The Lived Experience of Family Nurse Practitioners Performing Sexual Health Assessments

Madeleine Mary Lloyd

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THE LIVED EXPERIENCE OF FAMILY NURSE PRACTITIONERS
PERFORMING SEXUAL HEALTH ASSESSMENTS

by

MADELEINE M. LLOYD

A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

THE LIVED EXPERIENCE OF FAMILY NURSE PRACTITIONERS
PERFORMING SEXUAL HEALTH ASSESSMENTS

by

Madeleine L. Lloyd

Adviser: Professor Keville Frederickson

Sexuality incorporates a multitude of feelings including beliefs, fantasies, and aspects of pleasure, intimacy, and reproduction. In addition, sexuality involves rights to gender identity and role, sexual acts and orientation. Sexual and reproductive health and rights is a global health, development, and human rights priority. Universal access to sexual and reproductive health is essential. Negative sexual health outcomes are increasing in the United States and sexuality is often a neglected area for health providers including nurses. With an increasing share of the primary care services nationally, family nurse practitioners (FNPs) have the means to provide quality sexual health care across the life span and improve universal access and sexual health outcomes. The purpose of this qualitative study was to understand the lived experiences of female FNPs when performing sexual health assessments on their adult clients in primary care. Family nurse practitioners are educated and trained to provide holistic, client centered nursing care inclusive of sexual health assessments. The study included in-depth interviews with ten female FNPs. These interviews were analyzed using van Manen’s interpretive phenomenological approach. The Self-Concept Mode of The Roy Adaptation Model guided this study. Understanding the phenomenon of the lived experience of female FNPs illuminated the common experiences and shared meanings for FNPs. The interpretive statement was: The performance of
A sexual health assessment by FNPs on their adult clients in primary care is the development of presence and prudence in relation to their level of their self-concept. Since sexual health affects all human beings, there are global nursing implications for education, practice, and research in understanding the meanings of the essential themes of presence, prudence, and self-concept.
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Madeleine (Mimi)
Dedication

This study is dedicated to the memory of my grandparents, Reginald and Eve Brown (Popa and Nana) who provided me with a delightful childhood environment to learn, play, and read. It was through their fun play, Big Bun, and a lovingly home cooked meal that I was able to achieve entry into SACAE in Adelaide, Australia. The beginning of it all. I am eternally grateful. What wonderful role models and cherished memories.
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Chapter I

Aim of the Study

Sexual and reproductive health (SRH) and rights are fundamental to individuals, couples, and families, and to the social and economic development of communities and nations (World Health Organization, WHO, 2014). Demands for SRH services are projected to grow and are becoming increasingly important areas of concern by global and national health care organizations (WHO, 2011& 2014). A study by Auerbach et al. (2012), reported this increase would be between 10% to 20% by the year 2020. It is vital that primary health care providers provide universal access for SRH services that are non-discriminatory (Center for Disease Control and Prevention [CDC], 2014; WHO, 2011).

Nurse practitioners, (NPs) including family nurse practitioners (FNPs), provide at least 16% of the primary care visits among the workforce population in the United States (U.S.). Family nurse practitioners comprise 48.9% of the national NP workforce (American Association of Nurse Practitioners (AANP), 2014) and approximately 76% of all NPs practices are in at least one primary care site (Burman et al., 2009, AANP, 2014).

Family nurse practitioners (FNPs) are predominately female (91%) and are educated to assess sexual health comprehensively and to discuss health promotion and disease prevention activities using a holistic client centered framework (AANP, 2014; National Organization of Nurse Practitioner Faculties [NONPF], 2014). The foundation of a comprehensive sexual health assessment begins with a thorough sexual history (Kaplan, 2009). It is the first step toward appropriate diagnosis and therapeutic intervention for most clients, and is a fundamental part of holistic nursing care (Hoglund & Ash, 2013). The Sexuality Information and Education Council of the United States (SIECUS, 2013) identified an urgent need for a new approach professionally
and publicly that promotes a broad, holistic framework for sexual health throughout the lifespan. Holistic care encompasses many facets of a client’s life and it is important for FNPs to recognize how sexual development depends upon particular family, cultural, physiological, and psychological circumstances. This holistic approach to client care supports FNPs involvement in a national coordinated strategy for creating a sexually healthier America.

The provision of sexual health care is a neglected area in primary care. According to Loeb, Lee, Binswanger, Ellison, & Aagaard (2011), 75% of primary care providers including FNPs, do not take a sexual history despite being an important component of holistic nursing care, a central part of human existence, and an increase in negative sexual health outcomes in the U.S. (CDC, 2011; East & Hutchinson, 2013). The Patient Protection and Affordable Care Act (2010) has positioned FNPs at the forefront of primary care, however, a national study by Maes & Louis (2011) reported only 2% of the NPs questioned conducted a sexual history with their clients age 50 and older, while 23.4% never or seldom do sexual health assessments. In addition, nurses continue to address sexual health in their practice less than their clients would desire (East & Hutchinson, 2013).

Over the past 20 years researchers have focused on nurse’s attitudes, comfort, knowledge, fears, and barriers to providing sexual health care using predominately quantitative methods, (Maes & Louis, 2011; Herson, Hart, Gordon, & Rintala, 1999; Lewis & Bor, 1994; Saunamaki & Engstrom, 2013). Additionally, the permission, limited information, specific suggestions and intensive therapy (PLISSIT) model (Annon, 1976) has been referred to in several studies as a guide to assist nurses and NPs to approach their client’s sexual history (Albaugh & Kellog-Spadt, 2003; Lewis & Bor, 1994; Longworth, 1997, Wallace, 2008) yet sexual health is still inadequately assessed.
There are no qualitative studies on female FNPs in primary care exploring how performing sexual health assessments on their adult clients make them feel. The experiences for female FNPs when performing sexual health assessments on their adult clients in primary care are important to human health and understanding. Knowing more about this illuminated the meaning of sexual health assessments for FNPs and provided new knowledge to guide further research, education and practice. The purpose of this qualitative, phenomenological study was to answer the research question, what is the lived experience of female FNPs when performing sexual health assessments with their adult clients in primary care. Adults in this study are aged eighteen years and older.

The Phenomenon of Interest

The phenomenon of interest in this study was the lived experience of female FNPs when performing sexual health assessments in primary care. To support the international SRH needs and essential human rights priority set by the WHO (2014), and the United Nations (2014), understanding the lived experience of FNPs when performing sexual health assessments on their adult clients is a critical component of improving the sexual health and well-being of individuals. The lived experience was selected to explore the unexamined assumptions of the FNP’s reality when performing sexual health assessments. There were an estimated 205,000 licensed NPs in the U.S. as of 2014, with 87.2% prepared in primary care. Since female FNPs (91%) are the substantial majority of NP providers, this study selected only female FNP participants (AANP, 2014). This study focused on adult clients as child and adolescent sexual health assessments deserve their own study due to the complexities of assessing minors. Additionally, Stevens (2005) conducted a pilot qualitative study exploring 3 unidentified specialty NPs’ experiences with adolescent sexual health.
Sexual health, as a formal concept was first defined in 1975 by the World Health Organization (WHO, 1975). Sexual health is a dynamic and non-static concept that reflects the cultural, historical, personal, and community attributes of time and place. The concept is broad in meaning and human’s rights to sexual health are well recognized and documented (Saunamaki & Engstrom, 2013; UN, 2014; WHO; 2014). The concept has developed significantly since 1975 and today nurses and NPs need to be informed and educated about the many aspects of human sexuality (Dahir, 2011; Giami, 2002; & WHO, 2011).

Sexual health adversity can accompany ill health and the provision of appropriate nursing care is required for disease treatment, disease prevention, and improved quality of life (Akinci, 2011; Ayaz, 2013; Steinke & Patterson-Midgley, 1996). Studies have highlighted the avoidance by registered nurses and NPs to address their client’s sexual health needs despite being recognized as a component of holistic nursing care and seen as an important component (East & Hutchinson, 2013; Gott, Galena, Hinchliff & Elford, 2004; Kotronoulas, Papadopoulou, & Patiraki, 2009; Maes & Louis, 201; Saunamaki & Engstrom, 2013).

Sexual health care in nursing is often not prioritized despite nurses being in a prime position to promote sexual health and well-being. Some of the perceived barriers for this nursing avoidance of sexual health assessments are the nurses’s:

- Lack of knowledge specifically about sexual issues,
- Lack of guidance from employers,
- The nurse’s time constraints,
- Lack of privacy on the wards,
- Large workload, the nurse’s assumption that it is not their responsibility and,

In addition, sexual health research studies have emerged that described the role of the nurse practitioner and their sexual health knowledge within specific NP specialties; such as the women’s health specialty, adolescent, sexual medicine, and older adult clients but none relating to FNPs in primary care (Dahir, 2011; Hughes & Wittmann, 2014; Maes & Louis, 2012; Mansell, Salinas, Sanchez, & Abdulrasulnia, 2011; Mena, 2010; Tomnay & Wallis, 2012).

The National Organization of Nurse Practitioner Faculties core competencies (NONPF, 2014) reported the ability to obtain a comprehensive health history, inclusive of a sexual health assessment, and perform a complete physical examination is an integral component of the FNP role. However, there are no formal practice core competencies published to date by NONPF specifically describing the components of a sexual health assessment. “Women’s and men’s reproductive health, including, but not limited to, sexual health, pregnancy, and postpartum care” (NONPF, p23). Additionally, there are no statements by major organizations on inclusion of sexuality education in nursing and medical schools. What the criteria for a sexual health assessment is undetermined. In the clinical setting, therefore, evaluation forms based on the national core competencies and domains for FNPs have no specific sexual health assessment objectives for performing a sexual health assessment.

Health promotion in a FNP model is directed towards empowerment and self care, with an emphasis on promoting positive health behavior change. It includes FNP actions that support lifestyle changes to prevent disease and promote health, not simply manage disease. In addition to health promotion, the FNP treatment plan includes three other areas; 1. Client specific

For clients, a comprehensive sexual health history provides an opportunity for open discussion about the sexual aspect of their life. For the FNP, pursuing a sexual health assessment acknowledges that part of their clients’ lives, provides a more holistic view and creates an enhanced outcome for both parties. However, health orientated literature on the positive dimensions of sexual health is limited in the nursing literature and this absence seems to contradict the emphasis placed on holism as the basis for nursing care (Finan, 1997). To this researcher’s knowledge, to date, there has been no work published that specifically studied the lived experience of female FNPs in primary care when performing sexual health assessments to uncover the meaning of this phenomena.

It is essential to understand the lived experience of FNPs in primary care when performing sexual health assessments to better understand human relationships from the perspective of the FNP and translate this understanding into effective and sensitive clinical nursing care. The research question that guided this study was, “What is the lived experience of female FNPs in primary care when performing sexual health assessments on their adult clients?” The study used Max van Manen’s (1990) interpretive phenomenological design to explore this phenomenon of interest. In studying the lived experience of female FNPs when performing sexual health assessments on their adult clients in primary care, an understanding of this phenomenon was obtained for the advancement of nursing knowledge into this essential area of practice.

**Phenomenon within Specific Context**
The phenomenon under study is the lived experience of female FNPs. The context for this study is a female FNP in primary care when performing sexual health assessments on their adult clients. Within this specific context an understanding of the female FNPs lived experience when performing sexual health assessments on their adult clients in primary care and a description of a thematic interpretative statement was the outcome. The knowledge gained will guide research, education, and practice of health professionals with clients in primary care settings, clients’ homes, and in other healthcare settings.

Sexual health assessments with clients create an opportunity for holistic client centered care, which facilitates communication about human sexuality (Hardin, 2013). All nurses are educated about the components of holistic nursing care (Dattilo & Brewer, 2005), which endorses the exploration of biological, psychological, social, cultural, emotional, and spiritual needs of all clients. Nursing theorists such as Peplau (1991), Rogers (1970), Roy (1984), and Parse (1998) all promoted a holistic framework in their conceptual models that includes the client’s sexuality. Building on nursing theorists such as Roy (1984), the FNP incorporates both nursing and medical knowledge using a holistic approach to help move the client to wellness (Hoglund & Ash, 2013). Given that holism is the scientific assumptions of nursing practice within the four domain concepts of person, health, environment, and nursing; it is essential that sexual health and sexual awareness be part of the FNP’s role.

The Healthy People 2020, a program of nationwide health promotion and disease prevention goals, as defined by the U.S. Department of Health and Human Services (USDOHHS, 2011), was first established in 1979 and are updated every decade. Currently, the leading health indicators reflect national high-priority health issues and communicate actions that can be taken to address them. Goals to reduce chronic diseases such as HIV/AIDS, reduce teen
pregnancies, and encourage responsible sexual behavior, suggest that FNPs must have the latest knowledge about human sexuality to assess clients’ sexual health and to improve the health of the U.S. population (USDOHHS, 2011).

The WHO in 2011 published SRH core competencies in primary care that reflect the attitudes, tasks, knowledge and skills needed by FNPs to protect, promote, and provide SRH services. In primary care, FNPs are one of the major entry points into preventative health care and are positioned to provide SRH services to clients (Wilmouth, 2007). Until there is an understanding of the experience of FNPs when performing sexual health assessments, meeting the goals of delivering comprehensive, quality, holistic nursing care with improved awareness, education, and sexual health outcomes will continue to not be achieved.

Physicians trained the first FNPs using the medical model for comprehensive health assessments and interventions (Dahir, 2011). The clinical development of FNP students was dependent on mentorship from primary care physicians. The medical model focuses on a solitary approach to the body according to individual systems and is not inclusive of the traditional holistic nature that is the philosophical underpinnings of nursing models of care (Barton, 2006). Nursing’s focus includes a strong health-teaching component, and is concerned about prevention of illness and health promotion (Chinn, 2013).

As the FNP role developed in the early years and FNPs were preparing to take over the education of other FNPs, the questions arose about the use of a nursing model as a framework for teaching and practice. Phillips (2010) explored the use of nursing science as a theoretical framework and suggested that nurses who believe in nursing science advocate the use of nursing theories and models as a framework for their health assessment. Additionally, nurses who doubt nursing science use nursing theory to a limited degree and rely on other scientific models and
theories. Phillips also reports that nurses who ignore nursing science primarily use medical models. Regardless of the nurse’s beliefs, all nurses deliver nursing care but the question that arises is “which approach to nursing presents [an effective] understanding of the wholeness of people and their environments?” (Phillips, 2010, p. 55).

The Roy Adaptation Model (RAM) (1984, 2009) is among many nursing models and theories to discuss nursing as a science and provides direction for the nursing process. A sexual health interview is integrated into the person’s total health assessment to provide holistic nursing care. The most significant factor affecting the sexual health assessment according to Roy (1984) is the nurse and their comfort level with his or her own sexuality. Roy’s model suggests comparable themes for FNPs. Individual beliefs, attitudes, and values toward sexuality will determine how the FNP interacts with the person. Being aware of one’s biases is the first step in overcoming the feelings of discomfort (Eckroth-Bucher, 2010). A nurse’s knowledge regarding sexual development, expression, reproduction, and sociocultural-spiritual aspects of sex, partnerships, and the family are needed for FNPs to perform a sexual health assessment including knowledge about sexual dysfunction and disease. Findings from this study developed knowledge on the FNP’s participant’s comfort level when performing a sexual health assessment on their adult client in primary care and supported Roy’s (1984) earlier findings.

Relevance to Nursing

The U.S. leading causes of death such as coronary artery disease, diabetes, obesity, hypertension, heart failure, smoking, and lung disease potentially have a significant impact on sexuality and sexual health (Bradway & Boullata, 2014; Ayaz, 2013, Steinke, 2010). In addition to physiological chronic diseases, many other facets influence human sexuality and sexual behavior such as social, emotional, psychological, cultural and spiritual, gender role and
expectations, sexual identity, and sexual experiences (Saunamaki & Engstrom, 2013, Finan, 2007). The quality of life for clients can be enhanced when the FNP uses a holistic nursing assessment approach. It is the FNP’s responsibility to assist, support, and provide care to all clients inclusive of their sexual health. However, these multidimensional aspects of sexual health and behavior raise many clinical, practical, and ethical concerns, which can represent a challenge for the FNP when performing a sexual health assessment (East & Hutchinson, 2013, & Hayter et al., 2013).

Client sexual concerns may arise from psychosocial issues (American Psychiatric Association, 2013; Cort, Attenborough, & Watson, 2001), from myths and fears (East & Jackson, 2013), after a post-surgical procedure (Levine et al., 2012), after an acute cardiac event and a new cardiovascular disease diagnosis (Steinke et al., 2013), from side effects of medications (Bradway & Boullata, 2014), from hormone imbalances (Kazer, Grossman, Kerins, Kris, & Tocchi, 2013 & Kaplan, 2009), and from aging (Muliira & Muliira, 2013). The American Psychiatric Association (2013) defined sexual dysfunctions to include delayed ejaculation, erectile disorders, female orgasmic disorder, female sexual interest/arousal disorders, genitopelvic pain/penetration disorder, and substance/medication-induced sexual dysfunction. Ayaz (2013) emphasized the need to include psychosexual awareness when assessing clients. The information gained may be useful to highlight educational needs and practice suggestions for better integration of client sexuality concerns with holistic care. Since FNPs are considered primary care providers and work in a variety of settings they have unique opportunities to address client sexuality and their sexual function during a routine health and physical exam (Bradway & Boullata, 2014, Ayaz, 2013 & Levine et al., 2012).
There are many advantages to addressing sexuality in a primary care practice setting including the ability to improve health outcomes (Steinke, et al., 2013, Wallace, 2008) to develop a relationship between nurse and client, and to provide opportunities for discussion (Kim, Kang, & Kim, 2011, Longworth, 1997). Additionally, FNPs can help clients understand how sexual feelings may be affected by illness, childbirth, medications, and hospitalization (Muliira & Muliira, 2013, Finan, 1997, WHO, 2011).

