply with informed consent in the consumer rights services outlined by the Health & Disability Commissioner (1996) discussed in Chapter One of this thesis.

Binty explains:

... for clients too, being far more aware of the information that is available for them and being far more aware of their rights, that they have a right to know and you are expected to teach them ... so that they have informed consent about their treatment ... people get on the internet and everything is just so much more readily available and because of that there's this expectation that we have to know it and share it. (Binty)

In order for a nurse to be comfortable addressing issues of sexuality with clients, Fay states that nurses need to have explored their own sexuality.

So if a nurse hasn't undergone that process of self-exploration and examined as part of her own culture her own sexuality and her own beliefs about sexuality, she can't help the patient ... a nurse must

feel comfortable with their own sexuality before attempting to discuss these issues with patients. (Fay)

From the perspective of a nurse who has broached sexuality issues with clients Binty supported Fay's statement.

... I feel more comfortable about it and being in tune, I suppose it very much reflects on me being in tune with who I am ... (Binty)

Jane also makes a supporting statement.

... if you appear to be embarrassed then you are probably perhaps a little bit self conscious about your own sexuality and if you deal with your own sexuality, well I think you can get over that embarrassment. (Jane)

With the introduction of cultural safety guidelines into the nursing curriculum by NCNZ (2002), all students should be provided with the opportunity for self-exploration to examine their own values and beliefs. It is therefore the responsibility of undergraduate education to ensure that these opportunities are available to students. While time has specifically been assigned for exploring ethnicity within the cultural safety guideline framework, it is questionable whether the same time has been set aside for exploring sexuality and if not, this needs to be rectified.

Summary

This chapter has explored the nurse educators' perceptions and experiences of sexuality in nursing practice in the clinical setting. The data was presented under three categories, however, it must be acknowledged that there is an overlap between these categories.

- Definition of Sexuality
- Sexuality and the Client
- Nursing Practice Related to Sexuality

Within these three categories, the foundation knowledge and attitudes toward sexuality in nursing education was established. Sexuality was well described by the participants, collectively, providing a full and rich portrayal of the word. Individually, their knowledge base of sexuality is both broad, yet specific in some parts. The diverse range of clinical experience and expertise of the participants provided similar descriptions of how client sexuality can be affected, as were their perceptions of what nursing practice related to sexuality is or could or should be. Links were identified between sexuality, altered client sexuality and the role of the nurse, thus forming a loop. Without these links, a connection with sexuality in nursing education would be difficult and this would have been cause for concern.

Consequently, this chapter provides the foundation for the next, which explores the nurse educator's perceptions and experiences of practice related to sexuality in undergraduate nursing education. The information in this chapter is not the major focus of this research, but is a foundational part of the evidence.

Chapter Five

Nurse Educators' Perceptions and Experiences of Practice Related to Sexuality in Undergraduate Nursing Education

Findings and Analysis

Introduction

Analysis of the interview transcripts has provided insight into the world of a small number of nurse educators and provides an understanding of their perceptions and experiences of practice related to sexuality in undergraduate nursing education. Having established a nurse educator loop in Chapter Four, a further link is required between the loop and practice related to sexuality in undergraduate nursing education.

The diverse range of specialty experience and years of experience both in clinical practice and nursing education amongst the participants is more evident in this chapter. While many similarities were identified, some differences also became clear.

Comments related to sexuality in nursing education are discussed under headings similar to those in the literature review:

- Knowledge and Attitudes
- Comfort, Discomfort and Embarrassment
- Curriculum/Programme Content
- Sexuality Assessment of the Client

Knowledge and Attitudes

All nurse educators first complete undergraduate nursing education and practise as registered nurses. They then move into a teaching position (having completed a Degree at Master's level) in a tertiary institute where they receive 'teaching' education if they have not had previous teaching experience. However, nurse educators are not taught how to teach a specific subject. When I asked participants what preparation had they had for the role, most educators acknowledged that sexuality was not covered in their own nursing education.

... it certainly wasn't covered in my training. (Edith)

I don't remember it being taught. (Binty)

I don't think I was taught it as a student ... (Jane)

None of the participants considered that they were formally prepared for teaching sexuality in nursing education. They rely on clinical and life experiences.

... it really depends on what people have done in their role as registered nurses and probably what has happened to them in their education ... (Edith)

I haven't had any formal training to teach it ... just the life experiences of an RN [registered nurse], what you've picked up from work ... I've gone to inservices and stuff [sic], but I wouldn't say I've had any formal training. (Tory)

Others gained their knowledge through:

... life experiences ... my own readings and my own resource material It's no secret that I have dealt with major issues of sexuality in my life ... I believe I can pass on sound knowledge to

the students I possibly tend to raise issues of sexual preference more than other tutors. (Fay)

Fay is suggesting that personal issues of sexuality provide her with the vehicle to pass on sound knowledge and this is discussed further in Chapter Six.

Tory was the only participant who felt that teaching sexuality from life experiences or experiences as a registered nurse could have a negative influence within nursing education. Tory suggested that if an educator is uncomfortable with issues of sexuality, this discomfort could be reflected in the nursing education provided by that educator.

... life experiences ... what you've picked up from work ... I mean that in itself could be problematic because if you, as an RN felt really uncomfortable and people do feel uncomfortable about those issues, and then you come into education you are going to carry that with you into education. (Tory)

Ramifications of educator discomfort are discussed later in this chapter.

As well as teaching from life experiences, Fay had attended a seminar where sexuality was included.

I went to a weekend seminar at the Burwood Spinal Unit and one of the sessions was on sexuality in the spinal patient and nobody went, there was only two of us were present. (Fay)

This lack of attendance at an educational seminar related to sexuality and the spinal client is of grave concern. This provides an insight into the attitude of some practising nurses, that sexuality issues are not perceived as a basic human need or part of the role of the nurse to be concerned with or embarrassment is too great. This was identified in a summary of the literature by Kautz et al., (1990).

One educator did acknowledge that new educators may not include sexuality in the courses that they teach.

... for a new tutor that is coming in they may not think that widely
... (Jane)

Binty, as a new educator, confirms this.

It is there [sexuality], but I guess not actually realising that it is there or that I actually take it to that depth. ... I know for myself with teaching at the moment it's like you're flat out trying to cover the basics over time, ... becoming more aware that there is [sic] elements, there is scope for it to come in ... (Binty)

Jane added that perhaps awareness of sexuality issues should be raised with new educators, but currently this is not happening. Essentially, none of the educators considered that they have been formally prepared for teaching sexuality in nursing education, but they have prepared themselves through life experiences, their experience as a registered nurse and reading the literature. However, is the employing organization required to take some responsibility in preparing educators for their role to teach practice related to sexuality in order to promote holistic client care?

When participants were teaching aspects of sexuality in the classroom, they were applying experiential knowledge from clinical practice, life experiences and readings from the literature.

Educators seem to be more comfortable teaching sexuality within the same context as their clinical experience.

... just like any other comfort zone ... it goes with your knowledge, with your job and your expertise ... (Edith)

Fay, who has experience in elderly rehabilitation units, raises issues of sexuality and the older person with the students.

... I deal with attitudes to aging. I will deliberately raise the issue of sex, why shouldn't an 80 year old couple have sex, and how would you help them deal with the issues? Don't you know that there are creams and stuff around that will help vaginal dryness?
(Fay)

Tory has a background in surgical nursing and teaching the medical/surgical course, includes the following sexuality issues when teaching in the classroom.

We talk about mastectomy ... about how a woman might actually grieve for the loss of her breast because that's part of her image and what makes her a female. Or a hysterectomy, like women actually grieve for the loss of their uterus because now they are no longer perceived as a person who can make a baby, which is all part of that gender of being female We talk about testicular cancer and I'll reinforce how important it is for a male to actually do self-examination whereas a female it's promoted so heavily with the breast examination, but testicular examination isn't promoted a lot. (Tory)

Tory also explained, that when teaching outside of her clinical expertise, she prefers to invite guest speakers. One example that she gave.

I don't feel skilled to give credit to talk about ... purely sexual health issues like gonorrhea ... I don't feel qualified to actually teach that or have the knowledge to. I'm sure I could read a book and figure it out, but I would prefer to get somebody from the Sexual Health Centre to teach it ... I would feel a bit fake if I stood up there and started talking about gonorrhoea and syphilis ... I've

never seen them ... I don't know what the current practices are.
(Tory)

On the other hand, Edith's background in health promotion as a public health nurse, where she used to visit boy's secondary schools and talk to fourteen year olds about sexual health issues, provides her with the knowledge, skills and degree of comfort to teach 'sexual health' within undergraduate nursing education.

When I'm talking to the class, I can do the talking about STD's and condom and all that, that's sort of health promotion ... (Edith)

However:

I can make it easy by saying "this is sexuality and this is the types of gender that you can have" ... you will come across all different people in different relationships ... that's easier than when you have got one person and you are told "this is Janice and she is having a total hysterectomy and she is having her vagina removed as well and how are you going to ..." because that's a personal thing then.
(Edith)

This aspect of nursing is outside Edith's scope of practice and 'comfort zone' and she does not feel comfortable teaching it.

... I mean I haven't done a lot of nursing in a hospital [setting].
(Edith)

As Tory summarises:

Like I'm thinking back in my clinical practice which all leads back to what you're comfortable with ... what you actually feel comfortable teaching ... (Tory)

Others felt that age, maturity and years of experience teaching in the classroom gave them the confidence and degree of comfort to teach sexuality to nursing students, which is discussed in the next section.

Comfort, Discomfort and Embarrassment

Comfort

When I asked the participants how they felt about teaching sexuality-related issues in nursing education, the responses were:

I don't have a problem with them. (Sunny)

Oh for me it's a win, win situation ... it puts me in front of them and doesn't allow them any room for innuendo, gossip, lies, general talking. The facts have been put in front of them. I'm not denying them, they can't deny them and therefore there is nothing to talk about. (Fay)

...it's never bothered me. I am really quite open about it. I have been with my own family and don't feel uncomfortable talking to students. (Jane)

I really don't think that I'm uncomfortable with sexuality and talking about sex ...I think I'm OK doing it, I'm a bit 'out there' ... (Tory)

Two educators suggested that maturity and experience in teaching were factors that have reduced their discomfort and have provided them with confidence to teach sexuality-related practice.

I think it must be an age thing ... and experience ... (Sunny)

Binty, as a new tutor supports the above

I think maturity certainly helps ... maturity and experience. (Binty)

There was general consensus that all educators should be teaching issues of sexuality in relation to client care within nursing education and that they should feel comfortable in this role. However, some opinions on this were stronger than others.

I think we should all be involved with it and probably comfortable with it. I think there is a connection with cultural safety [as defined by NCNZ] and I think we should all teach that. If people feel "I am not comfortable with that" then they have to overcome it and appear ... [comfortable/confident] ... [educators] know what is appropriate and what is expected of them ... (Edith)

I would wonder, "why are we there?" if we're not able to cover those sort of things, because it's life. (Binty)

Sunny was divided on this issue.

There's one part of me that says yes, we should be able to, but there's the other part of me that says, there will always be people who won't be comfortable with that area of discussion ... culturally it's not the right thing to do. (Sunny)

Will educators of a cultural or religious background where sexuality may be viewed as 'taboo' for open discussion, elect not teach this area of nursing education?

