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Differences between the Attitudes and Behaviors of Oncology Nurses: Inclusion of Sexuality Concerns as a Component of Care

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DIFFERENCES BETWEEN THE ATTITUDES AND BEHAVIORS OF ONCOLOGY
NURSES: INCLUSION OF SEXUALITY CONCERNS AS A
COMPONENT OF CARE

By

Mary Diane Ashley

A THESIS

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ABSTRACT

DIFFERENCES BETWEEN THE ATTITUDES AND BEHAVIORS OF ONCOLOGY
NURSES: INCLUSION OF SEXUALITY CONCERNS AS A
COMPONENT OF CARE

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This was an exploratory descriptive study. The "Wilson and Williams Sexuality Survey" (1988) was used with revisions to include a definition of sexuality. The sample consisted of 109 oncology nurses who care for adult oncology clients from five Midwestern institutions. There was a significant difference in attitudes and behaviors of oncology nurses regarding sexuality as a component of care ($t = -.53.96$; d.f. = 109; $p = 0.00$). It was expected that positive attitudes would yield more behaviors, this was not the case. However, a moderately strong relationship was found between the attitudes and behaviors ($r = .6088$; $p = 0.00$). Basic nursing education, age, personal health history and the role of the chemotherapy staff nurse were examined. Erickson, Tomlin and Swain (1983) nursing theory, "Modeling and Role-Modeling" was utilized to explain how the nurse as an individual may view the client's world regarding sexuality concerns.

Dedication

To my sons, my family, and especially to my husband of 25 years.

Acknowledgement

I would like to recognize those individuals who helped me to complete my goals.

I would like to thank Alyssa Ashley for the many hours she spent editing my many revisions. I would also like to thank Judy Shell for her assistance by providing correct terminology and editing of my data collection tool and Marion Stiles and Tom Doyle for assistance with the printing of my data collection tool, "The Ashley Revision of the Williams and Wilson Sexuality Survey."

I would also like to thank the Clinical Nurse Specialists who assisted with data collection: Jackie Keene, Mary Pat Johnson, Jeannette Ekberg, Glenda Kaminski and Kelly Guswiler. And last but not least, my special thanks to those who had the most patience with me: Dr. Kay Kline, Dr. Terry Rosander, Agnes Britton and Linda Scott.

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CHAPTER ONE

INTRODUCTION

Individuals are composed of emotional and physical needs. The individual cannot be dissected into components, but rather must be viewed as a combination of those components that combine to form a person. Every individual is in need of human touch, affection, and interaction with others. In the purest form, this is an explanation of what sexuality is: touching, talking, and the fulfillment of the need to be loved and to love another.

The reflection in the mirror has an impact on the woman who has just had a breast removed because of cancer. The degree of impact on the emotional and physical components of the individual can partly be explained by our individual differences. Differences in individuals are often shaped by past experiences and how we perceive ourselves, as well how we perceive that others view us. The woman who has contained her femininity within the boundaries of her breast may feel devastated by the loss of a breast. For another woman, a loss of a breast is merely an inconvenience.

The role of the oncology nurse is to care for and nurture the cancer patient. The nurse and the cancer patient each have a prescribed role that makes them different, yet each is alike because of their need for human touch, affection, and interaction with

others. It is in this context that sexuality is revealed to be more than the physical act of sexual intercourse. Sexuality is a component of who we are, it is also a basic human need (Fisher, 1985; Lamb, 1991; Smith, 1989, 1994; Williams, Wilson, Hongladarom & Hengeveld; McDonell, 1986; Wilson & Williams, 1988).

The Oncology Nurses Society, in collaboration with the American Nurses Association, validated the inclusion of issues related to sexuality as a component of care. These two nursing societies developed "Standards of Care" to guide nurses in assessing, educating, and counseling oncology patients (Clark & McGee, 1992; Gamel, Davis & Hengeveld, 1993; Hogan, 1991; Kautz, Dickey & Stevens, 1990; Longman, 1990; Smith, 1989, 1994; Waterhouse & Metcalfe, 1991). However, review of the literature suggests that oncology nurses are not consistently assessing oncology patients for sexuality concerns (Gamel, Davis & Hengeveld, 1993; Kautz, Dickey, & Stevens, 1990; Lewis & BorDphil, 1994; Matocha & Waterhouse, 1993; Smith, 1989; Williams, Wilson, Hongladarom & McDonell, 1986; Wilson & Williams, 1988).

Wilson and Williams (1988) reported that 97% of the 937 Registered Nurses who responded to their study reported an attitude which reflected a belief that issues related to the individual's sexuality was an important component of care. However, Wilson and Williams (1988) reported that the use of the nursing diagnosis of "alteration in sexuality" was used only 32% of the time, which demonstrated a behavior that was inconsistent with attitude. This study replicates the Wilson's and Williams' (1988) study with the addition of a definition of sexuality. Wilson and Williams (1988) did not provide a definition of sexuality for their study. The addition of a definition of sexuality

may possibly have provided a knowledge base that was consistent for each oncology nurse when reporting present attitudes and behaviors regarding the sexuality concerns of the oncology patients.

Problem

Personal observation has led to the belief that oncology nurses do not consistently assess the oncology patients for sexuality concerns. Education and counseling regarding concerns of sexuality issues are not regularly provided to the oncology patients. The reasons cited by oncology nursing peers are (a) cancer patients are too sick to care about sex, (b) patients do not ask, (c) it's the physician's responsibility, and (d) lack of comfort with discussion of patient's sexual concerns. The literature suggests that personal discomfort stems from personal beliefs and biases, and perceived inadequacy of knowledge (Dudas, 1993; Kautz, Dickey & Stevens, 1990; Lamb, 1991; Lewis & BorDphil, 1994; Masters, Johnson, & Kolodny, 1995; Matocha & Waterhouse, 1993; Shell, 1992; Smith, 1989; Williams, Wilson, Hongladarom & McDonell, 1986; Wilson & Williams, 1988).

The literature has reported that the inclusion of assessment, education, and counseling of issues regarding the sexuality of the individual has become a valid component of care (Cartwright-Alcares, 1995; Ofman, 1994; Smith, 1994). Increases in survival time and legalities of informed consent have been linked to the emphasis placed on including sexuality concerns as a component of care (Anderson, 1991; Anderson & Lamb, 1995; Coughlan, 1987; Lamb, 1991). Garfinkel (1995), a consultant for the American Cancer Society reported:

Survival rates from cancer - that is those who are alive 5 years after diagnosis - were 1 in 5 in the 1930s, 1 in 4 in the 1940s, and 1 in 3 in the 1960s. In recent years, 4 in 10 patients have survived 5 years (p. 2).

Decisions to start treatment, or continue treatment must be made on the basis of informed consent. Informed consent consists of knowledge of all the potential limited and permanent side effects of treatment. This knowledge includes the impact of treatment on (a) the patient's ability to engage in sexual intercourse, (b) the patient's ability to receive pleasure from sexual intercourse, and (c) the psychosocial components of sexuality (Anderson, 1991; Smith, 1989, 1994). Adaptation to the side effects of treatment on the client's sexuality is enhanced by the provision of information by nursing (Anderson, 1991; Griffiths & Leek, 1995; Ofman, 1994; Shell, 1992; Smith, 1994).

When assessment of sexuality needs is excluded by oncology nurses, the patient may be left ill equipped to deal with those needs and possibly unaware of the short and long term effects of cancer treatment (Anderson, 1991; Chamorro, 1991; Lamb, 1991; Shell, 1992). Anderson (1991) explains that prior to the diagnosis and treatment of cancer, many patients had reported satisfactory sexual relationships. Preventive interventions in the form of patient education can decrease the incidence and severity of treatment effects to the patient's sexuality, if these interventions are delivered during the early phases of treatment. Fisher (1985) maintains that providing education about sexuality concerns provides permission to the patient to discuss sexuality concerns at that time and later as new sexuality concerns surface.

Justification

Abraham Maslow (1954, 1987) studied human behavior and proposed a theory of how humanity seeks to strive to be the very best it can be. To reach a level of maximum potential requires progression through a hierarchy of needs from the basic physiological needs of food, shelter, sleep and oxygen upward to self-fulfillment. Progression upward is analogous to climbing the steps of a house. The first step is the physiological needs; then safety and security are next. The safety and security needs are met when there is consistency of routines and honesty from those around us. Continuing upward, the next steps are love and belonging needs. After love and belonging needs are met, then one progresses upward until individual maximum potential and self-fulfillment is reached. See figure 1 for a visual model of Maslow's hierarchy of needs as interpreted by Erickson, Tomlin and Swain (1983).

Sexuality of the individual is a very important component of each of Maslow's levels, from sexual intercourse for the purpose of procreation to the more complex levels of a relationship that consists of communication, trust, love and sharing (Ebersole & Hess, 1990; Hogan, 1980; Lilley, 1987). The components of sexuality are the same for all individuals, but for those with cancer, those issues related to their sexuality may be intensified due to losses associated with their cancer. Losses that are part of the treatment for cancer include loss of body parts, bodily functions, loss of hair, and loss of relationships (Anderson, 1991; Chamorro, 1991; Schover, 1986; Shell & Smith, 1994).

Maslow suggested that as we progress through the hierarchy of needs, we may

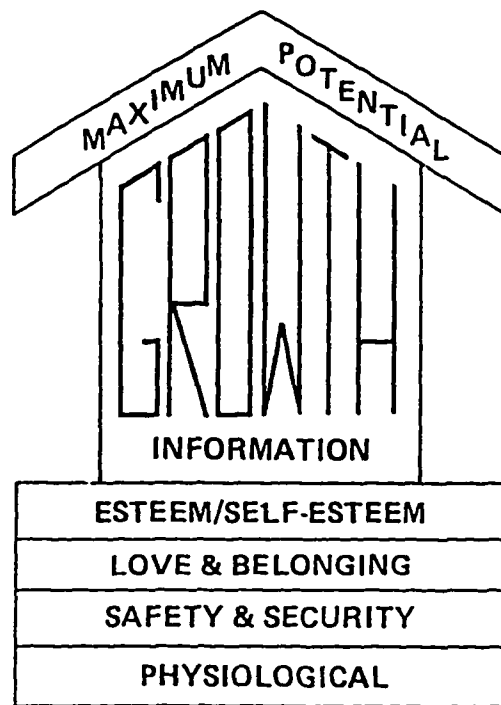


Figure 1 Maslow's hierarchy of needs

Note. From Modeling and role-modeling: A theory and paradigm for nursing (p. 57), by H. C. Erickson, E. M. Tomlin, and M. A. Swain, 1983, Englewood Cliffs, New Jersey: Prentice-Hall. Copyright 1983 by Prentice-Hall. Reprinted with permission from Helen Erikson (See Appendix A).

simultaneously have partially satisfied and unsatisfied needs (1987). Individuals may need to revisit previously met needs during a crisis, such as the crisis of cancer. Nursing is in a position to provide interventions which enable the patient to progress upward toward maximum potential and individual fulfillment (Erickson, Tomlin & Swain, 1983). Unfortunately, interventions that address sexuality concerns are not always provided by nursing.

Kautz, Dickey, and Stevens reported that nurses in general have accepted the inclusion of sexuality concerns as a component of holistic care, although the actual behaviors do not reflect this attitude of acceptance (1990). The omission of the behavior of assessment of sexuality concerns may be a reflection of myths and stereotypes to which nurses subscribe. The nurse's own sexual beliefs and knowledge deficits may be factors that contribute to the perpetuation of those myths and stereotypes (Coughlan, 1987; Masters, Johnson, & Kolodny, 1995; Matochia & Waterhouse, 1993; Nevidjon, 1984; Smith, 1989). The definition of sexuality that the individual has internalized may also be a factor for omission of sexuality concerns as a component of care. Nurses may define sexuality as the physical act of sexual intercourse, and not the broader definition that includes the physiological and the psychological components. If the nurse is interpreting sexuality as being the act of intercourse, there may be a hesitancy to ask questions about a client's sexuality concerns. This hesitancy may also stem from personal views that one does not discuss a subject perceived as being very private (Chamorro, 1991; Medlar & Medlar, 1990; Steinke & Bergen, 1986; Williams, Wilson, Hongladarom & McDonell, 1986).

In the 1970's, nearly twenty five years after Maslow (1954) first proposed the "Human Needs Theory," the American Nurses Association and the Oncology Nurses Society included sexuality as a valid component of care (Gamel, Davis & Hengeveld, 1993; Longman, 1990; Ofman, 1994; Smith, 1989, 1994). Prior to the 1970s, the emphasis of treatment by medicine and nursing was concentrated on the critical tasks of keeping the patients alive (Smith, 1994). Now health professionals are looking at quality of life issues because patients are surviving longer, and there is a desire by the patients to return to a normal life style (Ofman, 1994; Schover, 1986; Shell, 1992; Smith, 1994). Many oncology nurses continue to believe that patients are too busy surviving and coping with treatment to care about sexuality issues (Kautz, Dickey & Stevens, 1990). The definition of sexuality may be a key variable. Nurses may be viewing sexuality from a narrowed perspective of sexual intercourse, rather than from the broader definition in which sexual intercourse is only a component.

Purpose

The purpose of this study was to explore the relationship between the attitudes and behaviors of oncology nurses with regard to the sexuality concerns of the oncology patient. Do oncology nurses, who perceive oncology patients to have sexuality concerns, demonstrate behaviors that include assessment of sexuality issues, provision of sexuality education and sexuality counseling as a component of care?

CHAPTER TWO

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

In this chapter, the conceptual framework will be discussed as a basis to explore oncology nurses' attitudes and behaviors regarding the sexuality of the oncology patient. The literature review will begin with a general search of the literature and then focus on those studies that have explored nursing attitudes and behaviors regarding the sexuality concerns of oncology patients.

Conceptual Framework

Erickson, Tomlin, and Swain (1983) developed the theory "Modeling and Role-Modeling" for nursing to help the patient achieve health. Modeling is the process of data collection by the nurse. The nurse views the patient's world from the patient's perspective, then analyzes and synthesizes the data using "relevant concepts and a theoretical base" (p.153). The nurse then role-models for the patient by providing interventions that facilitate the patient's achievement of health and well being. Modeling and Role-Modeling provides a framework for investigating and understanding attitudes and behaviors of oncology nurses in regards to the sexuality concerns of the oncology patient. Erickson, Tomlin, and Swain (1983) use the word client when discussing the individuals for whom nurses provide care. Erickson, Tomlin, and Swain (1983) state:

A patient is one who is given aid, instructions, and treatment with the expectation that such services are appropriate and that the recipient will accept and comply with the plan. A client is one who is considered to be a legitimate member of the decision-making team, who always has some control over the planned regimen, and who is incorporated into planning and implementation of his or her own care as much as possible (p. 20).