Previous research studies have explored in a quantitative fashion the barriers to incorporating a sexual assessment into FNP’s practice and examined the FNP’s attitudes and beliefs about sexual activity (Maes & Louis; 2011, & Mena, 2010). Studies have shown that nurses tend to avoid sexual health issues with their clients although they regard it as an important area to address (Jaarsma et al. 2010, Saunamaki & Engstrom, 2013, Guthrie, 1999) and feel that clients do not expect to be asked about their sexuality (Magnan, Reynolds, & Galvin, 2005, Cook, 2000). In contrast, other studies have reported clients wanting to be asked about their sexual health (Sadovsky & Nusbaum, 2006; Southard & Keller, 2009; Vitrano, Catania, & Mercadante, 2011). By interviewing female FNPs in primary care, an understanding of the lived experience when performing sexual health assessments illuminated the essence and informed what the FNPs felt when performing sexual health assessments. This study contributes to the discussion of the science and art of nursing as it relates to sexual health assessments.

**Justification for the Study**

Nursing is the nation’s largest health care profession and most health care services involve some form of care by nurses (American Nurses Association [ANA], 2013). Female FNPs are the largest subgroup of NPs and are key providers of primary care including SRH services in the U.S. (Auerbach et al., 2012). “Nurse practitioners are responsible for ensuring that all
Americans have access to high quality, comprehensive sexual and reproductive health care” (Auerbach et al., 2012, pg 55). Family nurse practitioners need an accurate sexual health assessment of clients in order to screen, treat, and manage their sexual health needs including sexually transmitted infections (STIs), assist with family planning, and identify sexual dysfunction needs. Yet, studies have shown that FNPs in primary care do not routinely document the sexual health of patients when performing a routine health maintenance visit (Ayaz, 2013; Dahir, 2011).

Researchers have consistently found, over the past 35 years, that FNPs provide safe, cost-effective care (Donald et al., 2014; Horrocks et al., 2002; Laurant et al., 2009) that is comparable to the care provided by physicians. Additionally, clients are satisfied with the care provided by FNPs (DiCenso et al., 2003; Donald, 2014) and they trust the NPs’ clinical decisions (Benkert, Hollie, Nordstrom, Wickson, & Bins-Emerick, 2009). Clients also feel that FNPs listen to their problem and discuss their concerns (Thrasher & Purc-Stephenson, 2008), and believe that FNPs are approachable and have expert communication skills (Beal & Quinn, 2002). Known for longer consultation times with clients, FNPs ensure that their clients receive more information (Kinnersley et al., 2000) and counseling (Sidani et al., 2006) to emphasize health promotion, and involve clients in self-care management of their chronic and acute conditions (Charlton, Dearing, Berry, & Johnson, 2008).

Researchers have demonstrated the nature of NP practice that is grounded in nursing tenets dating back to Florence Nightingale (Keeling & Bigbee, 2005). What is less apparent is how the evaluation of this approach to care can be translated into a format that health care decision makers can understand. The results of this study contribute to the existing body of scientific literature on FNP health assessments including sexual health assessment. The FNP’s
interpretative statement was illuminated. Therefore, the purpose of this qualitative, phenomenological research study was to explore the lived experience of female FNPs in primary care when performing sexual health assessments on adults.

Assumptions and Biases

My biases and assumptions for this study come from a professional role as a practicing FNP, clinical preceptor, and educator for over 20 years. In primary care there is often a mental health connection to each physiological symptom and this connection is particularly true with client’s sexual health issues. I assumed that all FNPs should be performing comprehensive health assessments that include a sexual health assessment and I align myself with Sr. Calista Roy’s (1984) beliefs about the nurse’s comfort level with their own sexuality will determine the performance of a comprehensive sexual health assessment. I have seen well-meaning colleagues and student FNPs when performing sexual health assessments where the focus is only on the negative aspects of sexual health such as STI screening. Rarely is sexual health discussed as a positive experience with their clients. When a comprehensive sexual assessment is not completed the FNP is silencing the voice of sexual health exploration with their clients (Tolman, Striepe, & Harmon, 2003).

Questions regarding sexual behavior, sexual abuse, sexual orientation, the effects of aging, pregnancy, and the sexual side effects of medications, are rarely asked. Discussions about how clients see themselves, how they actually behave, and what their sexual desires are, is often what clients want to talk about when given the opportunity. I believe that to obtain a comprehensive sexual health assessment within a holistic framework, a trusting, nurse-client relationship must be established first and then this relationship can be nurtured through time.
Therefore, a caring relationship between client and nurse must be conveyed to the client so that an effective sexual health assessment can be performed.

**Summary**

Chapter one describes the phenomenon of interest for this phenomenological study, which is to understand the lived experience of female family nurse practitioners when performing a sexual health assessment in primary care on their adult clients. This understanding will describe the lived experience of family nurse practitioners when performing sexual health assessments. The researcher’s assumptions and biases were revealed. Chapter two will describe the evolution of this study, identifying historical, theoretical, and experiential contexts.
Chapter II

Evolution of the Study

Despite the implementation of the WHO Reproductive Health Strategy from 2010 to 2015 to strengthen SRH services there are unmet need for contraception, a lack of comprehensive SRH services for adolescents and young people, poor prevention and management of the consequences of unsafe abortion, gender inequality, violence against women and girls, and high rates of cancers related to reproduction. Some of the identified reasons are the inequalities between and within countries, persistent disparities between women and men, and between social and ethnic groups (The United Nation’s Secretary-General’s report, 2014, & IOM, 2011b).

The U.S. lacks an integrated approach to sexual health and sexual health outcomes are poor (Swartzendruber & Zenilman, 2010; CDC, 2014). For example, despite the widespread prevalence of Human Papillomavirus Virus (HPV) in the U.S., which affects four out of five people, approximately half of all U.S. adolescent females have never been vaccinated, and only one-third have received the recommended 3-dose vaccination. In contrast, approximately 80% of females aged 14 to 19 years in Australia, received at least one dose of the HPV vaccine in 2012, and 70% completed the full series (Jena, Goldman, & Seabury, 2014).

The incidence of human immunodeficiency virus (HIV) has not decreased since the 1990s and rates of sexual transmitted infections (STIs), unintended pregnancy, teen pregnancy, and abortion are higher in the U.S. than in many developed countries (CDC, 2014; Robert & Frantz, 2014; Swartzendruber & Zenilman, 2010). Lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons have significant health disparities as compared to heterosexuals on almost all leading health indicators (Unger, 2014; Beagan, Fredericks, & Goldberg, 2012; IOM,
2011b) and women of color fare worse than white women in every aspect of reproductive health (CDC, 2014). The provision of health care has not kept up with the increased incidences of negative sexual health outcomes. Some of the suggested factors for this are poverty level, low education levels, access to quality sexual health services, and minorities’ distrust and fear of discrimination from health care providers. (CDC, 2014; Institute of Medicine [IOM], 2011a).

Family nurse practitioners started practicing in the U.S. over 50 years ago and today the role has been implemented in at least 60 different countries (Sangster-Gromley, Martin-Misener, & Burge, 2013b). However, there is a lack of international consensus on how to best define, introduce or implement the FNP role into primary care and there is a need to establish best practices guidelines for continued knowledge development of factors affecting successful role implementation (Sangster-Gromley et al, 2013; Delamaire & Lafortune, 2010). It is essential that FNPs are able to fully enact their full scope of practice to provide holistic care inclusive of sexual health to all clients nationally and internationally.

As primary care providers, FNPs in the U.S. are well positioned to address health disparities including gender and sexual minorities, reducing the prevalence of STIs, and improve the general quality of care for all (USDOHHS, 2011). Historically, sexuality and sexual health have not been a health care priority across all genders, particularly within the nursing context despite sexual problems being highly prevalent for both men and women (Ayaz, 2013; IOM 2011b). Family nurse practitioners pride themselves on providing holistic and patient centered care; however, integrating sexual health and associated care regarding sexuality into practice is challenging (Hayter et al., 2013). This may be in part due to knowledge, education, and confidence (East & Jackson, 2013). Furthermore, human sexuality is multidimensional
incorporating social, biological, emotional, psychological, cultural, and spiritual dimensions (Hayter et al., 2013).

There is a need to understand the many other dimensions that raise clinical, practical, and ethical concerns for FNPs when performing sexual health assessments to work towards providing comprehensive, holistic nursing care that includes sexual health. It is important that FNPs embrace, engage, and contribute to the discourses on sexuality and safer sex. Understanding the lived experiences of female FNPs when performing sexual health assessments is the first step towards improving sexual health outcomes. This study facilitated nursing to move closer to the goals of providing holistic client center care that is inclusive of sexual health. Clinical decisions made by FNPs and resources they draw upon are not well defined (Nieminen, Mannevaara, & Fagerstrom, 2011). Some of this ambiguity of client care can be explained by reviewing the history of the FNP’s clinical role, education, and the social and political changes in sexual health care.

**Historical context of the nurse practitioner**

Florence Nightingale in 1859 was the first nurse to address the importance of a comprehensive assessment including the reason for critical observation.

> It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort…if you cannot get the habit of observation one way or another you had better give up on being a nurse, for it is not your calling, however kind and anxious you may be (Nightingale, 1968, p.125).

The late nineteenth and early twentieth century began the modern age of nursing and with it a reshaping of traditional care, new technology, and new nursing paradigms. Additionally, professional consciousness-raising created new practice models and recognition of nursing
knowledge created within a social-political context (Kagan, Smith, Cowling, & Chin, 2009). A pediatric nurse, Loretta Ford, initially conceptualized the role of the nurse practitioner in the mid-1960s. It was her vision that introduced a new nursing model of advanced care in the U.S. The role developed as a solution to increase access to health care services in primary care especially in rural settings. Community health nurses expanded their training in physical and psychosocial assessments and provided advanced, comprehensive nursing care to children in Colorado (McGivern, 2010).

The first FNP training program was based in Colorado and was started in 1971. It included four months of intensive theory and practice in a medical center supervised and trained by physicians. Family nurse practitioners performed comprehensive physical assessments after completing courses in normal growth and development, variations of growth patterns, and psychosexual development (Leitch & Lang, 1983; Sox, 1979). The overarching objective of the FNP’s program was to increase both technical functions (seen as cure-related) and to expand the traditional nursing (seen as care-related) functions (Asubonteng, McCleary, & Munchus, 1995). The focus for FNPs was to bring the concepts of family nursing and holistic care into primary care. The initiative of nursing addressing the ‘whole’ person incorporates the idea that FNPs would complete comprehensive assessments of their clients. The FNP role depended on the assistance and cooperation of physicians for clinical training. Formally prepared FNPs and trained nursing faculty were sparse. Therefore, teaching clinical health assessment initially lacked a nursing theoretical framework (Bates & Lynaugh, 1973).

In spite of the support FNPs had in the 1980s, some physicians were opposed to the FNP model. In 1985, the American Medical Association voted to discontinue federal funding support for FNP educational programs despite documented studies attesting to the nurse practitioners’
value. Nurses, traditionally, are in the realm of caring and medicine in the curative realm. Conflict surrounded the FNP’s role-task expectations as it overlapped with the cure-care functions. Health care is inoperable without both functions and hence nursing and medicine have interdependent roles (Asubonteng, et al., 1995).

Formalized training at master’s level obtained greater professional and economic recognition, and provided FNPs with a professional nursing organizations certification. In 1997, after several years of lobbying, FNPs obtained Medicare provider status and gained reimbursement for their health care services in a primary care setting (O’Brien, 2003).

Professional roles and scopes of practice have adapted for the FNP with changes in technology, politics, consumer knowledge, and economics. As a result, changes in nursing curriculum have led to the development of new knowledge and an increased emphasis on the synergy between the client and the FNP. Evidence of adaptation has come from the expanding roles of FNPs as described in The Institute of Medicine report, The Future of Nursing: Leading Change, Advancing Health (2011a) and by Congress passing The Patient Protection and Affordable Care Act (2010). Both documents demand the profession of nursing to examine new ways of delivering high quality care to more clients across all settings.

Family nurse practitioners work in a variety of settings from small and large, private and public practices, in clinics, schools, and workplaces and in both urban and rural settings. Depending on each state’s licensing laws, FNPs function independently and/or in collaborative practice agreements with physicians. Despite these advances, disagreement and uncertainty exists by some as to where role boundaries between nursing and medical and allied health professionals begin and end (Naylor & Kurtzman. 2010). How this has influenced the FNP’s ability to perform a comprehensive sexual health history is unclear.
Today, FNPs are registered nurses who have advanced education and advanced clinical training, which gives them the expertise to provide a wide range of primary and acute health care services to individuals of all ages. Graduate-level education preparation leads minimally to a master’s degree with a specialty in family (AANP, 2014). As stated in The Future of Nursing: Leading Change, Advancing Health (2011a) and The Patient Protection and Affordable Care Act (2010) the need for advanced practice nurses continues to grow and in particular the need for FNPs in primary care continue to grow. As a result, the impact FNPs can have on performing sexual health assessments and providing holistic nursing care in the future is significant.

**Historical context of sexual health**

The evolution of sexual health dates back to the mid-19th century with a primary social orientation towards procreation. Marriage was the only recognized social situation in which sexual activity and procreation was legitimized (Edwards & Coleman, 2004). During the 1960s, this prospective changed with the feminist movement, the sexual revolution, and the introduction of oral contraception. The concept of reproductive health emerged as an individual choice and human right and the contraceptive pill created a legitimate medical reason for distinguishing between sexual activity and procreation. The sexual revolution developed three areas: 1. Premarital sex, 2. Liberation of female sexuality, and 3. A greater willingness to talk openly about sex but not in the health care environment (Rathus, Nevid, & Fichner-Rathus, 2005).

In 19th and 20th century America, the health care environment was male dominated and within a patriarchal culture (Ehrenreich & English, 1974). Female participants in research studies were virtually absent. In 1966, Masters and Johnson published the “human sexual response” and discussed orgasm including female orgasm but from a male prospective. This started a proliferation of academic women studies in illuminating women’s experiences of sexuality but
often using a male model framework.

The World Health Organization (WHO) published the first international concept of sexual health in 1975. In the early 1980s, in response to the HIV-AIDS epidemic, STIs prevention strategies developed, sexuality changed from an individual focus to population health based, and acknowledgement of diverse sexual cultures was noted. For the first time nursing research emerged focused on sexual behavior including the effects of divorce on family relationships (Fitzpatrick & Kazer, 2012). Most recently, erectile dysfunction and sexual disorders including female sexual dysfunction were defined with expanded treatment options available across genders and sexual orientation (APA, 2013). Health insurance companies started to reimburse for sexual health treatments, and include pharmaceutical agents as a treatment option. Sexual dysfunction has been recognized as a legitimized “disease” that requires assessment, evaluation, and treatment (APA, 2013).

In 2011, the IOM (2011b) released a report *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* which identified data collection on gender identity and sexual orientation necessary to form a better understanding of each of these groups at different stages in life. *Healthy People 2020*, for the first time acknowledged health disparities in the lesbian, gay, bisexual and transgender (LGBT) populations requiring health care changes to provide quality, accessible care for people self-identified as LGBT. A report by Fenway Health (2013) reported that 50% of transgender people report having to educate their medical provider about transgender health care.

United States Vice President Joe Biden called transgender discrimination “the civil rights issue of our time” (Hartofelis & Gomez, 2013). Despite increasing public awareness of the health care disparities among transgender individuals, this population remains one of the most
marginalized and underserved in healthcare. The most common barriers to health care access in this group included reluctance to disclose gender identity (32%), lack of healthcare provider sensitivity/experience in treating transgender patients (32%), and financial barriers such as lack of health insurance (64%) and inability to pay (46%) (Xavier, 2000). Lack of awareness, knowledge, and sensitivity among healthcare providers deepens the health care disparities for this population. Due to fear of discrimination by healthcare providers, one third of transgender individuals, and 48% of transgender men have avoided preventive health care (National Center for Transgender Equality, 2012).

Most FNPs did not learn about LGBT sexual health concerns and are unaware of the kind of discordance between sexual identity and sexual behavior in nursing school (IOM, 2013). Discussions on gender identity and sexual orientation is recommended for all encounters (IOM, 2013). Literature reports that negative provider attitudes toward sexual minority patients may negatively affect care for LGBT persons (IOM, 2011). However, it is still unknown if this finding in the literature is translated to actual provider behavior. This study gained insight into an understanding of the FNP participant’s experiences with diverse adult clients.

**Experiential Context**

I started my nursing career 31 years ago in Adelaide, Australia as a nurse assistant in a private nursing home. I was 17 and the reality of living with chronic diseases and aging became real. I was unaware of the full scope of responsibilities and possibilities that existed with every nurse-client encounter. As my career progressed my clinical encounters brought me to a new level of exploration and have helped me to refine and focus my contributions as a nurse.

In 1991, I was recruited by a major New York City hospital and relocated as part of the solution to the nursing shortage in the U.S. I was assigned to a busy urban emergency room
I was initially shocked, then concerned about the lack of client access to primary care services and the misuse of the ER as a place for routine primary care.

Growing up in Australia, a national health care system (Medicare) allowed access to health care for every Australian. My family and I had the same family physician that took care of all health care needs regardless of urgency and/or time of day. I remember the physician would on occasion visit our home attending to our fevers, asthma attacks and vomiting. This continuity of health care inspired me to become a FNP. I wanted to teach patients the benefit of having a medical home and a consistent health care provider for preventative services and comprehensive routine care. I was unable to return to Australia at that time, as the role of a FNP had not been formally recognized.