It was suggested that if the educator is more comfortable teaching sexuality, it will be taught more widely and in more depth, and the students will discuss the topic more freely.

... there will be some people [tutors] that will be more comfortable and will choose to do more. (Edith)

I'm sure there will be tutors that some students will be far more comfortable discussing issues of sexuality with ... (Fay)

Whilst areas of comfort were discussed by the participants, so too were areas of discomfort and embarrassment.

Discomfort and Embarrassment

Areas of discomfort and embarrassment were discussed by some educators when teaching sexuality to student nurses.

I still believe some tutors would have some difficulty talking about it ... if you appear to be embarrassed then you are perhaps a little bit self conscious about your own sexuality and if you deal with your own sexuality well, I think you can then get over that embarrassment. (Jane)

If people are not comfortable in their own sexuality and their own expression of their own sexuality, they are not comfortable talking about it with other people. (Fay)

Edith felt that even the word 'sexuality' itself can cause discomfort for some people which creates an 'issue' of sexuality before any discussion has taken place.

... maybe it's the word sexuality which makes it sound such a big deal. (Edith)

As a consequence, in order to teach sexuality in nursing education, it was suggested by Sunny and Edith that the students require a 'working definition' of sexuality so that the educators are clear about the content being delivered.

You need to know what the word sexuality means ... you can deliver the material and be 'matter of fact' about it. (Sunny)

... that's the kind of typical thing about sexuality ... as nurse educators, is reduce the type of ...[be specific] bring it down to a manageable level which is no big deal. (Edith)

While Fay expressed that teaching sexuality to students has benefits to both her and the students, she did add:

The only time I get a little wary is if questions become personal. "Are you married now?" No. "Are you in a relationship?" Yes ... Then my question would be "is that really any of your business? Am I asking you about your private life?" I think some things are personal and should remain there and I've never had any problems with that attitude. (Fay)

There was only one participant who expressed discomfort in teaching a particular area of sexuality and this feeling came through several times throughout the interview, despite establishing that there would be few situations in the clinical setting where this information would be required.

... I'm thinking that you are saying ... we should be talking about how often you should be doing it ... [the sexual act]. (Edith)

Cultural issues, as defined by NCNZ (2002) in the literature review, can influence the level of comfort that an educators feels while teaching sexuality. The two following quotes relate to ethnicity.

... I have had a student in my class who has come from my own background ... but culturally I would have not talked about that type of thing. I suddenly became aware of the cultural issues, the boundary issues because there was a male from my own ethnic background and that was quite challenging. I remember thinking "I have to do this, I have to just remember he is a student and move on." (Sunny)

Yeah, talking about Maori too, I think that older Maori women, I think they have been brought up to be coy about talking about sex ... so I am mindful of that. With them I am not willing to say too much. Although on the other hand, I suppose, they should be being, rather than protecting their tender attitude or whatever it is, maybe they should be hardened up. (Edith)

Throughout all of the interviews, this was the only time that Maori issues were raised. While others may have considered Maori issues and sexuality from a Maori educator's point of view, from a Maori student's point of view, or from a Maori client's point of view, it was only on this occasion that Maori was discussed. This is somewhat surprising given the courses that some of these participants teach, particularly the cultural safety courses and also the slight increase in the number of Maori students. Perhaps with the participants being non-Maori, they did not feel it was appropriate to speak on behalf of Maori and this was not an issue that I pursued any further.

Edith uses the following techniques as a 'safety net' to avoid offending when teaching sexual identity and sexual orientation issues.

I always assumed that there is somebody in my class who is lesbian or gay, because of what I know about the statistics and the population and so I am always quite mindful of that. (Edith)

Several participants expressed concern, that if the educator is uncomfortable teaching issues of sexuality, aspects of sexuality related to client care will be trivialised or lost completely.

If you can't stand up there and confidently talk about a sensitive topic like sexuality and make it a matter of fact everyday thing, then you will lose the group definitely ... (Sunny)

You know, if you're embarrassed about it you won't teach it or don't teach it well ... if I was embarrassed about something I'd just get over it, or just say, "read it up in the book," like I would fob it off, let them do it, I wouldn't be teaching it if I was really embarrassed about it ... people don't talk about things they are embarrassed about, or they do it in a blasé way that the importance is not given to it. (Tory)

... so as educators, I have to be honest, even I have skipped the area ... (Sunny)

Effects of Nurse Educator Discomfort

If students perceive discomfort or reluctance from the educator in talking about issues of sexuality, this will affect the dynamics and discussion in the classroom. The attitude of the educator could negatively influence the attitude of the students.

I think you would have some students that would raise it [sexuality] just to see what the reaction was going to be, but I think others though they would avoid, I mean, they would sense that the tutor is uncomfortable and they may 'shut down' and opportunities for discussion will not develop. If I was a student and the tutor was uncomfortable with the topic, I would avoid any discussion. (Binty)

Fay has experienced situations described by Binty, where the educator has demonstrated embarrassment and the students have avoided questions and discussion, but she has also had the following experience.

... I have also equally had experience, not in the role of sexuality, where the tutor has been embarrassed at a question asked by the student and the student has just deliberately kept pushing it and kept expanding it and getting the tutor more uptight. I've had to step in and protect them. (Fay)

Sunny shared an awkward and embarrassing incident that occurred while she was teaching sexuality in the classroom

I had a man in the classroom, and it was his body language. I am going back a few years. He was sitting absolutely laid back with legs wide open and I'm talking away and he was right in front of me and that was a time I felt most uncomfortable. Nothing he said, it was just his whole body and I had to keep looking into different directions. I'd ignore that side of the classroom because I think it was becoming a little ... I don't think it was threatening in a way, but it was just all the silent messages that were there with his whole body ... but now it wouldn't worry me ... I think he was getting the word sexuality muddled up with sex and it just wasn't going to be like that. (Sunny)

Sunny's comment confirms why both the educator and the student require a clear understanding of what sexuality is prior to any in depth discussion around it. These situations are challenging examples to the educator and it is likely that the skills and expertise, rather than the knowledge of the teacher, are being 'tested' by the students. As Sunny explained, this situation would not bother her now, as teaching experience has given her confidence and comfort when discussing issues of sexuality.

Other participants suggested that if an educator is uncomfortable teaching sexuality or particular aspects of sexuality, then another educator should deliver the sexuality content of the course. Rather than not do justice to the subject, this would enable the educator to remain safe and ensure that sexuality is taught well and not 'skipped over.'

Well, if they recognise that and they say to the Head of Department or the Programme Director, "look I'm happy to be responsible for this paper, but I don't wish to deliver this aspect of it" that's the

honesty which comes with self reflection and it's better they do that than not doing justice to the subject. No matter what the subject is. (Fay)

I suppose for some people they would feel more comfortable about it than others, and I suppose it's how can we help to work around that? Or is it going to be that if it is coming into the curriculum are you going to see some people stepping back and saying, no I'm not able to go there, and others stepping forward saying, it's OK we can pick it up and run with it. And that's OK ... Because that way hopefully it is done well, than done badly or skipped. And I would rather see it done well with those that feel comfortable with it and that are supported to actually teach that and feel OK about that. (Binty)

Jane, however, has a differing opinion.

Well, if they came into teaching they have to understand that we are teaching students that are going to deal with everybody in the community and they have to deal with this ... It's this age-old thing of whether the nurse should be entitled to say "no, I don't want to care for people" in some, perhaps related to termination of pregnancy or something. (Jane)

The three words comfort, discomfort and embarrassment, were used by the participants to express different feelings while teaching sexuality related issues to nursing students. The participants identified factors that contributed to these feelings, for example, teaching outside of their own clinical expertise, age and maturity, experience in teaching and teaching 'personal' aspects of sexuality. Any discomfort that an educator has can be detrimental to the learning for the student, and the alternative of bringing in another educator was offered if an educator is uncomfortable teaching sexuality.

As educators, most of us have areas within our courses that others have greater comfort and expertise in, and we invite them in to deliver that part of the course, on our behalf. Although, this is acceptable for the planned teaching of sexuality, what is to happen when the subject is raised spontaneously in the classroom? For me, these situations occur often enough, whereby it is a requirement that I am both knowledgeable and comfortable with this area of discussion.

Curriculum/Programme Content

Integration of Sexuality within the Programme

Participants were unanimous that sexuality should be taught within the undergraduate nursing curriculum. The following participants explained.

Nurses need to learn about sexuality just as they do any other aspect of nursing and that is through education. (Edith)

I think it needs to be treated as a client need we should be teaching it. It doesn't need to be anything bigger than anything else. But it should be as important as everything else. (Jane)

All educators felt sexuality should be integrated into every course within the programme.

... it would have to be woven through like cultural safety is ... (Edith)

... you can't deal with it in isolation ... (Sunny)

Sexuality per se should not be stand alone. It should be integrated in the whole concept of cultural safety where an individual's sexuality is just part of that individual, the same as their age, their race, their religion and those issues, their socio-economic status and those sort of things, getting a more complex holistic look at our individual patient ... (Fay)

... it is something like communication. It has to be weaved [sic] right through the whole thing, like culture, ... It has to be built in, it must not be left to drop, it is being done in that paper, in that course, so I don't have to worry about it ... (Sunny)

As well as integrating sexuality within all of the courses, it was suggested that the actual teaching of sexuality should focus on 'normalising' it and making sexuality part of our everyday life.

I definitely think it needs to be integrated because if you want to make this 'normal' it needs to be done within the context of the subject ... to have a course that talks about sexuality, it makes it almost abnormal. It doesn't make it part of our day-to-day stuff. (Tory)

It doesn't need to be any bigger than anything else, but it should be as important as anything else (Jane)

It was suggested by several participants that the integration of sexuality be introduced in the first year of the programme to link in with communication skills and assessing client needs.

I think it is one of those topics ... like communication, it has to go right through ... From year one ... (Sunny)

... the first module I guess, communication and I'm sure it fits there. That would be the first year and woven through. (Edith)

... probably started in year one really when you are looking at the needs [of the client] ... (Jane)

Visibility of Sexuality within the Programme

Some participants were unsure of where sexuality was included within the programme/curriculum, they were only aware of where they

themselves taught sexuality. This highlights the low profile that sexuality has within this Bachelor of Nursing Programme.

Well I don't know if it is within the curriculum ... I can only talk to you about where I was with the different things because I am not sure if the thread is carried right though. (Sunny)

I don't think I can comment on that because I honestly don't know the content of some of the other papers that are taught ... my direct involvement really comes down to the cultural safety element where I teach across the three years ... (Fay)

I think at the moment it is limited. I may be a bit unfair because I don't see or hear what you teach. (Jane)

Jane and Tory challenged the visibility of sexuality within the programme/curriculum, it is not in the course descriptors, learning outcomes or course content, for example:

... it is not as a word in the new curriculum, sexuality, actually, in fact it will be in the delivery, it should be, just the same as spirituality is not terribly evident in our course descriptors, but it will be in the delivery of it ... (Jane)

As this programme is reviewing the documentation, sexuality has since been included in one course descriptor.

Tory, who discusses sexuality in more depth than other educators, stated that sexuality is not written in her lecture notes and she would have difficulty proving that she actually addresses sexuality in the course. However, when questioned further, she conceded that sexuality is evident in the assessment of the course.