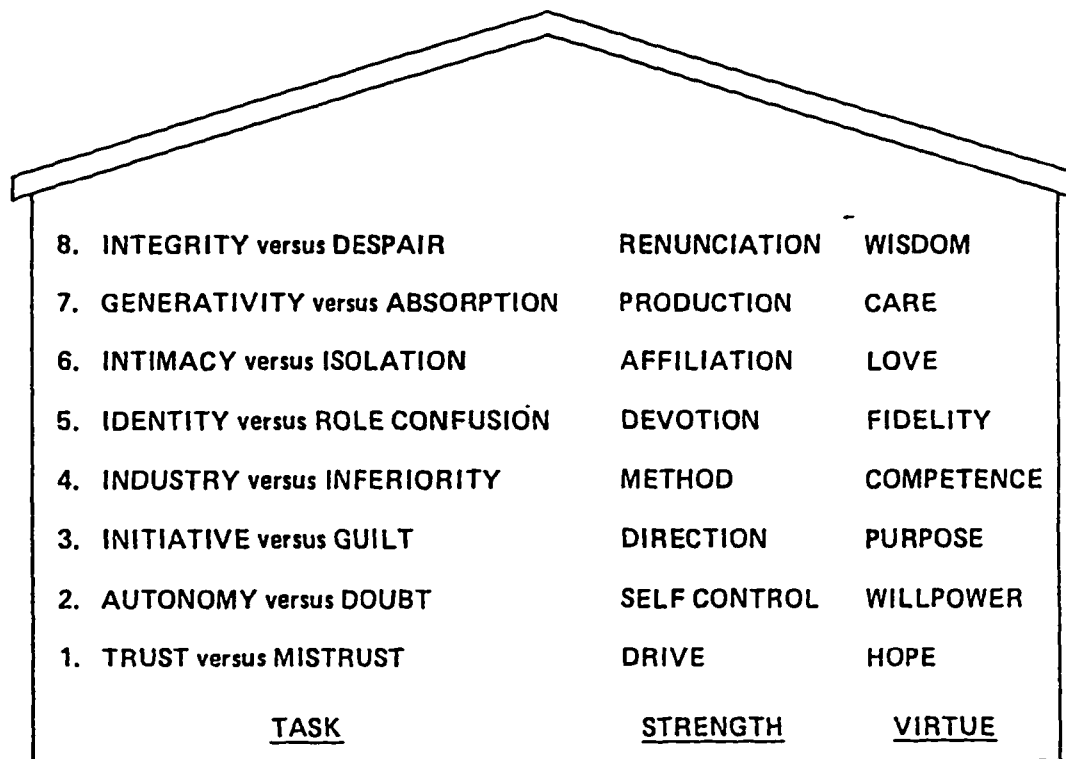
It could also be said that when the oncology nurse assesses the client for sexuality concerns, control is given to that patient. The client can either discuss the concerns that might be present, or decline to do so. In this relationship the nurse does not assume that sexuality concerns are not an issue for this client. From this point on, the term client will be used instead of the term patient when describing or discussing individuals for whom the nurse cares.

Nurses and clients are individuals, even though they have different roles. As individuals they have the same basic human needs and developmental tasks that are required to progress through developmental stages, unfolding in their own unique way (Erickson, Tomlin, & Swain, 1983, p. 70). Erickson, Tomlin and Swain (1983) incorporate Erik Erikson's (1959) and Maslow's (1954) theories to explain how people are alike and different. Maslow expressed a belief that all people have the desire to be the best they can be in the physiological and psychosocial realm. Each step upward in their hierarchy of needs is one step closer to self-fulfillment. Basic physiological needs of food, shelter, sleep, and oxygen must be met for survival of the individual (1987). The oncology nurse assists the client to achieve basic physiological needs on a daily basis as

part of the care they provide to the client. Erickson, Tomlin and Swain suggest that there is a "need to know" (p. 59) and the "acquisition of knowledge meets safety and security needs"(p. 59), therefore safety needs may be met when the client senses honesty and openness in the nurse-client relationship. Coping with the effect of cancer and treatment can be facilitated with information provided by the nurse, especially when sexuality concerns exist. The ability to cope facilitates the fulfillment of the higher needs of love and belonging and esteem/self-esteem (Anderson, 1991; Erickson, Tomlin & Swain, 1983; Hogan, 1991; Nevidjon, 1984; Shell, 1992; Steinke & Bergen, 1986).

Erik Erikson (1959) proposed that each person works through psychologic developmental stages (See Figure 2). As each person progresses through developmental tasks, there are gains in strengths and attitudes that contribute to individual personality. When a person is confronted with illness such as cancer, development of the individual may be delayed or revisited. The cancer client's sense of self is challenged when there is body change which affects the client's perception of their femininity or masculinity, a component of the client's sexuality. Role changes further attack perceptions of self when the client is no longer able to maintain former roles. Hospitalization, with the associated loss of privacy, may inhibit the completion of developmental tasks regarding intimacy issues. Provision of privacy and facilitation of communication between significant others promotes developmental task completion for the client with cancer (Shell, 1992, 1994; Shell & Smith, 1994; Nevidjon, 1984).

Resolution of developmental tasks are dependent on the degree to which basic human needs are met. In some individuals the stress of an illness may necessitate



8. INTEGRITY versus DESPAIR	RENUNCIATION	WISDOM
7. GENERATIVITY versus ABSORPTION	PRODUCTION	CARE
6. INTIMACY versus ISOLATION	AFFILIATION	LOVE
5. IDENTITY versus ROLE CONFUSION	DEVOTION	FIDELITY
4. INDUSTRY versus INFERIORITY	METHOD	COMPETENCE
3. INITIATIVE versus GUILT	DIRECTION	PURPOSE
2. AUTONOMY versus DOUBT	SELF CONTROL	WILLPOWER
1. TRUST versus MISTRUST	DRIVE	HOPE
<u>TASK</u>	<u>STRENGTH</u>	<u>VIRTUE</u>

Figure 2. Erikson's developmental stages

Note. From Modeling and role-modeling: A theory and paradigm for nursing (p. 62), by H. C. Erickson, E. M. Tomlin, and M. A. Swain, 1983, Englewood Cliffs, New Jersey: Prentice-Hall. Copyright 1983 by Prentice-Hall. Reprinted with permission from Helen Erikson (See Appendix A).

revisiting a developmental or basic needs stage that was not fully resolved (Shell, 1992; Walsh, VandenBosch & Boehm, 1989). Understanding by the oncology nurse of the theories of developmental task development and satisfaction of basic human needs provide a theoretical base for assessment of the client.

Erickson, Tomlin, and Swain (1983) introduce several concepts for the client in their theory for nursing. Concepts regarding the client include "health," and "adaptation." Concepts that related directly to the nurse are "facilitator," "unconditional acceptance," and "nurturance [sic]." Health does not necessarily mean the absence of disease, but it is the person's ability to adapt and continue toward holistic health, growth and development (Erickson, Tomlin, & Swain, 1983, p. 46). Adaptation occurs when a person responds to stressors in a positive manner and by using coping mechanisms that promote health, growth and development (Erickson, Tomlin, & Swain, 1983, p. 47).

The nursing role is explained by the concepts of facilitator, nurturer, and unconditional acceptance of the client. The nurse facilitates the client to develop his or her own strengths and move toward health. Nurturance by the nurse is providing the care that facilitates the client with unconditional acceptance of the client's view of the world. Unconditional acceptance means acceptance of a person as is, without judgements being made about the person (Erickson, Tomlin, & Swain, 1983, p. 48 - 49).

Facilitation of health includes the provision of assessing sexuality concerns and provision of sexual education. If sexuality issues are a concern to the client, the nurse must be able to facilitate and nurture the client to incorporate new body images and styles of communication. With the nurse's assistance, the client will be able to continue

to adapt and maintain health through self-care resources.

To facilitate the client toward holistic health, the nurse first models the client's world. "Modelling [sic] contains both the art and science of nursing. It combines scientific aggregation and analysis of data with the image and understanding of the world from the client's view" (Walsh, VandenBosch, & Boehm, 1988, p. 759). The nurse is viewing the world from the client's perspectives and understanding. "When one sees the world as the client does, then one can role-model." 'Role modelling [sic] is the facilitation of the individual in attaining, maintaining, or promoting health through purposeful interventions' (Walsh, VandenBosch, & Boehm, 1988, p. 759). The nurse is ready to role-model the client to health by facilitating the client's actions through unconditional acceptance of the client as worthwhile and important. Acceptance of the client's view of the world facilitates the client to mobilize resources and strive for adaptive equilibrium, a stage of health (Erickson, Tomlin & Swain, 1983).

The concepts of unconditional acceptance and nurturance [sic] as they apply to the nurse, provide a framework for understanding the impact of the nurse's perspectives as the nurse models the client's world. The nurse's perspectives may affect the way the nurse models the client's world. Individuals, whether nurses or clients, are different because of past experiences, cultural differences and beliefs. It is because of these differences that each nurse may model the client's world differently based on perceptions which may be inaccurate for the client (Dudas, 1993; Medlar & Medlar, 1990).

When the nurse models the client's world from the nurse's perspective, the nurse may not be able to provide unconditional acceptance because of his or her own view of

the world. "Modeling and Role-Modeling" may provide each nurse with an understanding of his or her individual perspectives. The outcome would be the ability of oncology nurse to view the individual client's world and assess the need for implementation of care that includes sexuality concerns as a component.

There was nothing found in the literature that suggests that "Modeling and Role-Modeling" has been used to explain nursing attitudes and behaviors. Discussion with the author, Dr. Erickson, supported using "Modeling and Role-Modeling" as a framework for viewing all individuals, not just clients (personal communication, May 7, 1996). This conceptual framework will provide a foundation for understanding the nurse as an individual. Literature which suggested the need for a replication of the original Wilson and Williams (1988) study, with the addition of a definition of sexuality, will be presented next.

Literature Review

There may be more information about the attitudes and behaviors of oncology nurses regarding the sexuality concerns of the oncology clients. However, in a review of the literature that has been published regarding sexuality and the oncology clients, only a few studies were found. This literature review will begin with a broad overview of research that examines the attitudes of healthy individuals regarding the appropriateness of the nurse discussing sexuality concerns. The literature review will then address research that is specific to oncology nurses and oncology clients.

General research. Waterhouse and Metcalfe (1991) investigated the attitudes of the general public regarding nurses discussing sexual concerns with clients. The subjects

consisted of 88 randomly selected individuals who voluntarily completed a lengthy questionnaire. The study sample consisted of 73% male participants, and two-thirds of all the participants held a bachelor degree or higher. Twenty-six percent of the respondents felt that nurses should always, or almost always, discuss sexual concerns with their clients. This is a very small percentage of the participants, and does not strongly support the inclusion of sexuality concerns as a component of nursing care. The data does suggest that there are some clients who expect their nurses to initiate a discussion regarding sexuality concerns. Study design and small sample size limit generalization to the population in general. However, the study provides consideration for the validity of the inclusion of an assessment by the nurse for sexuality concerns of the client. Although this study addressed sexual concerns it did not provide a definition of sexuality.

Kautz, Dickey and Stevens (1990) conducted a study at their hospital to investigate why nurses were not meeting hospital care standards in the area of sexuality. Their subjects were 312 registered nurses. The conceptual framework was based on the basic needs of all individuals which included self-esteem and sexuality issues.

The tool used by Kautz, Dickey and Stevens (1990) consisted of a three- part, fifty-three item questionnaire based on a literature review. Reliability was established with nurse managers completing a test/retest which was computed at 0.65. Validity was established by a panel of experts.

Part one of the Kautz, Dickey and Stevens (1990) tool included thirteen variables which might interfere with nurses providing assessment of sexuality concerns as a component of care. The nurses rated their level of agreement with each statement.

Factors which interfered with initiating a discussion regarding sexuality concerns of the clients included: (a) other registered nurses do not discuss sex, (b) client too ill to discuss sex, and (c) discussions of sexuality concerns cause client anxiety.

Part two presented scenarios that were to be ranked by priority of importance when providing care to clients. Overall the registered nurses ranked "teaching pain management" as a number one priority. Registered nurses who provided care on the medical-surgical unit rated "discussion of sexual concerns" as fifth in a list of five nursing interventions.

Part three consisted of scenarios in which the nurse initiated the discussion of sexuality concerns. The nurses were to rank their knowledge and willingness to address the sexual concerns of the client in each scenario. The registered nurses perceived themselves as knowledgeable and willing to address sexuality. Limitations of this study included the lack of previous testing of the tool and different scenarios written for individual nursing units such as pediatrics and medical-surgical units.

Oncology nurses were not targeted by Kautz, Dickey and Stevens (1990), but were included. A definition of sexuality was not provided in the questionnaire; however the study's conceptual framework did suggest a definition of sexuality which is consistent with this proposed investigation of attitudes and behaviors of oncology nurses regarding the sexuality concerns of oncology clients.

Matocha and Waterhouse (1993) investigated current nursing practices regarding the sexuality of their clients. Subjects were selected by systemic probability sampling of the nurses registered by the State Board of Nursing in a South-Atlantic state. Five

hundred responded, with 98% being female and 68% had received either a diploma or baccalaureate education. The instrument, "Survey on Sexuality Practice" was developed for their pilot study and based on the conceptual framework of "Annon's Permission, Limited Information, Specific Suggestions, and Intensive Therapy Model" (Annon, 1974). This model describes levels of sexual counseling. Content validity was established with a panel of experts and pretested for clarity. The Cronbach alpha level of the revised questionnaire was 0.93. Test re-test reliability was not measured.

Matocha and Waterhouse (1993) reported that nurses' behaviors did not reflect the attitude of the 59% who believed it was a nursing function to discuss sexual health, and the 69% who reported comfort with the subject. The reported behaviors of the nurses for the previous year included: (a) 34% had not assessed the sexual health of their clients, (b) 75% had offered to discuss sexual concerns with less than 10% or fewer clients, and (c) 72% of the nurses had never used the nursing diagnosis of "altered sexuality."

Matocha and Waterhouse (1993) utilized regression analysis to determine the effects of different variables on registered nurses' practices regarding sexuality concerns of their clients. Variables consisted of: (a) practice area, (b) place of employment, (c) perceived knowledge, (d) perceived role responsibility and (e) comfort levels. These variables were found to be statistically significant predictors of inclusion of sexuality concerns as a component of care ($p < 0.01$). Findings of this study are similar to the Wilson and Williams study (1988) which found that 67% of the subjects were comfortable talking about sexuality, and the nurse waited for the client to initiate a

discussion of sexuality concerns. Weaknesses of the study included volunteer bias, limited reliability of instrument, as well as an omission of a definition of sexuality in the instrument.