My nursing goal in the U.S. was to, therefore, keep patients out of the ER and perform evidence based age appropriate health screening and preventative care. Today I can provide full scope primary care services, which includes health promotion, and disease prevention activities. I perform comprehensive health assessments that include sexual health assessments adapted to each individual’s need and use this opportunity to incorporate positive sexual health promotion as well as disease prevention.

After several years of practicing as a FNP, in a large busy primary care practice, I came to realize that the majority of health related issues contained a psychological component, either consciously or subconsciously. To strengthen my psychological knowledge and clinical skills, I returned to study and obtained a postmaster’s nurse practitioner certificate in psychiatric mental health. This expanded my nursing care plans to include psychopharmacological management for clients that I see in a primary care setting.
I have always been interested in the way that people experience the world. My view is that nurses assist and care for people to bridge internal and external experiences through meaningful interpersonal connection as well as through other therapeutic measures. I have often seen well-meaning clinicians silence the voices of clients by not asking sexual health questions or perform sexual health assessments. Not performing sexual health assessments brings about the FNP not having full information about the client that results in non-existent holistic nursing care, health inequities, and sub-optimal advance nursing care.

One of the most satisfying rewards as a FNP is having caring relationship with clients and their family members that is inclusive of their sexual health. Clients are comfortable to question their sexuality, share personal stories, acknowledge health concerns, and discuss issues that are private and clandestine. Clients are referred to me for comprehensive annual physical examinations including sexual health assessments. Many are the partners and family members of established patients. Some of the sexual health reasons for the client visit and referrals are physical abuse, child abuse, and lack of intimacy, family planning discussions, dyspareunia, sexual satisfaction, menopausal changes, STIs, and gender orientation discussions.

My experience has shown that conversations about these issues do not easily or naturally come up and the FNP has to set the tone and be educated to handle these issues when they arise. Having explored my own beliefs and feelings on sexuality has enabled me to have a strong self-concept and “become”. I now do not shy away from what at times can be difficult and uncomfortable conversations with clients as there is cancer to detect, physical/emotional abuse to stop, HIV transmission to be reduced, and a more enjoyable quality of life through intimate sexual relations to be enjoyed by all humans. A greater understanding of FNPs’ lived experiences when performing sexual health assessments were obtained.
Conceptual Context

Roy’s adaptation model of nursing provided the framework for this study (Roy & Andrews, 1999). The foundation to Roy’s Adaptation Model (RAM) is the goal of enhancing life processes through adaptation. Roy’s Adaptation Model (Roy, 1984) emphasizes the propositions that the individual is constantly interacting with their environment. The person, as thinking and feeling individual is viewed as an adaptive system with regular and cognator control processes that act through four effector modes (physiological, self-concept, role function and interdependence). Behavioral responses, such as sexual behavior and sexual identity, are classified as either adaptive or ineffective and are observed within and across the four modes. The philosophical assumptions of the RAM are based on humanistic values (Roy, 2009). The client is the focus of nursing, how a client and a nurse both adapt to their subjective experience is central to knowing and valuing. This model helped to focus on human life patterns that emerge from adaptive sexual health processes, thus advancing the understanding of people as adaptive systems over time (Perrett, 2007).

Human sexuality is a basic need of humans and affects the total well being of a person and is manifested by behaviors in the self-concept mode, role function and interdependence modes (Roy, 1999). Family nurse practitioners are educated in the physical, social, and behavioral sciences, which provide a foundation for the skills of assessment and counseling in the area of human sexuality. Family nurse practitioners deliver client–centered care, and create the environment for the care of the client (Hardin, 2013).

The goal of nursing within the RAM is to promote and maintain health and quality of life. Within the Roy model, clients define what being healthy means to them (Roy, 1984). Roy’s theory proposes that as adaptive systems, humans respond to stimuli in an effort to initiate a
coping process, which has an effect on behavior, which leads to responses that are either adaptive or non-adaptive (Roy, 2009). The FNP is responding to many forms of stimuli as they perform a sexual health assessment. Telling their lived experiences may be a part of the FNP’s adaptation. As the themes emerged from this study the applicability of the propositions of RAM were examined. The FNP role continues to be a dynamic and ever-adapting phenomenon that meets societal needs and complexities and transforms clinical practice (Callaghan, 2008). This study broadened the understanding of the female FNP’s lived experience when performing a sexual health assessment.

**Summary**

Chapter two described the historical context of the FNP role, the emergence of sexual health in the US and how its emergence in society reflected the prevailing culture, history, and politics of the time. The experiential context of the researcher was revealed in that there is a preexisting interest, self-awareness of performing a comprehensive sexual health assessment, and current clinical practice in the area of sexual health assessments in the primary care setting. The Roy Adaptation Model was introduced as a possible, theoretical context for the study.
Chapter III

Methodology

The purpose of this study was to explore the lived experience and understand the meaning of sexual health assessments from the perspective of female family nurse practitioners in primary care on their adult clients using Max van Manen’s (1990) phenomenological research method. The term lived experience is derived from the German *Erlebnis-* experience as we live through it and recognize it as a particular type of experience. The phenomenological approach centers on the early works of Husserl, Merleau-Ponty, and the phenomenological method of van Manen (1990/2012). This method explores directly the originary or prereflective dimensions of human existence and was used to investigate female FNPs experiences when performing sexual health assessments on their adult clients (van Manen & Adams, 2010).

Phenomenology, initially used by Emmanuel Kant in 1764, is a systematic process of uncovering and describing the internal meaning and structure as it is lived in one’s everyday existence, in their lifeworld, the world of their lived experience (van Manen, 1990). The aim of phenomenology is to produce descriptions of phenomenon so the essential structure of the experience is understood. Phenomenology offers a way to obtain an essence, which is the most essential meaning of the experience (Merleau-Ponty, 1945/1962/2002). Meanings are revealed from the perspective of the individual who experienced those feelings (van Manen, 2012).

**Phenomenology**

Phenomenology is the science in which we come to know the mind as it is in itself through the study of the ways in which it appears to us (Merleau-Ponty, 1945/2002). Phenomenology is the study of our experiences and how we experience them; our perceptions of what events we experience. Phenomenology attempts to identify the invariant features of how
objects are perceived and pushes our consciousness into reality to attribute how we perceive events. The essence of our consciousness is experienced in the first person and is defined by the first person.

These essences of our consciousness are then a description of the phenomenon. The objective of the research is in the investigation, interpretation, or description of what is, as consciously experienced. Phenomenology is considered to be a philosophy, an approach and a method (Husserl, 1931) and has been used in the discipline of nursing as such (Munhall, 2012). A phenomenological approach benefits nursing because as a discipline we are concerned with understanding the human being in a holistic manner. The perspective of humans and their lived experience about particular phenomena, such as female FNPs when performing a sexual health assessment, is the meaning to be shared with the listener, explored, and described in a cogent whole.

In conducting phenomenological research the focus will be the quest for meaning, the mystery of meaning, as well as the meaning of the FNPs’ responsibility for the clients, and for the organic, material, and technological world we inhabit (van Manen, 2012). The researcher chose this methodology to best confront the unexamined assumptions of the personal, cultural, political, and social beliefs, and views of FNPs when performing sexual health assessments. As FNPs shared their individual experience, the phenomenological method uncovered the essences of their experiences and essential themes were obtained. In this chapter the history and evolution of phenomenology will be discussed, specifically the philosophical viewpoint of Maurice Merleau-Ponty (1945/1962/2002) and the phenomenological method of Max van Manen (1990/2012) that guided this study.

**Edmund Husserl.**
Edmund Husserl (1859-1938) was one of the most influential philosophers of the twentieth century. He invented the “phenomenological method” for the analysis of physical and mental phenomena. As a transcendental phenomenologist, his main focus was on the pure description of the lived experience (Annells, 1996). His concept of the lifeworld is understood as what individuals experience pre-reflectively, without resorting to other’s interpretations (Dowling, 2005). Lived experiences involve the immediate, pre-reflective consciousness of life. Therefore, an attempt is made to understand the essential features of a phenomenon as free as possible from cultural context.

Through phenomenological reduction, Husserl (1931) asserted the elimination of all preconceived notions, whereby, a subject may come to know an essence directly. This is known as bracketing. Bracketing purifies the consciousness that he sees as intentional and necessary to achieve credibility, rigor, and to reduce bias. Intentionality refers to the internal experience and an inseparable connectedness of being conscious to the world (van Manen, 1990), therefore, essences is dependent on consciousness (Husserl, 1931). Husserl expanded upon Descartes’ proclamation, “I think” (Stumpf, 1994, p. 496); and stated “I think something” (Stumpf, 1994, p. 496). Husserl’s “something” eventually became known as phenomena.

Maurice Merleau-Ponty.

Merleau-Ponty (1908-1961), an existential phenomenologist, further expanded on the works of Husserl, focusing on understanding experiences and how they exist in context to the phenomenon (Merleau-Ponty, 1945/2002). His work expanded on the rediscovery of the original experience, giving additional clarity to it. Merleau-Ponty stated the importance of the perception of experiences in the context of the individual’s situation (Merleau-Ponty, 1945/2002). Several
of his themes are critical to the philosophical foundation of this study and include the lived experience, embodiment, awareness, and consciousness.

Merleau-Ponty’s framework focused on the existence of the human form in terms of the lived experience, embodiment, or the meshing of the individual and the world in which he exists, and perception. The definition of Merleau-Ponty’s lived experience is the individual’s perception and how it is influenced by embodiment within the lifeworld: spatiality, corporeality, temporality, and relationality (Merleau-Ponty, 1945/2002). Through our bodies we have access to the world and it is through perception that we know both our interior and exterior worlds. The body is our anchor to the world (Merleau-Ponty, 1945/1962) and though the conditions of the world may limit the body, it does not determine it. People are in charge of determining their bodies through their own choices and embodiment gives meaning to the space around itself. It is through consciousness and embodiment that we are aware of being in the world and we gain access to the world.

Spaciality is when the parts of the experience, interrelated in some way, become enveloped in each other giving rise to the totality of the experience itself (Merleau-Ponty, 1945/2002). Spaciality within the context of this study defined the connectedness between the FNPs and their clients. Spaciality becomes essential when describing the experiences of the FNPs because it is within this relationship that the experience develops.

Corporeality is an essential, distinguishable, and the tangible part of the experience in which individuals related to reflecting on past experiences. This reflection, through such areas as the consciousness, the world, and the human body in turn created and defined the meaning of current experiences, thereby defining our experiences through past, present and future events.
Corporeality within the context of this study was the meanings and feelings reflected upon by the FNPs.

Temporality is a conscious, absolute point of orientation; in which past events define our orientation to the present. Temporality within the context of this study was the description of the FNPs’ feelings when performing the interview as they reflected on past experiences. Recalling the past experiences influenced by the physical orientation within the experience resulted in how the experiences were perceived by the FNPs.

Relationality is a kinship of meanings between experiences, which allows for connection of perceptions. Connection of perceptions gives meaning to the phenomenon in a totality of the experience. Relationality within the context of this study was how the FNPs related to several experiences and applied meaning to the way in which these experiences occurred.

Merleau-Ponty’s philosophical framework was used within this research study. Using his framework, the concepts of awareness and consciousness was applied. Awareness allowed the FNPs to sense what they were experiencing at that moment. Consciousness referred to the FNPs’ relation to the world and interpretation of that relation within the experiences. These concepts, when used in researching the lived experiences of female FNPs when performing sexual health assessments on their adult clients, illuminated the awareness and consciousness experienced by FNPs.

Max van Manen.

Max van Manen (1990), a phenomenologist, expanded on the contributions of Merleau-Ponty by explaining that the lived experience includes intersubjectivity (validation between individuals), bracketing, and reflectivity. He further expanded upon the Merleau-Ponty’s (1945/2002) concepts of person, time, space, and relationships, which define the lived experience.
of the individual through unique perceptions. In researching the lived experience, phenomenological questions were raised to describe meaning and significance to the phenomena (van Manen, 1990).

Van Manen (1990) supported the notion that the researcher and the participants, through communication and interpretation, come to describe and understand the meaning of sexual health assessments. This scientific research cannot be understood unless it is actively performed. Participating in the interaction of the lived experience allowed for illumination of the existential meanings, participant descriptions, and the researcher’s interpretations, provided the methodology created by van Manen to allow for understanding of the phenomenon. Based on its recent development and the structure it provided for analyzing data, van Manen (1990) phenomenological method was selected for this study. In addition, van Manen’s approach is well suited for this research as sexual health assessments are important for FNPs to reflect upon and discuss to obtain a description of the phenomenon and a platform for further studies to emerge on this significant lived experience.

**Description of the Method**

Max van Manen’s (1990) phenomenological (existential-descriptive-hermeneutic) method is greatly influenced by Merleau-Ponty (existential), Husserl (descriptive) and Heidegger (interpretive) philosophies and consists of six research activities. The six research activities are mentioned here but their specific application to this study is described in greater details in the next chapter. The research activities included:

1. Identifying a phenomenon of interest.

2. Conducting an investigation of the phenomenon as the lived experience, not as it is conceptualized
3. Reflecting on illuminated essential themes that characterize the phenomenon.
4. Writing and rewriting in order to describe the phenomenon.
5. Maintaining a strong relation to the phenomenon in terms of pedagogy.
6. Balancing the context by considering the parts as well as the whole. (p. 132)

First, identify the phenomenon of interest by identifying the lived experience that is of strong interest to the researcher. Drawing on both personal and professional life experiences helped to identify the phenomena. The need to discovery the understanding of the female FNPs’ lived experience when performing sexual health assessments on adult clients becomes the beginning and end point for the research (van Manen, 1990). Second, the researcher should be open and aware of the world of the FNPs to allow for better understanding of the perspective of the experience by the individuals. Third, using reflectivity, thoughtful insight, and understanding, the significance of the phenomenon can be reported. Through this research essential themes that define the meanings of the lived experience of FNPs when performing sexual health assessments were identified. Fourth, through writing and rewriting and dwelling on the nature of the experiences the FNPs had when performing sexual health assessments allowed for the participants’ voices to be heard. Fifth, through a relationship to the phenomenon, rigor and strength in the research process held meaning and guidance. By adhering to the phenomenological research beliefs a genuine description and understanding of the lived experience through interpreting the perception of the FNPs’ experiences, writing and interpreting the essences and meanings, relating these essences to relevant literature, to reflect, and understand it. The gradual process of reflection on the lived meaning from each FNP participant allowed the researcher to gain perceptual experiences of the participants. Sixth, involves careful
analysis of each part of the research process, determining essential themes, and relating them to the whole phenomenon (van Manen, 1990).

Summary

Chapter three described the methodology of the study. Phenomenology was explained and related through the works of Husserl, Merleau-Ponty, and van Manen. The research process of van Manen was discussed through the six steps of the methodology. Chapter four will focus on the application of van Manen’s phenomenological research activities and the steps used to conduct this research.
Chapter IV

Methodology Applied

This study investigated the lived experience of female FNPs when performing sexual health assessments in primary care on their adult clients from a phenomenological qualitative perspective. The study used the philosophical underpinnings of Merleau-Ponty (1945/1962) for this research, in combination with the research method of van Manen (1990). Human experience was the main epistemological basis for this research and the study proposed to discover the lived experience of individuals within a particular phenomenon. This process guided the researcher in collecting and analyzing data and included the exploration and description of the meanings of the female FNP’s lived experience when performing sexual health assessments on adult clients in primary care.

Research Activities

According to van Manen (1990), the purpose of phenomenological research is to establish a reconnection to the original experience. This lived experience of a phenomenon gives an opportunity to examine the world and recall the meaning of the event. The first step in van Manen’s process (1990) is to identify a phenomenon of interest.

The lived experience of the female FNPs when performing sexual health assessments in primary care on their adult clients is the phenomenon of interest. This topic is important for me as the inclusion of a sexual health assessment with clients allows the FNP to better understand the client’s need and ultimately allows the FNP to provide quality comprehensive, holistic nursing assessment which will improve the client’s quality of life. What the FNP experiences when performing sexual health assessments was the impetus for my inquisition to the FNPs interpretation, response, and adaptation to this experience.
The second step of van Manen’s process (1990) pertains to the investigation of the phenomenon. Max van Manen’s methodology along with in-depth interviews provided the opportunity for the participants’ stories to be shared and described their experiences from their own perceptions rather than from how others conceptualize the experiences. The study provided the opportunity to gain knowledge of the lived experience from female FNPs in primary care when performing sexual health assessments on their adult clients within the phenomenon itself.

The third step of van Manen’s process (1990) reflected on essential themes, which characterized the phenomenon. By interpreting what the participants said, the dialogue was edited into themes and meanings giving description and definition to the phenomenon. Through listening, transcribing, and reflecting on the emerging themes, the phenomenon was revealed. Insights into the essences through reflection, clarification, organization, and illumination made explicit the meaning of the lived experience (van Manen, 1990).

Van Manen’s fourth step began with developing themes of the identified lived experiences. This combination of language and thoughtfulness, allowed the experience to “show itself precisely as it shows itself” (van Manen, 1990, p 33). Constant attention to the overall interpretation of the study was incorporated into the separate themes that emerged to give totality to the data. Through rewriting themes, uncovering, seeing, pondering then reflecting, the process of bringing meaning to the surface happened. From this ongoing process of mining for meaning, re-thinking, reflecting and rewriting, on each FNP’s transcription, meanings and themes emerged.