... if you look in my course content, that would not be obvious, and it's almost like a hidden agenda, you say you do it, but if I had to

prove it to you I actually don't even think it's written in my lecture notes, it's something I just verbalise. So my proof would have to be asking some of the students whether they can actually recall that and chances are they probably don't ... Sexuality is not written in the learning outcomes ... (Tory)

Interviewer - In some of your assessments?

Yeah. It is in my assessment because one of my assessments is on breast cancer and we talk about what sort of issues, and the answers have to be the body image issues, the sexuality issues, those sort of things. (Tory)

Binty felt that the amount of sexuality taught in each course would be at the discretion of the educators because sexuality is not necessarily 'governed' by the curriculum.

I honestly don't know if it does [get taught] within the curriculum unless the tutor chooses to do so. You know, because of their experiences and of who they are and who they represent for themselves in life that they actually choose to bring that in, and that's their choice, and not because we are actually being governed and told to do so. I think it actually comes from personal preference ... (Binty)

When talking about sexuality during the interviews, five of the participants referred to cultural safety as defined by NCNZ (2002). Fay explains:

I believe Nursing Council have got it right in splitting race and ethnicity out and just making it part of the cultural safety syllabus ... if one looks at the 2002 guidelines for the teaching of cultural safety, it is interesting to note that race and ethnicity are way down at about five and six in the classifications of what can be deemed a

culture, and in fact sex and expressions of sexuality come much higher. Sex and gender issues are up at around about two or three in the Nursing Council definitions. It comes before ethnicity and race. And I very, very strongly support the Nursing Council in this ... (Fay)

Yet sexuality has a lower priority and visibility in the programme than ethnicity. Fay further explains that students are required:

to under go that NCNZ defined process of self-exploration so that she [sic] is aware of her own values and beliefs about her own sexuality, or his own sexuality, about what she thinks of other sexual behaviours. (Fay)

It is therefore the responsibility of undergraduate education to ensure that these opportunities for discussion are available to students. However, in the evidence that follows, time issues were identified as factors that impact on the quantity and quality of sexuality taught within the courses.

Several participants felt that lack of time was a factor affecting their focus on sexuality within their courses.

I would like to have more time with it ... we don't give enough hours to that area of study ... (Sunny)

... being able to work within the time constraints I could bring more of that into it. (Binty)

... I have sexual health ... in my paper ... , but it's probably the first thing I sacrifice if I am running out of time ... if I'm pushed for time ... cardiovascular disease and musculoskeletal disease take priority over sexual health, over sexually transmitted disease ... (Tory)

"Indeed nurses can readily identify with the medical student outburst quoted by Moore (1978) 'we get taught a hell of a lot about gastrointestinal function, but we get taught damn all about sexual functioning' (cited in Keane, 1982, p. 81), particularly as some nurses assume that clients with illness have more important priorities than issues of sexuality (Warner et al., 1999).

The most significant finding identified from the data analysis is that there is one area of practice related to sexuality that is taught poorly, or not taught at all. This area is sexuality assessment of the client. While all the participants acknowledged that issues of sexuality should be integrated throughout the nursing programme, sexuality assessment has not been included.

Sexuality Assessment of the Client

Students are first taught client assessment skills in the first year, where they are taught the nursing process – assessment, nursing diagnosis, planning, implementation and evaluation of care. It was unanimous that when teaching assessment of the client to student nurses, the sexuality section is inadequately taught. In fact, the word sexuality is not written on the nursing care plan (teaching/learning assessment tool). While self-concept and reproduction are included on the nursing care plan, sexuality itself does not have its own entity. According to Edith:

We used to have it ... but it was changed to reproduction. (Edith)

When I asked Edith why the wording was changed, Edith did not know why.

The first nursing care plan that students write is for an older person in the rest home setting, and in previous years, 'not applicable' was written in the reproductive section.

That's right, because under reproduction it used to be not applicable. ... I used to say to them, ... it's not that it's not applicable, there are things that they still have ... the anatomy side and the physiology side of things. Rather than look at it from a sexual side of things ... we would go through and say, "are there any discharges" but we never looked at it from a sexuality point of view ... the word reproduction indicated purely the physical aspects. (Sunny)

Other comments made in the reproductive section were:

... whether they were married or not, or never married and they write how many children they have had, if they were women, that's all I have seen them doing. (Edith)

Reproduction is there, but you see, people often think reproduction, they don't think sexuality. It's not the same thing. Your reproduction and how that's affected as in needs etc, to me is different than sexuality. So, self concept, it may be in there, but it only is the nurse that has got the 'nause' and realises that that might be where it is, it's the only place I think on the care plan where it could be addressed. (Jane)

I asked participants if they had ever taught the students how to take a sexuality history.

No. I would be honest about that ... I don't think so ... great emphasis is placed on the physical, getting that person better physically and what they have to do for that person physically, and I honestly don't think we give enough emphasis on the other things. (Sunny)

I don't teach things like that ... (laughter) ... I have taught those subjects a long time ago and I don't think I would have eluded to it at all, probably. (Edith)

Of the six participants, only three have discussed issues of sexuality with clients and Binty is the only one who has broached sexuality issues with clients. This may be a factor contributing to the lack of sexuality assessment within this nursing programme due to the link between the clinical practice of the educator and what is taught in the classroom by that educator.

Student Nurses' Role in Sexuality Assessment

While all participants agreed that client-related sexuality issues should be taught within the curriculum, there were differing views on whether students should be undertaking sexuality assessment of the client. Edith and Fay suggested that sexuality assessment of the client was not necessarily the role of the student nurse. Edith stated the following:

If I was having treatment for cancer [hysterectomy] I don't know whether I would particularly want a student nurse coming up and telling [sic] me about my sexuality. And that's quite interesting because me saying, student nurse and maybe that's something that comes with a more experienced nurse ... Probably because of the deep personal communication. (Edith)

I would probably want them to be focusing on getting on with the job and using good nursing skills ... you want somebody that knows what they are doing. (Edith)

And I think that sometimes ... if somebody asks a question that's quite good because it means they want to talk about it ... you can't really force it on some people. When you are talking about sexuality, then they might be a very private person. (Edith)

Interviewer – How would you know if they wanted to talk about it?

You would probably approach it and then probably you would get non-verbal feedback. (Edith)

... I think how do you ask those questions and how do you respond to their questions and how do you elicit that it is the right time and the right place is really important. And I don't think we are doing that. And as I said earlier, maybe you want a more experienced nurse (muddled) not the students' role. But it would be if the students were prepared for it. (Edith)

Again, effective client assessment skills are imperative, however, if students have not practised these skills in undergraduate nursing education, when and how do they learn them?

Fay who agrees that the students are not prepared for raising sexuality issues with clients, and who does not teach students how to take a assess a client's sexuality needs, made the following response.

No we do not teach them that. Students shouldn't be asking patients those questions ... they are also private questions and if the patient wants to know, they will ask. (Fay)

... the only time I referred to it was when you're admitting a patient and they are obviously gay or homosexual, it's important to know that, because we can get the problems of families, particularly with gay men, who haven't told their families ... (Fay)

Both participants felt that whilst this is the role of the 'experienced' nurse, it is not the role of a student nurse. During this part of both discussions, it would have been interesting to challenge both participants, but as interviewing participants is an information gathering exercise, I felt unable to pursue the matter further. These were their personal/professional views and I felt to pursue the matter may be felt

as challenging their opinions and therefore the discussion did not go into any further depth.

While Binty did not suggest that students should not be addressing aspects of sexuality with clients, she herself did not address sexuality issues in the early years of her clinical practice, she felt that she lacked preparation and maturity for that role.

... it's certainly not something that I ... would have felt comfortable going there at the beginning of my practice. I don't remember going into that area ... talking to patients about it. I don't think I was prepared for it. I don't think I had the maturity for it either.
(Binty)

Binty further suggested that clients assess a nurse's maturity and experience before sharing personal information about themselves.

... clients very much still look at ... someone's maturity and experience ... I think if you have someone that is obviously young, they gauge by the questions you are asking and how you engage with them and how you establish relationships ... I don't think clients would disclose such personal information to a very young person, unless it was obvious that they are mature for their age.
(Binty)

From the comments of these three participants, it seems that 'student nurse' is synonymous with 'young' and these views have been supported in the literature (Crumlish, 2004; Van Ooijen & Charnock, 1994). However, the majority of our students are not young school leavers. Many of our students are mature, with many life experiences to contribute to their nursing career. From my experience, a client will disclose personal information to a nurse that they feel comfortable with and this is not necessarily governed by age, maturity or experience. It

is whether the nurse exhibits competence and confidence in her/his role in regard to knowledge, attitudes and including communication skills.

Lack of Client Sexuality Assessment in the Programme

Of the educators who teach or have previously taught students how to perform a health assessment of the client, some do discuss aspects of sexuality with the students, but none of the educators teach the students 'how to broach the subject of sexuality with the client.' All teaching of client sexuality issues assumes that the client will raise the subject or ask questions of the nurse. In fact, the participants were unaware that the literature strongly suggests that clients prefer healthcare professionals to raise issues of sexuality with them (Cort, 1998; Crisp & Taylor, 2001; Gamel et al., 1993; Steinke, 2000; Waterhouse, 1996; Weston, 1993), just as I was, until undertaking this literature review.

I don't think we prepare them, full stop ... I am only talking about from my experience. (Sunny)

We are probably missing how to raise the subject with the client. I remember teaching sexuality a long time ago, before the courses came in to the Institute, but it was more to say "this could be bothering the person", or "this could be interfering with their process", not so much "what are we going to do about it" or "what we can do about it". And that was all, it was just telling them [the student] that sexuality is a need ... (Jane)

We don't actually teach them very well how to elicit information from them, you know, and that's not an easy thing to do either, to actually teach What you do say is, one of the most important skills of a nurse is observation skills ... And that's verbal as well as visual observation. (Jane)

With regards to mental health.

... I think even when the students are out on clinicals, even in their general assessment, and say in interactions with clients, they're still not going to that depth. And I honestly don't know even if it does go into that depth in say their theory when you're looking at medications, implications of nursing education [for the client], I've never seen that come up in their work books about sexuality or looking at the impact of someone's sexuality with whatever medication they are taking. I've never had it raised as a question with me about what is the impact, so maybe it is something that we are missing in our curriculum. (Binty)

Within the medical/surgical course.

I probably don't teach them so much to ask the questions about it, I more teach them to inform them that it could be an issue I don't think I actually teach the students to sit down and say "look, it might affect your libido." What I do say is that you need to be aware that the person who has had a myocardial infarct. [infarction] is going to ask you stuff about ... I take the more passive approach rather than ... Because as I say they may ask you stuff about, you know, can I actually engage in sexual activity or will I kark [sic] it? Will this extra work and stress on my heart be the undoing of me? So I probably teach them, yeah, we're quite reflective now. It's not that approach of you go and ask them, if they want to know about it they'll ask you, which is a stand back approach to education. (Tory)

It was during this part of this interview that I turned the audiotape off. Both Tory and I became very reflective in relation to our teaching practice and the moment was extremely intense, overwhelming and emotional. Tory had thought that she was addressing sexuality issues with the students really well, but on reflection during our discussion, we

both acknowledged that we were both taking a passive approach toward the client instead of being proactive and preparing students to broach sexuality with them. Tory summarised our discussion as follows.