Oncology research. Williams, Wilson, Hongladarom and McDonell (1986) conducted an exploratory descriptive study to investigate registered nurses' attitudes regarding the sexuality concerns of cancer clients. Nursing researchers were observing changes in the way the American public viewed sexual issues. It was noted by the investigators that nursing educators had just begun to include human sexuality as a component of the educational programs in the 1960s. In 1979, the Oncology Nursing Society developed written standards of care for oncology clients, standards which included sexuality concerns as a component of care.

Williams' et al. (1986) study was developed to examine the current attitudes of registered nurses regarding their client's sexuality concerns. Subjects were selected using a convenience sample of registered nurses who attended an educational offering. Data were collected over a 16 month period. There was no control for changes in attitudes over time.

The instrument items developed by Williams et al. (1986) were taken from a review of the literature. Content validity was established by a panel of experts in both oncology and sexuality. Attitudes were measured by 40 items with responses from "strongly disagree" to "strongly agree." Some items were reversed scored so that higher scores represented a positive attitude toward sexuality concerns. Two items on the questionnaire represented behaviors that would reflect attitudes. One question Williams

et al. (1986) asked the nurses, was to provide a self-report of the inclusion of breast and testicular self-exam teaching to clients accomplished in the past month. The other asked the nurses to report the percentages of clients who had been informed of the nurses' availability to discuss sexual concerns.

Chi-square analysis was performed on each attitudinal and behavioral score.

William et al. (1986) reported that attitudinal and behavioral items were independent of age, education and nursing speciality. Attitudinal responses reported included: (a) 55.3% of the nurses agreed that their attitude was similar to other nurses, (b) 67% indicated they were comfortable discussing sexuality concerns, and (c) 40% felt that they had a professional responsibility to discuss sexuality concerns.

For the two behavioral items, teaching breast self-exam (BSE) and testicular self-exam (TSE), 43% of the respondents felt these items were appropriate for teaching, but they had never taught BSE or TSE. Three percent responded that they had told a client they were available to discuss sexual concerns, 19% frequently offered to discuss sexual concerns. The remainder of the respondents reported that they never or seldom offered to discuss sexuality concerns with clients in the preceding month. The attitudes and behaviors reported by the majority of the nurses that participated in this study indicated that the nurses did not feel that discussions of sexuality concerns were the nurses' responsibility. Comments reported by nurses reflect those in the Kautz, Dickey and Stevens (1990) study. Lack of time, and attitudes toward sexuality concerns were believed to be the same as other nurses. Limitations included the use of an untested instrument, lack of control over time and absence of a definition of sexuality.

Wilson and Williams (1988) focused their investigation on oncology nurses and their attitudes and behaviors regarding the sexuality concerns of oncology clients. The instrument was developed from the pilot study conducted by Williams, Wilson, Hongladarom and McDonell (1986). The themes, which included comfort of nurses, personal attitudes, responsibility of role, behaviors demonstrated with peers and clients, and utilization of resources, were developed from the original instrument and a search of the literature. The content validity of the revised tool, "The Williams and Wilson Sexuality Survey," was determined by a panel of experts who rated each item on a scale of one to three for appropriateness with an Interrater agreement of 92%.

Attitudes were reported by responding to statements which were rated on a scale from "strongly disagree" to "strongly agree." The attitude section contained six questions that were specific to pediatrics, and not included in the publication of the Wilson and Williams (1988) study. Four items were dropped after data was collected because of poor response from participants. Factor analysis was used to identify clusters of variables with commonalities. The coefficient alpha for the revised scale was 0.82. Factor analysis was also used for the behavioral items, with two questions being dropped. The coefficient alpha for this revised scale was 0.78.

Wilson and Williams (1988) hypothesized that oncology nurses with more positive attitudes toward sexuality concerns would report more nursing behaviors related to sexuality concerns. The questionnaire was sent to a randomly selected sample from the Oncology Nursing Society and the Association of Pediatric Oncology Nurses. Of the questionnaires returned, 937 were useable. Demographic data was of a nominal level,

and descriptive statistics were used. Respondent characteristics included: (a) female (96.75%), (b) 31-40 years of age (42.8%), (c) graduate of a baccalaureate nursing program (48.2%), (d) provided care to hospitalized cancer clients (52%), (e) identified oncology as the area of speciality (90%), and (d) indicated 3-10 years of oncology experience (74%).

Attitude scores ranged from 33-90 with higher scores reflecting a more positive attitude. Nursing responses were characterized as those who: (a) felt that sexuality concerns should be a component of care (91%), (b) agreed that sexual activity was decreased in illness (51%), (c) 57.9% reported comfort discussing sexuality concerns, and (d) 92.4% agreed that they would be comfortable if the client initiated the discussion. Behavioral scores ranged from zero to thirteen. The reported behaviors of the nurses included: (a) use of nursing diagnosis of sexuality (32%), (b) discussions of clients' concerns of loss of attractiveness (82%), and (c) continuing the conversation with the significant other (64%). Written comments by nurses included lack of time and privacy as barriers to inclusion of sexuality concerns as a component of care.

Data analysis using multiple-step-wise regression, demonstrated a positive relationship between years of experience and behaviors and the inclusion of the sexuality concerns as a component of care. The variables of age, educational experiences, and personal experience with cancer were not significantly related. Lack of knowledge was cited as the main reason for not addressing sexuality concerns of clients.

There is a question of the validity of the responses reported by Wilson and Williams (1988) in the absence of a definition of sexuality. A weakness of the study was

a lack of a definition of sexuality. The inclusion of a definition of sexuality may have provided a baseline for evaluation of individual attitudes. A strength was the randomly selected large sample size which allows for generalization of the results.

Gamel, Hengeveld, Davis and Van Der Tweel (1995) investigated factors that influence the inclusion of sexuality concerns as a component of care by Dutch nurses. Their study was a descriptive correlational study using the conceptual framework of "The Theory of Reasoned Action." This is the same conceptual framework that Wilson and Williams used in their 1988 study. This theory assumes that behavior is under voluntary control and intention is the determinate of action. The instrument used for Gamel et al. (1995) was investigator designed. Factors which might influence sexual health care behaviors were elicited from the participants with the provision 24 sexual health care behaviors.

The variables under investigation by Gamel et al. (1995) were (a) frequency of the inclusion of sexuality concerns as a component of care, (b) sexual knowledge of the respondents, (c) nursing comfort regarding the inclusion of sexuality as a component of care, (d) attitude toward inclusion of sexuality concerns as a component of the professional role, (e) attitude toward sexual activity and illness, and (f) a subjective norm that was unique for their study. The subjective norm was the perceived attitudes of clients, peers, nursing supervisors and medical doctors.

The tool used by Gamel et al. (1995), the Provision of Sexual Health Care, contained seven variables and seven total scores. In addition, investigators requested from participants that they include the motivator for each response. The rationale

provided by Gamel et al. (1995) for the additional question of motivation would parallel the depth provided by interview method of data collection. The additional response of motivation would provide details and missed information. This was a unique variable that was incorporated into the study design that has not previously been mentioned in literature reviewed. Content validity was established by a panel of experts with a reliability of 0.79 alpha and Cronbach alpha of 0.96. A pilot test was conducted.

Statistical analysis of the data for the Gamel et al. (1995) included estimations of missing values in 66 of the 129 questionnaires returned. The 66 questionnaires included those with one to two missing values. All the missing values were estimated using the "randomized blocks estimation method for missing values" (p.307). The replacement of the missing values was accomplished after the general information sections of those questionnaires with missing data and those completed questionnaires were compared. There was not a significant difference found between the completed questionnaires and the ones with missing data ($p = 0.05$)

The participants were female ($n = 90$), with a mean age of 34.41 and 60% were married. Seventy eight point eight percent were diploma graduates with 7.79 year of oncology experience. Participants reported that they rarely and/or never provided sexual health counseling (SHC). There was a significant relationship found in only two of the factors that might influence the provision of SHC by the oncology nurses. Nursing comfort with SHC ($r = 0.53, P < 0.00$) and knowledge regarding sexuality issues ($r = 0.54, P < 0.00$).

Unique to Gamel et al. (1995) was the introduction of a subjective norm. The

oncology nurses were asked what value they perceived that their peers and supervisor placed on inclusion of sexuality assessment as part of the clients care. The findings suggested that there was a perception that nursing supervisors expected the inclusion of psychosocial support rather than instruction and information, yet there was also the reported perception that clients expected instruction and information. No relationship was found between continuing education and provision of sexuality concerns as a component of care, this finding was consistent with Wilson and Williams (1988) findings. Gamel et al. (1995) reported "that attitude toward professional role was not significantly related to the provision of SHC" (p. 312). Williams, Wilson, Hongladarom and McDonell (1986) and Wilson and Williams (1986) also reported that sexuality concerns were not seen as a priority by the nurses who participated in their study.

This study's strengths included a very detailed review of the conceptual framework and the validity and reliability measures of the investigator designed instrument. The use of probability sampling compensated for the small sample size. A possible limitation to this study was the use of statistics to calculate for missing values on the returned questionnaires, as there is not a certainty that common characteristics among participants guarantee similarities in responses. A definition of sexuality was not included but the behavioral activities were very explicit which may have partially compensated for the lack of a definition.

Summary

In summary, after reviewing the literature, there are many inconsistencies between nursing attitudes and behaviors regarding the assessment of sexuality concerns

as a component of care. Oncology nurses consistently have reported an attitude that assessment of sexuality concerns should be a component of the care they provide to the oncology client, however, the behaviors do not demonstrate this attitude.

The definition of sexuality was consistently not reported in the literature reviewed (Gamel, Hengeveld, Davis & VanDerTweel, 1995; Kautz, Dickey & Stevens, 1990; Matocha & Waterhouse, 1993; Williams, Wilson, Hongladarom & McDonell, 1986; Wilson & Williams, 1988). No other nursing studies were found which addressed the attitudes and behaviors of the oncology nurses regarding the sexuality concerns of the oncology client.

The conceptual framework of Erickson, Tomlin, and Swain (1983) provides an understanding for how nurses and clients are alike and different. Each individual is at a different place developmentally and in the fulfillment of basic human needs (p. 70). Oncology nurses who understand the origination of their own personal beliefs and attitudes are equipped to model the client's world and assess for sexuality concerns.

The literature review has established that oncology nurses maintain an attitude that assessment of sexuality concerns is an important component of care. Provision of a definition of sexuality and the identification of the issues related to sexuality as a component of care, may decrease the differences reported between attitudes and behaviors of oncology nurses regarding the sexuality concerns of the oncology client.

Implications for Study

The investigation of oncology nursing attitudes and behaviors regarding the sexuality of the oncology client has implications for other nursing investigators.

Replication of the Wilson and Williams (1988) study with the inclusion of the definition of sexuality fulfills a recommendation that was made by Wilson and Williams in their 1988 study. Sexuality must be clearly defined to provide a framework from which the oncology nurse examines his or her own attitudes regarding inclusion of sexuality concerns as a component of care.

Research Question

Is there a difference between attitudes of oncology nurses regarding the sexuality concerns of the oncology client and the behaviors which demonstrate inclusion of sexuality concerns as a component of care?

Definition of terms

Sexuality. The definition of sexuality provided by Medlar and Medlar (1990) will be used by this study:

Sexuality is a basic, fundamental aspect of human development, personality, and behavior. Sexuality is more than sexual behavior: It encompasses one's feelings of femininity or masculinity and how one acts, dresses, speaks, and relates to others within one's entire network of social and interpersonal relationships. It is an irreducible component of personality (p.46).

Component of care. The phrase "component of care" will represent the components of assessment of sexual needs and sexuality concerns, sexual education and sexual counseling that professional registered nurses provide to the client.

Assessment of sexuality needs and sexuality concerns. Assessment of sexuality needs and sexuality concerns is a systematic collection of data, obtaining a baseline

history and identifying current concerns regarding the components of the individual's sexuality (Cartwright-Alcares, 1995; Clark & McGee, 1992).

Sexuality education. Sexuality education as a component of care is defined by Gamel, Davis, and Hengeveld (1993) as "a short-term nurse-patient interaction in which information was given in an individualized manner and included an assessment of the patient's learning needs " (p. 1222).

Sexuality counseling. Sexual counseling regarding sexuality concerns as a component of care is defined by Gamel, Davis, and Hengeveld (1993) as: "a long term series of nurse-patient interactions which focus upon patient-rather than nurse-identified goals" (p. 1222). This definition of sexuality counseling is consistent with Erickson's, Tomlin's, and Swains' (1983) theory of "Modeling and Role-Modeling."

Attitudes. "Attitudes are relatively stable predispositions to respond in particular ways. The formation of attitudes is a complex phenomena that is mediated by such factors as personal experience, parental influence, group pressure, and cognitive information" (Wilson & Williams, 1988, p.50).

Behavior. Behavior is defined for this study as "any or all activities of a person, including physical actions, which are observed directly, and mental activity, which is inferred and interpreted" (Urdang & Swallow, 1983, p. 117).

Oncology nurse. Oncology nurse is defined as a registered nurse that provides care part time or full time to a individual or individuals with a medical diagnosis of cancer.

Oncology client. An oncology client is an individual with a medical diagnosis of

cancer.

CHAPTER THREE

METHODOLOGY

In this chapter the study's design, targeted population, instrument and procedures for data collection will be described and discussed.

Design

This is a descriptive comparative study to determine if there is a difference between the attitudes and behaviors of oncology nurses as they pertain to the inclusion of sexuality concerns of the oncology client as a component of care. This study will also describe the attitudes that oncology nurses report regarding the sexuality concerns of the oncology client and also the behaviors the oncology nurse demonstrates when caring for the oncology client. Characteristics of the oncology nurse will also be described.

Sample

Subjects for this study were registered nurses who were caring for adult oncology clients during the months of June 1, 1996 through and September 1, 1996. Although a convenience sample was utilized in this study, it is understood that a non-random design may decrease the ability to generalize the study's findings to other oncology nursing populations. The oncology nurses who participated may have had attitudes that are not reflective of the entire population of oncology nurses. To partially compensate for this

design weakness, five data collection sites were selected in the Midwest. Those sites were Traverse City, Michigan; Grand Rapids, Michigan; St. Joseph, Michigan; Omaha, Nebraska; and Lakeland, Florida. These areas were chosen because of the convenience of clinical nurse specialist in these areas who were willing to facilitate data collection. Each collection site provided a pool of potential participants. It was hoped that by accessing various areas of the Midwest that the sample size would be large enough to compensate for design weakness. A sample size of 200 participants was attempted, with a total of 235 surveys sent to the five institutions. Of those 235 surveys sent out, 120 were returned. Of those returned surveys, 109 were useable for statistical analysis.