The fifth step of the research methodology is to maintain a strong relation of the phenomenon in relation to pedagogy provided an orientation to the method. Constant referring and constant re-orientation to the question of what is the lived experience of female FNPs when
performing sexual health assessments avoided deviation, guessing, and bias opinions. This allowed for the true phenomenon to emerge. The technique of re-orientation prevented me from being side tracked, or given to speculate or settle on preconceived opinions, self-reflections, self-indulgence, or abstract theories (van Manen, 1990).

In the sixth and final step of the research methodology is to balance the context of the study by considering the parts as well as the whole, including reflection, and stepping back from the data revealed the entirety of the research phenomenon. Max van Manen (1990) suggests throughout the research to step back and evaluate the wholeness in context to its parts to see how the parts contribute to the whole. In keeping an open mind, each theme from the female FNPs’ experience was culminated into a descriptive meaning about the experience when performing sexual health assessments. The movement from the whole to the parts allowed for a deeper exploration while being grounded with the larger context.

**Rigor**

As described above, maintaining a strong relevance of the phenomenon in relation to pedagogy is the fifth step of the research process. Constant re-orientation by the researcher to the question: What is the lived experience of female family nurse practitioners when performing sexual health assessments with their adult clients, allowed for heuristic questioning and distinctive rigor. This enabled the true phenomenon to emerge. As van Manen (2012) stated “A high-quality phenomenological text cannot be summarized...rather one must evaluate it by meeting with it, going through it, encountering it, suffering it, consuming it, and as well, being consumed by it.” (p. 355).

Establishing trustworthiness of the transcripts is a fundamental component of rigor in qualitative research and has direct implications for the legitimacy of nursing science (De Witt &
Ploeq, 2006). Criteria to maintain rigor, and establish trustworthiness as suggested by Lincoln and Guba (1985) is aimed at credibility, dependability, transferability, and confirmability.

Credibility was established by asking the participants to read their transcripts for validation of truth and offer additional comments. The researcher contacted seven of the participants via electronic mail and asked for validation by asking if these themes and subthemes represented their experience as a whole (i.e., “resonates well”; “I agree”; “My experience for sure”; “good summation”; “there is nothing I would add or change” (personal communication, January, 2015). An in depth description of the exact methods of data gathering, analyzing, and interpretation promoted dependability and described how to replicate the study. Transferability relates to the extent that similarities in the findings may relate to other settings. Providing detail about the setting and the events taking place allows readers to assess whether people and events could be applicable elsewhere. Three expert researchers independent of each other read transcripts, meaning units, subthemes, and essential themes and agreed about them. This third party process supported dependability. To document the confirmability of findings, an audit trail of tape recordings, field notes, methodology log, and a reflexive journal are available to challenge the thoughts and assumptions of this research (Lincoln & Guba, 1985).

Bracketing is used to reduce bias and increase rigor and is a fundamental strategy in phenomenology (Husserl, 1973). Van Manen (1990), however, does not embrace bracketing and asks: “If we simply try to forget or ignore what we already “know”, we might find that the presupposition persistently creep back into our reflections” (p.47). Rigor was obtained in this study through the researcher explicitly listing assumptions and biases. The researcher keeping a journal also maintained the rigor so that thoughts, feeling, sights, sounds, and personal
experiences throughout this process were documented and used to reflect and reduce potential biases.

**Recruitment**

**Protection of Human Subjects**

After successfully defending the research proposal I obtained City University of New York (CUNY) Institutional Review Board (IRB) approval (Appendix A). Next I recruited female FNP participants by purposeful sampling and participant snowballing. I attended professional local nurse practitioner meetings and sent electronic mail to six primary care practices that employed FNPs in an urban setting of the North East of America. Three of the practices responded and four of the participants were recruited by direct electronic mail. Three FNP participants were recruited from the local nurse practitioner professional organizational meeting after leaving their electronic mail address for me to contact them. Four additional FNPs were recruited using a snowballing method. All FNPs interested in this study were contacted by me through secure electronic mail and a copy of the study IRB informed consent form and inclusion criteria was sent for them to review prior to meeting the participant (Appendix B & C)

Once inclusion criteria were met, the process for informed consent consisted of the following: The FNP participants were informed of the research purpose, aims, and goals by the researcher. Included in the informed consent was the invitation to participate, disclosure of pertinent information for the purpose of the research, procedures of the interview process, and the participant’s voluntary agreement to participate. All aspects of the study were explained both prior to meeting via electronic mail and again on meeting them face to face prior to being interviewed. I reinforced that the FNP’s participation was strictly voluntary and they could withdraw from the study at any time without being penalized. I explained that data would be
kept for three years in a secure locked filing cabinet or secure computer and then destroyed confidentially. Once each participant was fully knowledgeable about the research protocol and expresses a desire to participate, a signed consent form was obtained. Demographic information was also collected on each participant (Appendix D).

**Sample Criteria**

Sample criteria consisted of being a board certified, female, FNP with a minimum of 3 years of primary care experience. All participants had to agree to performing sexual health assessments routinely on adults (18 years and above) during their annual physical examination. Two potential participants did not meet criteria because they had less than three years of work experience as FNPs and one stated that they did not routinely perform sexual health assessment on adult clients at their annual physical examination. Both the participant FNP and I arranged a mutually convenient interview time and the participant chose a private location for us to conduct a private face to face interview.

**Summary**

Chapter four described the applied method of phenomenology using van Manen’s (1990) analysis of qualitative research and its applicability to this study. The preservation of the study’s rigor, the recruitment process, protection of human subjects and, sample criteria of the study were revealed.
Chapter V

Findings

This study explored the phenomenon of the lived experience of female FNPs performing sexual health assessments on their adult clients. The participants were FNP who were performing sexual health assessments on their adult clients. The researcher used the descriptive phenomenological method outlined by van Manen (1990) for the data analysis. This chapter will describe the study sample, description of the participant’s experience, interview setting, methodology applied for the research analysis, the narrative phrases that captured the meanings, the essential themes, and the concluding interpretive statement.

Study Sample

The participants were ten female family nurse practitioners (FNPs). Their ages ranged from 32 to 63 years; the mean age was 44.8 years. All of the participants were certified by the American Nurses Credentialing Center (ANCC) and had a minimum of three years of clinical experience in primary care. Three were doctorally prepared, two PhD, and one DNP. Six of the ten identified themselves as White, two Black, one Filipino-American, and one Hispanic. Five were married, two single, two divorced/separated, and one co-habited. The years of FNP experience ranged from 4.5 years to 26 years with a mean of 12.5 years. Eight worked full time in clinical practice and two part-time. Three worked in a private practice, four in community health centers, two in corporate health, and one in student health.

To maintain anonymity participants selected their own pseudonym. The lead question for all participants was “Tell me about your experience when performing sexual health assessments on your adult clients”. From the moment this question was asked to then end of the conversation, the interviews lasted between 44 to 76 minutes. The mean interview time was 59 minutes. All interviews were voice recorded using two audio recorders; one as an original and the other as a
backup. The researcher later transcribed all the recordings. After the interview, the researcher thanked the participant, and informed them that their interview transcription would be sent via electronic mail for additional comments, corrections, and edits.

Following each interview and as soon as practical, the researcher journaled observations, thoughts, and feelings about each interview. In the journal, nonverbal behaviors such as posture, tone of voice, and eye contact were also noted. This data is not communicated in a transcript but is relevant, and is a part of the “living sense of the experience before we have lifted it up into cognitive, conceptual, or theoretical determination or clarity” (van Manen, 2014, p. 39).

**Description of the Interview Environment and Participants’ Experiences**

Descriptions of the participants provide an imagery of the person and an understanding of the personality, which in turn is helpful to understanding the meaning from which the experience is derived. According to van Manen (1990), it is easier to talk about experiences rather than write about them because talking leads to a more genuine and true lived experience dialogue. Listed below are a summary of interview settings and a description of the participants from which the data were obtained.

**Participant #1 - Noeli.**

I met Noeli at her place of work, a busy family practice. It had been snowing heavily the night before and the sidewalks and streets outside the practice were snowy and icy. The waiting room was sparsely decorated with no pictures on the beige walls. Glass sliding doors would open frequently allowing the cold winter air into the waiting room. There were 3 rows of light brown wooden chairs with five patients in the waiting room: a mother with her baby in a stroller, two middle aged women speaking Spanish, a young man wearing all black and an older man hugging his legs and swaying. Noeli is a tall, thin, energetic, smiling woman aged 38 years. She
was wearing black leggings and a white long sleeve shirt. She had just finished teaching a yoga class for five of the clinic patients and was now on her lunch break.

For privacy we walked to an examination room in the back of the practice and she placed a sign on the outside of the exam room door “breast feeding in progress do not enter”. She stated that she was eager to get started and excited to be interviewed. I sat at the exam room desk in front of the computer screen and Noeli sat in the patient interview chair. I turned my body to the left of the table to face her directly. She spoke quickly when answering the lead question. Over time, she continued to speak in a strong tone of voice, knowledgeable, and confident in her answers pertaining to her experiences when performing sexual health assessments. We were interrupted once by the loudspeaker system attached to the telephone sitting on the desk in front of us, the phone was quickly silenced. This interview lasted 44 minutes.

The following is a brief excerpt from the descriptions related to her experiences performing sexual health assessments,

I ask, “Is that your only partner”? as a way of gauging if there is anything else going on...I find men will sometimes say [they] have three partners. [They] use condoms with the two and not with my wife. How do I respond to that? I try to be really non-judgmental. I talk about that there are still risks associated with that and offer STD counseling. It definitely comes up inside [of Noeli], “that dog”, but I also realize, I guess I have evolved as a nurse practitioner in a couple of ways. People are going to live their life. They are going to make choices. They’re not the choices that I would necessarily make, but if I am going to have a relationship and meet them where they are at, then that’s not my role. I can be aware of my feelings and it shouldn’t change the way I offer services.... I had to realize if I’m working harder than the patient I had to step back, and
then look at that because that means that we are not on the same page. And it’s hard because you see people making choices that are really harmful.

This was the first interview for this research study, and the researcher felt anxious, but as Noeli continued to speak and cover more and more of the phenomenon the researcher listened more to her story through her voice and body movements. One of the most salient parts of the interview was when Noeli stated,

I have a very integrated approach and that’s why I wanted to teach yoga [to her clients]. I think everything is connected our emotional being, are mental state of mind, and our physical body, are all totally connected, and if you are not hitting in all of these areas, you are missing out on finding. Really we are good at treating symptoms in the current medical model but we are not great at identifying causes.

**Participant #2 Kylie.**

After commuting to Kylie’s urban practice in a heavy rainstorm, the receptionist asked the researcher to have a seat. Sitting in the patient waiting area ready to be introduced, the researcher noticed the reception area had an air of formality. The waiting area was furnished with large bright paintings on the wall, warm beige carpet; soft, brown leather lounge chairs and couches, which were modern, clean and inviting. Kylie appeared young, with a bright smile, and pretty as she introduced herself and we walked back to her examination room where she had taken a break for lunch.

Kylie age 32 years was dressed with a red dress and her black hair long to the middle of her back. She sat at her desk in front of her computer and the researcher was placed to the right side of her so that the desk would not be a barrier for open discussion. When she sat down she reported feeling nervous. Kylie was quietly spoken, and initially had a nervous giggle. As she
felt more comfortable, she giggled less and her tone of voice was stronger. This interview was 45 minutes. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

Initially very uncomfortable because I’m just generally uncomfortable talking about a lot of private stuff in my private life especially with my friends.... I am just a very private person so for me to go into an interview with someone I just met, especially like with new patients, it gets kind of awkward… I used to be a little hesitant to ask the question [about sexual health] and maybe, a little shy to ask; but now I kind of go right into it. It’s like any other assessment question, specifically with the sexual orientation part, and what kind of sexual activities; whether it’s anal intercourse, anal receptive, or anal insertive. I’ve never used those words before, but now it kind of just flows for me.

One of the most salient parts of the interview was when Kylie stated,

I’ve gotten better at it... when I use to work as a nursing student in a nursing home and I had to wipe a lot of poo, and clean people up, and things like that. At that time, I would be very giggly because I wasn’t very comfortable with it but as time progresses...well this is part of my job. It’s something I’ve been exposed to, and so the more I’m exposed to it the more comfortable I am with it.

Participant #3 Stephanie.

The researcher met Stephanie outside the subway station in a residential neighborhood. It was a cold winter’s day with blue sky above, so the walk was brisk. She greeted the researcher with a warm, happy smile stating she was looking forward to being interviewed. The interview was conducted in the researcher’s apartment, which was two blocks away. Stephanie was dressed in a long black winter skirt and sweater, wool black hat and grey scarf. Stephanie is 39 years of
She sat at the dining table directly opposite the researcher. General conversation flowed easily on first meeting outside and the interview started after pouring water into glasses at the dining table. This interview lasted 62 minutes. Stephanie spoke confidently, often laughing at herself, and the stories she told about her clients. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

I think it is easy and comfortable with the women. With the men sometimes it can be a little bit uncomfortable. When it’s the guys or the men are probably in their 50s and 60s… the age kind of between them and myself, I am reminding them of their daughter and that can sometimes be a little bit uncomfortable, and I kind of have to think, “Yes I do have to do this. When I talk to women there’s sort of that common women’s bond… you don’t have the same bond with men. I remember one time this guy, I’m like, “Ok, you know I need to do”… We were talking about its [sexual health] part of your physical that it’s good to do a genital exam, and you know, usually the guys are like “alright”, kind of resigned that they have to do it. But this guy he was like “no problem”. Draws are down, he’s standing there he flips his penis, he’s standing in the back, I’m like, “oh my god you’ve got to be kidding me” [thinking this]. (Laughing)

This was the only interview conducted at the researcher’s home. At first the researcher felt exposed, but the conversation was lively, Stephanie appeared relaxed, and a lot of laughing took place. One of the most salient parts of the interview was when Stephanie stated,

When I was younger it was like, “Oh gosh, how am I going to deal with this? How am I going to talk to a person about this? I think it was scarier at first, maybe hard to find the words at first, and then, what are you going to do with the information? That was more
intimidating… I’m used to it now. At first it used to be, “Oh shit! “What do I do”? And I’m here looking down, and I get out of there. Now, I just finish…as matter as factually and respectfully as I can.

**Participant #4 Michelle.**

The researcher met Michelle in the early evening at her clinical practice site. It was the end of her clinic day so the researcher sat in the reception area for her to finish seeing clients. The waiting area had white plastic chairs in a single row. They were lined up against the dull light yellow walls in a long narrow room. It appeared worn, dull, and cold. Several middle-aged people dressed in white lab coats were coming out of a closed office door. They stopped to talk with the front desk staffs that were three women concerned about the surprise party they had given earlier and trying to resolve what to do with the leftover food.

Michelle came out of the same door wearing a white knee length lab coat, black stethoscope around her neck and hosting a friendly smile. During the walk back to her office she commented on her long day. She had seen twenty-two patients for primary care and spoke about how tired she was, and yet had several hours of notes and follow up phone calls left before she could go home. She sat in front of her computer and the researcher sat to her left. She is 58 years of age. This interview lasted 70 minutes. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

At the beginning when I first started...I was a little uncomfortable but then I think with experience...it’s almost like another organ system. When I first graduated, and let’s say having a male that was a gay client, sometimes I was a little uncomfortable in asking probing...you know I guess the word it’s like probing or touching on sort of sensitive topics, like anal sex or if someone was very promiscuous, ...afraid I was going to be
sounding too judgmental. But I think as time went on, and you get more clients, gay clients, straight clients, you know, you get like such a big variety of different clients and different circumstances. Some of them are bisexual. Some of them are gay, heterosexual, and then it just becomes another organ system. So, I think, it’s just with experience you become more comfortable communicating with a person.

One of the most salient parts of the interview was when Michelle stated,

Is it because of our patriarchal society, where we are not comfortable talking about these things [sexual health]. It’s that something, that is just a puritanical society we are so to speak. Where those things aren’t discussed, it just gets perpetuated in education, and…like say for myself, it took a lot of working with patients, and being more comfortable, and having more experience to get to that place. I feel like, I probably could have done a lot better at the beginning had it been more emphasized, because it’s another organ system. It’s a part of someone’s life, and it’s an important part of somebody’s life, and it’s just like their lungs, their heart, their musculoskeletal, you name it…but in primary care you have to do everything. In primary care you have to do psych, you have to do everything, so it’s really intimately involved in the patients’ health.

**Participant #5 Grace.**

The researcher met Grace in the lobby of a City University in the early evening, after her day at work. She was wearing a green skirt, white buttoned shirt, with her black loosely wavy, short hair neatly sitting above her shoulders. After riding the elevator to the third floor an empty classroom was found for the interview. Conversation flowed quickly and easily as Grace commented of running late with her last client and having to rush out of work for this interview. Grace age of 50 years, sat at one end of a long conference room table. The researcher sat across
the table from Grace who asked questions about the interview. In particular, how the collection of data would be used, and the confidential taping of the interview. After responding to her questions, the tape recorder was turned on. This interview lasted 59 minutes. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

It’s just questions and answers we start with. Just ask the questions very nonchalant and just say, “Sex with guys, girls, or both”? And that’s usually how I start out...I find that the more neutral that I am, or the more open I am with it and relaxed, they [client] are very forthcoming with information…When I started out, I was more awkward but once you become comfortable with skills, it just a matter of fact...You learn how to do these things. You compartmentalize everything, so you just do what you need to do. To provide care...regardless of what you feel is morally or religiously. Whatever you need to do objectively.