... I say to students, the patient may ask you about can they have sex and this is how you answer. In reality what would be more productive is for me to say you need to broach it with the patient. But I don't do that. I don't do that. (Tory)

Interviewer - Is there any reason for that?

I have no idea ... I really don't know because I'm sort of thinking now ... Whether it's not that I've given it that much value before, that's a concern it probably is that I haven't really thought about it because I haven't actually been confronted with it ... But this has been really reflective, because I thought that I was really ... Integrated the thing [sexuality] and felt really comfortable about it and not going on about it, but in reality when I think about it I don't put a big enough emphasis on it, you know, about sexuality, because there's pretty much not one disease I can think about that your sexuality isn't affected by. (Tory)

I think if we did it, [teach sexuality assessment] if we did it completely well, we create a generation of nurses who are comfortable with it. You know, I imagine the influences that we have. (Tory)

My interview with Tory is summarised in her own words.

I've really enjoyed it and I do think the thing I'm going to go away with is actually re-looking at what I do teach. Or not so much what I do teach but how I teach it, the context that I put it in. For me, because I just think that whilst I believe I integrate it in areas that I am clinically au fait with I am probably not bringing it in, in a way

that is influential, I don't think I'm putting as much emphasis as I could. So this is something I will certainly be addressing this semester ... so that will be great. (Tory)

Summary

This chapter has provided insight into the world of a small number of nurse educators in order to gain an understanding of their perceptions and experiences of practice related to sexuality in nursing education.

The diverse range of specialty experience and years of experience both in clinical practice and nursing education among the participants is evident in this chapter. Commonalities amongst the perceptions of the nurse educators have been explored, including the lack of formal preparation for teaching sexuality in undergraduate nursing education and factors that affect the level of comfort or discomfort when teaching sexuality to nursing students. Sexuality and cultural safety (as defined by NCNZ, 2002) have been a linking thread throughout. There was consensus that sexuality in undergraduate nursing education should be integrated and time issues were raised as a factor influencing the teaching of sexuality within the courses.

Differences amongst the perceptions also became evident. There was a range of ideas as to whether all nurse educators should be comfortable teaching sexuality within the courses and it was suggested that the amount of sexuality taught is determined by educator comfort and preference. Participants agreed that sexuality assessment of the client was poorly addressed, if at all, with the students. However, some participants challenged whether sexuality assessment of the client should be the role of the student nurse.

These commonalities and differences indicate that both personal and professional experiences of the nurse educator, both in clinical practice

and nursing education, strongly influence perceptions, and the quantity and quality of sexuality that is taught in nursing education.

During some of the interviews, I sensed a feeling of 'togetherness.' We were two people, who had allocated time to talk about sexuality in professional terms. It was a privileged occasion, loaded with reflection, emotions, self-doubt, self-praise and interspersed with much laughter. Essentially, I was left with the impression that each educator was doing the best that they could, within the time constraints, and with the knowledge that they had, in regard to teaching practice related to sexuality.

I am not, however, suggesting that these are optimum education levels. There is a definite void. Hopefully, when the results of the study are made known, the educators will further critically reflect on their practice, with a view to making positive changes. Ultimately, if changes are made within nursing education, this provides the potential for positive changes in clinical practice and improved outcomes for clients.

The analysis of the findings from both the data in this study and the data from the literature have been developed into A Model of Practice Related to Sexuality. Chapter Six will discuss the analysis of the findings from both Chapter Four and Chapter Five within the framework of this model.

Chapter Six

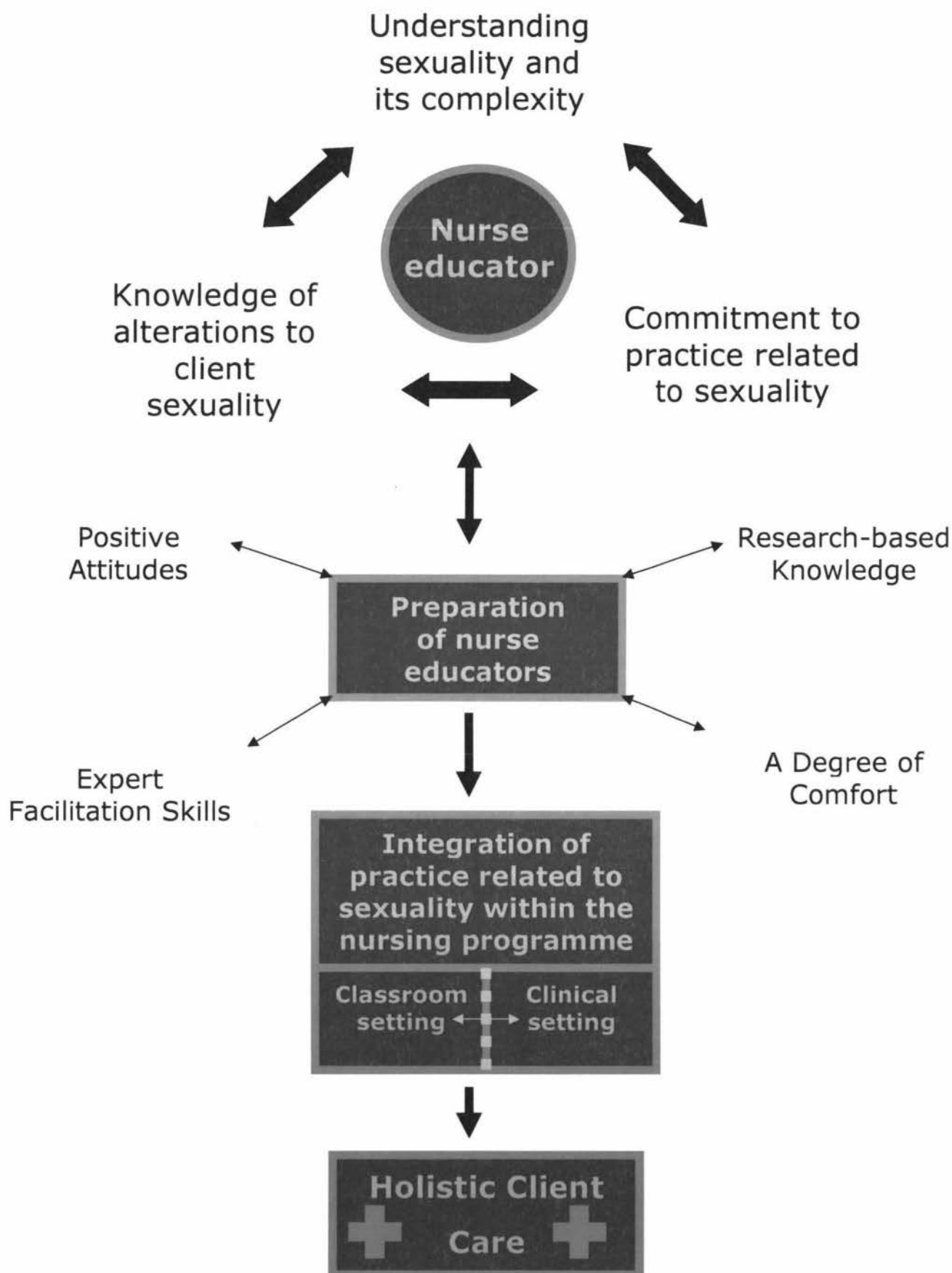
A Model of Practice Related to Sexuality in Nursing Education

Introduction

This research has explored nurse educators' perceptions and their experiences of nursing practice related to sexuality in clinical practice and nursing education in the New Zealand setting. Sexuality-related nursing practice can be described as nursing practice that relates to any aspect of a client's sexuality for example: biological sex, gender identity, gender orientation, self-concept, self-identity or sexual behaviour which may or may not be altered through illness, disease, disability and medical interventions or treatments.

With the aim of adequately preparing students for practice related to sexuality, this research has shown that nurse educators are required to have an understanding of sexuality and its complexity, knowledge of how illness/disease, disability and medical interventions may alter a person's sexuality and a commitment to practice related to sexuality, together forming a loop. Further to this loop, nurse educators must be prepared for teaching practice related to sexuality which requires research-based knowledge, positive attitudes, a degree of comfort and excellent facilitation skills.

After the nurse educator is adequately prepared for teaching practice related to sexuality, sexuality-related practice must be integrated into the programme. If a nursing curriculum promotes preparation of students toward providing holistic care, (the total person, not just a sum of their parts) then students must be prepared for sexuality-related practice, both in the classroom setting and clinical setting.



**A Model of Practice Related to Sexuality
in Nursing Education**

As a result of these findings, A Model for Practice Related to Sexuality in Nursing Education has been developed and the findings from the literature and the study are now discussed within the framework of this model.



Nurse Educator

It is imperative that nurse educators accept that nurses in clinical practice have a role in assisting clients with alterations in their sexuality, and a commitment toward sexuality-related practice. For nurse educators to have a commitment to sexuality-related practice they must have a clear understanding of sexuality and its complexity in order to have knowledge of the impact that illness/disease, disability and medical interventions may have on a client's sexuality.



Understanding Sexuality and its Complexity

The major themes from the definitions of sexuality presented by the participants are consistent with definitions or descriptions of sexuality in the literature, including a text by Crisp and Taylor (2001) used within this nursing programme. Participants confirmed that sexuality is a complex and ill-defined concept (Guthrie, 1999), but considered that they had a 'working' knowledge and understanding of the term. As Van Ooijen and Charnock (1995) explain, the complexity of sexuality adds further credence to the importance of developing an understanding of sexuality within our own lives and how we might include it in the management and care of our clients. Without a clear understanding of

sexuality, this 'complex and ill-defined concept' may contribute to a lack of understanding in clinical practice, whereby, individual nurses may have different perceptions of sexuality from other nurses and their clients (Guthrie). Two participants agreed that it is important to have a working definition of sexuality when teaching sexuality issues, for the same reasons suggested by Guthrie.



Knowledge of Alterations to Client Sexuality

When a working understanding of the nature of sexuality had been established, the participants acknowledged the effect that illness/disease, disability and medical interventions have in altering the many dimensions of a client's sexuality, and specific examples were volunteered, all of which are cited in the literature (Guthrie, 1999; Ross et al, 2000; Van Ooijen & Charnock, 1994). Examples included surgical removal of limbs and organs, paralysis following trauma or a cerebro-vascular accident (stroke), depression, arthritis, respiratory, cardiac and gastrointestinal conditions. The examples provided by the participants in regards to the effect disease and medical interventions can have on a client's sexuality do not cover the whole range of possible issues. During the interview, I was seeking the participants' perceptions of the effect that illness/disease and medical interventions may have on a client's sexuality. I was trying to establish whether they perceived that nurses have a role in assisting clients with issues related to sexuality, thus completing the loop. As Warner et al. (1999) explain, illness not only touches on a person's physical being, but also on their self-image, erotic desires, emotional and sexual relationship and reproductive decisions. If nurses ignore this key factor in a person's general well being, they are failing to deliver holistic care (Parr, 1998; Van Ooijen &

Charnock, 1994; Warner et al. 1999; Waterhouse, 1996; Weston, 1993; Woods, 1987).

