WHO'S TALKING NOW? AN EXPLORATORY STUDY
EXAMINING NURSES' INVOLVEMENT IN PARENT-CHILD
COMMUNICATION RELATED TO SEXUAL HEALTH AND
THE FACTORS THAT INFLUENCE THIS INVOLVEMENT

by

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ABSTRACT

Unplanned pregnancy and sexually transmitted infections can negatively impact the health of adolescents. Teens require sexual health education to assist them in making informed choices regarding their sexual health. School-based sexual health education is one means in which adolescents acquire this knowledge. Another important source for this information, as identified in the literature, is from their parents. There are a number of studies that suggest that many parents may require support to enhance their ability to effectively communicate with their children about sexual health. Nurses are in a prime position to assist families with sexual health communication. However, there is a dearth in the literature regarding nurses’ involvement in parent-child sexual health communication.

The qualitative research method of focused ethnography was used to investigate nurses involvement with parent-child communication related to sexual health. Data were obtained from twelve community health nurses during audio-taped interviews. Trigger questions were used to explore nurses’ practice related to their involvement with families and sexual health communication.

Content and thematic analyses were used to identify themes in the data. Data analysis revealed that nurses do not necessarily initiate sexual health communication discussion with families. However, families often come to nurses, through the programs they carry out with the public, to ask questions related to sexual health and communication. Nurses support families in a number of ways. Nurses believe that parents are the primary educators of their children and that education should start early. The participants recognized that comfort levels in families around sexual health discussion
varies and can impact communication. Comfort level and lack of resources are factors impacting nursing practice. Education related to sexual health education and supporting families is lacking in undergraduate programs.

The findings can assist nurses and nurse educators to provide support to families with sexual health communication. Undergraduate nursing programs need to integrate sexuality education into their current nursing curricula. More research is required identifying parental needs related to parent-child sexual health communication.
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CHAPTER I
INTRODUCTION

Sexuality is an integral aspect of every human being and is a fundamental part of the personalities of all men, women and children. It encompasses the physical, physiological, psychological, social, emotional, cultural and ethical dimensions of sex and gender (Health Canada, 1994). Therefore, promoting positive sexual health is important for the enhancement of well being for all of us. Although there are many factors necessary for achieving optimal sexual health, the provision of sexual health education is one important strategy that promotes this achievement. Sexual health education (SHE) enables individuals to develop knowledge, motivational skills and critical awareness to enhance sexual health and to avoid sexual problems (Health Canada, 1994, p. 7; Rodriguez, 2000).

Comprehensive sexual health education should be multifaceted incorporating a multidimensional approach that includes school-based sexual health programs, community sexual health programs, and family-based approaches (Jaccard, Dittus, & Gordon, 2000). Parents are the primary sexual health educators of their children and can play an important role in their children’s development of optimal sexual health (Hickling, 1999; Kirby & Miller, 2002; Woody, 2002). A key value inherent in the Guidelines for Comprehensive Sexuality Education (National Guidelines Task Force, 1996) is the notion that “individuals, families, and society benefit when children are able to discuss sexuality with their parents and/or other trusted adult” (p.7). Parents are in a unique position to provide sexual health education explicitly and implicitly. Beausang (2000) stated that parents’ ability or inability to provide sexual health education early in life might
influence aspects of their children's sexual attitudes and behaviour during childhood continuing into adulthood. Whitaker, Miller, May and Levin (1999) describe the positive influence parent-adolescent discussions about sexuality can play on the ability for the adolescent to make responsible sexual decisions further reinforcing the notion that parent-child sexual communication appears to be a strong determinant of adolescent sexual behavior.

Although many parents believe they should be responsible for their child's SHE, the extent to which parents are providing SHE is unclear (Weaver, Byers, Sears, Cohen, & Randall, 2002). A study completed by McKay, Pietrusiak and Holowaty (1998) reported that 70% of parents they surveyed indicated that most parents do not give children the SHE they need. Another study found that only 52% of parents had confidence in the ability to provide their children with SHE. Kirby and Miller (2002) stated that parents find it difficult to communicate with their own children about sexual health (and vise versa) and these discussions occur “infrequently and inadequately” (p. 93).

As a nurse working with adolescents in both clinical and school settings, it has become increasingly apparent to me that there exists a wide variance in parent-child communication about sexual health. Results of the aforementioned studies and my own anecdotal evidence indicate that some parents may require support to assist them in providing sexual health education to their children. Not only are there numerous studies demonstrating the importance of parent-child communication about sexual health in reducing adolescent sexual risk behaviour (Jaccard et al., 2000), encouraging parents to be the primary sexuality educators is currently quite politically acceptable (Kirby &
Miller, 2002). Strengthening the capacities of families and communities to maintain and improve the sexual and reproductive health of their members is an important strategic direction for stakeholders to undertake in the effort to promote optimal sexual health of Canadians (Health Canada, 1999). Healthy sexual development during early childhood is a factor noted to have a profound effect on healthy sexuality and sexual decision-making throughout life (Health Canada, 1999).