Instrument

The instrument consists of two tools: (a) data collection tool and (b) participant characteristics tool. The tool was developed by Williams, Hongladarom and McDonell (1986) and then revised before and after data collection by Wilson and Williams (1988). Wilson and Williams (1988) had two purposes for their study. One purpose was instrument refinement of the "Williams and Wilson Sexuality Survey", and the other purpose was to describe attitudes and behaviors of oncology nurses regarding the sexuality of the oncology client. The original tool before revision by Wilson and Williams (1988) contained 40 attitudinal items and two behavioral items. After review of the literature, revisions were made by Wilson and Williams which included dropping nine questions on the attitudinal scale and adding a behavioral theme.

The revised tool contained the following attitudinal themes: (a) nurse comfort with inclusion of sexuality concerns as a component of care, (b) belief about success of

interventions, (c) personal attitudes regarding sexuality concerns if experiencing illness, (d) sense of responsibility/professional role, (e) rights to privacy/sexual activity for the hospitalized patient, and (f) attitudes toward sexual behavior occurring during illness. Behavioral themes included: (a) behaviors when providing care to clients, (b) behaviors of collaboration with co-workers, and (c) utilization of resources.

To estimate content validity, the test item pool was reviewed by three experts (oncology and/or sexuality). Each item in the test pool was rated on scale of one to three for appropriateness of content for inclusion into the instrument. "Interrater agreement on the items was 92%. All items were retained with minor changes in wording" (Wilson & Williams, 1988, p. 50). Construct validity was determined by using factor analysis following data collection for the Wilson and Williams study.

After data collection (Wilson & Williams, 1988) six of the 31 items of the attitudes section were dropped which left 25 attitudinal items. Of the 25 items, four were dropped because of poor response rates. As a result of factor analysis, those 21 items were reduced to 15 items. Therefore, the revised "Williams and Wilson Sexuality Survey" has 15 items that measure attitudes with a coefficient alpha of 0.82.

The behavioral part of the scale originally contained 12 item, but factor loading resulting from factor analysis reduced the number of items to 10 with a coefficient alpha of 0.78 for the revised tool. Therefore the revised "Williams and Wilson Sexuality Survey" (Wilson & Williams, 1988) contained 10 items on the behavioral scale. (See Appendix B for a copy of original survey; "The Williams and Wilson Sexuality Survey").

Dr. Wilson, the author, provided permission to use and or revise any part of the

tool in a letter dated February 1994 (See Appendix C). A change was made in the original order of two of the attitudinal statements to decrease the possibility of an error due to the wording of the statements. The changes pertained to the statements "I am not comfortable initiating a discussion regarding sexuality with my patients" and "I am comfortable initiating a discussion regarding sexuality with my patient's significant other.". The original ten behavioral statements were reworded and one more statement was added regarding assessment of sexuality concerns.

For this study the "Williams and Wilson Sexuality Survey" has been renamed "The Ashley Revision of the Williams and Wilson Sexuality Survey" and contains a total of 26 items. The attitudinal scale consists of items 1-15 and utilizes a Likert-like scale from "strongly disagree" (1) to "strongly agree" (6). Items numbered 4, 5, 6, 9, 12 and 15 are reversed scored so that the higher score represents a more positive attitude. The measurements is of ordinal level, but by summation of the scores, the total score can be considered interval level (Polit & Hungler, 1991).

The behavioral scale consists of items 16-26. These items which were of a nominal level of measurement, and were reworded to include a reference to frequencies of behaviors demonstrated by the oncology nurse. Nominal level items were rewritten to reflect ordinal level responses. Responses on the survey were "never" (1) to "always" (4). By the method of summation of the scores, the data was utilized as interval level data (Polit & Hungler, 1991). Interval level data for both attitudes and behaviors were able to be statistically tested using a paired t-test to answer the research question.

Items 27 through 42 reflect the second part of the tool which collected data on the

participant's characteristics. These items were placed at the end of the tool to decrease the possibility of participants developing prejudice to the tool and possibly influencing their responses. The majority of the responses are nominal level, with exceptions of basic nursing education which is ordinal and age which is of interval level. The percentage of the participant's daily caseload of oncology clients is investigated with the use of one ratio level item.

The instrument was reviewed by four oncology registered nurses after the first revision of the tool. The reviewers were looking for clarity, ease of administration and clerical errors. The format was changed to a booklet format at this time to eliminate pages making the survey easier to use and mail. Clerical errors were also corrected. This revision was also reviewed and the recommendations were made by four more oncology nurses. A factor was added to the list of factors that might impede a discussion of sexuality by the oncology nurse. The statement added was "not appropriate for patient." Two experts, one in both sexuality and oncology and one in sexuality also reviewed the tool for clarity, ease of administration, and correct terminology. A small pilot study of four oncology nurses was utilized before data collection began to again review the tool. This pilot study was for the purpose of tool refinement and assessment of clarity. Reliability for "The Ashley Revision of the Williams and Wilson Sexuality Survey" was established during data analysis in this study. The Cronbach alpha level for attitudes was .8686 and for the behaviors the Cronbach alpha level was .8736. In summary, "The Ashley Revision of the Williams and Wilson Sexuality Survey" has fewer pages utilizing a booklet format, and nominal level measurements have been replaced with a higher

levels of measurement whenever possible (See Appendix D for copy of "The Ashley Revision of the Williams and Wilson Sexuality Survey").

Procedures

Approval for the study was obtained from the Grand Valley State University Human Research Review Committee (See Appendix E). After approval was granted for the study, contact was made with five medical institutions that care for oncology clients. Medical institutions were selected for data collection as a result of the investigator's knowledge of the geographic area and prior residency in the area. The Clinical Nurse Specialist who provides care to oncology clients at each institution was contacted and they indicated a willingness to participate in this study. The Clinical Nurse Specialist was chosen to be a contact person because of familiarity with the research process and nursing staff, as well as access to the nurses who care for adult oncology clients in each institution. Consent from each institution for data collection was obtained prior to the process of data collection (See Appendix F through Appendix J).

The procedure for obtaining subjects and data collection was accomplished with the cooperation of the Clinical Nurse Specialist at each institution. Because this is a study that involves nursing, permission for proceeding was based on individual institutional policies. Each potential subject was given a packet with the materials needed to participate by the Clinical Nurse Specialist. The packets were either hand delivered or placed in individual message containers by the participating Clinical Nurse Specialist. One institution, St Joseph chose to mail out the packets and include the members of the local oncology society. Each packet contained: (a) "The Ashley Revision

of the Williams and Wilson Sexuality Survey," (b) a cover letter which explained informed consent (Appendix K), (c) and a stamped envelope addressed to the researcher.

Each participant had the opportunity either to complete the questionnaire or to decline. Participants were asked to return surveys within one week. The follow-up consisted of a letter to the Clinical Nurse Specialist which was posted at each participating institution (Appendix L). The letter was sent to thank participants and remind those who hadn't mailed their surveys, that they still could do so. At the end of the data collection period, August 1996, another letter was mailed to each institution informing the institution that data collection had been finalized (Appendix M). Each participant was advised that they could request survey results following data collection and data analysis and the results would be mailed to them. No individual requests were made, but each institution will be sent the completed results.

Data was recorded as it was received, with each survey assigned a number to facilitate data entry. Each participating institution was also assigned a code to provide identification of institution location, as well as a specific color. The risk to the subjects were minimal. There was a possibility of individual discomfort due to the topic of sexuality. By using stamped individual envelopes mailed directly to the researcher, the participants were allowed time to complete the survey in privacy to reduce the risk of possible discomfort. Use of correct terminology was used to decrease sensitivity and discomfort related to the topic. Confidentiality of individual participants was maintained by not requesting the name of the respondent, and by the use of a code to represent each institution. Accessibility to information reported on individual tools was limited to the

data analyzer and investigator to protect confidentiality.

CHAPTER FOUR

RESULTS

In this chapter the preparation of the data and its subsequent analysis will be discussed. The characteristics of the 109 participants will be discussed, as well as the statistical analysis of the attitudes and behaviors. The research question, is there a difference in attitudes and behaviors of oncology nurses regarding the inclusion of sexuality as a component of care, will also be addressed .

Preparation and Analysis of Data

Data was gathered from five medical institutions utilizing the tool, "The Ashley Revision of the Williams and Wilson Sexuality Survey." Surveys were returned via the postal service during the time frame of the first of June 1996 through the first of September 1996. A total of 235 surveys were initially mailed to the five institutions with a return rate of 51%. Of the 120 surveys returned, 11 contained large blocks of missing data. Most significant was the absence of data on pages two and three of nine of the returned surveys. Careful examination of the surveys did not reveal any difference between the 11 incomplete surveys and the 109 completed surveys to account for the missing data. Two of the eleven surveys were missing data from the demographics section. Of the 109 remaining surveys, missing data was random and without a pattern.

The statistical mean was used to replace 14 incidences of missing data (Polit & Hungler, 1991, p. 558).

Returned surveys were coded and data entered using the statistical software "Statistical Package for Social Sciences" (SPSS/WIN) for data analysis. Scientific rigor was maintained by utilizing several steps in the data recording process: (a) a code book was utilized to ensure consistency and accuracy, (b) data were entered using the prearranged code, and (c) data were then scrutinized to detect errors or inconsistencies in data entry.

Descriptive statistics were used to analyze the participant characteristics. The mean, standard deviation, and frequency distributions were utilized to describe the sample. The differences between attitudes and behaviors of oncology nurses regarding the oncology client were analyzed using a paired t-test with a significance level set at $p < 0.05$. The Pearson r was used to test for a relationship between the attitudes and behaviors of the oncology nurses. The independent t-test was used to test for differences between the oncology nurses who report administering chemotherapy and those staff nurses who do not administer chemotherapy. The Spearman rho correlation coefficient was used to investigate the correlation between basic nursing education, and attitudes and behaviors.

Characteristics

The sample of the oncology registered nurses who care for adult oncology clients and who participated in the survey was predominately female (96.3%) with a mean age of 38.01 (s.d. = 9.31). Table 1 provides a comprehensive description of the

characteristics of the participant's except for participants age and years of experience, those may be found in Table 2 and Table 3. The highest degree held by the largest percentage of nurses (38.5%) was the Associate Degree in Nursing. The primary area of practice was of hospitalized clients (77.1%) and the primary nursing role was that of a staff nurse who administers chemotherapy (50.5%). Membership in the Oncology Nursing Society was reported by 48.1%, yet 66.7% reported not attending a national program in the last two years.

Sixty-six point seven percent reported not attending an oncology national program in the past two years, and more than half (62.4%) had not attended an educational offering in the past year where sexuality was on the agenda. Comments written by participants contained the following themes: (a) would attend if closer to home, (b) would like institution to offer educational programs related to sexuality, and (c) if given the training would be comfortable discussing sexuality with clients.

The number of nurses who reported oncology to be their area of expertise was 74.1%, with a mean of 6.51 (s.d. = 5.27) years of experience. The mean of oncology clients reported to be part of the daily caseload of the nurses was 70.37 (s.d. = 28.51). Personal experience with cancer was reported by 5.5% of the participants and 22.9% had a significant other diagnosed with cancer. Of those responding to the question regarding personal experience with a health problem affecting their sexuality, 38.9% reported that they have experienced such a health problem.

Table 1

Characteristics of the Sample of Oncology Nurses

Characteristic	N = 109	f	%
Sex: Male		4	3.7
Female		105	96.3
Basic Nursing Education			
Diploma		22	20.4
ADN		48	44.4
BSN		38	35.2
Highest Degree Earned			
Diploma		16	14.7
Associate, non-nursing		4	3.7
ADN		42	38.5
Bachelor, non-nursing		4	3.7
BSN		34	31.2
Master, non-nursing		1	.9
MSN		8	7.3
Nursing Organization			
ONS		52	48.1
ANA		7	6.5
Both of the above		3	2.8
None of above		44	40.7

Table 1 (Continued)

Characteristics of the Sample of Oncology Nurses

Characteristic	N = 109	f	%
Primary Nursing Role			
Staff Nurse		30	27.5
Chemotherapy Nurse		3	2.8
Radiation Therapy Nurse		3	2.8
Staff/Chemotherapy*		55	50.5
Home Health Nurse/Infusion		6	5.5
Hospice Nurse		1	.9
Clinical Nurse Specialist		6	5.5
Research/Clinical Trials		2	1.8
Case Manager		3	2.8

Table 1 (Continued)

Characteristics of the Sample of Oncology Nurses

Characteristic	N = 109	f	%
Primary Area of Practice			
Hospital Inpatient		84	77.1
Ambulatory Outpatient		11	10.1
Home Care		8	7.3
Hospice		1	.9
Research/Trials		3	2.7
Office		2	1.8
Oncology Nursing Area of Expertise			
No		28	25.9
Yes		80	74.1
Attended oncology program in last 2 years			
No		72	66.7
Yes		36	33.3
Attended sexuality educational program			
No		68	62.4
Yes		41	37.6

Table 1 (Continued)

Characteristics of the Sample of Oncology Nurses

Characteristic	N = 109	f	%
Been diagnosed with cancer			
No		103	94.5
Yes		6	5.5
Significant other diagnosed with cancer			
No		84	77.1
Yes		25	22.9
Experienced Health Problem Affecting Sexuality			
No		66	61.1
Yes		42	38.9

Note. * Denotes the role of the staff nurse who administers chemotherapy. Percentages do not add up to 100% due to rounding. Frequencies may not add up to 109 because of missing data.

Table 2

Reported Ages of Participants

Age	f	%	Age	f	%	Age	f	%
20 =	3	2.9%	38 =	4	3.8%	56 =	0	0.0%
21 =	1	1.0%	39 =	3	2.9%	57 =	1	1.0%
22 =	1	1.0%	40 =	7	6.7%	58 =	0	0.0%
23 =	2	1.9%	41 =	3	2.9%	59 =	0	0.0%
24 =	3	2.9%	42 =	9	8.6%	60 =	1	1.0%
25 =	4	3.8%	43 =	5	4.8%	61 =	2	1.9%
26 =	0	0.0%	44 =	2	1.9%			
27 =	2	1.9%	45 =	4	3.8%			
28 =	2	1.9%	46 =	1	1.0%			
29 =	1	1.0%	47 =	3	2.9%			
30 =	3	2.9%	48 =	2	1.9%			
31 =	2	1.9%	49 =	1	1.0%			
32 =	4	3.8%	50 =	4	3.8%			
33 =	3	2.9%	51 =	1	1.0%			
34 =	5	4.8%	52 =	1	1.0%			
35 =	6	5.7%	53 =	0	0.0%			
36 =	3	2.9%	54 =	1	1.0%			
37 =	4	3.8%	55 =	1	1.0%			

Table 3

Years of Experience as Oncology Nurse

Years	f	%	Years	f	%
< 1	10	8.7	11	5	4.3
1	16	13.9	12	4	3.5
2	14	12.2	13	6	5.2
3	6	5.2	14	3	2.6
4	6	5.2	15	2	1.7
5	3	2.6	16	2	1.7
6	9	7.8	17	0	0.0
7	3	2.6	18	1	.9
8	4	3.5	19	1	.9
9	3	2.6	20	2	1.7
10	15	13.0			

Attitudes

The attitude scores of this sample of oncology nurses ranged from 26-88 with a mean of 63.19 (s.d = 11.01) The possible score ranged from 15-90. The higher the score, the more positive was the attitude of the oncology nurse. See Table 4 for the attitudes reported by this sample of oncology nurses.