One of the most salient parts of the interview was when Grace stated,

There are times in which you just need to be in the moment and be a human being. Just tell your feelings, and not necessarily try to be that reserved person that’s trying to get the person to get to their own answers. Sometimes they need help coming to the answers.... and that’s for their safety. And sometimes you have to do commands also. “Do this. Do that.”, and other times, you can sit down and have a conversation, and you may need to give more guidance on a personal note. I don’t do that too much [personal disclosure]”.

Participant #6 Roxie.

The researcher met Roxie for dinner at a large and spacious diner in her neighborhood. She wore a pale yellow, floral dress, she had short brown hair, and a rain coat in her hand. She
hosted a warm and friendly smile. She was 52 years of age. The researcher sat opposite Roxie in a booth, in the furthest corner away from the entrance door. There were only a handful of tables occupied and none near the interview booth. A general conversation not related to the interview started as menus were read. The tape recorders were started after a light dinner was ordered. This interview lasted 74 minutes. Roxie readily answered the researcher’s question. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients, “I think my taking of a history [now] is more fluid than it was. It was more prescribed when I initially started practicing and I think now it’s more fluid”. She appeared distressed as she narrated her experiences.

I was trying to be very open and nonjudgmental, while I was being judgmental...I don’t think I’m cold, but definitely more of a professional demeanor, um, that’s not what I want to say. I think I’m…I think, I have the same sort of internal, and hopefully it’s not external, but internal sort of body language, cringing, that I’ve seen in my students. So hopefully that doesn’t manifest itself outward.

One of the most salient parts of the interview was when Roxie stated,

I am much more comfortable with it [sexual health assessment] as I have gotten older than I think I was when I was younger, fresh out of school, and working. I was 26 when I finished my NP program. So I think, I just felt, you know, I ask people, but it felt more prying, and now, I feel like it’s an opportunity to do a lot of education, and a lot of talking about relationships, if it’s appropriate. You know, how they’re feeling with the person or the people they are having sex with. If they are feeling safe, I certainly ask about, “Are your being forced to have sex”? But it feels like an important part of the
interview and it often opens the door to a lot of other stuff. I feel like it’s kind of a
gateway question.

**Participant #7 Elizabeth.**

It was a dark and rainy night when Elizabeth was interviewed. It was after her clinic
session around 7pm. The practice was empty of both patients and staff. Elizabeth was alone at
the practice when the researcher met her outside the clinic front door. Her greeting was a quick
smile as she started to speak about her day at the practice. She was wearing black pants, a black,
long sleeve sweater, and snow boots. She escorted the researcher to a place for umbrellas and
coats in her examination room. Elizabeth then led up one flight of stairs to a brightly, artificially
lighted, and windowless conference room on the floor above. Elizabeth sat at the end of an
elongated conference table, closest to the doorway, the researcher opposite her. Elizabeth spoke
quickly, and in a loud, robust tone of voice. She is 63 years of age. This interview lasted 76
minutes. The following is a brief excerpt from the descriptions related to her experience of
performing sexual health assessments on her adult clients,

I was always comfortable with asking people who they are sexually active with. I never
documented [sexual orientation], but when I came here one of the Docs here said “No,
it’s ok to put down if they are sexually active with men, or women, or both men and
women”, and so I started doing that. Even though you’d see it in my note but now if you
look at my social history and you’d know the rationale for all this stuff is just like
normalizing whatever it is. Oh no I never had a problem. Again it’s all political how we
treat people in our society, and as I said I come out of the 60s.

One of the most salient parts of the interview was when Elizabeth stated,
I come out of an interracial background but I identify as a black women...I was the second wave of the feminist movement. You know, the first one came a couple of years before me. So I remember going to college, you know, that was also the beginning of black nationalism ...I feel like I have loose boundaries than most people...So as far as being gay, that really didn’t start coming out until I would say maybe the early 70s early 80s. I mean, whenever all that stuff was going on no one really talked about it, but then when friends of mine started coming out it’s like, “It is what it is”. It’s no different than anything else, and what I try to do with all my clinical encounters, everything is just normalized, and it’s a safe space if you want to tell me something.

Participant #8 Savannah.

The researcher met Savannah in the early evening, after her day at work. The meeting location was at the security desk of a city university. She spoke quickly, and stated she was excited to be interviewed as she was thinking about applying for doctoral school with a friend next year. She was escorted to the elevator and got off on the fourth floor. After finding an unoccupied classroom, Savannah sat at a long and narrow conference room table at the end closest to the door. The researcher sat directly across the table from her. She had short brown hair and was dressed in a black knee length dress. She is 33 years of age. After signing the informed consent form she was eager to speak. This interviewed last 52 minutes. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

I was very nervous for the first one [sexual health assessment] and now it’s ok. I’m going to be honest with you, it doesn’t have to do with my awkwardness with a woman, and there is one part of it [the physical examination] I don’t like, so I have a very hard time.
I’m very scared to put my fingers in [a vagina or rectum]. So when you are trying to find the cervix, I am like very nervous... When you’re touching something it’s a totally different feeling than when you are just looking at something. So I guess, when I was a nurse, I was looking at things and handing off, but I am now actually touching something. It’s definitely a nervous feeling to touch.

One of the most salient parts of the interview was when Savannah stated,

I mean it definitely comes from my own views about sexuality. My parents, it definitely has to do with the way I was raised too. Like, we did not talk about sex. Like it was very, it wasn’t strict but it wasn’t like open. I was raised a little more loosely than most kids just because I have hippy parents, but we still didn’t discuss that. So that definitely impacts the way the way that I see patients. I think if I hadn’t had so many personal experiences myself with GYNs, I would, also, feel weird around the women doing it; but because I’ve been to so much GYN myself it’s easy for me to understand what these women are going through, and I can talk to them about it. Because I am not a man, I have no idea, you know, I can’t really identify with their feelings, or wanting from me. So I don’t feel comfortable on the same level as them.

**Participant #9 Elayne.**

The researcher met Elayne at her clinic site after her morning session. She gave a warm smile, and introduces her front desk staff and colleagues. She was dressed in loose black trousers, a white shirt with a padded green short sleeve vest over it. She had light reddish, brown hair with a slight wave to her shoulders. The interview was conducted in an enclosed glass wall conference room at the back of the clinic. There was a large over table which she sat at the furthest end from the door and the researcher sat to her right. She spoke with confidence and was
eager to help conduct nursing research. She is 46 years of age. She silenced the conference phone and made a cup of tea. She leaned in to start the interview. The interview lasted for 46 minutes.

The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

Taking a sexual history is a skill. I think it evolves over time and from what I see when I also teach students, it makes me more aware of how uncomfortable people can get taking a sexual history. Over time I’ve become more comfortable asking sexual questions and I am hoping that this puts my patients at ease, when I am asking questions. I feel good when someone is confiding in me, because I feel that it is information that I need to know to take care of them as a whole. I feel that it is important enough to answer such an intimate, personal question, and I am hoping that they are answering honesty.

One of the most salient parts of the interview was when Elayne stated,

Sometimes you feel frustrated; you may feel helpless, that you really do not want this person to come in. In family practice I am very often treating partners without the other partner knowing. So I may know one partner may have a STD, or has a mistress, or is involved in high risk sexual behavior, and this other partner may not know. It’s difficult to have someone in front of you that thinks that they are in a monogamous relationship when you may know differently. Obviously, for confidentiality reasons, I cannot say anything. But again at that point, you really feel helpless because you are really trying to help the person in front of you, but you can only guide them. You can’t make the decision for them. I think the ultimate decision does not rely on me or my belief. As a provider we are not judgmental, we are just presenting the facts. As a provider you have
to realize that’s what your role is. Your role is to guide them, and to give them education, and to help them make good health care choices.

**Participant #10 Nina.**

The researcher met Nina 6pm at the security desk of a local college at the end of her clinic day. She was running late. She wore a pink silk summer short sleeve blouse with a gold dainty cross around her neck. A pink and cream pencil shaped skirt to her knees with open sandals. Her hair was thick, brown, and curly to her shoulders. She was bubbly and cheerful. She was 38 years of age. Nina was speaking about being late as she rode the elevator to the third floor. An empty classroom was found and Nina situated herself around a long and narrow classroom table. The researcher sat opposite her at the side of the end closest to the door. Nina sat with her arms open, leaning forward ready to be interviewed. The interview lasted 65 minutes. The following is a brief excerpt from the descriptions related to her experience of performing sexual health assessments on her adult clients,

I really like speaking to them about their sexual practices, and what it is they do, and why they don’t use condoms, and why have they slept with so many people because I’ve got to that point where I can actually speak to them like that. I just like it. I understand it. I know what I know as a woman, especially as a woman of color. This is not something that is not necessarily taught to us. We learn what we learn from either TV, or friends, so you have to be able to teach them. It’s a good thing to me. It’s fulfilling.

Nina recalled her experiences she stated,

I have overheard doctors tell patients, “Well, you’ve got herpes because you couldn’t keep your legs closed”, that’s none of your business first of all. Second of all, that just makes them less likely to come to you, and they can have something worse, and not want
to come to you because you are being judgmental. You are instilling their values on them….I can’t tell them what to do. I can’t judge them for their life.

One of the most salient parts of the interview was when Nina stated,

It’s interesting. It’s like almost being in a soap opera but you’re not part of it. It just like hearing all the gossip of somebody else and it’s like, oh you can put your two cents in here and there and hope that they make the right decision but ultimately, you know, if they don’t, you’re like, well they are going to be back here for something.

Thematic Analysis

After the researcher transcribed each FNP’s account of their lived experience verbatim, their transcription was returned to each participant for validation. The participants all agreed with their transcriptions, three edited their words for clarity, and two added some additional thoughts and comments. All of the participants’ edits clarified the original themes of the transcripts. Max van Manen’s (1990) fourth research step of writing, and rewriting to describe the phenomenon commenced.

Using a wholistic reading approach, the first read of the transcripts was to focus on the totality of the participants’ life story and identify phrases that reflected the fundamental meaning units of the text (van Manen, 1997). The researcher wrote notes and common words spoken within the margins to represent potential reoccurring themes within the dialogue of every transcript in relation to the participant’s experience. Following this first read, a highlighting approach was adopted, which involved reading the text several times and using a different color highlight to correspond to the “structures of experience” (van Manen 1990, p.79) The researcher carefully reflected on the participants statements and grouped examples by their corresponding color to identify the meaning units and initial themes. Each meaning unit was assigned a
different and specific color to highlight a particular theme. For example, comfort (the first theme) was coded bright yellow. Writing and rewriting allowed for a textual reflection of situations of the lifeworld, forming an understanding of what the experience was and creating meaningful relations to physical and mental being (van Manen, 1990).

Using the line-by-line approach to reflect upon each sententious phrase, the researcher re-read the transcripts again and asking, “What does this sentence or sentence cluster reveal about sexual health assessments from the FNP’s experience?” “What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?” (van Manen, 1990, p.92). Then the meaning units were clustered according to the fundamental meaning associated with them. After reflection on each clustered group for redundancy, saturation, and overlap, they were reduced to sub themes. Using the line-by-line approach, the question “Which of these sub-themes are incidental themes?” was asked. By excluding the incidental themes, meaning units, sub themes, and a list of essential themes were finalized (Appendix E).

Again the transcripts were read, re-read, and re-highlighted. The themes were re-examined and participants’ statements were re-lived as the emotion behind the statements were reviewed and analyzed again. After a more thematic analysis was done the numbers of sub codes under the essential themes were collapsed into a more concise number of subthemes as some of them had similar meanings. For example, within the essential themes of presence, the sub theme nurse-client relationship and the corresponding meaning units were collapsed into involvement in an effort to reduce the meaning units within the theme to be more concise and relevant. The process of the fourth step provided the researcher with the tools to understand the emerging
narratives and corresponding codes that captured the meanings of themes as described by the FNPs.

**Essential Themes**

Three essential themes were derived from the emergence of the initial sub themes and meaning units to identify internal and external knowledge, which made the themes specific to the phenomenon researched (van Manen, 1990). The 3 essential themes give order to the research and disclose the evolving meaning and imagery of the lived experiences. Researching the lived experiences of female FNPs when performing sexual health assessments identified the following 3 themes, which are the primary structures of the lived experience:

Theme 1: Self-concept

Theme 2: Presence

Theme 3: Prudence

These themes constitute essential essences of the perceived experience by family nurse practitioners when performing sexual health assessments with their adult clients. Each theme has a sub theme(s) with corresponding meaning units. Table 1 displays the three essential themes and their subsequent sub theme(s).

Table 1. *Summary of the Essential Themes and their Sub Themes*

<table>
<thead>
<tr>
<th>Essential Theme</th>
<th>Sub Theme</th>
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<tbody>
<tr>
<td>Self-Concept</td>
<td>Comfort</td>
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<tr>
<td></td>
<td>Self-Awareness</td>
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<tr>
<td>Presence</td>
<td>Involvement</td>
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<td></td>
<td>Styles of Care</td>
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<tr>
<td>Prudence</td>
<td>Professional Conduct</td>
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Essential Theme I: Self Concept

The following phrases captured the meanings that were contained in the theme of self-concept.

“Being a provider with experience has really helped me. The more patients that you see the more comfortable you get” (Elayne); “You just feel more comfortable when you have seen the same thing fifty times” (Michelle); “When I started out I was more awkward but once you become comfortable with your skills it’s just a matter of fact” (Grace). “I’m inexperienced and it makes me uncomfortable when I’m inexperienced…I have to get over it but how do you get experience when you’ve felt like uncomfortable because you’re nervous? It's sort of like you have to have confidence”. (Savannah)

Self-concept in this study was a composite of beliefs and feelings that the FNP participants thought about themselves at a given time as individuals. The self-concept is formed from internal perceptions and from the perceptions of others’ reactions. The self-concept directs behavior (Roy, 1984) and in this study whether a sexual health assessment was performed by the FNP. The FNP’s self-concept is significant because it is the sense of self as a physical, social, and spiritual or moral being and is central to everything that they do. The self-concept is involved in nursing assessment and planning when performing sexual health assessments.

The self-concept mode according to Roy Adaptation Model has two components; the physical self and the personal self. The physical self includes body sensations (“I feel great”) and body image (“I need to lose weight”). This physical self, therefore, includes appearance, sexuality, functioning, and health and illness states. The personal self has three components: self-consistency (“I’m really anxious about doing an examination”), self-ideal (I want to do a pap smear better”), and moral-ethical-spiritual self (“I believe that every person deserves a sexual
health assessment”) (Roy, 1984). Therefore, the perceived feelings by the FNP participants, which was brought on when performing sexual health assessments, is shaped from their self-concept and, therefore influences the FNP’s behavior and clinical performance.

Noeli described adapting her sexual health assessment depending on the client’s behaviors. In this excerpt, Noeli highlighted how she evaluated her belief system, and who she is in relation to the universe. She says,

The topic of sex brings up a lot of personal issues, societal issues, to be in a position, to then have your own issues or beliefs or whatever it is and then talk to some people about it... Sometimes complete strangers, people of other genders, of different ages. Sometimes you definitely pick up on a vibe where I feel like energetically there maybe something going on. So I may be a little more guarded with what [sexual health] topics I bring up. If I have a patient say “oh you sure look pretty today” or “are you married?”...I tend not to bring up the subject [sexual health] so much and in as much detail.

Sub Theme of Self Concept: Comfort

Comfort is a substantive need throughout life and is a constituent of holistic nursing care that has been cited by influential leaders over the past four decades (Nightingale (1968), Potter and Perry (2000), Lewis and Collier (1996), Wong, (1995), Bobak and Jensen (1993), McIlveen and Morse (1995), Kolcaba (1991), and Watson (1999).

All of the female FNP participants’ stories had a varying level of “comfort” when performing a sexual health assessment. These were heard throughout their stories when describing their client’s gender, client’s age, client’s health complexities, and the client’s sexual orientation to name a few. The FNP’s personal self and physical self of their self-concept contributed to the FNP participants’ comfort when performing sexual health assessments.
The participants described feelings of being “alone”, “scared”, and “uncomfortable” when first performing sexual health assessments. Moments of discomfort for the more experienced FNPs lessened with clinical exposure and experience but some of the participants spoke about still feeling “embarrassed”, “being unsure”, the need for “acquiring new knowledge and skills”, and “figuring it out” when performing sexual health assessments especially for gender minorities’ sexual issues.

The following phrases captured the meanings that were contained in the theme of self-concept and the sub theme of comfort;

“Getting older makes me realize the importance of men’s health” (Roxie’s moral-ethical self); “It feels awkward for me with the men more than the women” (Savannah’s body sensation); “It’s easier to do a sexual history on women for me than men” (Noeli’s self-consistency); “With the males it’s a little more awkward just because I have to actually put my hands on their private area...That to me kind of makes me feel uncomfortable” (Kylie’s body sensation).

Most of the female FNP participants described feeling uncomfortable when performing sexual health assessment on clients that were older than themselves; especially if male and older as can be heard through Noeli’s excerpt above and these phrases below,

“The girls I don’t mind, especially the young girls but I find around the older women and especially the older men ...it does make me really uncomfortable.” (Savannah); “Some of the older men it’s harder sometimes” (Roxie); “The age between them and myself...I am reminding them of their daughter...that can be a little bit uncomfortable; I think they [older women in their 50s and 60s] are easier to talk to about it [sex] and my comfort level, I’m more comfortable with them.” (Nina).
Some of the participants spoke of interactions with sexual health areas that they had none or limited exposure, education or training as either RNs or FNs such as lesbian, gay, bisexual, and/or transgender (LGBT) clients, sexual abuse, domestic violence and rape. In this research the FNP’s comfort level varied depending on their personal self. The FNP’s personal self behaviors were expressed in verbalization of thoughts and feelings as well as actions, as seen in the following statements,

“I respect another person’s right to their choices and I’ll just give them information.” (Elizabeth); “How to do that safely [anal sex]...I’m not familiar with this” (Stephanie); “Well depending on who you are working with, especially in situations having to do with, arson, arsonists, rape, perpetrator, victim, rapists or whatever you are dealing with. It plays on your emotions but you have to pull yourself together and do what you need to do.” (Grace).