Holism includes ways of interacting with clients on a personal level and not wholly reliant on objective information about the structure and function of the body (Crisp & Taylor, 2001). Holistic nursing has been described by Crisp and Taylor as "a comprehensive way of being, knowing and doing in the delivery of knowledgeable, skillful and human-centred nursing care, which relates to people as greater than the sum of their parts" (p. 969). Only a holistic assessment is likely to reveal all the problems that a client has (not just what they have presented with) so that the nurse can assist the client to address these problems (Van Ooijen & Charnock, 1994).



Commitment to Practice Related to Sexuality

Sexuality and problems related to sexuality were described by the participants as a component of nursing care, but they also acknowledged that nurses and nursing over the years have neglected to include sexuality into their nursing practice. Multiple authors have highlighted concerns about practice related to sexuality (Aylott, 2000; Crouch, 1999b; Kautz et al., 1990; Parr, 2002; Steinke, 2000; Waterhouse, 1996) and this aspect of care is often over looked, partly through lack of understanding (Van Ooijen, 1996). It is vital that nurse educators link an understanding of sexuality and knowledge of alterations in client sexuality, with the role that nurses have in providing holistic care toward maintaining and enhancing client's sexuality.

Having established that the participants do have an understanding of sexuality and its complexity, that they do have knowledge of alterations to a client's sexuality and that they do accept that nurses have a role in

assisting clients with issues of sexuality, only one participant expressed a 'commitment' to practice related to sexuality ie: only one participant completed the loop. This loop forms the first part of the model.

The one participant who expressed a commitment to practice related to sexuality acknowledged that nurse educators need to take a proactive approach toward sexuality in an attempt to provide better care for clients. The organisation also needs to take some responsibility in preparing nurse educators to ensure that a holistic approach to client care is taken in relation to teaching undergraduate students.

When examining this loop, it became clear that a further link is required – a link between sexuality-related practice in the clinical setting and sexuality-related practice in nursing education. As Grigg (1997) states, nurse educators must be part of the process of accountability for the quality of care that students provide to clients. Grigg and Crouch (1999b) suggest that having a sexual health knowledge is not enough, nurse educators require adequate preparation.

Preparation
of nurse
educators

Preparation of Nurse Educators

There is a need for nurse educators to be adequately prepared for teaching sexuality issues, (Crouch, 1999b; Eliason, 1996; Grigg, 1997; Hayter, 1998; Mc Haffie, 1993; Rafferty, 1995), but the educators in this study have not been adequately prepared. Grigg and Weston (1993) suggest that it is the responsibility of the educator to gain sufficient knowledge to enable them to facilitate sexuality education and others suggest that attending formal courses or inservice education sessions was a requirement (Webb, 1988).

The participants acknowledged that they had not received what they considered to be 'formal education' in how to teach sexuality-related nursing practice to undergraduate students. Most participants could not recall sexuality issues being addressed in their undergraduate education, though for some this is several years ago. This is confirmed by McKay, Armstrong and Gordon (1992, cited in Grigg, 1997), few healthcare professionals are provided with the opportunity to explore sexuality in a structured and supportive way in their initial training.

Preparation of nurse educators

Research-based Knowledge

Research does not appear to be the basis for most nurse educators' knowledge of sexuality. The participants gained their knowledge from clinical practice, life experiences and reading the literature, so in their individual ways, they have taken on the responsibility of (what they deem to be) preparing themselves for this role.

A significant finding from this study that has not been identified in the literature, is the influence that an educator's clinical practice has on their comfort levels when teaching sexuality in undergraduate nursing education. Participants strongly suggested that they were more knowledgeable and more comfortable in discussing sexuality issues with students in nursing specialties in which they have clinically practised, for example, medical/surgical and health promotion. While Lewis and Bor (1994) found a correlation between knowledge and practice in clinical practice, there is no evidence in the literature of a correlation between clinical practice knowledge of the nurse educator, and comfort of the nurse educator in teaching sexuality issues to student nurses. This was a significant finding in this study and is worthy of further research.

The literature strongly suggests that clients prefer that sexuality be raised by the healthcare professional (Cort, 1998; Crisp & Taylor, 2001; Gamel et al., 1993; Steinke, 2000; Waterhouse, 1996; Weston, 1993). The participants, however, were surprised when I made this suggestion. They felt that a client would raise the issue if they wanted to discuss aspects of sexuality. As a result, none of the participants provided the students with cues that may promote an opening for assessment or discussion about sexuality issues with the client suggested by the following authors (Crisp & Taylor, 2001; Ross et al., 2000; Van Ooijen & Charnock, 1994; Warner et al., 1999).

As these educators have predominately gained their knowledge and attitudes experientially, some authors suggest (McKay et al., 1992, cited in Grigg, 1997; Rose & Platzer, 1993) that this is not adequate preparation for the role of teaching sexuality to nursing students. Knowles (1982, cited in Sutherland, 1997) explains that, life experiences can be an obstacle to new learning, for example, negative prejudices and old ways of doing things. One participant did raise similar concerns to Mc Kay et al., in regard to educators teaching from their own clinical practice and life experiences.

Experiential Learning

Experiential learning is an accepted theory of learning, although not without its critics. According to Kolb (1984) who developed the theory, some saw it as gimmicky and faddish, too pragmatic for the academic mind or too close to the anti-intellectual and vocational trends in America at the time. Brookfield (1995) believes that the quantity or length of experience is not necessarily connected to its richness or intensity, for example, in an adult educational career spanning 30 years the same one year's experience can in effect, be repeated 30 times. Criticos (1993) adds "if experience in itself was so valuable, then humans who are enmeshed in experience ought to be more

knowledgeable than they are" (p. 161). Unless the experience is examined and reflected on and meaning has been drawn from it, it has little educative value.

Never the less, Jarvis, Holford and Griffin (1998) describe experiential learning "as the process of creating and transforming experience into knowledge, skills, attitudes, values, emotions, beliefs and senses" (p. 46). Torbert (1972, cited in Criticos, 1993) states that effective learning follows effective reflection, which is supported by NCNZ (2002) cultural safety guidelines. This reflection is an expectation of all nurses, but additionally, it is the role of the nurse educator to facilitate this process so that student nurses:

... will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans and disempowers the cultural identity and well-being of an individual. (NCNZ, 2002 p. 7)

In 1997, Grigg considered that there were few willing tutors, let alone expert tutors, to facilitate sexuality learning encounters. The facilitators of the programme in this study do not profess to be 'expert' facilitators of sexuality learning experiences. However, they are willing facilitators and they all are teaching aspects of sexuality relevant to their courses, albeit not necessarily research-based.

Formal Education

If the participants were interested in formal education around issues of sexuality in nursing practice, where would they go? While I had not actively sought out courses on sexuality in New Zealand, I have not seen them advertised in the New Zealand nursing journals, as other courses for nurses are. One avenue for education is Sex Therapy New

Zealand Ltd (STNZ) who run modular courses for psychologists, counsellors and medical professionals. A two-day foundation course with STNZ, is available to anyone and covers the following: information on human sexuality, sexual problems and their treatments, and development of the therapist's self-awareness and confidence as a sexual being. Having attended this course, I would highly recommend this course to other nurses. This may assist in raising the profile of sexuality in nursing practice and nursing education and give nurses in any setting the opportunity to underpin their practice with theoretical based knowledge and understanding.

Rose and Platzer (1993) suggest that education must be based on research, as accurate information can lead to a sound knowledge base, which in turn can lead to attitudinal changes.

Preparation
of nurse
educators

Positive Attitudes

Cultural Safety Issues

Cultural safety issues, as defined by NCNZ (2002), were raised as areas of concern particularly sexual minority clients and older clients. These areas of concern have been discussed in the literature where nurses have attitudinal biases or negative attitudes, which has the potential to compromise client care.

Fay raised the issue of homophobic nurses caring for sexual minority clients. As Palmer (1998) suggests, nurses are not immune from the social forces that create and reinforce negative stereotypes and "negative stereotypes can seriously limit a person's understanding of an individual's expression of sexuality" (p. 15).

Eliason (1998) reports that the attitudes of student nurses, registered nurses and even some nurse educators toward lesbian, gay and bisexual people, were more negative than toward racial minorities. In a survey by Randall (1989), these concerns were supported. Randall states that a "notable number" of nurse educators think that "lesbians would molest children, that lesbian behaviour is disgusting ... and lesbians are a source of AIDS" (p. 305). Randall's study is 15 years old. However, more recent evidence in Ashcroft's (2002) unpublished study, explored examples of negative comments made by nurse educators about sexual minorities, particularly lesbians, both inside and outside the classroom. This confirms that educators are still expressing prejudicial attitudes and according to Randall, nurse educators should be held accountable for the influence they have on students and others.

The importance of NCNZ (2002) Cultural Safety Guidelines was *stressed* by the participants as being an important part of the nursing curriculum where students must reflect on their values and beliefs in regard to the beliefs and practices common to particular groups of people including age, gender, sexual orientation, socio-economic status, ethnicity, religion and disability in an effort to avoid unsafe cultural safety. Unsafe cultural practice has been described as "any action which diminishes, demeans and disempowers the cultural identity and well being of an individual" (NCNZ, 2002, p. 7).

NCNZ (2002) and Weston (1993) explain that nurse educators should be encouraging students toward a high level of tolerance with sexuality and how it is expressed, to avoid unsafe cultural practice. Clear and Carryer (2001) support this view, "if we neglect issues such as diversity in cultural identity and sexual expression within education, we are in no position to calmly lay claim to such attributes as culturally competent care ..." (p. 35).

It is important to note that issues around Maori nurses or clients were not raised by any of the participants in relation to clinical practice. This

lack of cultural discussion was also reflected in the literature review and is a major limitation. It is imperative that cultural issues are addressed within discussions on sexuality as different cultures have different norms and values about sexual activity and sexuality discussions. Sexuality is influenced by cultural/ethnic rules and norms and these underpin what is acceptable/unacceptable behaviour with a culture (Crisp & Taylor, 2001). Sadly, the views of Maori/Pasifika clients and nurses (and other cultures) therefore remain silent in this study, which is a significant deficit in research in the New Zealand setting. As nurse educators we need to know the expectations of clients and nurses from other cultures in regard to sexuality to enable holistic care for all clients, by all nurses.

Professional Role

Of major significance is the fact that two participants did not view sexuality assessment of the client as part of the students' role at all. Fay and Edith did not feel that it was appropriate for students to be addressing sexuality issues with clients, unless the client raised the issue. This finding is a significant one in this study.

Both Fay and Edith suggested that discussion on sensitive issues with clients should be done by an 'experienced' nurse, meaning, not a young nurse, but a nurse who has practiced for a number of years and has gained experiential knowledge and skills. However, the main concern in the literature is that nurses are not experienced in addressing issues of sexuality with clients. Nurses are exhibiting inexperience in this area of nursing care. Sexuality issues being discussed by a young or inexperienced nurse was identified by Albarran and Bridger (1997, cited in Crumlish, 2004) and Van Ooijen and Charnock (1994). When explaining to group of women that nurses are expected to assess clients holistically and to deliver holistic care, two questions were asked; "But how can you expect that from a 21 year old?" and "How can a slip of a girl understand my situation?" (Van Ooijen & Charnock, 1994, p. 55).