Individual attitudes. Questions two, three, twelve, fourteen and fifteen of the attitudes section of "The Ashley Revision of the Williams and Wilson Sexuality Survey" are themes that relate to the nurse's personal feelings regarding sexuality. Seventy eight percent of the participants agreed with the statement that they would want sexuality counseling from a nurse, and 79.8% agreed that they would be comfortable receiving sexuality counseling from a nurse. Seventy nine percent agreed to a belief that sexuality occurs whether one is ill or well, and 52.2% disagreed that a diagnosis of cancer would eliminate a desire for sexual activity. The majority of the participants disagreed that sexual activity was inappropriate while hospitalized (86.3%). More than half of those who participated would want sexual counseling (78%), would be comfortable with a nurse discussing sexuality (79.8%) and would continue to perhaps engage in sexual activity if diagnosed with cancer (52.2%).

Comfort with the inclusion of sexuality. The theme in questions six, eight, nine, ten, and eleven reflect the individual's personal comfort with the topic of sexuality and providing sexuality as a component of nursing care. Responses indicate a higher degree of comfort if the patient or significant other initiates the conversation. The majority agreed that if the client (97.2%) or the significant other initiates the discussion (89.9%)

Table 4

Attitudes of Oncology Nurses

Attitudes Reported in Percentages	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
	1	2	3	4	5	6
1. Sexuality concerns should be a routine component of nursing care for oncology clients.....	1.8	6.4	1.8	14.7	42.2	33.0
2. If I were an oncology client, I would want to receive sexuality counseling from a nurse.....	4.6	9.2	8.3	28.4	35.8	13.8
3. If I were a client, I would be comfortable receiving sexuality counseling from a nurse.....	1.8	10.1	8.3	27.5	41.3	11.0
4. Offering sexuality counseling is not an integral component of primary nursing care.....*	11.0	40.4	17.4	12.8	14.7	3.7
5. Sexuality is not a major concern for my clients.....*	18.3	41.3	21.1	11.0	7.3	.9

Table 4 Continued

Attitudes of Oncology Nurses

Attitudes	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
Reported in Percentages	1	2	3	4	5	6
6. I am not comfortable initiating a discussion regarding sexuality with my clients.....*	8.3	22.9	14.7	23.9	21.1	9.2
7. Discussion of sexuality concerns contributes to the client's recovery...	.9	6.4	10.1	33.9	34.9	13.8
8. I am comfortable initiating a discussion regarding sexuality with my client's significant other.....	6.4	21.1	18.3	28.4	22.9	2.8
9. A specialist would do a better job of discussing sexuality concerns with a client.....*	1.8	12.8	9.2	19.3	40.4	16.5
10. I am comfortable discussing sexuality if the client initiates the discussion.....	.9	.9	.9	18.3	61.5	17.4
11. I am comfortable discussing if the client's significant other initiates the discussion.....	.9	4.6	4.6	20.2	53.2	16.5

Table 4 Continued

Attitudes of Oncology Nurses

Attitudes	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
Reported in Percentages	1	2	3	4	5	6
12. Sexual activity, which provides intimacy for a couple, is inappropriate while a client is hospitalized.....	36.7	35.8	13.8	5.5	4.6	3.7
13. Nursing intervention in sexuality problems and concerns increases the client's well-being.....	1.8	3.7	2.8	25.7	53.2	12.8
14. Sexual activity, to include sexual intercourse, occurs whether someone is ill or well.....	1.8	8.3	11.0	13.8	45.0	20.2
15. If I had a new diagnosis of cancer, sexual activity would be the farthest thing from my mind.....*	7.3	33.0	11.9	19.3	19.3	9.2

Note. (1) Strongly disagree, (2) Disagree, (3) Slightly Disagree, (4) Slightly Agree, (5) Agree, and (6) Strongly Agree. * Indicates questions that were reversed scored. The higher the score, the more positive the attitude. The term patient was used on the survey and replaced by client for this table.

they would be comfortable discussing sexuality. However, the largest majority responded in agreement to a specialist being able to do a better job of discussing sexuality (76.2%).

Inclusion of sexuality as a component of care. More than half of the sample agreed that sexuality concerns should be a routine component of care (89.9%) and offering sexuality counseling is part of the professional role (68.8%). Eighty point seven percent agreed that sexuality is a major concern for their clients. The majority also agreed that nursing intervention increases well-being (91.7%). The attitudes reported by the oncology nurses indicate a belief that inclusion of sexuality as a component of care is valued by the oncology nurse and the client. Comments written by participants on the surveys included these general themes: (a) lack of privacy for conversations about sexuality, (b) belief that terminal clients do not have sexuality concerns, and (c) comfort of the nurse is dependent on the circumstances and relationship with the client.

Behaviors

The behaviors of the oncology nurses will now be presented as they relate to the inclusion of sexuality as a component of care. The range of scores on the behavior survey was 11-32, with a mean of 16.17 (s.d. = 4.19) (See Table 5). The behavioral score on the returned surveys was 11- 44, but "not applicable" was penciled in for four of the eleven categories of questions. Nine percent of the 109 responses contained the category of "not applicable" (N/A) penciled in. The behaviors where a "not applicable" response was penciled in included: (a) discussion of sexuality concerns with other nurses to plan care for the client, (b) inclusion of nursing diagnosis, and (c) questions 10 and 11 related

Table 5

Behaviors Reported by Oncology Nurses

Behaviors Reported in Percentages	0	1	2	3	4
	N/A	Never	Occ	Freg	Always
1 How often do you assess your clients' for their sexuality concerns?.....	.0	21.1	67.0	11.9	.0
2. How often have you offered sexuality counseling to your client's or their significant others in the last 6 months?.....	.0	47.7	45.0	7.3	.0
3. How often have you discussed a client's feelings regarding their perceived loss of attractiveness to their sexual partner?.....	.0	23.9	50.5	25.7	.0
4. How often have you discussed your client's concerns regarding sexuality with the client's significant other?.....	.0	40.4	52.3	7.3	.0
5. How often have you discussed client's sexuality concerns with another nurse in order to plan care for the client?.....	.9	35.8	53.2	9.2	.9

Table 5 (Continued)

Behaviors Reported by Oncology Nurses

Behaviors Reported in Percentages	0	1	2	3	4
	N/A	Never	Occ	Freg	Always
6. How often have you included the nursing diagnosis "Potential for Alteration in Sexuality" in your nursing care plans?.....	.9	76.1	22.0	.9	.0
7. How often have you used teaching tools or visual aids during a discussion of sexuality with an oncology client?...	.0	77.1	19.3	1.8	1.8
8. How often have you discussed alternate positions for an oncology client who is experiencing an "alteration in sexuality" and may not be able to utilize former patterns of sexual intercourse?.....	.0	74.3	21.1	4.6	.0
9. How often have you discussed alternatives to "genital to genital" sex with an oncology client?.....	.0	78.9	19.3	1.8	.0

Table 5 (Continued)

Behaviors Reported by Oncology Nurses

Behaviors Reported in Percentages	0	1	2	3	4
	N/A	Never	Occ	Freg	Always
10. When caring for a known gay/lesbian client, how often have you discussed alterations in sexuality that pertain to cancer and its treatment?.....	5.5	79.8	12.8	1.8	.0
11. When caring for a known gay/lesbian client, how often have you discussed alterations in sexuality with the significant other?.....	5.5	81.7	11.0	1.8	.0

Note. Numbers represent the choices as they appeared on "The Ashley Revision Of the Williams and Wilson Sexuality Survey" with the inclusion of the category of N/A which was added during statistical analysis . The choices: (0)"Not applicable," category added for data analysis, (1)"Never," (2) "Occasionally," (3) "Frequently," and (4) "Always." On the original surveys sent out client was replaced with the term patient.

to the gay/lesbian client. Statistical testing was accomplished to determine if the addition of a N/A would change the means of the scores. The rating of zero did not significantly affect the behavioral scores. The ratings were changed for analysis to "not applicable" (0), "never" (1), "occasionally" (2), "frequently" (3), and "always" (4). This was accomplished to provide a more accurate reporting of individual behaviors. The actual possible score became 0 - 44. A decision was made to include this category into data analysis. The Cronbach's alpha was .879 (N = 103) for the behavioral tool with the N/A inclusion.

In reporting the results of the behavioral part of the tool, the response with the highest percentage is reported. The reader is referred to Table 5 for the complete results. Assessment of sexuality concerns was a behavior that was reported to be accomplished "only occasionally" by 67% of the respondents. The offer of counseling in the last six months was reported to be done "occasionally" by 45%. The remaining respondents reported that they had not offered sexuality counseling in the last six months.

Discussion of client feelings regarding perceived loss of attractiveness was accomplished "occasionally" by 50.5% of the respondents. Slightly more oncology nurses responded that they "occasionally" discussed the client's concerns regarding sexuality with the client's significant other (52.3%). Fifty three point two percent of the respondents reported that they "occasionally" discussed the client's sexuality concerns with another nurse in order to plan care for the client. Nursing diagnoses are not used in one of the institutions surveyed, from which 26% of the participants responded. Only .9% of those respondents reported "not applicable;" the rest were included in the 76.1%

who reported not using the nursing diagnosis of "alterations in sexuality."

Greater than three-fourths of the respondents denied: (a) using visual aids 77.1%, (b) discussing alternate positions (74.3%), (c) discussing alternate ways of interacting sexually (78.9%), or (d) discussing sexuality with known gay/lesbian clients and their significant other (79.8% gay client and 81.7% significant other).

For the two questions regarding gay/lesbian behaviors, there were several written comments. "I haven't cared for that kind of patient that I am aware of" and "I haven't cared for any yet." Related to the gay/lesbian questions were also comments declaring lack of comfort. "I am not comfortable with gay sexuality" and "I know nothing of that kind of intimacy, and I would never feel comfortable discussing something I know nothing about."

Table 6 reports the factors that the participants reported would impede a discussion of sexuality with a client. These factors may provide insight into why there are omissions of behaviors. The factors reported by the participants that would impede a discussion of sexuality were (a) personal embarrassment (24.8%), (b) lack of knowledge (46.8%), (c) not the job of a registered nurse (5.5%), (d) client would be too embarrassed (45%), and (e) not appropriate for the client (32.1%).

Research Question

The research question that was developed for this study was: Is there a difference between attitudes of oncology nurses regarding the sexuality concerns of the oncology client and the behaviors which demonstrate inclusion of sexuality concerns as a component of care? Statistical analysis used in this study was the independent and

Table 6

Factors Which Would Impede a Discussion of Sexuality with Client

Factor	f	%
1. I would be embarrassed	27	24.8
2. Lack of knowledge	51	46.8
3. Not job of RN	6	5.5
4. Client would be embarrassed	49	45.0
5. Not appropriate for client	35	32.1

Note: Those who checked an option are listed as yes, i.e., this would be a factor that would impede a discussion of sexuality with a client.

paired t-test to ascertain differences. Relationships of the variables were explored using the Pearson r and Spearman rho correlation coefficients. Significance level was set at $p < 0.05$ for all tests.

The attitudes of the oncology nurses were measured using the Attitudes section of the tool, "The Ashley Revision of the Williams and Wilson Sexuality Survey." The attitudes ranged from 46 - 81 ($\bar{x} = 63.1$, s.d. = 11.01). The behaviors were measured by the behavior portion of the same tool. The behaviors ranged from 11 - 28

($\bar{x} = 16.17$, s.d. = 4.19). In order to determine if there was a significant statistical difference in the attitudes toward the inclusion of sexuality as a component of care and the reported behaviors performed by the oncology nurses, a paired t-test was used. A statistically significant difference was identified between the reported attitudes and behaviors of the group ($n=109$) ($t = -53.96$; d.f. = 108; $p = .000$). Because there was a significant difference between the attitudes and reported behaviors, several possibilities were statistically explored to explain the differences. Nursing role, age, basic nursing education, and health status were investigated for possible relationships with attitudes and behaviors of the oncology nurses and explain the differences..

The Pearson r was then used to determine that there was a moderately strong relationship that was statistically significant between the attitudes and behaviors of the 109 participants ($r = .608$, $p = .000$). This means as attitudes are more positive, more behaviors are reported.

The staff nurse role. The sample ($N = 109$) had two main subgroups. Those subgroups were the staff nurses who do not administer chemotherapy ($n = 30$) and the

staff nurses who do ($n = 50$). The independent t-test was used to test for a difference between the attitude mean of the two groups and difference between the behavior mean of the two groups. The staff nurse attitudes ($\bar{x} = 60.23$, $s.d. = 10.70$) and the staff nurse who administers chemotherapy attitudes ($\bar{x} = 61.98$, $s.d. = 10.95$) were not significantly different. There was a significant difference found ($t = 3.42$; $d.f. = 80.73$; $p = .001$) between the behaviors of the staff nurse ($\bar{x} = 13.76$, $s.d. = 2.26$) and the staff nurse who administers chemotherapy ($\bar{x} = 15.92$, $s.d. = 3.5$).

A paired t-test was used to test for the differences between the attitudes and behaviors for each of the two groups; the staff nurses and the staff nurses who administer chemotherapy. The mean of the attitudes of the staff nurses ($\bar{x} = 60.23$, $s.d. = 10.70$) and their behaviors ($\bar{x} = 13.76$, $s.d. = 2.26$) demonstrates a significant difference ($t = 26.79$; $d.f. = 29$; $p = .000$) which was expected because of the overall ($N = 109$) results. The means of the attitudes of the staff nurses who administer chemotherapy ($\bar{x} = 61.98$, $s.d. = 10.95$) and their behaviors ($\bar{x} = 15.92$, $s.d. = 3.53$) were also statistically different ($t = -35.96$; $d.f. = 54$; $p = .000$). There was a smaller numerical difference found between the attitudes and behaviors of the staff nurse and the attitudes and behaviors of the staff nurse who administers chemotherapy.