Historically, nurses have played a major role in the provision of health education, including providing sexual health education to children, families, and communities. Teaching is an essential component of nursing practice (Bastable, 2003). Public health nurses in particular, are in a prime position to provide a holistic approach to health promotion (Evans, 2000) that includes addressing sexual health education needs. Contemporary public health nursing operates under the premise of a population health approach. A population health approach aims to improve the health of an entire population through implementation of strategies that build the capacity to achieve the health goals and well being of individuals, families, and communities (Health Canada, 2001). A key strategy to build community capacity is to think “upstream”. Thinking “upstream” is defined as providing interventions or actions “earlier in the causal stream” (Health Canada, 2001, p. 19). Nurses working with families to support sexual health communication is a health promotion intervention that is clearly thinking “upstream” in that the goal of this increased parent-child sexual health communication may have a positive impact on healthy child development and personal health practices as these children become adults.
Problem Statement

Nurses can and do play a pivotal role in supporting parent's promotion of their children's development of healthy sexuality through their encouragement for parent-child communication about sexual health. However, the degree to which nurses support parent-child communication varies between nurses. Although there is considerable literature identifying the importance of supporting parent-child communication about sexual health, there remains paucity in the research aimed at identifying how nurses support this. Therefore, research exploring nurses' involvement in parent-child communication related to sexual health is warranted.

Purpose

The purpose of this study was to explore and describe nurses' involvement in parent-child communication related to sexual health and identify factors that influence nurses' practice in this area. Objectives for this study included: (a) to provide information and insight into the current nursing practice related to parent-child communication about sexual health; (b) to understand how nurses foster communication at the different developmental stages of children; (c) to explore nurses' current beliefs and values about supporting parent-child communication about sexual health; (d) to identify how nurses learn to provide and promote parent-child sexual health communication; (e) to identify educational needs to support nurses in their ability to provide parent-child sexual health communication; (f) to identify factors that enhance and hinder nurses' ability to foster parent-child communication about sexual health.
Research Question

What is nurses’ involvement in parent-child communication related to sexual health and the factors that influence this involvement?

Significance of the Research Study

The goal of this research was to provide rich description of the experiences, process and culture of nurses working with families and their involvement in parent-child communication related to sexual health. As a result of the findings from this study, implications for nursing practice, education, research and public policy are elucidated in Chapter 5.

Assumptions

Assumptions are “basic principles that are accepted as being true on the basis of logic or reason, without proof or verification” (Polit & Hungler, 1999, p. 695). The researcher made the following assumptions regarding the research study: (a) nurses share a culture; (b) nursing culture affects the significance a nurse places on the importance of fostering parent-child communication about sexual health; (c) nursing practice and expertise varies from nurse to nurse; (d) the nurses who volunteered to participate in the study shared their honest practice, experiences, values and beliefs around parent-child sexual health communication.
Organization of the Thesis

This thesis is divided into five chapters. Chapter One has provided an introduction to the research study. Included in the introduction is a discussion of the background to the research problem, problem statement, purpose of the research, research question, the significance of the study and assumptions. Chapter Two offers a critical review of relevant literature to the proposed study. Chapter Three presents the research methodology of focused ethnography used in this study. This chapter also provides a description of the sample, sample selection, ethical considerations, data collection, data analysis, and issues of scientific rigor. Chapter Four elucidates the study findings. Finally, Chapter Five concludes with a summary of the study findings. This chapter includes implications for nursing practice, education, research and public policy.
CHAPTER II
REVIEW OF RELATED LITERATURE

In this chapter, relevant literature pertaining to parent/child sexual health communication and the role of nursing are discussed. Literature from the following areas is reviewed: sexual health education, parent-based sexual health education, children's perspectives on sexual health communication and parental perspectives on sexual health communication. Finally, the role of nursing in supporting families with sexual health communication is elucidated.

Sexual Health Education

Sexuality is a fundamental component of being human. It includes "sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction" (Pan American Health Organization & World Health Organization, 2000). The meaning of sexual health differs amongst individuals depending on a diversity of beliefs, values, customs and experiences (Health Canada, 1994). As a result of this rich diversity, it is difficult to have one definition of sexual health that fully represents and encompasses these differences. There is debate noted in the literature related to defining health as this word is often value-defined and carries the assumption of medical authority and objectivity (Health Canada, 1994; Pan American Health Organization & World Health Organization, 2000; Teitelman, 2004).