A similar discussion occurred with Edith where I reminded her that we now have many more 'mature' rather than 'young' student nurses and Edith did then acknowledge that if the students were adequately prepared for assessing sexuality issues, then it would be part of their role.

Albarran and Bridger (1997, cited in Crumlish, 2004) identified that clients may be reluctant to initiate discussion about sexual issues if they perceive that the nurse does not appear experienced or mature enough to deal with their concerns. Binty, as a mental health nurse, is the only participant to have raised issues of sexuality with clients in clinical practice. Her previous experiences support the view that addressing sexuality issues with the client tends to be the role of an experienced nurse, as this did not happen until later in her clinical practice years. She did not feel that she had the preparation from undergraduate education, or the maturity to raise the issues earlier on in her career. She acknowledges that there is a lack of sexuality assessment education in this programme, even in the mental health courses, and suggests that sexuality issues should be included in all courses.

The literature also supports the inclusion of sexuality within all courses, McHaffie (1993), NCNZ (2002) under the auspice of the cultural safety guidelines, and Webb (1988). With adequate preparation and the discussion being initiated by the nurse, the nurse should be perceived by the client as 'experienced and mature' for discussing issues of sexuality. It is my understanding that the aim of a nursing curriculum is to prepare students for holistic client care and this must include preparation for practice related to sexuality. Nurse educators need to acknowledge that the expectations of the clients have changed and we need to move proactively and prepare students for the demands of their role as holistic carers. The role of the nurse is to raise the topic of sexuality with the client in a calm and professional manner, but to be

prepared for and respect the client who prefers to keep this part of their life private (Ross et al., 2000).

It is therefore possible for nurse educators to take negative and/or biased attitudes, whether they be cultural or professional issues, into the classroom and convey these to the student, unless critical reflection has occurred. Reflection must include knowledge from the literature and examination of their own attitudes and biases toward issues of sexuality. It is for these reasons that many authors emphasised the importance of the educator having adequate preparation in order to teach sexuality-related practice.

According to Grigg (1997), only educators who have specialist sexuality knowledge and who are comfortable with that knowledge and their own sexuality, are equipped to deal effectively with the demands of sexuality education. "It is vital that education of this kind is provided by 'experts' ..." Grigg (p. 63). My expectation of the nurse educator is that they are prepared for the role of teaching sexuality-related practice. This preparation must include research-based knowledge, development of positive attitudes, expert facilitation skills and the commitment required to enable them to facilitate student learning in the area of assessment of sexuality needs of the client.

Crouch (1999b) explains, if holistic and humanistic care is to be delivered to clients then nurse education needs a positive approach to address the issues openly and in a planned way. A commitment to practice related to sexuality requires that nurse educators accept that practising nurses and students have an important role to play in assisting clients with alterations in their sexuality.

A Degree of Comfort

Nurse educators are uncomfortable and anxious about highlighting sexual matters, which is a contributing factor toward nurses not being prepared for clinical practice related to sexuality (Grigg, 1997; Rafferty, 1995; Van Ooijen & Charnock, 1994; Webb, 1988; Weston, 1993). Contrary to the literature, (acknowledged to be 10 years old) the educators in this research, expressed comfort, rather than discomfort when teaching sexuality within the courses that they currently teach, particularly when teaching aspects related to their previous clinical experience.

Only three participants identified examples of discomfort that they have experienced. Edith finds teaching the personal aspects of sexuality or the physical sex act uncomfortable. Fay expressed issues of concern only when students questioned her about her sexual relationship. Sunny voiced difficulty teaching sexuality when there was a male in the class of the same ethnic background in which sexuality is not openly discussed, particularly by women, in front of men. Sunny's ethnic perspective was in conflict with her role as an educator, in this instance, which highlights differences in sexuality values and norms between ethnic cultures. This issue was not raised anywhere else by her.

A positive link between clinical practice knowledge and comfort in teaching within the same context was clearly shown by some participants. Other factors that increase comfort when teaching sexuality were identified as age, maturity and the number of years of teaching in the classroom. However, none of the above factors are discussed in the literature.

Perhaps with age and maturity, comes quality reflection and comfort with one's own sexuality, which according to Grigg (1997) assists with teaching issues of sexuality. Grigg adds that it is educators who are comfortable with their own sexuality, who are better able to "cultivate sensitive and perceptive communication skills about sexuality" and to "safely and intuitively integrate sexuality education into the curriculum" (Grigg, p. 62).

Two participants made similar comments. Jane felt that dealing with one's own sexuality will reduce any embarrassment and Fay proposed that if one is not comfortable with one's own sexuality, they will not feel comfortable discussing sexuality with others and these comments are well supported by multiple authors. Nurses must examine and reflect on their own sexuality, and being aware of their own attitudes and values in order to be comfortable discussing sexuality with others (Crouch, 1999a; Grigg, 1997; Guthrie, 1999; Hayter, 1996; Morrissey, 1996; Peate, 1995; Rafferty, 1995; Van Ooijen & Charnock, 1995; Weston, 1993).

Effect of Nurse Educator Discomfort

The participants agreed that if an educator is not comfortable teaching sexuality, it will either be, 'skipped over, or done badly,' and this is the concern both in this study and throughout the literature, that sexuality is poorly addressed within undergraduate nursing education.

It was conceded, that if an educator is uncomfortable teaching issues of sexuality, an alternative educator should be brought in. Most educators have areas within their courses that others have greater comfort and expertise in, and they are invited to deliver that part of the course. Although, this may be acceptable for the planned teaching of sexuality, what is to happen when the subject is raised spontaneously in the classroom? These situations occur often enough to require that most

educators are both knowledgeable and comfortable with this area of discussion.

It appears from the literature that all nurses in clinical practice are expected to address sexuality issues with clients to provide holistic care. Sexuality should be on every nurse's agenda (Fitzpatrick, 2002) and must include all clients (Lewis & Bor, 1994). To overlook sexuality as a key factor in a person's well-being can represent a failure to deliver holistic care to the client (Lamp et al., 2000; Parr, 2003; Van Ooijen & Charnock, 1994; Warner et al., 1999; Waterhouse, 1996; Weston, 1993; Woods, 1987). If we allow educators who are uncomfortable teaching sexuality, not to teach it, what example are we setting for the students? This presents an anomaly between what we expect of nurses in clinical practice and what we expect of nurse educators. As Grigg (1997) explains, nurse educators are role models for learners. Nurse educators must set an example and practise what they preach.

Jane challenged the professional responsibility of an educator who chooses not to teach an aspect within the programme, or poorly addresses any aspects within the curriculum. This 'lack of professional responsibility' was compared with deciding which clients they do not want to care for, for example, women who are having a termination of pregnancy or lesbian/gay or HIV/AIDS clients. Generally, in the clinical setting, nurses are required to 'get on with the job,' whatever is required, in a non-judgemental manner unless they are able to find a colleague to replace them.

Discussion took place around the response of students in relation to the educator displaying discomfort while teaching sensitive topics, such as sexuality. Examples from both ends of the spectrum were cited. In one situation, the students may 'shut down' and not ask questions and choose not to participate, thus losing discussion and learning opportunities. The other situation shared was when students feel the

discomfort of the educator and pursue questioning or further discussion in an attempt to further embarrass the educator. While the literature did not refer specifically to the behaviour of students if the educator is seen to be uncomfortable, both examples suggest the importance of an 'expert' facilitator. These uncomfortable situations can occur with any teacher, in any classroom, but particularly with new educators. Educators are role models for learners and it is a requirement that educators do not exhibit signs of discomfort when discussing issues of sexuality (Grigg, 1997). Reflective practice is promoted by Brookfield (1995) for teachers to see themselves as students do, recognize the effects of their teaching on students and address poor teaching practices.

Preparation
of nurse
educators

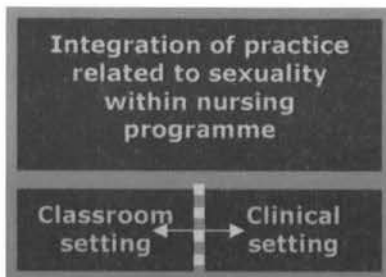
Expert Facilitation Skills

As discussed earlier, teaching experience has given participants the confidence and comfort to teach sensitive issues such as sexuality. Crouch (1999b) states that, student nurses have their own sexual history, attitudes and perceptions and conflicts within the group could easily develop. Any conflicts need to be defused quickly, highlighting the need for 'expert' facilitators when dealing with sexuality education (Crouch, 1999b; Eliason, 1996; Grigg, 1997). It is my belief that 'teaching experience,' with critical reflection, has assisted my confidence in teaching sexuality. As Brookfield (1995) advocates, critical reflection enables teachers to see themselves as students do and to recognize the effects of this practice on students. Knowing how to facilitate the classroom environment is the key to any constructive discussion, and facilitators of sexuality learning experiences need to be 'expert facilitators,' reiterating that teachers of sexuality require adequate preparation.

In summary, the nurse educators in this study, while willing facilitators, are not 'adequately' prepared for teaching practice related to sexuality, despite attempts to prepare themselves for this role. In this situation the nurse educators 'do not know, what they do not know' and until this study, their awareness of sexuality issues, particularly, sexuality assessment of the client in nursing education, had not been challenged. Appropriate preparation of nurse educators is fundamental to the quality of sexuality education (Grigg, 1997).

I would like to close this discussion with the following quote as a message to all nurse educators.

Working in the field of sexuality is like walking through a minefield blindfolded as one manoeuvres between encouraging personal exploration and respecting people's rights to their own boundaries and privacy. We strongly recommend that you 'practise what you preach' and participate in training courses yourself before running them. (McKay et al., 1992, cited in Grigg, 1997, p. 65)



Integration of Practice Related to Sexuality within the Nursing Programme

Classroom Setting

Participants were unanimous that sexuality issues should be taught within the undergraduate nursing curriculum. All participants are teaching some facets of sexuality within the courses that they teach. However, the visibility of sexuality within the programme was

challenged. Contrary to Crouch (1999b) who suggests that sexuality requires an overt approach within the curriculum, educators in this study were only aware of their own involvement in teaching sexuality and knew little about what their colleagues were teaching in regard to these issues. It was identified that sexuality was not written in the course descriptors, (sexuality has since been included in one course descriptor) learning outcomes or course content, despite gender and sexual orientation being clearly identified for inclusion into all nursing curriculum in New Zealand, as recommended by the Cultural Safety Guidelines NCNZ (2002). Only one educator includes sexuality in a course assessment.

If sexuality is within the curriculum documentation, the course coordinator is responsible to ensure that the learning outcomes are met and the course content is delivered. In this way, we are 'governed' to ensure that sexuality is taught; not leaving it to the discretion of the nurse educator. Currently, it is reliant solely on educator preference as to the quantity and quality of sexuality education delivered within each course.

All educators recommended that sexuality be integrated into every course within the programme, commencing in year one and then woven throughout the learning, just as communication skills are. Several participants likened sexuality to cultural safety (as defined by NCNZ, 2002) and communication, as subjects that must be integrated within the programme and introduced within the context of the courses. This view is supported by McHaffie (1993) and Webb (1988). Webb suggests that the curriculum must adopt an approach that acknowledges the importance of sexuality in the same way that nurses incorporate themes such as communication and problem-solving skills - in all stages of their work.