The Pearson r was used to test for a correlation between the attitude means and behavior means of each group. Each demonstrated a moderately strong relationship

between attitudes and behaviors. The staff nurse who reported not administering chemotherapy ($r = .6070$, $p = .000$) and the staff nurse who did report administering chemotherapy ($r = .5454$, $p = .000$). Although the chemotherapy nurses reported more behaviors, the relationship was weaker between the attitudes and behaviors than the relationship found between attitudes and behaviors of the staff nurse.

Age. Age interval was tested for the sample of 105, using a Pearson r correlation. There was not a statistically significant relationship found. Age does not appear to be a factor that might have influenced this sample's attitudes ($r = -.0325$, $p = .742$) and behaviors ($r = .1180$, $p = .231$).

Basic nursing education. The factor of the individual's basic nursing education was tested using a Spearman rho correlation between the group who reported a health problem ($n = 42$) that affected their sexuality and the group that did not ($n=66$). The relationship between basic nursing education and the attitudes of those with a health problem ($r = .2738$, $p = .079$) and the attitudes of those without a health problem ($r = .2254$, $p = .071$) was not significant. The relationship between basic nursing education and the behaviors of those with a health problem ($r = .1636$, $p = .301$) and the behavior of those without a health problem ($r = -.0034$, $p = .978$) was also not statistically significant.

CHAPTER FIVE

DISCUSSION

In this chapter the statistical analysis will be discussed within the framework of "Modeling and Role-Modeling." (Erickson, Tomlin & Swain, 1983). Then the limitations and strengths of this study will be discussed. The instrument, "The Ashley Revision of the Williams and Wilson Sexuality Survey," will then be reviewed. The implications for nursing and suggestions for future research will conclude this discussion of attitudes and behaviors of oncology nurses regarding the inclusion of sexuality as a component of care.

Discussion of Statistical Analysis

Table 6 provides a comparison for this study and the study being replicated, (Wilson & William, 1988). In their study: (a) the majority were 31-40 years of age however, 27.2% were over 40 years of age, and (b) the basic nursing degree was a Bachelor in Nursing. For this study, the 40.5% were over 40 years of age. The basic nursing education was that of an Associate in Nursing .

Age. As an individual matures, Erikson (1959) proposed that there is a progression through developmental stages (See Figure 2). Utilizing Erickson's developmental theory as a basis for theoretical reasoning, it could be said that as an individual nurse matures, the comfort level with discussions of sexuality would increase. The reported attitudes for "comfort initiating a discussion of sexuality" were just slightly

less (45.9%) for those who agreed with this compared to those who disagreed (54.2%). The reported comfort level on the attitude tool was higher when the client initiated the discussion of sexuality (97.2%)(See Table 2). Although age was statistically tested for a possible correlation with attitudes and behaviors, it was not statistically significant to explain nursing behaviors related to the inclusion of sexuality as a component of care. This was also the finding of the Wilson and Williams study (1988).

Basic nursing education. Another factor that was statistically tested for a possible correlation was basic nursing education. The participant's basic nursing education was not found to have a statistically significant relationship with attitudes and the inclusion of behaviors that include sexuality as a component of care. However, the Wilson and Williams (1988) study reported that those with more experience and education reported more nursing behaviors.

Professional nursing membership. Oncology nurses may choose to have membership in the Oncology Nurses Society, through which they may be credentialed. This is one of the many functions of the society. Another function the society has is to promote guidelines for care of the oncology client (Longman, 1990). The Oncology Nurses Society also provides literature for client teaching and continuing education for oncology nurses. Membership in the Oncology Nurses Society was reported by 48.1% of the participants and 33.3% reported attending a national meeting in the past two years. Thirty-seven point six percent reported attendance at a program that included sexuality. Membership in a nursing society does not guarantee that members will benefit by the programs offered. One oncology nurse responded with a written comment on the survey:

"I have not seen any inservices offered close to home; would like to attend."

Two very comprehensive booklets are printed by the American Cancer Society for oncology clients: Sexuality and cancer: For the man who has cancer and his partner, and Sexuality and cancer: For the woman who has cancer and her partner (Schover, 1988). Attendance at oncology meetings, where representatives of the American Cancer Society are present, provide exposure to this resource. Each includes pictures depicting alternate positions for those experiencing an alteration in sexuality. It is possible that an oncology nurse who has not had exposure to educational programs or has not attended meetings of the Oncology Nurses Society would not be aware of this resource. Could this be the reason 74.3% of the respondents had reported never using teaching tools or visual aide, 78.9% reported never discussing alternate positions for sexual activity, and 74.3.% are not comfortable discussing the topic with a client?

The Oncology Nursing Society has suggested guidelines (Longman, 1990) regarding the education of nurses who administer chemotherapy. It is recommended in the guidelines that oncology nurses who administer chemotherapy be given advance training. The components of the training and certification include the side effects of chemotherapy and instructions for care of the oncology clients. During the time the oncology nurse administers chemotherapy, often client concerns are discussed. It would be expected that the nurse who is trained and certified to give chemotherapy would also be more likely to discuss those concerns that the client may have to include sexuality concerns. Statistical analysis did show a positive relationship between behaviors of inclusion of sexuality as a component of care and the role of the oncology nurse who

administers chemotherapy. There was also a significant difference found between the statistical mean of the behaviors of the oncology nurse who administers chemotherapy and those of the nurse who does not administer chemotherapy. This may suggest two things. One, that there is a possible relationship between time spent with the clients during chemotherapy administration and the behaviors of sexuality that are demonstrated. The other possibility is that the training and education that the oncology nurse is provided before being allowed to administer chemotherapy increase behaviors. This is an area that warrants additional research.

Basic nursing education was not proven to be statistically significant. This suggests that it may be education that the work place provides that may be more significant to the inclusion of sexuality as a component of care than the education received in the basic nursing program. This is interesting because lack of knowledge was a reason reported by 46.8% of the participants as to what would inhibit the inclusion of sexuality as a component of care. This is consistent with written comments made by the respondents on the surveys they returned: (a) "Would want an inservice because nurses are capable if prepared," (b) "I am embarrassed that I am not comfortable initiating this conversation because of my lack of knowledge," and (c) "I feel comfortable talking to patients, especially women about body images, but when it comes to discussing sexual practices I feel naive and embarrassed." Comments were also included regarding time limitations and staffing patterns. Time limitations and staffing patterns were also noted in the Wilson and Williams (1988) study as a factor that inhibited nursing behaviors that included sexuality as a component of care.

Modeling and Role-Modeling

The nursing theory of "Modeling and Role-Modeling" (Erickson, Tomlin, & Swain, 1983) may be used by individual nurses as a model for providing care to their clients. The nurse models the client's world and then role-models, or provides interventions that the client needs to facilitate their reaching a level of health that is attainable for that individual.

The responses of the participants of this study suggest that nurses as individuals would be comfortable with a nurse initiating a discussion of sexuality with them if they were the client. The model of the individual nurse's world suggests that they are able to view the client's world from an objective viewpoint, free of individual bias. Yet, the same sample also reports that they are comfortable when the client initiates the conversation, and uncomfortable initiating a conversation with an oncology client related to sexuality concerns. Forty-five percent responded that such a conversation with a client would be difficult because the client would be embarrassed and 32.1% responded that a discussion of sexuality was not appropriate for the client. These findings suggest that the nurses have modeled their own world and not the client's world. There may be a superimposing of their world onto their clients. Yet, 79.8% reported that they would be comfortable with a nurse discussing sexuality, they have modeled for the clients a world that presumed the clients to be embarrassed and proceed to role-model the client's world without inclusion of sexuality.

Was the model, then, based on a lack of education regarding sexual practices and sexuality needs of the oncology client, or rather the personal model of the oncology

nurses? If the later were true then perhaps the nurse caring for the oncology clients has not progressed upwards or completed the necessary developmental phases (Erickson, 1959). This does not appear to be the case. The data suggests that the attitudes are positive, and it may be that the behaviors are a reflection of a lack of knowledge. Embarrassment may be from a lack of knowledge and when this is transferred to the client, it becomes the client's embarrassment. The data also suggested that the nurses who administer chemotherapy do include behaviors, perhaps because they do have the additional knowledge of: (a) the effects of chemotherapy, (b) the effects of the cancer, and (c) available resources for counseling and teaching regarding sexuality.

An educational concern may also include the topic of gay/lesbian sexuality. Five point five percent of the participants responded to the two behavioral questions regarding gay/lesbian sexuality with a "not-applicable." Seventy nine point eight percent responded that they never discussed alterations in sexuality with a gay/lesbian client. Eighty one point seven never discussed sexuality concerns with the significant other of the gay/lesbian client. Comments written on the returned surveys pertaining to this topic included (a) "I haven't cared for that kind of patient that I am aware of," and (b) "I know nothing of that kind of intimacy, and I would never feel comfortable discussing something I know nothing about." This may be a moral issue, or an issue of a lack of education regarding the subject of gay/lesbian sexuality. The inclusion of "not applicable" and the written comments added by the participants may suggest that the lack of education is not specific to just gay/lesbian sexuality, but to sexuality in general.

Limitations and Strengths

Limitations of this study include sample size and design of the study. It is possible that there were oncology nurses who wanted to participate, but were unable to. Summer vacations may have limited access to individual message systems, and therefore the ability to respond within the time requirements for data collection. Sample size limits generalization outside this population of oncology nurses. There is also the possibility of selection bias, only those oncology nurses who had an interest in sexuality may have participated. The use of a statistical mean for the missing values may not reflect what the participant would have reported. The question which asked each respondent to check those factors which would impede a discussion of sexuality with a client may have not been inclusive enough to allow additional data to be obtained to explain why sexuality is not being included as a component of care.

The strengths of the study include the inclusion of the five different medical institutions and three different states. The use of a booklet format may have encouraged participation as well as the privacy that the stamped return envelope provided. The inclusion of the definition of sexuality was also a strength as it provided a common ground from which to base the individual responses.

Discussion of the Instrument

The authors of the Wilson and Williams (1988) study suggested that a definition of sexuality be added. This was accomplished in this study with a cover letter that included a definition of sexuality to be used (See Appendix K). "The Ashley Revision of the Williams and Wilson Sexuality Survey" contained one additional behavior that was

not part of the original "Williams and Wilson Sexuality Survey." That behavioral question was placed at the beginning of the behavioral tool: How often do you assess clients for sexuality concerns? Twenty-one point one percent reported "never", and 67.0% reported "occasionally." (See Table 7). The rationale for the inclusion of this question was to explore the possibility that oncology nurses are including sexuality as a component of care. The reported responses to this question suggested that oncology nurses are assessing their clients for their sexuality concerns. Fifty-two point three percent reported that they "occasionally" discussed clients sexuality concerns with another nurse, yet, only 22% reported that they "occasionally" used the nursing diagnosis of "alteration in sexuality." An oncology client may have many medical concerns that are of a higher need for the client than sexuality, so an "alteration in sexuality" may not be a need. The assessment phase may also not be translated into the behaviors of teaching and counseling due to time limitation, privacy issues, or education limitations. The behavior of assessment of the client's sexuality concerns and the behavior of verbal communication of these concerns to other oncology nurses is suggested by data analysis of this population of oncology nurses.

It would be also recommended that if "The Ashley Revision of the Williams and Wilson Sexuality Survey" is used by future researchers, that the category of "not applicable" be added to the behaviors tool as part of the survey. To include this category would allow every potential participant the opportunity to include a N/A. It would also be helpful to ask for an explanation as to why the provision of the behavior is not applicable. It is also suggested that a question be added to the demographics section. A question

Table 7

Characteristics of Sample Compared to Wilson and Williams Sample (1988)

Characteristic		Ashley (N = 109)	Wilson (N = 938)
		%	%
Sex	Male	3.7	3.3
	Female	96.3	96.7
Age	20-30 years	21.2	29.9
	31-40 years	39.2	42.8
	>40 years	40.5	27.2
Basic Nursing Education			
	Diploma	20.4	30.0
	ADN	44.4	17.4
	BSN	35.2	48.2
	MSN/MN	—	4.1
	ND	—	0.1
Highest Degree Earned			
	BSN	31.2	54.8
	MSN/MN	7.3	35.9
	Others	—	9.2
Membership in Nursing Organization			
	ON	48.1	66.0

Table 7 (Continued)

Characteristics of Sample Compared to Wilson and Williams Sample (1988)

Characteristic	Ashley (N = 109) Wilson (N= 938)	
	%	%
Primary Nursing Role		
Staff Nurse	27.5	21.2
Head Nurse/Supervisor	—	15.6
Clinical Nurse Specialist	5.5	15.5
Other	—	47.8
Primary Area of Practice		
Hospital Inpatient	77.1	52.0
Ambulatory	10.1	15.5
Home Health Agency	7.3	5.8
Office	1.8	7.4
Educational Institute	—	6.8
Oncology Area of Expertise		
Yes	74.1	90.0
Years Of Experience		
3-10 years	43	74.0

Note. Dash indicates lack of comparison value

which would provide researchers information regarding the certifications that had been earned by each potential participant.

Implications for Nursing

There are several implications for nursing suggested by the results of this investigation of nursing attitudes and behaviors regarding the inclusion of sexuality as a component of care. The first is the importance of advanced education for oncology nurses which may be provided by the institution that the oncology nurses are associated with or sponsored by the Oncology Nursing Society. Advanced education for the oncology nurse may include: (a) developmental stages and specific sexuality needs, (b) communication skills, and (c) specific education regarding the sexuality concerns of oncology clients.

Privacy appears to be an issue and concern of this population of oncology nurses as evidenced by the participants written comments. Administrators may want to adjust the physical space to accommodate privacy for discussion and for intimacy between clients and their significant others. Provision of materials that relate to issues of sexuality could be displayed in a common area. When the clients and significant others view informational literature, it may prompt discussion, and those nurses who reported comfort when their client initiates the conversation would be able to fulfill the client's need as well as to fulfill their own basic needs of comfort. Permission is also granted to discuss issues of sexuality when information regarding all aspects of sexuality are free and available. Material that could be provided for the clients and their significant others may include: (a) information for support group, (b) make up, wigs and turbans,

(c) nutritional supplies and (d) the booklet, Sexuality and Cancer: For the man who has cancer, and his partner and Sexuality and Cancer: For the woman who has cancer and her partner (Schover, 1981). Each of these is a valuable component of fulfilling basic human needs, as well as the higher needs of sexuality.