Nina spoke about her first experience with a male to female transgender client who had had genital reassignment surgery but she was unaware of her client’s surgery or sexual orientation prior to her physical examination. This statement described the way Nina felt when she did not obtain all of the sexual history assessment data prior to the physical examination:

I didn’t know what to do with myself. I couldn’t even look at her afterwards because it was so shocking to me and that is something I will never forget. I was also kind of upset because I could have hurt her. I didn’t know what I was doing. I have never been trained in that. I didn’t know; I can feel torn at times.

The FNP’s sense of self was influenced by their prior experiences, reactions and social interactions. Striving for integrity and self-consistency played a role in the self-concept of the FNP as Michelle described “normalizing” the sexual health assessment for gender minorities as their level of comfort improves. She stated,
Having a male that say was a gay client; sometimes I was a little uncomfortable, touching on sort of sensitive topics like anal sex, but I think as time went on and you get more clients with gay clients, straight clients...like such a big variety of different clients and different circumstances some of them are bisexual some of them are like I say gay, heterosexual then it just becomes another organ system, so I think with experience I became more comfortable communicating with people.

Several FNP participants described coping strategies, which are defined as the habitual responses used to maintain adaptation and to maintain integrity (Roy, 1984) when performing sexual health assessments in times of stress. Kylie demonstrated coping strategies. She says,

I would get a lot of looks, and they [heterosexual clients] would say, “of course I am with a male” or “of course I with a female” so...I felt I didn’t really need to ask it anymore just due to my population [suburbs], and I guess where I was practicing it wasn’t as common. But now I’m more comfortable with it being in the city. A lot of people are either gay, or lesbian, or both, so I feel like that’s a little easier to talk to being with more of a liberal patient population.

Two personal characteristics, race and religion were discussed by some of the FNP participants. Race, sex, class, and religion are some of societal discriminations that affect the individual’s self-concept (Roy, 1984). Nina spoke about her being a FNP and a woman of color. She stated,

I just like it. [Women’s sexual health] I understand it. I know what I know as a woman, especially as a woman of color. This [sexual health] is not something that is necessarily taught to us when we learn what we learn from either TV or friends; to be able to teach them [women clients of color] is a good thing to me. It’s fulfilling.
Elizabeth’s self-concept and comfort when performing sexual health assessments were demonstrated when she stated,

That’s an opening for them to talk about maybe how they are feeling. You know, what experiences they have had as a person of color….I kind of open that door for them and it’s not that my experiences have been that at all because I think being interracial I have a very different experience in how I grew up. .. I’m sure I have experienced racism but I react to it very differently because I will call you out on it. That’s how we were raised. So if you don’t internalize it then you have less problems so I don’t internalize racism.

Sub Theme of Self Concept: Self-Awareness

The personal self is affected by how accurate the FNP is in knowing themselves and perceptual self-awareness is a stimulus affecting the self-concept (Roy, 1984). The FNP’s perceptual ability to take in and interpret feedback of others allows for the perception of self to be more accurate. Self-awareness in the FNP also included for some participants a cultural self-awareness. This allowed them to practice more effectively and improved their ability to intervene in certain cultural sensitive situations. Self-awareness progressed with clinical experience, professional, and personal maturity for the FNP. The participants spoke about how their prior exposure to sexual health issues or lack of exposure to life experiences (e.g. personal relationships) influenced their lived experience when performing sexual health assessments. The following phrases captured the meanings that were contained in the theme of presence and the sub theme of self-awareness:

“I have a sister who is gay so I always ask women if they are having sex with women, other women, or men or both and try to make women who identified as being gay feel comfortable and not automatically ask about contraception.” (Roxie); “If you don’t feel
comfortable in discussing sex in general you’re not, you know, I have no problems taking about sex.” (Elizabeth); “When I was younger it was like oh gosh how am I going to deal with this? But I can cope with it [sexual abuse] and I am more comfortable, it’s evolved over time. I can accept now that life’s complicated” (Stephanie); “If you have been exposed to this as part of your philosophy and part of your practice that I think over time it just evolves” (Elayne);

The participants described their personal experiences as a client in the health care industry and how this played a role in their self-awareness. Savannah states,

If I hadn’t had so many personal experiences myself with GYNs I would also feel weird around the women doing it; but because I’ve been to so much GYN myself it’s easy for me to understand what these women are going through and I can talk to them about it.

Nina demonstrated this when she says, “Knowing how horrible experience that was [the participant personally having her first pap smear]...This is why we do it [making it less scary for her young female patients]...bringing in your own life experience I guess into how you practice”. Elizabeth also states her personal medical history and the effect this had on her self-awareness,

When I’m talking to my women “oh yeah I’ve gone through that, I’ve gone through that” it’s complete understanding of what you’re talking about...I’m talking to my patients and I can say “yes this is really common this happens all the time” and you can have a very different conversation.

Some of the participants spoke about their own family environment as a child and sex discussions influencing their self-awareness. Kylie says,
When I have my own kids I want them to be more open with me…I feel that was something I had to learn through my friends and through my relationships and through work, talking to patients, and doing a sexual health history.

Nina also described her mother’s lack of discussion around sex influencing her performing a sexual health assessment on her clients,

My mother didn’t talk about it. I didn’t understand it. So at least they (the clients) have someone to talk about it and not learn it from TV which is, that’s not where I learnt it but that’s where they seem to learn it now media.

**Essential Theme II: Presence**

Presence as a concept is a widely elusive concept in nursing and a valuable part of the shared human experience for the nurse-client relationship (Bunkers, 2012; Hessel, 2009; McMahon & Christopher, 2011). Client-centered care is made possible with the nurse’s knowledge of the social, emotional, and interactional factors that influence a person’s behaviors and includes a biopsychosocial-spiritual assessment. The promotion of human betterment is a nursing goal through presence (Roy, 1984).

The two sub themes contained in Essential Theme II are 1. Involvement, and 2. Styles of care. Illustrations of the essential theme II presence emanated from the participants’ narratives. The following phrases captured the meanings that were contained in the theme of presence;

“Building the relationship” (Noeli); “Try and create a more comfortable space for people to talk to me about what’s going on so asking questions” (Roxie); “I really try to make a connection with the patient in terms of really looking at them in the face and being at their level…I listen to them and I don’t blow them off and that’s because I take
what they say. I don’t walk out the room, and I don’t dictate to them, and I don’t just hand them a prescription” (Michelle).

Presence was a central theme described by all participants. They all spoke of having “a relationship” with the client in terms of “sounding that you care”, “open communication”, “trust” and the importance to educate and be a resource for their clients. Most described being present as a “partnership” with their client and work environment. Michelle says, “Both decide what works best”.

**Sub Theme of Presence: Involvement**

Involvement means more than just providing for the client’s physical needs by merely completing a nursing intervention or treatment and maintaining a distanced approach to care. Involvement is goal-directed and open attendance encompassing both being with and doing for patients (Kostovich, 2012). In this study involvement the FNP participant recognized the client as a person who at times was “scared”, “vulnerable”, and in need of reassurance and safety.

All the participants described “management of time” when the appointments necessitated sexual health assessments and the meaning units pertaining to this were placed under the sub theme of styles of care. There was a general sense from the FNPs in this study that through presence an environment for the promotion of human betterment was established. The following phrases captured the meanings that were contained in the theme of presence and the sub theme of involvement;

“I feel like its [sexual health assessment] something special”. (Elayne); “It can’t get any better than that” [client confiding her past sexual experiences] (Stephanie); ”That’s what makes me happy in this job and the fact that people trust me enough to tell me things and to trust. It’s kind of cool in a way to be involved with that”. [Sexual health] (Nina).
Performing sexual health assessments were described by the participants as providing holistic nursing care and were associated with a “good relationship”. Noeli states, “It’s the nursing model where you look at the whole”. Noeli continued to describe having her own health belief system in order to be “not so system based in terms of medical systems. [FNPs] are more family system orientated and looking at the environment and these other components when treating a person”.

Elayne also illustrated this, she stated,

Confiding in me their sexual history because I feel that it is information that I need to know to take care of them as a whole, and I feel that it is important enough to answer such an intimate, personal question, and I am hoping that they are answering honesty. This partnership relationship was evident again when Michelle stated,

It’s a business and it’s a profession so you have to make peace with both of those ends. I mean, you want to keep a patient; you want to have them happy. You want them to want to come back and you want to have a good relationship with them, and keep them in their best health.

The participants described their level of involvement with their clients, having a commitment to their work, and “closeness” to the client. They described a sense of connection that went beyond the physical but described the connection as a kind of “energy”. Elizabeth highlighted her commitment, connection and her desire to go beyond to provide comprehensive nursing care in this excerpt with a client who was having an abortion. She says,

If they were pregnant I would walk them over to our clinic and they got an abortion. I remember people saying you know “how could you do that?” “Because that’s what they
need”...I touch base with them after to make sure that they are ok. It’s important. That’s just what I do...these are the patients that I am connected to.

Stephanie described the involvement as “nurse’s intuition” or “sixth sense” when performing sexual health assessments. She stated,

If there is a pause, or hesitancy...then I’ll kind of you know, take the step back, and say “you know what I sense?” something might be happening or if they are still not giving me information I might directly start asking, “well is someone hitting you or is someone hurting your feelings?

Michelle’s example of the sub theme involvement illustrated her presence from which came job satisfaction, connectedness, and open communication. Michelle stated,

I really love what I do and I think ...a lot of the patients pick up on it, because I enjoy it. I go in there with a big smile on my face. A lot of these patients I have seen for 5 years so they are like my kids almost. I know everything about them or if I don’t remember I’ll write myself little notes. I feel like people should feel comfortable. They should feel like they want to talk to you about anything and sexual health is a big part of it. I feel like that’s kind of what we’re here for, is to be this kind of safe haven where people can just come and feel like they can just talk to you about anything.

Many of the participants spoke about the environment as a barrier such as the use of electronic health records when performing sexual health assessments and its effect on their involvement. Michelle highlights the computer as a barrier to involvement as it interferes with her interaction with the patient, she states: “I feel like it just takes away from the therapeutic relationship... I feel like I want to like have eye contact with somebody and really show them that I am really focusing on them and not the computer”. Elayne spoke about the practice
environment creating a positive presence for the clients and one that supports a diverse client population. A “LGBT friendly” environment was seen as having rainbow triangle posters throughout the office and in the exam rooms. She states, “This designates you as a place that patients know that they can come to for services and they will not be judged based on their sexuality”.

Sub Theme of Presence: Style of Care

The identification of FNPs’ style of care in this study is alluded to in the theoretical literature by Morse (1997) as one of the three components of nursing actions within The Comforting Interaction-Relationship Model. Morse describes the individual nurse's style of care as a number of patterned approaches, which develop from a combination of nursing strategies and selected according to the clinical context and client needs.

The nurse participants spoke about establishing a routine, which they adapted, based on the client and their presence with the client. Most participants described their FNP role as being a “resource” or “educator” to the client when performing sexual health assessments. The following phases captured the meanings that were contained in the sub theme styles of care within the essential theme of presence;

“I just don’t go as beyond [with clients older than 50 years] as I would with maybe the 18 to 26 year olds” (Nina); “My style is really dependent on who's in front of me” (Roxie);

“If I have someone identified in a high risk group I take a more comprehensive sexual history than I do for my married folks” (Grace); “So it’s not standardized; I have looser boundaries than most people….I’m friends with some of my patients…I don’t have a problem with that” (Elizabeth); “Is that your only partner”? [Noeli asks] as a way of
gauging if there is anything else going on; I use it as a segway to being healthy [Erectile Dysfunction] (Stephanie);

All the providers’ stories included asking some of the same sexual health question to their clients. These phrases, as stated by each of the FNPs, within the context of their dialogues, became the sub theme styles of care within the context of the essential theme of presence. Noeli says, “Are your partner’s men, women or both? That’s a standard line that I have”. Savannah said, “We actually have a computer program that sort of guides you along which is good for me” Stephanie described her style of care when performing sexual health assessments, in particular the “mechanics of the exam” (physical examination) and collection of a client’s first Pap smear. She recounted,

I kind of like doing first pap with women because they are so nervous...before they lay down I explain to them what’s going to happen, and I get out the speculum and show what’s going on, and I say “there will be no surprises. I will not touch you without telling you first what I am going to do”...“I am going to put the speculum in, this is how it is going to feel and now if you take a couple of deep breaths” and I feel like I usually can walk them through it.

The participants spoke about adapting their style of care around using a computer when performing sexual health assessments. Michelle states,

I put the computer away and I go like this [she turns her chair and body away from the computer] and I look at the patient in the face, and that’s how I talk to them...I really try to make a connection with the patient in terms of really looking at them in the face and being at their level and not be at a desk...I think that makes such a big difference and...That’s how I want to practice.
The FNPs participants spoke about styles of care and “balancing” the sexual health assessment for complex clients (clients with HIV positive, diabetes) and adapted the client encounter for the amount of time available. Noeli states,

*You get overwhelmed in the visit when you have someone that has diabetes, hypertension, chronic pain, and then you get into the psychosocial issues and then you realize their lives are chaotic and then there is a mood disorder on top of it and you have a fifteen minutes visit so it’s a marathon not a sprint.*

Noeli continued and highlighted many of the participants’ “stereotyping” the client’s sexual health needs and type of sexual activity based on appearance, specific demographics, and other health related problems. The degree of inclusiveness of a sexual health assessment altered depending on the client’s personal characteristics. She says,

*Whenever I do have a HIV patient I guess it shouldn’t be any different but I definitely take a more thorough sexual history...I know providers are notoriously bad at being able to estimate risk and who is doing high risk [sexual] behavior and who is not. So there should be standard open ended questions that hits that but I in my day to day life, I have to say I don’t always do that [standard open sexual health question] and I probable do have an internal barometer for asking my teenagers or my HIV positive patients a little bit more, probing questions or my younger patients as opposed to someone who has been married or in a relationship.*

Elizabeth described her styles of care in relation to time management and say, “*it’s a thirty minute visit so you get to spend a lot of time educating and talking*”. Michelle highlights this balancing of time when she says, “*This is kind of what gets me in trouble in terms of my workflow.... Sometimes you have to put limits on it [sexual health assessment] because of time*
and have them come back” Later she stated, “we are so pressed for time because there’s they’re back to back. The physicals are 30 minutes and the sick visits are 15[minutes]. So that’s another thing that’s always up here is the time factor”

Nina described her story of styles of care when she had to inform a client of their HIV positive status and a new diagnosis of genital herpes on the same, “that was probably one of the harder things because it happened on a Saturday when your staff is limited and nobody is there and you have fifteen other people waiting for you”.

Several participant spoke about “The gateway question” as styles of care for the FNP participant to set the tone for sexual health assessments. It was often a way of letting the client know that this was a “safe place” or a way of “probing more deeply”. Roxie illustrated this when she states, “I certainly ask about are you being forced to have sex…it feels like an important part of the interview and it often opens the door to a lot of other stuff…it’s kind of a gateway question”. Noeli supported this, she stated, “Sometimes what I do if they are married, I asked “Is that your only partner?” as a way of gauging if there is anything else going on and you would be surprised what people will answer”.

Elizabeth illustrates her gateway question to explore cultural differences, she states,

I want to know what they are studying you know and then they will ask me what I’ve studied and I will then talk about what my dissertation and the fact that my master’s thesis was around race. That’s an opening for them to talk about maybe how they are feeling. What experiences they have had as a person of color. I kind of open that door for them.
Stephanie’s story reflects the gateway question, creating a trusting environment, and illustrates presence when performing sexual health assessments and her styles of care about sexual abuse, rape, and domestic violence. She says,

Sometimes people feel they can’t talk about it [sexual abuse] and if someone asks them then it opens up that door... I have seen relief in some of my patients when I ask them very directly “Are you having the sex”. Are you having pain when you have sex? And all of a sudden it’s ok to talk about it.

**Essential Theme III: Prudence**

Ethically based decision-making is one of the hallmarks of professional practice. Ethical principles in nursing include autonomy, beneficence, and non-maleficence, justice, dignity, and truth. All of these major ethical considerations are required for delivery of quality care by FNPs to all clients without racial, ethnic, socio-economic, age, gender, religious or other bias. (Huycke & All, 2000). Prudence is using reason to make sound judgments from provider to client. It is ethically mandated to provide care that is reasonable and appropriate given the circumstances at hand (Larrahee, 1996). In this study, the FNPs participants’ judgment was placed under the essential theme of prudence and the sub theme of professional conduct.

The essential theme III prudence was given to behaviors demonstrated by each participant within the context sexual health assessments on their adult clients. The researcher condensed several meaning units to obtain the sub theme of professional conduct into the essential theme of prudence. The following phrases, as stated by each FNP, captured the meanings that were contained in the theme of prudence;

“If someone was very promiscuous you know afraid I was going to be sounding too judgmental”; (Noeli) “I can’t tell them what to do I can’t judge them for their life, it’s
their life and I feel like that’s just the way you know you try to teach them better ways of going about things but ultimately they are their own person and they make their own decisions” (Elayne): “It's hard to take a step back and not be judgmental on them regarding that [infidelity]” (Stephanie).