Sexuality Assessment of the Client and Communication Skills

Sexuality assessment and/or raising and discussing issues of sexuality with clients can be described as the crux of practice related to client sexuality. The most significant finding of this study is that sexuality assessment of the client, (as a client need, activity of daily living or functional health pattern) is inadequately taught. Taylor et al. (2001) explain that because sexuality permeates an individual's life, both in illness and in health, it should be a concern for nurses in professional practice. Warner et al. (1999) consider that "taking a sexual history is the first step to an appropriate diagnosis and therapeutic intervention for patients, and is a fundamental part of holistic nursing care" (p. 34). Participants in this study are not teaching the students how to raise and discuss sexuality issues with the client, even though sexuality is an integral part of an individual and to ignore it, is to neglect an important aspect of a client's well being.

Within the programme, some courses specifically have 'client assessment' as a learning outcome, for example, "applying nursing assessment skills to plan, implement and evaluate culturally safe nursing care." However, although sexuality assessment should be integral to the client assessment, it is not taught adequately in this nursing programme. Educators in these courses were honest in their responses and acknowledged that they did not teach this component of the client assessment well. For example, the only aspect raised by Fay was issues of gender orientation when teaching sexuality assessment of the client.

Tory initially thought that she was teaching sexuality assessment well, until our interview, where upon reflection, she recognised that she was taking a passive rather than an active approach to client sexuality issues. Tory was raising awareness of issues that clients may have and

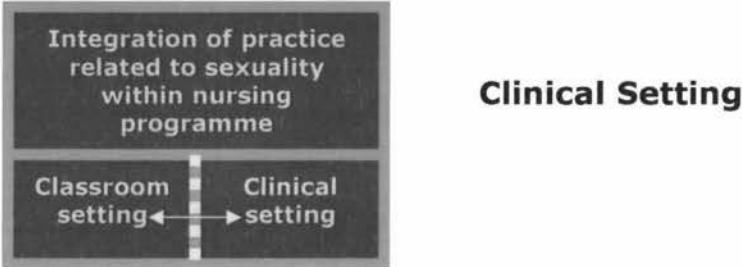
may ask questions about, but had not been suggesting that the students raise sexuality issues with the client.

The dilemma is, how do nurses learn sexuality-related practice without the knowledge, skills and support from nurse educators? Will the client's sexuality needs be met if nurses are not taught how to address sexuality issues with clients in undergraduate education? According to a number of authors, preparation for assessing sexuality of the client includes the following components - a cognitive (theory and research) component, an affective (feelings and attitudes) component and a communicative component. The communicative component should include practice in talking about sexuality and role-play using realistic practice and rehearsal opportunities (Baraitser et al., 1998; Crouch, 1999b; Palmer, 1998; Savage, 1998; Warner et al., 1999; Waterhouse, 1996; Webb, 1988).

Clearly, students, our future nurses, require cues, practice skills and rehearsal opportunities in assessing the sexuality of the client (Baraitser et al., 1998; Crouch, 1999b; Palmer, 1998; Savage, 1998; Warner et al., 1999; Waterhouse, 1996; Webb, 1988), just as they are taught assessment skills for other client needs. Role-play is a learning tool used to encourage participation by improvising behaviours that may be encountered in the nurse-client relationship and has been found to be more effective than lectures (Shearer & Davidhizar, 2003). Nursing programmes need to specifically address the importance of taking a sexual history and offer practicums in how to do so within the curriculum (Warner et al., 1999).

According to Ross et al., (2000) comfort comes from both practice and a sense of control over the subject matter and this comfort is then conveyed to the client. Unless the nurse has the skills to be able to broach the topic in an appropriate and sensitive manner, the client is likely to suffer in silence (Palmer, 1998). The same can be said for

discussions on sexuality in the classroom. It is the role of nurse educators to facilitate an environment where students reflect on their own sexuality, values and beliefs (as defined by NCNZ, 2002), and where issues or concerns related to sexuality can be freely discussed. As in most classrooms, the 'class rules' are established and maintained and the educator facilitates discussion or sets parameters. In the case of sexuality, it is important to give the students 'permission' and encouragement to talk about sexuality, as it is not always considered appropriate for adult conversation. To the surprise of Baraitser et al. (1998), students' discomfort about discussing sexuality decreased after only a two-hour session in the communication skills course.



One could say that the cognitive and affective components are partially met by the nurse educators, however, while communication is a thread throughout the curriculum, communication skills 'tuned' for client sexuality assessment are not addressed at all. Waterhouse (1996) believes that nurses learn to be 'comfortable' with aspects of client care primarily through 'repeated practice,' however, these opportunities are not available to students in relation to sexuality, in this nursing programme. Jane suggested that one of the best places to teach sexuality is in the clinical setting, when it arises, but students must be adequately prepared prior to entering the clinical setting, just as they are for other nursing skills.

The aim is for the students to gain confidence in using language that previously was not familiar to them and these should be practised both in the clinical setting and the classroom (Baraitser et al., 1998).

Introducing sexuality as part of the nursing curriculum is of little value if nurses cannot integrate the theory into practice (Guthrie, 1999).

As Coleman states:

While there is more openness in discussing sexuality in our culture today, many health care professionals still find it uncomfortable to talk about sexuality in an open and comfortable manner ... The problem has been and continues to be the inadequate training that professionals receive ... In more than 20 years of teaching human sexuality to medical students, physicians and other health care providers, I continue to find that the most difficult issue is to develop the comfort and ability of the health care professional to discuss sexuality with patients. (Coleman, cited in Ross et al., 2000, p. v)

The dilemma within this programme is, how will students gain clinical experience in addressing issues of sexuality with clients if they are not prepared within the classroom setting? Without adequate preparation, students are unable to provide holistic care for clients.



Holistic Client Care

Anderson (Ed.) (2002) defined holistic health care as a philosophy of care which is comprehensive or is total client care that considers the physical, emotional, social, economic, and spiritual needs of the person; their response to illness and the effect of illness on their ability to meet self-care needs.

It needs only a fairly cursory scrutiny of the nursing literature to realize that the idea of holistic care ... appears to be well

established within nursing. Most nursing models and theories are based on the holistic model ... writing about this is one thing, doing it is another. (Van Ooijen & Charnock, 1994, p. 46)

Do nurses actually provide holistic care to clients? Many nurses feel inadequately prepared for the things that some clients say to them, particularly sensitive topics, and do not know what response would be helpful (Van Ooijen & Charnock, 1994). The literature clearly states that clients prefer that nurses (healthcare professionals) raise the subject of sexuality for discussion and nurses are even less prepared for this proactive approach to client care.

According to Warner et al. (1999) "taking a sexual history is the first step toward appropriate diagnosis and therapeutic interventions for most clients and is a fundamental part of holistic nursing care" (p. 34). "Many people believe that to ignore sexuality, would be to overlook a key factor in people's general well-being and so would represent a failure to deliver holistic care" (Weston, 1993, p. 26).

Having analysed the findings from this study, nurses and nurse educators are not including sexuality assessment of the client in their practice. Consequently, students are inadequately prepared for practice related to sexuality and clients will not receive holistic care.

Van Ooijen and Charnock (1994) add that, if clients have a right to receive the best possible care, then nurses have a duty to provide it and to do this, nurses have a duty to perform a holistic assessment. Only a holistic assessment is likely to reveal all the problems that a client has (not just what they have presented with) so that the nurse can assist the client toward meeting their self-care needs (Le Mone & Jones, 1997; Van Ooijen & Charnock, 1994).

However, nurses are unable to provide holistic care if they have not had adequate preparation for the role. According to Ross et al. (2000),

while some healthcare professionals have received lectures on sexuality, there has been little emphasis on the practical skills required for asking questions and discussing issues of sexuality with clients. "A sexual history needs to be approached with more preparation than a general history" (Ross et al., p. 7).

Summary

For the delivery of holistic care, student nurses must be adequately prepared for practice related to sexuality. The following is a summary of the basic assumptions that underpin the Model for Practice Related to Sexuality in Nursing Education.

Nurse educators must have an understanding of sexuality and its complexity, knowledge of alterations to client sexuality and a commitment that practising nurses have a role in assisting clients with alterations in their sexuality, or sexuality-related practice, thus forming a loop. A further link is required between the loop and nursing education, whereby nurse educators must be prepared for their role in teaching practice related to sexuality to nursing students. This preparation must include research-based knowledge, development of positive attitudes, a degree of comfort and expert facilitation skills. With adequately prepared nurse educators, sexuality related practice must be incorporated within the nursing programme, both in the classroom setting and clinical setting.

The ultimate aim of this Model of Practice Related to Sexuality in Nursing Education is to facilitate adequately prepared students to practise holistic client care.

As this model is newly developed, its effectiveness has not been assessed and this is a limitation of any untested model or theory. One

benefit though, is that this model may be adapted for other sensitive areas for discussion within nursing education.

A strength of this model is that its purpose is similar to the Royal College of Nurses in England (cited in Aylott, 2000) guidelines aimed at improving nurses' understanding of the impact of sexuality-related practice. Three of these aims were to:

- raise the awareness of the professional role that nurses can develop in the area of sexuality and sexual health.
 - highlight some of the professional development issues that will need to be considered.
 - provide professional, ethical and legal guidance on best practice.
- (Aylott, 2000. p. 609)

If the Royal College of Nurses in England can develop guidelines aimed at improving practice related to sexuality, can the same be achieved by a professional nursing body in New Zealand?

Chapter Seven

The Study in Conclusion

Introduction

In this chapter, the findings from the literature and this study are drawn together into a cohesive conclusion. The research questions are addressed in three concluding statements. Implications for practice and suggestions for further research in nursing education, will be discussed.

The nursing literature identifies that sexuality is an integral part of holistic client care. However, research continues to indicate that nurses generally, *do not* address issues of sexuality with clients. While there is no absolute reason attributed to this deficit in client care, issues within undergraduate nursing education and the nurse educators have been implicated.

It is stated in the literature that sexuality education in nursing is insufficient and does not adequately prepare students for practice related to sexuality (Crouch, 1999a; Giddings & Wood, 1998; Grigg, 1997; Jolley, 2002; Kautz et al., 1990; Lewis & Bor, 1993; Morrissey, 1996; Palmer, 1998; Rafferty, 1995; Savage, 1998; Webb, 1988; Weston, 1993).

Additionally, it is clear that:

- nurse educators need to be adequately prepared for the role of teaching sexuality (Crouch, 1999b; Eliason, 1996; Grigg, 1997; Hayter, 1998; McHaffie, 1993; Rafferty, 1995).

- sexuality is inadequately covered within the nursing curriculum (Jolley, 2002; Rafferty, 1995; Ross et al., 2000; Van Ooijen & Charnock, 1995).
- nurse educators are uncomfortable teaching sexuality (Rafferty, 1995; Van Ooijen & Charnock, 1994; Webb, 1988; Weston, 1993).

While most of the literature is written by nurse educators, it appears to be their own views and/or anecdotal views of other nurse educators from reviews of the literature. I was unable to find research that is specifically focused on the perceptions and experiences of nurse educators in regard to practice related to sexuality in nursing education. Coupled with this, the literature is from overseas and is not necessarily the perceptions or experiences of lecturers within the New Zealand nursing curricula, and the literature is now somewhat dated. Before assumptions about sexuality-related practice in New Zealand undergraduate nursing education and nurse educators can be made, the current situation within the New Zealand nursing curricula needs to be explored. To my knowledge, a study of this nature has not been undertaken. These issues identified from the literature review formed the basis of my research. The original research questions for this study were.