Suggestions for Future Research

Additional testing of the revised tool would be beneficial with other populations of oncology nurses. Additional testing would allow for a wider generalization of the results to other oncology nurses. Suggested changes to the tool would allow for continued exploration of the differentiation of the staff nurse and the staff nurse that administers chemotherapy. Perhaps the addition of a question which would elicit knowledge as to what certifications that the participants possess would be helpful. Gamel, Hengeveld, Davis and VanDerTweel (1995) asked for a motivator for each response, perhaps this could not only be used for those questions where N/A is chosen, but also for the question regarding those factors that would impede a discussion regarding sexuality with the client. It is possible that there are factors that have not been taken into consideration because they are unique to a certain population of oncology nurses.

A possible research study might also utilize a pre and post test study for two groups of new oncology nurses. One group could be provided with a specialized course regarding human sexuality, and the other group given instructions to prepare them for testing for the certification process by the Oncology Nurses Society. An experiential study which would investigate the variable of education would be useful in determining if credentials from the Oncology Nurses Society produce an increase in behaviors that

include sexuality as a component of care.

Two other factors may need to be taken into consideration for future researchers. One is the changes occurring in the delivery of health care and the other is the downsizing of hospital for economical reasons (Aiken, 1990; Coulter, 1997). The trend is to provide care for clients outside the hospital. As a result, those that are being cared for in the hospital are requiring increasingly complex care. The oncology nurse that cares for hospitalized clients, is likely to have a larger assignment of clients to manage care for, that are sicker. The Williams and Wilson (1988) tool was designed for oncology nurses that work in the hospital setting, but at a different time in nursing history. Researchers may want to investigate the actual needs regarding sexuality issues that exist for both the oncology client in the community setting and the client that is hospitalized.

Another variable that has not been addressed in the literature that was reviewed for this study was effect of gender on the responses and behaviors of the oncology nurse. Would female oncology nurses report more behaviors that include sexuality as a component of care if the client is female rather than male. The tool, "The Ashley Revision of the Williams and Wilson Sexuality Survey" does not include the ability to determine what effect the gender of the client has on the inclusion of sexuality as a component of care. It is suggested that this variable be addressed with future revisions of the tool.

In conclusion, the data suggests that oncology nurse's attitudes reflect that sexuality is an important component of care, although behaviors are not demonstrated. The data suggests that oncology nurses are reporting behaviors of assessment. The

behaviors, however are not reflected in the reported use of the nursing diagnosis of "alteration in sexuality." but not communicating those behaviors with documentation. More research is needed to determine if the perceptions of oncology nurses match the needs and concerns of the oncology clients regarding sexuality. If the oncology nurse is perceiving embarrassment because of a knowledge deficit on the nurse's part, would sexuality education change this? It is hoped that the process of this study and the reporting of the results will result in: (a) an increase in awareness of the sexuality concerns of all clients, (b) an increase in the inclusion of the behaviors of assessment of sexuality as a component of nursing care, and (c) the provision of education regarding sexuality to both the oncology nurse and the client.

APPENDICES

Appendix A

Authorization for Use of the Maslow and Erickson Diagrams

Date: Tue, 7 May 1996 11:24:45 -0500
From: Helen Erickson <helenerickson@mail.utexas.edu>
To: Mary Diane Ashley <ashleym@river.it.gvsu.edu>
Subject: Re: modeling amd role-modelin

Hi! You have our permission. All you have to do is state (under the figure) Reproduced with permission from (insert title of the book and author). Glad to hear that it has come together for you. the next MRM conference will be Oct 6-9 in St Paul Minn. I know it is too late to present a paper, but I think you could still present a poster if you would be ready. If not, maybe you'll be ready for the next conference in two years. Also, I'd be very interested in what you did your work on. Best wishes, Helen Erickson.

>Dr Erickson, greetings from Grand Rapids , Michigan. I am currently using
>MRM as my conceptual framework for my thesis. I would like to include two
>of your figures in the body, to help explain how and why I am applying
>the concepts. I am using Eriksons developmental stages and Maslow's
>hierachy of needs to explain nursing behaviors and attitudes regarding

? Help	M Main Menu	P PrevMsg	- PrevPage	D Delete	R Reply
O OTHER CMDS	V ViewAttch	N NextMsg	Spc NextPage	U Undelete	F Forward

"Williams and Wilson Sexuality Survey"

Demographic Variables:

- 76

7. Do you consider oncology nursing to be your area of specialty?

Yes _____ No _____

If yes, how many years of experience do you have in oncology nursing:

1-2 years _____

3-5 years _____

6-10 years _____

>10 years _____

8. What percentage of your average client caseload is oncology patients?

_____ 100%

_____ 75-100%

_____ 50-75%

_____ 25-50 %

_____ <25%

9. In the past two years, have you attended a state or national oncology educational program?

Yes _____ No _____

10. Have you ever had a diagnosis of cancer?

Yes _____ No _____

11. Has a significant other ever had a diagnosis of cancer?

Yes _____ No _____

12. Have you ever had a disease or a course of treatment (i.e. surgery, chemotherapy, orthopedic procedures) that has impacted on your sexuality?

Yes _____ No _____

Williams-Wilson Sexuality Survey

		Strongly Disagree					Strongly Agree
* 1.	Sexuality concerns should be a routine component of nursing care for oncology patients	1	2	3	4	5	6
(2)	Hospitalized patients do not have the right to lock their doors	1	2	3	4	5	6
(3)	It upsets or embarrasses me to see spouses or significant others lying in bed with patients	1	2	3	4	5	6
* 4.	If I were an oncology patient, I would want to receive sexuality counseling from a nurse	1	2	3	4	5	6
* 5.	If I were a patient, I would be comfortable in receiving sexuality counseling from a nurse	1	2	3	4	5	6
* (6)	Offering sexual counseling is not an integral component of primary nursing care	1	2	3	4	5	6
7.	At times I have felt that my nursing care of a client was incomplete because I had not addressed sexuality as a component of nursing care	1	2	3	4	5	6
* (8)	Sexuality is not a major concern for my patients	1	2	3	4	5	6
* (9)	I am not comfortable initiating a discussion of sexuality with my clients	1	2	3	4	5	6
* 10.	I am comfortable initiating a discussion of sexuality with my client's significant others	1	2	3	4	5	6
* 11.	Discussion of sexual concerns contributes to the patient's recovery	1	2	3	4	5	6
(12)	I feel discouraged after offering sexual counseling to my patient because it never seems to make a difference	1	2	3	4	5	6
* (13)	A specialist does a better job of discussing sexual concerns with patients than I could possibly do	1	2	3	4	5	6
* 14.	I am comfortable discussing sexuality if the client initiates the discussion	1	2	3	4	5	6
* 15.	I am comfortable discussing sexuality if the client's significant other initiates the discussion	1	2	3	4	5	6
(16)	Sexual desire is normally decreased during chronic illness such as cancer	1	2	3	4	5	6
(17)	I have felt uncomfortable in the past when I've interrupted patients engaged in sexual activity	1	2	3	4	5	6

- * (18.) Sexual activity is inappropriate under any circumstances while the patient is hospitalized 1 2 3 4 5 6
- * 19. Nursing intervention in sexual problems/concerns increases the patient's wellbeing 1 2 3 4 5 6
- * 20. Sexual activity occurs whether someone is ill or well . . . 1 2 3 4 5 6
21. My attitudes on sexuality are similar to those held by most other nurses 1 2 3 4 5 6
- * (22.) If I had cancer, sex would be the farthest thing from my mind 1 2 3 4 5 6
23. Some people with cancer can have a closer sexual relationship than they did prior to diagnosis 1 2 3 4 5 6
- (24.) If I had cancer, my sex life would be negatively affected by the disease 1 2 3 4 5 6
25. A serious disease such as cancer can enhance a sexual relationship 1 2 3 4 5 6
- If you are caring for pediatric clients, please continue to answer questions 26-31, then continue on with question 32. If not, please continue to answer questions 32-48.
26. Sexuality is a concern for adolescents experiencing cancer 1 2 3 4 5 6
- (27.) I am not comfortable in answering an adolescent patient's questions regarding sexuality 1 2 3 4 5 6
28. Discussion of future sexuality issues for adolescents undergoing active treatment is an appropriate nursing function 1 2 3 4 5 6
- (29.) Sexuality should not be discussed with adolescents . . . 1 2 3 4 5 6
- (30.) It is the parents' responsibility to discuss sexual issues with their children/adolescents 1 2 3 4 5 6
31. I am comfortable discussing sexuality concerns with the parents of adolescent patients who are undergoing cancer treatment 1 2 3 4 5 6

32. Does your unit provide private time (uninterrupted time) for patients and their spouses or significant others?

Yes _____ No _____

33. In your routine nursing care of oncology patients, do you use the nursing diagnosis "Alteration in Sexuality"?

Yes _____ No _____ N/A (The setting in which I'm employed does not use nursing diagnoses.)

- (a) If yes, how many times in the past month have you used this diagnosis?

> 20 _____
 10-20 _____
 5-9 _____
 < 5 _____
 Never _____

- (b) If yes, how many times in the past month have you used this diagnosis in planning postoperative care?

> 20 _____
 10-20 _____
 5-9 _____
 < 5 _____
 Never _____
 N/A _____ (Your caseload of patients does not include surgical patients)

34. To how many patients and/or their significant others have you offered sexual counseling in the past 6 months?

25-50 _____
 15-24 _____
 5-14 _____
 < 5 _____
 0 _____

35. In caring for a cancer patient who has experienced an alteration in sexuality, how frequently do you initiate a referral to a specialist in order to provide for sexual counseling?

76-100% _____
 50-75% _____
 25-49% _____
 < 25% _____
 Never _____

- (a) If you have initiated a referral, which of the following specialists do you use most?

_____ Clinical nurse specialist
 _____ MD
 _____ Psychologist/psychiatrist
 _____ MSW
 _____ Enterostomal therapist
 _____ Clergy
 _____ Sex therapist/educator

36. How many times in the past 6 months has one of your cancer patients and/or their significant other requested assistance regarding sexuality?

> 20 _____
 10-19 _____
 5-9 _____
 1-4 _____
 0 _____

37. Does your work setting offer continuing education programs in sexuality?

Yes _____ No _____

38. Have you discussed patient sexual concerns with another nurse in order to plan care for that patient?

Yes _____ No _____

39. Has the subject, Alterations in Sexuality, been a topic for nursing grand rounds on your unit?

Yes _____ No _____

40. Do you include "Potential for Alteration in Sexuality" in your nursing care plans?

Yes _____ No _____

41. Have you addressed possible alterations in sexuality with preoperative patients?

Yes _____ No _____

42. Have you discussed with patients their concerns about loss of attractiveness to sexual partner?

Yes _____ No _____

- (a) If yes, have you continued the discussion with their spouse or significant other?

Yes _____ No _____

43. Have you used any teaching tools or visual aids during a discussion of sexuality with an oncology patient (i.e. penile implants, diagrams of sexual positioning etc.)?

Yes _____ No _____

44. Have you discussed alternate positions for intercourse with an oncology patient who is experiencing an alteration in sexuality?

Yes _____ No _____

- (a) If not, what factor(s) would impede this discussion?

_____ Embarrassment
 _____ Lack of knowledge
 _____ Not the job of an RN
 _____ Patient would be too embarrassed

45. Have you discussed alternatives to "genital to genital" sex with an oncology patient?

Yes _____ No _____

46. If you are caring for a known homosexual patient, have you discussed alterations in sexuality that pertain to cancer and its treatment?

Yes _____ No _____ I have never cared for a known homosexual patient _____

- (a) If yes, have you continued this discussion with his/her significant other?

Yes _____ No _____

- (b) If no, have you made an appropriate referral to someone who would discuss the issue?

Yes _____ No _____

47. I am comfortable presenting a continuing education program on penile implants to co-workers.

Yes _____ No _____

If you are caring for pediatric clients, please continue to answer question 48.

48. Have you discussed a possible alteration in sexuality with an adolescent patient who has undergone cancer treatment (e.g. experienced the loss of limb, testicular relapse etc.)?

Yes _____ No _____

Appendix C

Authorization to Revise the "William and Wilson Sexuality Survey"



College of Nursing

Health Science Center
Box 100157
Gainesville FL 32610-0157
Area Code 904 392-3311
392-3324
392-3331

February 15, 1994

Diane Ashley
5105 Blaine SE
Kentwood, Michigan 49508

Dear Ms. Ashley:

I am pleased that you are interested in using the Williams-Wilson Sexuality Survey in your research. You have my permission to modify it and use it.

I am sending you a copy of the instrument we used for the study reported in the January/February 1988 issue of Oncology Nursing Forum. We found that some of the items on both the attitude scale and the behavior scale were not useful to use either because many subjects did not answer the questions or the item had a very low factor loading in the factor analysis. The 15 items used on the attitude scale and the 10 items used on the behavior scale are circled on the enclosed copy. The items marked with a star on the attitude scale were reverse scored. In addition to a factor analysis of the behavior scale item, we eliminated any items that did not measure behaviors that were under the control of individual nurses. Note that all of the behavior items except question 34 were scored 0 or 1.

A report of results from the subset of pediatric nurses in our sample appeared in the Journal of Pediatric Oncology Nursing, 6, 127-132 in 1989.

I wish you success in your research endeavors and hope that this instrument will be useful to you. I would appreciate a copy of any report that results from use of the WWS. Please call me if I can be of further assistance.

Sincerely yours,

Margaret E. Wilson, RN, PhD
Associate Professor

Equal Opportunity/Affirmative Action Institution

The Ashley Revision of
The Williams and Wilson Sexuality Survey

ID#

Date:

Directions: Please circle the number that represents your response to questions 1-15, from strongly disagree (1) to strongly agree (6).

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
----------------------	----------	----------------------	-------------------	-------	-------------------

1. Sexuality concerns should be a routine component of nursing care for oncology patients..... 1 2 3 4 5 6
2. If I were an oncology patient, I would want to receive sexuality counseling from a nurse..... 1 2 3 4 5 6
3. If I were a patient, I would be comfortable receiving sexuality counseling from a nurse..... 1 2 3 4 5 6
4. Offering sexuality counseling is not an integral component of primary nursing care..... 1 2 3 4 5 6
5. Sexuality is not a major concern for my patients..... 1 2 3 4 5 6
6. I am not comfortable initiating a discussion regarding sexuality with my patients..... 1 2 3 4 5 6

	Strongly Disagree	Disagree	Neutral Disagree	Neutral Agree	Agree	Strongly Agree
7. Discussion of sexuality concerns contributes to the patient's recovery.....	1	2	3	4	5	6
8. I am comfortable initiating a discussion regarding sexuality with my patient's significant other.....	1	2	3	4	5	6
9. A specialist would do a better job of discussing sexuality concerns with a patient.....	1	2	3	4	5	6
10. I am comfortable discussing sexuality if the patient initiates the discussion.....	1	2	3	4	5	6
11. I am comfortable discussing sexuality if the patient's significant other initiates the discussion.....	1	2	3	4	5	6
12. Sexual activity, which provides intimacy for a couple, is inappropriate under any circumstances while a patient is hospitalized.....	1	2	3	4	5	6
13. Nursing intervention in sexuality problems and concerns increases the patient's well-being.....	1	2	3	4	5	6

38. In the past year, have you attended an educational program that included topics related to the sexuality concerns and issues for oncology patients?