Sub Theme of Prudence: Professional Conduct

The professional conduct of the FNP enables them to seek and take counsel on new or difficult situations, to make correct judgments about what to do or what to avoid, and to decide to respond in a particular way, and take action (Hartweg, 1991). In this study, some of the FNP participants internally deliberated between their personal attitudes, beliefs, and judgments with their professional responsibilities when performing sexual health assessments. The FNP participants remained prudent as they adapted to their client’s sexual health questions and answers and internally dealt with their personal values and individual beliefs.

Prudence was a central theme across all participants. All participants spoke about the importance of being “non-judgmental” when listening to their client’s stories. Having an exterior professional demeanor while at times being “judgmental internally” was pivotal to their professional conduct. Moral reasoning and the ability to distance their own beliefs from those of the clients were evident. The sub theme professional conduct evolved from all the participants and their stories. This was expressed in many of the participant’s experiences when they described their experiences in relation to dealing with their own feelings as reflected here by Savannah:

I find myself being a little bit judgmental about it [married men’s infidelity] because I feel like that’s wrong and when they are single and asking me about it [safe sex with multiple sexual partners] I’m sort of very easy going. We’ll talk more in depth about the
STDs. So I guess that’s partially my own thing with the situation...it definitely comes from my own views about sexuality.

Michelle also demonstrated this, she says,

Touching on sort of sensitive topics like anal sex or if someone was very promiscuous… afraid I was going to be sounding too judgmental. Not that I was honestly ever judgmental I think a little. You know it’s the provider more than the patient feeling uncomfortable...I think that’s so integral to being a professional it’s not, you know, to have preconceived notions about patients.

Kylie discussed the way she felt when she removed an old tampon from a client while maintaining professional conduct and hiding her true feelings. She says,

Not to be judgmental I say, “No I’ve seen this before this happens more often than you think”, and you try and make them more comfortable but then inside myself thinking “that’s kind of gross, why would you not know that you have a tampon in there? How could you have had intercourse with an old tampon in there? So that to me was a little weird.

The participants in the following examples described professional conduct.

Elayne demonstrated prudence with her story of professional conduct, she stated,

You can only guide them you can’t make the decision for them. The ultimate decision does not rely on me or my belief. Again, as a provider, we are not judgmental. We are just presenting the facts, and I guess, as a provider, you have to realize that’s what your role is. Your role is to guide them and to give them education and to help them make good health care choices.

Noeli showed the struggle between her internal feelings and being prudent. She says,
I felt angry, is the right word yeah. You know sometimes you just hit like ignorance and all these judgments, it’s even hard saying that but you know, it’s tough. You see people making poor choices or having double standards and to try and maintain the equanimity and it’s not easy.

Roxie also supported this. She stated, “This is not at all either a judgment of what you are doing, nor am I trying to get into your personal business this is purely for information about diagnosis and treatment about what’s going on with you”

Interpretive Statement

The sixth and final step in the research process is balancing the context of the study by considering the parts as well as the whole (van Manen, 1997). This included reflecting and stepping back from the data (parts) in order to grasp the entirety of the research phenomenon. By stepping back and evaluating the wholeness in context to its parts the researcher will see how the parts contribute to the whole. Narrative phrases and meaning units provided the sub themes and essential themes to capture the lifeworld that the FNP illuminated. Narrative phrases from every interview illustrated these themes, which related the parts of the research to the wholeness of the phenomenon.

The researcher incorporated each theme from the FNPs’ experiences with an open mind to culminate into an interpretive statement about the experiences of FNPs performing sexual health assessments. By applying van Manen’s methodology from step 1 to step 6, conducting interviews, reflecting on themes, writing, rewriting, and interpreting the lived experience of FNPs performing a sexual health assessment was uncovered and illuminated.

The final thematic interpretative statement of the lived experience of FNPs performing sexual health assessments captured the totality of the themes. The performance of a sexual health
assessment by FNPs on their adult clients in primary care is the development of presence and prudence in relation to their level of their self-concept. This interpretive statement was derived from the combination of the three essential themes that emerged from this research. This statement reflects the connection of all themes and the overall meaning derived from them. When sexual health assessments are performed by FNPs the level of their self-concept determined the development of their presence and prudence with their adult adults in primary care. It was written to contribute to nursing science the entirety of this research phenomenon.

Summary

Chapter V described the findings of the research setting, study sample and description of the participants. A description of the data analysis process using van Manen (1990) and the themes defined by the participant’s stories were included. The three essential themes 1. Self-concept, 2. Presence, and 3. Prudence emerged from phenomenological reflection and interpretation. The essential structure that captured the essence and meanings of the human experience for FNPs when performing sexual health assessments on their adult client is was described in the interpretive statement. The performance of a sexual health assessment by FNPs on their adult clients in primary care is the development of presence and prudence in relation to their level of their self-concept.
Chapter VI

Introduction

Chapter 6 will expand upon the concepts of the final thematic interpretative statement of the lived experience of female FNPs performing sexual health assessments. The interpretive statement is offered to capture the essence of the lived experience in this research. This chapter will present findings of the study, discussion of the findings, limitations of the study, implications for nursing education, practice, and research, reflections of the researcher’s experience, and recommendations for further research.

Findings of the Study

The purpose of this qualitative study was to explore the lived experience of ten female FNPs performing sexual health assessments with their adult clients in primary care. A review of the literature from the fields of anthropology, medicine, nursing, psychology, religion, and sociology was conducted. Within these disciplines, there were no previous studies addressing the lived experience of FNPs performing sexual health assessments, thus creating the need for this phenomenological study. The ten female FNP research participants’ ages ranged from 32 years to 63 years (mean 45 years) and years of FNP experience ranged from 4.5 years to 26 years (mean 13 years). All FNPs were board certified, actively practicing in a primary care setting, and had at least three years of work experience as FNPs. The narratives obtained from in-depth phenomenological interviews and follow-up electronic mails were analyzed using van Manen’s (1990) interpretive phenomenological methods. Understanding this phenomenon is of value to FNPs, other healthcare professionals, and educators as it illuminates the lived experience of FNPs performing sexual health assessments. The findings revealed three essential themes (I) Self-Concept; (II) Presence; and (III) Prudence and resulted in the following interpretive statement. The performance of a sexual health assessment by FNPs on their adult clients in
primary care is the development of presence and prudence in relation to their level of their self-concept.

Discussion of the Findings

The study explored the lived experience of female FNPs performing sexual health assessments on their adult clients in primary care and three essential themes emerged: self-concept, presence, and prudence. These three essential themes are the matrix of concepts, which described the FNPs’ performance of a sexual health assessment. Self-concept, presence, and prudence are linked; however, as Hempel (1952) specifies, these linkages may not be explicit in the participants’ initial elaboration of the performance of a sexual health assessment by FNPs. In order for the FNP to perform a sexual health assessment on their adult clients in primary care, in this research, their level of self-concept informed their presence and prudence.

Self-concept

Results of this study conceptually aligned with Roy’s Adaptation framework and the self-concept mode. According to Roy (1984), psychic and spiritual integrity is needed by the FNP to know who they are and this provides them with a sense of unity, meaning, and purposefulness in the universe. The FNP participants’ self-concept influenced their feelings as a physical, social and spiritual or moral being, and overall performance of the sexual health assessment. The FNP needed to be comfortable with themselves in order to discuss body image, body sensations, and sexual issues with their adult clients. For example, an FNP participant felt “uncomfortable” performing a sexual health assessment when they had limited exposure to discussing sexual issues in their personal life. In this case, the sexual health assessment was not well performed because the level of the FNP’s self-concept was poor and their ability to create an environment (presence) and make sound judgments (prudence) was compromised. Opportunities to improve
their client’s quality of life, be screened for cancers, and/or educated on sexual health promotion and disease prevention were missed.

Generally, an individual starts to develop their sense of self at birth and is a process that continues to develop through life. Developmental theorist who have provided an understanding of the process of the developing self are Freud (1949), Erickson, (1963), Piaget, (1954), and Neugarten (1979). The developments of moral thinking and moral judgment are also relevant to the developing self of the FNP and have been studied by Kohlberg (1981) and Gilligan (1982). Theses theories suggest that the developing self of the individual, including the FNP is based on physical, cognitive, and moral development and taking in the reactions of others to themselves. These experiences are cognitively organized into self-schemas and involve both the physical and personal self. Markus, (1977), studied self-schema and defined the term as cognitive generalizations about the self which are derived from multiple sources such as past experiences that organize and guide the processing of self-related information (Roy, 1984).

A sense of self arose in relation to the client and the wider society in the FNP’s process of performing a sexual health assessment. In this study, there were examples of the level of the FNP’s self-concept guiding their ability to feel comfortable about their performance or feel uncomfortable to approach the client about their sexuality and perform a sexual health assessment. When the felt uncomfortable they described feeling alone and embarrassed, and they lacked confidence. In these cases, the FNP modified or avoided performing a sexual health assessment.

**Presence**

Styles of care for the FNP changed depending on the FNP’s presence with the client. When the FNP experienced negative feelings such as embarrassment, gender-power inferiority,
or being alone then many of the FNPs did not perform a sexual health assessment. Poor communication techniques were noted by the participants such as not looking directly at the client or getting out of the examination room quickly and avoiding all sexual health conversations occurred.

Successful communication with the client and the coordination of care with health care team members including other disciplines was described as helpful to the development of the FNP’s presence. These forms of clinical support and guidance both informal and formal provided positive reinforcement to the FNP’s self-concept, which in turn promoted holistic, client-centered nursing care.

Maes and Louis (2011) surveyed 500 NPs (adult, family, and gerontological) with a 20% response rate to identify their sexual history-taking practices. Only 2% reported that they always conduct a sexual history with their clients aged 50 years and older and 23.4% never do. The NPs were more comfortable when the client was of the same gender supporting this researcher’s findings. In this study, the FNP’s versatility and the adaptability of the individual FNP participant’s style of care were heard throughout their stories. The FNP’s practiced different styles of care for younger and elderly clients, the anxious or embarrassed clients, and for men versus women versus transgender clients. This was consistent with Maes and Louis’s 2011 study as noted above.

A strong nursing self-concept empowers nurses in their work (Arthur & Randle, 2007). The FNPs in this study utilized their intuition and subjective measures to perform sexual health assessments and often perceived the feelings of their clients, which were expressed verbally and non-verbally. This dynamic illustrated the FNP’s use of self in the nursing process. Increased self-awareness enhanced the FNP’s use of self, which in turn influenced the quality and depth of
the sexual health assessment. The use of self can be an effective therapeutic process or approach depending on the FNP’s self-concept (Covington, 2005). For example, the FNP’s positive self-concept resulted in increased self-awareness that the client was “hiding” their feelings, which resulted in the FNP probing further and ultimately unveiling a sexual abuse history. Alternatively, a negative self-concept resulted in some of the FNPs not continuing the sexual health assessment because the client was perceived as being uncomfortable when in fact it was the FNP who was uncomfortable.

The self-concept involves stability of the self over time, consistency, unity, and organization of self. This is referred to as the focusing of self (Roy, 1984). Two areas that influenced some of the FNP participants’ stability of self were 1. the adoption of the electronic health records which created physical barriers between the participants and their client and 2. the diversity of the client’s sexual behaviors such as multiple sexual partners and LGBT clients.

Some of the FNP participants felt ‘comfortable’, ‘matter-of-fact’ or a desire to “normalize” every client and remove the individuality during sexual health assessments. This practice might cause the FNP to miss some of the unique health related conditions that pertain to each individual especially sexual minorities.

The FNPs experienced discomfort during sexual health assessments when, for example, there was a lack of knowledge on a particular aspect of sexual health, a lack of clinical exposure regarding sexual health topics or being unsure of clinical findings. In addition, some of the participants felt discomfort internally while maintaining professional integrity when dealing with clients who were LGBT, elderly clients in particular male, and when confronted with actions such as infidelity, single mother pregnancy, and removing foreign objects from orifices. As FNPs became more experienced in these areas of unfamiliarity the FNP’s self-confidence and level of
comfort level improved. A sexual health topic for several of the FNP participants that demonstrated this was asking their clients about sexual abuse. Over time, asking, knowing the available resources, and offering assistance became more comfortable for the FNP.

A standardized nursing style of care existed during the sexual health assessment. For example, every FNP participant asked clients about sexual preferences in the following manner, “Men, women, or both?” Three of the participants felt that the availability of standardized sexual health templates that are available through electronic health records (EHR) was helpful and five of the participants did not utilize sexual health assessment templates in as the questions and order of questioning were insufficient.

**Prudence**

Stevens (2005) conducted a pilot qualitative, phenomenological study to understand the lived experience of nurse practitioners in caring for the sexual health of adolescent clients. Three NPs from unknown specialties were interviewed and were reported as feeling comfortable discussing sexual issues with adolescents. Three themes were found; 1. discussing safe behaviors, 2. importance of parents not present, and 3. remaining nonjudgmental. One of Steven’s 2005 themes, remaining non-judgmental was consistent with this research study. Similar phrases such as “being non-judgmental” valuing their “uniqueness”, and “not telling them what to do”, resonated with this study under the essential themes of prudence. Of note, the second theme, importance of parents not present, was not heard through the FNP participants in this study when they spoke of their late adolescent clients, aged 18 years to 21 years. In addition, discussing safe behaviors was not a major theme in this study. One suggestion for this may have to do with the parental role that the FNP has with pediatric clients and ageism biases.
Nursing actions require that the FNP to intervene and consistently exhibit good judgment in requesting and reviewing information provided by the client. A prudent nurse is attentive, vigilant, cautious, perceptive, and generally governed by common sense (The University of Tennessee, 2014). Presence of prudent nurse concepts and practices are important to the FNP during sexual health assessments and were illustrated in this study by all FNP participants. For example, the FNP participants spoke of remaining non-judgmental despite their internal feelings.

According to Roy (1984), it is the nurse and their self-concept with his or her own sexuality that influences the FNP’s behavioral response when performing sexual health assessments. The FNP consciously and/or unconsciously evaluates the experience with their client and environment in order to label, clarify, define, and initiate a behavioral response (Roy, 1999). In this research, the prudent FNP participants performed sexual health assessments comfortably, with self-awareness, in partnership with their clients, while offering a “safe haven” to discuss sexual health issues when their self-concept was positive. This supports Roy’s three propositions a) a positive body image, b) objectiveness, and c) a healthy and open attitude towards sex. Following this logic, the level of the FNP’s self-concept may have a correlation with a nurse’s tendency to perform sexual health assessments or fail to assess sexual functioning and related issues.

**Limitations of the Study**

The study was limited in that it is representative of the ten female FNP participants in the group who all resided in a large urban city in the North East of U.S. and is not generalizable. The recurring aspects of the meaning and what is universal about the phenomenon that emerged may not be applicable to other populations, specifically to FNPs performing sexual health assessments. However, qualitative studies can provide valuable insight. Although the aim of
qualitative research is not to be generalized in the usual empirical sense, van Manen 2012 states, “in some way we could speak of phenomenological understandings as generalized…existential and singular generalization” (p.352).

Purposive sampling in phenomenological inquiry allows the researcher to select female FNPs because of their knowledge and verbal eloquence to describe their lived experiences and is interviewed for the purpose of sharing that knowledge in their own individual ways. The findings of the lived experiences in this study are based on reflective descriptions provided by the FNP participants and the interpretation of these experiences into sententious phrases that represent emerging themes. Other practice geographical locations and/or workplace settings such as home care, or male FNPs may produce a different perspective in performing a sexual health assessment. Expanding the FNP’s lived experiences of performing a sexual health assessment to include their pediatric and young adolescent clients in addition to their adult clients may provide a different perspective.

**Implications for Nursing Education and Practice**

This research study is a first effort in understanding the FNP’s experience when performing sexual health assessments on their adult clients. A primary finding from this study is the emergence of three essential themes; self-concept, prudence, and presence. The findings show the combination of these three themes laid the foundation for the FNP to perform a sexual health assessment and that having a positive self-concept influences the development of the FNP’s presence and prudence with their clients. The experiences, as told by the ten female FNPs in this study provided a better understanding of the FNP’s experience when performing a sexual health assessment. The following are implications for nursing education and practice that were derived from this research.
• FNP curriculum needs to provide opportunities to promote and build a positive self-concept around sexuality for the students. Forums, such as clinical case studies, clinical conferences, stimulation, and small seminar groups that address the student FNP’s own body image, promote objectiveness, and allow for honest exploration of their attitudes towards sex is recommended prior to performing sexual health assessments. Findings of this study tell us that allowing the FNP to explore their beliefs and feelings and to have self-awareness may dispel the myths and overcome the stigma that may prevent the FNP from providing holistic nursing care.

• The study findings support the need for increased provider awareness and education on the care of LGBT patients. Providers need to be mindful of and assess for population specific risk factors, offer appropriate screening, and provide culturally sensitive care to all patients.

• FNP educators need to provide opportunities for FNPs to obtain feedback, to discuss personal beliefs around sexual health and sexuality, and to discuss gender and sexual disparities. Globally, the healthcare needs of clients are becoming increasing complex and all primary care providers including FNPs are challenged to provide quality healthcare to all healthcare settings and sectors. Learning outside the classroom, from multicultural experiences in diverse and similar cultures worldwide is a challenge for today’s nursing educators. Being able to provide both didactic and clinical education that it culturally sensitive, unbiased, and congruent to FNP students is necessary.

• Examining the ethics of being a prudent FNP when performing a sexual health assessment needs to be added to curriculum. Additionally, the FNPs in practice need opportunities such as on-line chat rooms, for honest discussions of their feelings and their
desire to have a presence for their clients in a non-judgmental fashion despite cultural, social norms, and personal beliefs.