1. Do nurse educators have adequate knowledge and attitudes (preparation) for teaching nursing practice related to sexuality to nursing students?
2. Is there a lack of nursing practice related to sexuality within undergraduate nursing education?
3. Do nurse educators have a degree of discomfort or embarrassment while teaching nursing practice related to sexuality to nursing students?

Conclusions

The purpose of research in nursing or nursing education is to change practice, and given the findings from this study, changes within the curriculum will be recommended and content delivery may need to be revised or prioritised differently. To gain a commitment from the nurse educators in regard to teaching sexuality assessment of the client, further preparation is required. This preparation must provide the educators with research-based knowledge, development of positive attitudes, a degree of comfort and skills required to enable them to facilitate student learning in the area of assessment of sexuality needs of the client. This will include the cognitive, affective and communicative components discussed previously. Without a commitment from nurse educators, sexuality assessment of the client will remain a void in this nursing programme and clients will not receive the holistic care that they deserve.

From all of the discussion and the findings in the literature, the research questions can be answered as follows.

1. The educators interviewed are not adequately prepared for teaching sexuality assessment of the client. The participants lacked knowledge and/or positive attitudes in teaching students how to address issues of sexuality with clients, which is the foundation for practice related to sexuality.
2. In support of the literature, there is a lack of evidence of teaching nursing practice related to sexuality in nursing education, particularly, the teaching of sexuality assessment of the client being the crux of practice related to sexuality. The participants claimed that sexuality lacked visibility within the curriculum documentation and they were unsure who taught what aspects of sexuality in courses other than their own.

3. Contrary to findings in the literature, the participants expressed comfort, rather than discomfort when teaching areas of sexuality to students, particularly when teaching topics that reflect their previous clinical practice. Knowledge from their clinical experience, age, maturity and teaching experiences were identified as factors that increased their comfort levels.

Recommendations for Practice

The fundamental aim of any research in nursing practice or nursing education, is to improve client care and this research has focused on nursing practice related to sexuality within nursing education. The results from this research must be shared initially with the participants with a view to improving their practice. My recommendations for this nursing programme are for the educators to gain adequate preparation (knowledge and attitudes) toward improving the delivery of sexuality assessment of the client. Moves to change the curriculum in this school of nursing are required to enable nurse educators to adequately prepare students for practice related to sexuality to facilitate holistic care for clients.

Suggestions for Further Research

This research has focused on the nurse educators' perceptions and experiences of sexuality in nursing practice, but more specifically on sexuality in nursing education. Up until now, the views of nurse educators have been unknown and unheard. As this is the only research of this nature undertaken in the New Zealand setting, a more comprehensive picture would be achieved with the inclusion of nurse educators in a multi-site study. In effect this study has provided a base on which other studies can develop. A common trend found in most research is that, more questions than answers emerge and this is the case in this study, as Oakley (1992) suggests, "the best research is that which breeds more" (p. 9).

The most significant finding in this study is how poorly sexuality assessment of the client is taught. As this study was localised to one school of nursing in New Zealand, it would be of value to establish if sexuality assessment of the client is taught in other schools of nursing. This poses a number of questions.

1. If sexuality assessment of the client is taught in other schools of nursing, how is it taught? Who teaches it? Are all educators involved?
2. Are the teaching strategies identified in the literature, used in the classroom setting when teaching sexuality assessment of the client?
3. Do these strategies increase the student's knowledge and degree of comfort in discussing issues of sexuality with clients?
4. Do the undergraduate students preparing for state final exams feel adequately prepared for sexuality-related practice?
5. Do educators in other schools of nursing have the same degree of comfort when teaching sexuality as they do in this study?
6. Is there a correlation between clinical practice knowledge of the nurse educator and comfort of the nurse educator in teaching sexuality issues?
7. Where does sexuality 'fit' within other curricula around the country?
8. Is sexuality integrated, stand alone? What priority does it have? Is it identified in the curricula documentation?

According to the literature, nurse educators are required to be adequately prepared for teaching practice related to sexuality to undergraduate students and it was acknowledged in this study that none of the participants have received any formal education to prepare them for this role. However, is there formal education available to nurse educators in New Zealand? Are there nurses in this country who

have the 'expertise' to teach nurse educators how to teach sexuality-related practice? If so, how can their expertise be utilized?

Ultimately, the only way that the nursing profession can determine the effectiveness of a nursing curriculum and the practice related to sexuality that follows, is to survey clients after discharge from the healthcare facility to assess whether they are receiving information on sexuality. Are nurses addressing sexuality issues with clients? Are clients happy and comfortable with the information received from nurses? Do clients feel better informed about how their illness/condition/medical interventions may affect their sexuality? Do clients have strategies available to them to assist with alterations in their sexuality?

This study has provided a springboard for further exploration of nurse educators' perceptions and experiences of teaching nursing practice related to sexuality, and the impact of these perceptions and experiences on nursing education, can be examined. Many unanswered questions have arisen during the process of this research, this is but a beginning ...

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Sexuality-Related Practice in Nursing Education

Letter of Introduction

Hi

My name is Carol Ashcroft and I am a student at Massey University doing a Masters of Education Degree. As part of my thesis to complete the Masters of Education Degree, I am interested in talking to other nurse educators who teach on the Bachelor of Nursing Programme at XXXXXX about your perceptions and experiences of sexuality-related practice in nursing education. This will involve one or two interviews of 1- 1 1/2 hours duration at a time and place convenient to you. Ethical approval has been gained from the Massey University Human Ethics Committee.

If you have any questions please feel free to contact my research supervisors:

Sue Purnell, Massey University at Wellington.

Ph: 04 801 2794, Ext 6522

Email S.L.Purnell@massey.ac.nz

marg gilling, Massey University at Wellington,

Ph: 04 801 2794, Ext 6662.

Email m.gilling@massey.ac.nz

If you are interested in talking to me about your perceptions and experiences, please contact me and we can discuss what is involved in the study.

Work phone number is XXXXXX

Email XXXXXX

Looking forward to hearing from you

Carol Ashcroft



Sexuality-Related Practice in Nursing Education

Information Sheet

Researcher Carol Ashcroft XXXXXX
Email XXXXXX

You are invited to participate in a research study which is exploring the perspectives and experiences of nurse educators (at XXXXXX) of sexuality-related practice in nursing education. I am a nurse educator at XXXXXX and this research is being completed as part of a Masters of Education degree at Massey University at Wellington.

If you agree to participate in this study, you will be asked to take part in 1- 2 personal interviews with myself. I anticipate that the interviews will be of 1-1½ hours at a place and a time convenient to you. These interviews will be audio-taped, with your permission and the tapes will then be transcribed onto computer disks.

- You may refuse to answer a particular question or ask for a section of the tape to be wiped.
- You can ask that the tape be stopped at any time during the interview
- You may withdraw from the study at any time.
- I will answer any questions you have before or during the interview as they arise.

All information will have a pseudonym attached so that no information will identify you and this information will only be available to the transcriber, academic supervisors and myself. The transcriber has signed a confidentiality

agreement. You will have the opportunity to edit the transcribed material prior to any data analysis.

The information (tapes, transcripts and disks) will be kept in a locked filing cabinet at my residence. All disks and transcriptions will be held by the research supervisors for five years following completion of the study. The interview tape will be returned to you on completion of the study.

This study will be written up in the form of a thesis and the findings will be shared with other nurse educators. It is hoped that the results of this study will be published in a professional nursing journal. Some extracts from interviews will be quoted but no information which could identify you will be included. The thesis will be available to read at the completion of the study.

My research supervisors are:

Sue Purnell, Massey University at Wellington.

Ph: 04 901 2794, Ext 6522

Email S.L.Purnell@massey.ac.nz

marg gilling, Massey University at Wellington,

Ph: 04 901 2794, Ext 6662.

Email m.gilling@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, WGTN. Protocol 03/119. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Wellington Human Ethics Committee: Ph 04 801 2794, ext. 6358, email J.J.Hubbard@massey.ac.nz.

Thankyou for taking the time to read this information and I hope you will consider participating in this study.

Carol Ashcroft

**Sexuality-Related Practice in Nursing Education****Consent Form****Researcher**

Carol Ashcroft Ph XXXXXX
Email XXXXXX

I have read and understood the information sheet for volunteers to take part in this study. I have had the opportunity to discuss this study with the researcher and I am satisfied with the answers I have been given. I understand that taking part in this study is voluntary and that I may withdraw at any time. I understand that my participation in this study is anonymous and that no material which could identify me will be used in any reports of this study, unless I authorise as such. I have had time to consider whether to take part and I know who to contact if I have any questions about the study.

I consent to my interviews being audio-taped Yes/No

One copy of the consent form will be retained by the participant.

I voluntarily agree to participate in this study under the circumstances set out in the Information Sheet.

Signed _____

Witnessed _____

Date _____

Name _____

**Sexuality-Related Practice in Nursing Education****Transcriber Confidentiality Agreement**

I _____ have accepted the task of word processing the research data collected by Carol Ashcroft in order to complete a Master of Education Degree at Massey University at Wellington.

I understand that the data gathered for this research is confidential and I agree to take all necessary steps to ensure that any material on audio-tape or computer disk containing data from the interviews relating to the research will be:

1. Heard only by me and transcribed to disk in private.
2. Stored safely until returned to the researcher.
3. Treated as confidential.
4. At the completion all data on my computer will be deleted.

Signed _____ Date _____

Witnessed _____ Date _____

Full Name _____

9 July 2003

Carol S Ashcroft

Dear Carol

**Re: MUHEC: WGTN Protocol - 03/119
Sexuality-Related Practice in Nursing Education**

Thank you for forwarding the amended documentation as requested by the Massey University Wellington Human Ethics Committee.

The amendments you have made now meet the requirements of the Massey University Human Ethics Committee and the ethics of your protocol are approved.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Human Ethics Committee for further consideration and approval.

A reminder to include the following statement on all public documents, "This project has been reviewed and approved by the Massey University Human Ethics Committee, WGTN Protocol 03/119. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Wellington Human Ethics Committee, telephone 04 801 2794 ext 6358, email J.J.Hubbard@massey.ac.nz.

Yours sincerely



Jeremy Hubbard (Acting Chair)
Massey University Wellington Human Ethics Committee

Cc: Research Committee
Sue Purnell, College of Education, Wellington

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Te Kūmenga ki Pūrehuroa



Appendix Six

Semi-Structured Interview Guide

- What does the term sexuality mean to you?
- How do you think sexuality relates to nursing practice?
- How do you think sexuality-related practice relates to nursing education?
- What are your feelings on teaching sexuality-related practice to student nurses?
- Would you like to share some of your experiences of teaching sexuality-related practice with me?
- What preparation did you receive to enable you to teach sexuality-related practice?
- What are your feelings on the amount of sexuality content within the programme/curriculum?
- Do you think that all nurse educators should teach sexuality within the programme?
- Do you teach students how to take a sexual history and/or how to broach the subject of sexuality with clients?