- ____ 1. No
____ 2. Yes

39. Have you ever been diagnosed with cancer?

- ____ 1. No
____ 2. Yes

40. Has a significant other ever been diagnosed with cancer?

- ____ 1. No
____ 2. Yes

41. Have you ever experienced a health problem that has made a difference in your sexuality?

- ____ 1. No
____ 2. Yes

42. Which of the following factors would impede a discussion of sexuality with an oncology patient? Please check those that apply.

- ____ 1. I would be too embarrassed
____ 2. Lack of knowledge
____ 3. Not the job of an RN
____ 4. Patient would be too embarrassed or uncomfortable
____ 5. Not appropriate for patient

Thank you for completing the Ashley Revision of the Williams and Wilson Sexuality Survey. Please use the back of the page to add any comment you wish to make.

32. Primary area of practice

- ☐ 1. Hospital Inpatient
☐ 2. Ambulatory Outpatient
☐ 3. Home Care
☐ 4. Hospice
☐ 5. Other: Please specify _____

33. Primary nursing role as a direct care provider

- ☐ 1. Staff nurse
☐ 2. Chemotherapy nurse
☐ 3. Radiation therapy nurse
☐ 4. Staff nurse that also administers chemotherapy
☐ 5. Home health nurse
☐ 6. Hospice nurse
☐ 7. Clinical Nurse Specialist
☐ 8. Nurse Practitioner
☐ 9. Other: Please specify _____

34. Do you consider oncology nursing to be your area of expertise?

- ☐ 1. No
☐ 2. Yes

35. How many years of experience do you have as an oncology registered nurse?

_____ Years

36. What percentage of your average caseload consists of oncology patients?

_____ %

37. In the past two years, have you attended a state or national oncology program? (Example: ONS Congress)

- ☐ 1. No
☐ 2. Yes

14. Sexual activity, to include sexual intercourse, occurs whether someone is ill or well.....

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
-------------------	----------	-------------------	----------------	-------	----------------

1 2 3 4 5 6

15. If I had a new diagnosis of cancer, sexual activity would be the farthest thing from my mind.....

1 2 3 4 5 6

Directions: For the following questions, 16-26, please circle the number that represents your response, from never (1) to always (4).

Never	Occasionally	Frequently	Always
-------	--------------	------------	--------

16. How often do you assess your patients for their sexuality concerns?.....

1 2 3 4

17. How often have you offered sexuality counseling to your patients or their significant others in the last 6 months?.....

1 2 3 4

18. How often have you discussed a patient's feelings regarding their perceived loss of attractiveness to their sexual partner?.....

1 2 3 4

19. How often have you discussed your patient's concerns regarding sexuality with the patient's significant other?

1 2 3 4

<i>Never</i>	<i>Occasionally</i>	<i>Frequently</i>	<i>Always</i>
--------------	---------------------	-------------------	---------------

20. How often have you discussed patient sexuality concerns with another nurse in order to plan care for the patient?..... 1 2 3 4

21. How often have you included the nursing diagnosis "Potential for Alteration in Sexuality" in your nursing care plans?..... 1 2 3 4

22. How often have you used teaching tools or visual aids during a discussion of sexuality with an oncology patient?..... 1 2 3 4

23. How often have you discussed alternate positions for an oncology patient who is experiencing an "alteration in sexuality" and may not be able to utilize former patterns of sexual intercourse?..... 1 2 3 4

24. How often have you discussed alternatives to "genital to genital" sex with an oncology patient?..... 1 2 3 4

25. When caring for a known gay/lesbian patient, how often have you discussed alterations in sexuality that pertain to cancer and it's treatment?..... 1 2 3 4

26. When caring for a known gay/lesbian patient, how often have you discussed alterations in sexuality with the significant other?..... 1 2 3 4

Directions: Please provide the information requested for questions 27-42.

27. Sex

- ____ 1. Male
____ 2. Female

28. Age in years _____.

29. Education: Basic Nursing Program

- ____ 1. Diploma
____ 2. ADN
____ 3. BSN

30. Education: Highest Degree Obtained

- ____ 1. Diploma
____ 2. ADN
____ 3. Associate, non-nursing
____ 4. BSN
____ 5. Bachelors, non-nursing
____ 6. MSN
____ 7. Masters, non-nursing
____ 8. Ph.D.
____ 9. Ph.D., non-nursing

31. Nursing organization membership: Choose one

- ____ 1. ONS
____ 2. ANA (Member of the State Nurses Association)
____ 3. Both
____ 4. None of above
____ 5. Other: Please specify _____

Appendix E

Authorization from Grand Valley State University Board of Human Review



1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

May 7, 1996

Mary Diane Ashley
5105 Blaine SE
Kentwood, MI 49508

Dear Mary Diane:

Your proposed project entitled "*The Differences Between the Attitudes and Behaviors of Oncology Nurses Regarding the Inclusion of Sexuality Concerns as a Component of Care for the Oncology Client*" has been reviewed. It has been approved as a study which is exempt from the regulations by section 46.101 of the Federal Register 46(16):8336, January 26, 1981.

Sincerely,



Paul Huizenga, Chair
Human Research Review Committee

Appendix F

Authorization to Collect Data from Lakeland, Florida



1324 Lakeland Hills Boulevard • P.O. Box 95448 • Lakeland, Florida 33804 • (813) 687-1100

May 25, 1996

Mary Diane Ashley, RN, BSN, OCN
5105 Blaine S.E.
Kentwood, Michigan 49505

**RE: Exemption from Full Board Review Status for Research Study Proposal:
The Ashley Revision of the Williams and Wilson Sexuality Survey.**

Dear Ms. Ashley,


Your research study proposal was reviewed by the Nurse Practice Committee Chairperson, the Director of Professional Nursing Practice, and approval was given for collection of data from oncology nurses at Lakeland Regional Medical Center.

Your approval was granted under the following checked category of Exemption From Full Board Review (DHHS Regulation 45 and Federal Regulations 46).

- ☐ 1. Research conducted in established or commonly accepted educational settings, involving normal educational practices.
- ☐ 2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), if information taken from these sources is recorded in such a manner that confidentiality is maintained.
- ☒ 3. Research involving survey or interview procedures or the observation of public behavior, so long as confidentiality is maintained.
- ☐ 4. Research involving the collection or study of existing data, documents, records, pathological specimens or diagnostic specimens, if these sources are publicly available or if the information is recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

If any further information is required you may contact me at (941) 687-1360.

Yours truly,


Glenda Kaminski, MS, RN, AOCN, CRNI
Advanced Practice Specialist, Oncology
Lakeland Regional Medical Center, Lakeland, Florida

Appendix G

Authorization to Collect Data from Omaha, Nebraska



August 8, 1996

THE NEBRASKA METHODIST HOSPITAL
8303 DODGE STREET
OMAHA, NEBRASKA 68114-4199
(402) 354-4000

Ms. Mary Diane Ashley
5105 Blaine S.E.
Kentwood, Michigan 49508

Re: Research Proposal

Dear Ms. Ashley:

The Nebraska Methodist/Childrens Hospital Nursing Research Committee has reviewed your research proposal and have granted your request to conduct research at Methodist Hospital

Your contact person will be Jeanette Ekberg, RN, Clinical Nurse Specialist at 402/354-4511 or pager 221-1832. Jeanette has requested that you send her at least fifty copies of your questionnaire/survey. I believe that we agreed on sixty. Please give Jeanette a list of criteria/suggestions regarding appropriate subjects in addition to those identified in your proposal.

We also request that you state how you will be reporting your results to our staff, so that they might benefit from your study.

Best wishes in your endeavor to conduct a very worthwhile research project.

Sincerely,

Laraine Crane, CNS, CETN
Nursing Research Committee

LC/ld

Appendix H

Authorization to Collect Data from St. Joseph, Michigan



June 18, 1996

Diane Ashley
5105 Blaine SE
Kentwood, MI 49508

Dear Diane,


Since you have already had your proposal reviewed by the Human Research Review Committee at Grand Valley State University, you do not need to submit your proposal to the Internal Review Board at Lakeland Medical Center in St. Joseph, MI for a separate approval process.

I have reviewed your proposal entitled "The Differences Between the Attitudes and Behaviors of Oncology Nurses Regarding the Inclusion of Sexuality Concerns as a Component of Care for the Oncology Client", the original study, the letter to the participant, and the "The Ashley Revision of the Williams and Wilson Survey". In addition, the letter to the participant, the survey, and approval letter from the review committee at Grand Valley State University were sent to Jann Totzke, Director of Oncology and Support Services, and Katy Jones, Vice President of Operations and Patient Care Services for Lakeland Regional Health System. Your survey may be distributed to nurses caring for cancer patients within this organization for the purposes of collecting data for your study.

As Jann Totzke is the President of the Southwestern Michigan Chapter of the Oncology Nursing Society and I am the Programming Chair, we are in agreement that the surveys may be distributed to nurses involved with the chapter.

I will be assisting you with the distribution of the surveys through the mailboxes on the designated units and through inter-departmental mail. The survey will be briefly discussed at the department unit meetings for the Inpatient Oncology Unit and the Outpatient Oncology Clinic so that survey is recognized and returned whether or not it is completed. For those involved with the chapter, the surveys (10-15) will be sent to home addresses. I am estimating that the number of surveys required is between 42-50. I am looking forward to assisting you with your data collection, please let me know when I can expect the surveys. If there is anything else that I can do to assist you, please feel free to contact me.

Sincerely,


Mary Pat Johnson, RN, MS, AOCN
Oncology Clinical Nurse Specialist
(616) 982-4957

1334 Nopier Avenue, St. Joseph, MI 49085-2158 • 616/983-8300

Appendix I

Authorization to Collect Data from Grand Rapids, Michigan

300 Jettie St.
Grand Rapids
Michigan 49503
616 774-4200



July 22, 1996

Mary Diane Ashley, RN, BSN, OCN
5105 Blaine, S.E.
Kentwood MI 49508

Dear Ms. Ashley:

As Saint Mary's Health Services Institutional Review Board (IRB) Chair, and in accord with Saint Mary's Human Research Policy, I have reviewed your proposed study: *"The Difference Between the Attitudes and Behaviors of Oncology Nurses Regarding the Inclusion of Sexuality Concerns as a Component of Care for the Oncology Client."* We are approving your study as exempt from Federal Register regulations. It is my understanding that Saint Mary's Nursing Research Committee has reviewed your proposed study and agrees that it is exempt from these regulations.

I request, however, that you notify me in writing when you have completed this study.

Sincerely,


Sr. Myra Bergman, RSM
Chair, Saint Mary's Institutional Review Board

Appendix J

Authorization for Data Collection from Traverse City, Michigan

MEMORANDUM

TO: Kelly Guswiler, R.N., C.N.S., O.N.C

FROM: Janet Y. Jackson, R.N., M.S.N. 
Senior Vice President

RE: Ms. Ashley's Research Request

DATE: February 23, 1996

In response to your note, Ms. Ashley has my permission to approach our oncology nursing staff as part of her thesis investigation. Because patients will not be involved, the intervention of the Institutional Review Board will not be necessary. Mr. Cerny has authorized me to approve research participation in my areas of responsibility, where patients are not involved.

Should Ms. Ashley require specific documentation for her files in the event that this is insufficient, please let me know.

Appendix K

Survey Cover Letter

Dear Registered Nurse Caring for Adult Oncology Patient(s)/Client(s):

Thank you for taking this time to read this letter of introduction. The purpose of this study is to describe and compare the attitudes and behaviors of Oncology Registered Nurses regarding the sexuality concerns of the oncology patient(s)/client(s). You are being asked to participate in this study because you are currently providing care for adult oncology patient(s)/client(s). For simplicity, the survey will use the word "patient(s)" when referring to the individual(s) who receive care from an Registered Nurse.

The Clinical Nurse Specialist in your institution has agreed to make this survey available to you for the purpose of data collection for my study.

In order for there to be a common understanding of what sexuality means for the purpose of this survey, I have chosen to use the definition by Medlar, T., & Medlar, J. (1990). Nursing management of sexuality issues. *Journal of Head Trauma Rehabilitation*, 5(2), 46-51.

Sexuality is a basic, fundamental aspect of human development, personality, and behavior. Sexuality is more than sexual behavior: It encompasses one's feelings of femininity or masculinity and how one acts, dresses, speaks, and relates to others within one's entire network of social and interpersonal relationships. It is an irreducible component of personality.

Because the subject matter of sexuality poses a possible risk of individual discomfort, confidentiality of individual participants will be maintained by the use of a code to designate your institution. Access to information reported on individual questionnaires will be limited to the data analyzer and to the investigator to protect your right of confidentiality.

Participation in this study involves completing "The Ashley Revision of The Williams and Wilson Sexuality Survey", which will take approximately 15 minutes. Please feel free to write any additional comments on the survey. When you have completed the survey, please place it in the pre-addressed, stamped envelope, and return it to me within one week of receiving this packet.

By completing and returning the survey, you are giving voluntary, informed consent for your participation in this study.

Please return the survey even if you choose not to participate. A request for the results of the data analysis, or any questions you might have regarding this survey may be directed to Mary Ashley, 5105 Blaine S.E., Kentwood, Michigan, 49508.

Appendix L

Follow Up Notice

I want to thank those who have participated in my research study, of attitudes and behaviors of oncology nurses as they relate to the sexuality concerns of oncology patients, by completing **The Ashley Revision of The Williams and Wilson Sexuality Survey**. Your input will be added to those of other RN's who care for adult oncology patients.

For those who still want to be part of the study, please return your survey within the week. Thank you for your time.

Sincerely,

Mary Diane Ashley, RN, BSN, OCN

Appendix M

Notice of Termination of Data Collection

August 27, 1996

5105 Blaine S.E.
Kentwood, MI, 49508

Dear

I want to thank you for allowing me to collect data at your institution. Data collection for my study: "The Difference Between the Attitudes and Behaviors of Oncology Nurses Regarding the Inclusion of Sexuality Concerns as a Component of Care for the Oncology Client," is now complete. Data collection is officially finished as of September 1 to allow for mail delivery of all surveys completed at your institution and other data collection sites. I have had an excellent response rate from all of the sites from which I have collected data. I will be sending the results of my data collection when they are completed.

Sincerely,

Mary Diane Ashley, RN, BSN, OCN

LIST OF REFERENCES

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