- Clinical educators must provide training that includes multi-complex clients that have non-traditional sexual issues that ensure FNPs have appropriate training and offer continuing education for the more experienced FNPs who need to be updated on global, national and state policies surrounding sexual health goals and for positive sexual health outcomes.

- Clinical preceptors and FNP clinicians need to be supported, retrained, and educated on culturally congruent sexual health assessments for all clients in order to assess and maintain clinical competency-based education for today’s primary care environments. This includes improving communication skills, sexual health education that includes gender and population care throughout the lifecycle, public health prevention models that address health disparities and promotion of social justice. In this study most of female FNP participant reported significant gaps in the way they were prepared to address the sexual health of their adult clients.

- Providers of health care need to fund and support postgraduate FNP residency programs that provide guidance and feedback to less experienced FNPs to their build self-concept. A finding in this study suggests that having a colleague and an interprofessional team helped to develop a positive self-concept.

- Health care practices must provide better time management to allow for holistic primary care that is inclusive of sexual health assessments. It is easy to bypass important health maintenance component of sexual health, especially when feelings of discomfort and inadequacy are provoked as suggested from this study’s findings.
Reflections of Researcher’s Experience

This study has provided clarity that having a strong self-concept plays an essential role when performing a sexual health assessment. To understand the meaning of the lived experience of female FNPs during sexual health assessments, I was the “instrument” as well as the participant (Munhall, 2012). During this study I kept a journal throughout noting thoughts, feelings, experiences, and reflections during the research process. Initially, keeping a journal was performed to reduce theoretical, prejudicial, and suppositional intoxication (van Manen & Adams, 2010), however, it also became cathartic and rewarding for me. Hearing the participants stories, exploring their unique and shared human experiences, and finding the ontics of meaning within the phenomenon enabled me to have a richer understanding of phenomenology and influenced me by applying these finding into her clinical practice and teaching. Moreover, this study enriched my understanding of the lived experience during sexual health assessments and transformed her practice as a primary care provider and as a clinical preceptor by applying building a stronger self-concept. I obtained a new awareness as my feelings were validated by many of the FNP stories of their experiences during the intimate and essential client encounter of a sexual health assessment.

I believe that the interview environment did not meaningfully influence the interviews since it the participants’ stories that created the meaning and the interview environment did not alter their lived and pre-reflective space. Further studies on how the work environment changes the experience for the participant during sexual assessments should be further explored but for interview purposes it was not a meaningful factor. My interview skills and comfort improved over time and I reflected more deeply with each interview and journal entry.
The desire for me to share her lived experienced with less experienced participants who spoke of their difficulties during sexual health assessments and their clinical isolation arose several times. I did not act on those feelings because I was aware of the bias that could arise by discussing her personal values and feelings with the participants. I reflected on whether these feelings influenced the course and content of the interviews after each interview. Knowing this, faculty and clinical preceptors who are teaching FNPs must be aware of their comfort of their sexuality, feelings, and beliefs during their sexual health assessment. Building their self concept is the first step to teaching others.

**Recommendations for Further Nursing Research**

Nurses perform “*scholarly research through which the theoretical basis of nursing becomes explicit*” (Phillips, 2015, p.43). From the new knowledge gained from this study on the lived experience of female FNPs during sexual health assessments from a phenomenological perspective, it is my purpose to direct further qualitative and quantitative research studies. Given the lack of research on the FNP experience in primary care when performing a sexual health assessment, it is important to expand the understanding and body of work from the FNPs perspective. The study recommends the following areas of research:

- Further exploration of the concepts of self-concept, presence, and prudence, as they pertain to nurse practitioners (NPs) who perform sexual health assessments, especially NPs in other specialties such as adult/geriatric health, psychiatric mental health, women's health, and pediatrics.

- The male NP’s perspectives to identify unique factors.
• Methods to build the NPs’ self-concept and other clinicians with the tools necessary to examine their comfort, presence, and prudence and to find avenues to relieve them of the distress that may occur during sexual health assessments.

• Further exploration of the styles of care and patterns of relating for the NP and the effect this has on presence, prudence, self-awareness, and comfort.

• The client’s perceptions of the NP’s comfort, self-awareness, prudence and presence during sexual health assessments and how this impacts the client’s comfort and ultimately the NP’s delivery of client-centered care for sexual health needs.

• This study should be replicated with other NP specialties, gender minorities including transgender providers and clients, and other health care domains aside from nursing. This will further validate the essential themes of this study and to promote improved client centered care and improved inter-professional research and education.

• Educational models and testing for teaching cultural competent sexual health assessments.

Summary

This study explored the lived experience of ten female FNP when performing sexual health assessments on their adult clients. Sub-themes and the essential themes were revealed using van Manen’s (1990) methodology for transcript analysis. An interpretation of the textual writings of each participant’s story revealed three essential themes: 1) Self Concept, 2) Presence, and 3) Prudence. After reflecting on these essential themes, the interpretive statement was: The performance of a sexual health assessment by FNPs on their adult clients in primary care is the development of presence and prudence in relation to their level of their self-concept. The themes and summary interpretive statement were reflected upon using Roy’s Adaptation framework.
This study has implications for the discipline of nursing education, nursing practice, and nursing research. Implications for the discipline of nursing include improved sexual health assessments and outcomes. Implications for nursing education were specific to developing sexual health assessment curriculum that enables FNPs to explore their self-concept. The limitations of the study and reflections of the researcher’s experience were discussed. Finally, recommendations for nursing research involves further development and understanding of the themes of comfort, self-awareness, presence, and prudence in relationship to a positive self-concept through qualitative and quantitative studies.
Appendices

Appendix A.

DATE: July 31, 2013
TO: Madeleine Lloyd, RN, MS, FNP-BC, PMHNP-BC
FROM: Herbert H. Lehman College (CUNY) HRPP Office
PROJECT TITLE: [468977-1] The Lived Experience of family nurse practitioners in primary care who perform a sexual health assessment on adults
SUBMISSION TYPE: New Project
ACTION: APPROVED
APPROVAL DATE: July 31, 2013
EXPIRATION DATE: July 30, 2014
RISK LEVEL: Minimal Risk
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review categories # 6 & 7

Thank you for your submission of New Project materials for this project. The University Integrated IRB has APPROVED your research. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant’s understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any modifications/changes to the approved materials must be approved by this IRB prior to implementation. Please use the appropriate modification submission form for this request.

All UNANTICIPATED PROBLEMS (UPS) involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

This research must receive continuing review and final IRB approval before the expiration date of July 30, 2014. Your documentation for continuing review must be received with sufficient time for the IRB to conduct its review and obtain final IRB approval by that expiration date. Please use the appropriate continuation submission forms for this procedure. PLEASE NOTE: The regulations do not allow for any grace period or extension of approvals.

If you have any questions, please contact Tara Prairie at (718) 960-8960 or tara.prairie@lehman.cuny.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within the City University of New York’s records.
DATE: July 31, 2013
TO: Madeleine Lloyd, RN, MS, FNP-BC, PMHNP-BC
FROM: Herbert H. Lehman College (CUNY) HRPP Office
PROJECT TITLE: [468977-1] The Lived Experience of family nurse practitioners in primary care who perform a sexual health assessment on adults
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If you have any questions, please contact Tara Prairie at (718) 960-8960 or tara.prairie@lehman.cuny.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within the City University of New York’s records.
Appendix B.

CITY UNIVERSITY OF NEW YORK

Lehman College, Department of Nursing

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Project Title: The Lived Experience of Family Nurse Practitioners in Primary Care who Perform a Sexual Health Assessment on Adults

Principal Investigator: Madeleine Lloyd Doctorate Student
Graduate Center Nursing Science
365 Fifth Avenue New York, NY 100164309
Ph. 917-593-9807

Faculty Advisor: Dr. Kevile Frederickson EdD, FAAN - Dissertation Chair
Department of Nursing Lehman College
250 Bedford Park West
Bronx NY, 10468
Ph. 718-960-8378

Site where study is to be conducted: Public Space

Introduction Purpose: You have been invited to take part in a research study about the lived experiences of performing a sexual health assessment on your adult clients in a primary care setting. This study will be conducted by Madeleine Mary Lloyd, MS, RN, FNP-BC, PMHNP-BC from the Nursing Science department at The Graduate Center, City University of New York. The results from the research study will be contributed to a doctorate thesis. You are selected in this study because you are a family nurse practitioner with more than three years of experience practicing full time in a primary care setting. You see adult clients and perform a sexual health assessment on all new clients and during their annual comprehensive physical health assessment.

The results of this study may improve gain an understanding of the lived experience for family nurse practitioners in primary care when performing a sexual health assessment. During the interview an audio recorder will be used to transcribe the interview for research purposes only.

Procedures: Approximately ten individuals are expected to participate in this study. Each subject will participate in one interview. The time commitment of each participant is expected to about one hour. Each session will take place at a location that is convenient to you.

Possible Discomforts and Risks: Your participation in this study may involve reliving an uncomfortable experience. If you are troubled, as a result of this study you should inform the researcher and the interview will be stopped.

CUNY IR - Institutional Review Board

Approval Date: July 31, 2013
Expiration Date: July 30, 2014
Coordinator Initials: ZMG
Benefits: There are no direct benefits. However, participating in the study may increase general nursing knowledge of the lived experiences of family nurse practitioners when performing a sexual health assessment on adult clients.

Voluntary Participation: Your participation in this study is voluntary, and you may decide not to participate without prejudice, penalty, or loss of benefits to which you are otherwise entitled. If you decide to leave the study, please contact the principal investigator Madeleine Lloyd to inform them of your decision.

Financial Considerations: NA

Confidentiality: The data obtained from you will be collected via audio digital recorder. The collected data will be accessible to Madeleine Lloyd and Dr Keville Frederickson only. Confidentiality of your research records will be strictly maintained by assigning you a code number and alias name so that data is never directly linked to your name. In addition, all forms will be kept in a locked cabinet only accessible to Ms. Lloyd. The consent forms and data will be kept for 3 years after the study is completed and then shredded and disposed of confidentially. All digitally taped interviews will be downloaded onto one computer which will be password secure and in a secure password folder. This computer will be accessible only to Ms. Lloyd.

Contact Questions/Persons: If you have any questions about the research now or in the future, you should contact the Principal Investigator, Madeleine Lloyd, via email: mim_lloyd@hotmail.com. If you have any questions concerning your rights as a participant in this study, you may contact Tara Prairie ph. 718 960-8960.

Statement of Consent:

“I have read the above description of this research and I understand it. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions that I may have will also be answered by the principal investigator of the research study. I voluntary agree to participate in this study. By signing this form I have not waived any of my legal rights to which I would otherwise be entitled. I will be given a copy of this statement.”

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CUNY UI - Institutional Review Board
Approval Date: July 31, 2013
Expiration Date: July 30, 2014
Coordinator Initials: Z.L. Page 2
Appendix C

Inclusion Criteria

A female family nurse practitioner (FNP) board certified with at least 3 years of clinical experience in an urban primary care setting. The FNP has to answer yes to:

During my comprehensive annual client assessment (usually performed at first visit), I perform a sexual health assessment on my male and female adult clients.

(Adults = 18 years or older)
Appendix D

Demographic Data

Sheet

1. I am: ( ) Female ( ) Male ( ) I prefer not to answer

2. My age: ________________________________ (years)

3. Race: ( ) White ( ) Black ( ) Hispanic ( ) Asian/Pacific Islander ( )
   Other ____________________________________________________________

4. Marital Status: ( ) Single ( ) Married ( ) Divorced/Separated ( ) Widowed ( ) Co-habituate (living with a domestic partner)

5. NP Education: ( ) non-degree Certificate ( ) BSN/Certificate ( ) Masters ( ) Doctorate

6. NP Certification(s): ________________________________________________

7. National Certification ( ) ANCC ( ) AANP

8. Years of NP experience: ____________________________________________

9. Years of RN experience: ___________________________________________

10. Work Setting: ( ) outpatient clinic ( ) Private Office ( ) Community Center ( )
    Other(s) __________________________________________________________

11. Do you work ( ) Full time ( ) Part time ______ hr/week

12. Approximately how many clients do you see in a week? ________________

13. Do you see clients 18 years and older? ( ) Yes ( ) No

14. During my comprehensive patient assessment (usually performed at first visit and annually), I perform a sexual health assessment on my male and female adult clients ( ) Agree ( ) Disagree
### Appendix E

#### Essential Theme 1. Self Concept

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Meaning Units</th>
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</table>
| **Comfort**               | ● How am I going to deal with this?  
|                            | ● Comfort zone  
|                            | ● Nerve racking as hell  
|                            | ● Doing pap after pap, quickly developed rapport and skill  
|                            | ● Learnt from colleagues  
|                            | ● Over time more exposure to social issues  
|                            | ● Because I have been doing this for a while and because I am older it doesn’t bother me to ask questions like this. But I also have to check myself and say “ok you’re asking that because it’s important not because..to not being seen as voyeuristic  
|                            | ● In the young gay male population I’ve seen gonorrhea in the throat which I have never even seen back home. That’s kind of something that’s opening my eyes to all these things. I never use to treat before and now I am having to treat here. Even that being here, I am more focused on asking more of those questions.. so it kinda makes me more aware to ask those types of questions  
|                            | ● (LGBT) wasn’t in my radar of what to think about  
|                            | ● I think it is easy and comfortable with the women. With the men sometimes it can be a little bit uncomfortable  
|                            | ● I feel like there is more of the empathy there that makes me more comfortable talking to a young female patient versus someone else  
|                            | ● I don’t see a lot of heterosexual older men here and that’s probably the most uncomfortable I feel is examining them versus seeing the young females  
|                            | ● Examining his private areas that makes me uncomfortable in males  
|                            | ● I am just a very private person so for me to go into an interview with someone I just met especially like with new patients it gets kind of awkward  

### Essential Theme 1. **Self-Concept**

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Meaning Units</th>
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</table>
| **Self-Awareness** | - It definitely comes from my own views about sexuality. My parents, it definitely has to do with the way I was raised  
- You feel frustrated you may feel helpless  
- I don’t feel like I internalize it  
- We were all thinking “what would we do if we were 18, with a baby, with no job? and you realized how difficult it is to think about what you would do at that point.  
- I think I have the same sort of internal and hopefully it’s not external but internal sort of body language cringing that I’ve seen in my students so hopefully that doesn’t manifest itself outward.  
- I felt angry...You see people making poor choices or having double standards and try to maintain equanimity and it’s not easy  
- I can be aware of my feelings and it shouldn’t change the way I offer services  
- an internal barometer for asking “gaydar”  
- I don’t really have a feeling on a sexual history any more than I have on a medical or surgical history. I wouldn’t say it is anything different.  
- Did we learn to do this in school? I would say “no not at all” but this comes from my long history of being involved in reproductive rights for women so I think this also comes from a political ideology  
- You have women that are getting such fragmented care |
Essential Theme 2: **Presence**

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Meaning Units</th>
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</thead>
<tbody>
<tr>
<td><strong>Involvement</strong></td>
<td></td>
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<tr>
<td>● To take care of them as a whole</td>
<td></td>
</tr>
<tr>
<td>● Going to trust me</td>
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<tr>
<td>● It’s like almost being in a soap opera but you’re not part of it</td>
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<tr>
<td>● Opens the door to a lot of other stuff</td>
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<tr>
<td>● I have a very integrated approach</td>
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<tr>
<td>● I see the person as a whole</td>
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<tr>
<td>● I want to know more than your vagina I want to know you as a whole person</td>
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<tr>
<td>● They should feel like they want to talk to you about anything and sexual health is a big part of it. I feel like that’s kind of what we’re here for. Is to be like this kind of a safe haven where people can just come and feel like they can just talk to you about anything.</td>
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<tr>
<td>● Once I already know them they are very much more open to talk to me</td>
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<tr>
<td><strong>Styles of Care</strong></td>
<td></td>
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<tr>
<td>● My style is really dependent on who's in front of me</td>
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<tr>
<td>● There are times in which you just need to be in the moment and be a Human being and just tell your feelings and not necessarily try to be that reserved person that’s trying to get the person to get to their own answers</td>
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<tr>
<td>● I definitely take a more thorough sexual history than I would. (HIV positive)</td>
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<tr>
<td>● Between balancing everything that is going on in the clinic</td>
<td></td>
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<tr>
<td>● If I have someone identified in a high risk group, I take a more comprehensive sexual history than I do for my married folks; so it’s not standardized</td>
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<tr>
<td>● In school there was a set formula for asking about someone’s sexual history</td>
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<tr>
<td>● What we are doing is normalizing this process</td>
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<tr>
<td>● I always try to normalize</td>
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<tr>
<td>● My goal is to make them comfortable and to address their concerns in a manner that’s very caring</td>
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<tr>
<td>● Teach them better ways of going about things</td>
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<tr>
<td>● To be a resource for the person to get assistance when they’re ready</td>
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<tr>
<td>● To be able to teach them</td>
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Essential Theme 3: Prudence

Professional Conduct

- I can’t judge them for their life.
- I try to be non-judgmental. All these judgments, it’s even hard saying
- All these judgments it’s even hard saying that but you know it tough you see people making poor choices or having double standards
- Afraid I was going to be sounding too judgmental. Not that I was honestly ever judgmental I think a little you know it’s the provider more than the patient feeling uncomfortable
- As a provider we are not judgmental we are just presenting the facts
- Being a professional it’s not you know to have preconceived notions about patients
- Obviously for confidentiality reasons I cannot say anything. But again at that point I would say you really feel helpless because you are really trying to help the person in front of you but you can only guide them you can’t make the decision for them.
- It’s to be able to see through all of that and provide care as objectively as you can regardless of what you feel they’re doing and how you feel about it but how to do it safely
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