Despite the debate over assigning a definition to the term "sexual health", health experts and professionals agree that defining "sexual health" is achievable and warranted as long as the definition takes into consideration the sexual rights of individuals (Pan

2. The right to sexual autonomy, sexual integrity, and safety of the sexual body.
3. The right to sexual privacy.
4. The right to sexual equity.
5. The right to sexual pleasure.
6. The right to emotional sexual expression.
7. The right to sexually associate freely.
8. The right to make free and responsible reproductive choices.
9. The right to sexual information based upon scientific inquiry.
10. The right to comprehensive sexuality education.
11. The right to sexual health care” (p.11).

For the purpose of this thesis, the definition of sexual health, as outlined by the Pan American Health Organization (PAHO) and the World Health Organization (WHO) was used. PAHO and WHO defined sexual health as “the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality” (PAHO & WHO, 2000, p. 6). Human beings are sexual across their lifespan. Therefore, sexual well-being can be described as a positive life long process that includes an understanding of self, ability to experience optimal sexual development, the ability to share in relationships including intimacy, and the opportunity for reproduction if desired
(Health Canada, 1999). As an essential component for everyone, sexual health should be supported throughout life.

Significance of Sexual Health Education

Sexual health education is indicated as one strategy to support the development of optimal sexual health. Numerous studies have reported that sexual health education is an important factor that contributes to the well-being of Canadians (Haffner & Goldfarb, 1997; Moore & Rienzo, 2000; McKay, 2000). The Canadian Guidelines for Sexual Health Education (Health Canada, 1994) outlined that “sexual health education should be available to all Canadians as an important component of health promotion programs and services” (p.5). McKay (2000) stated that sexual health education plays a significant role in the prevention of sexual health problems such as unwanted pregnancies and sexually transmitted infections (STIs).

Health Canada (1999) identified that Canadians have unacceptably high levels of sexual and reproductive health problems. Adolescent Canadians appear to be a particularly vulnerable group in terms of experiencing sexual health problems. Although recent epidemiological data indicates a decline in the teen pregnancy rates in Canada, the rates are still considerably higher than in Europe and other developed countries except in the United States (Public Health Agency of Canada, 2006). In a study completed by Darroch, Frost and Singh (2001), Canada was ranked 19th out of 30 developed countries indicating that Canada has a moderate adolescent pregnancy rate. McKay (2004) stated that nearly 40,000 Canadian teens become pregnant every year. Kendall (2003) reported that pregnancy rates in British Columbia range from 8.2 per 1000 females aged 15 to 64.2 per 1000 females 19 years of age, placing British Columbia below the national average.
Unplanned or unwanted pregnancies can have negative impacts on both the health of youth and health care system costs. Pregnant adolescents typically delay access to prenatal care, have higher rates of tobacco, alcohol and other substance use during pregnancy, and are at an increased risk of intrauterine growth retardation and preterm births (Public Health Agency of Canada, 2006).

The Public Health Agency of Canada (PHAC) stated that rates of reportable sexually transmitted infections have increased in recent years (2006). In fact, there has been a substantial increase in STI rates for Canadian females aged 15 to 19 years of age. PHAC (2006) reported that chlamydia, gonorrhea, and HIV infection rates have increased at a disproportional rate in females aged 15-19 years. Sexually transmitted infections can be both life-altering and life threatening.

The National Guidelines Task Force (1996) stated that sexual health education can provide individuals with important health promoting information that can assist in reducing sexual and reproductive risks by forming and transforming knowledge, attitudes, skills and values related to sexuality. Sexual health education is a broad based, community-wide action that requires the collaboration of the educational, medical, public health, social welfare and legal systems of our society (Health Canada, 1994, p. 8). The Canadian Guidelines for Sexual Health Education recognize sources of sexual health education to include families, peers, caregivers, schools and other academic environments, health care settings, public health programs, social service agencies and community organizations (Health Canada, 1994, p. 11).
School-based Sexual Health Education

School-based sexual health education programs have been one avenue to promote knowledge attainment of sexual health. Schools have been identified as an ideal setting for the provision of sexual health education because school is the one location that nearly all people have contact with during their lifetime (PAHO & WHO, 2000). Kendall (2003) concurs that the role of school is universally accepted as a key arena for human physical, social, emotional and intellectual development (p.21).

McKay and Barrett (1999) indicated that there has been an increase in the presence of sexual health education in the formal curriculum of Canadian primary and secondary schools over the last two decades. Advancements in the theory and practice of effective sexual health education have occurred in regards to pedagogical strategies used to enhance the transfer of knowledge (Kirby et al., 1994; McKay, 2000; McKay & Barrett, 1999). Pedagogical strategies include the use of conceptual models that influence the cognitive domain (information); the affective domain (feelings, values, and attitudes); and the behavioural domain (decision-making, communication, and personal skills acquisition) (Fisher & Fisher, 1998; Kirby et al., 1994, McKay & Barrett, 1999; National Guidelines Task Force, 1996).

Over the last twenty-five years, there has been a significant amount of empirical research conducted on the effectiveness of sexual health education, particularly on what constitutes effective sexual health programs (Brown & Simpson, 2000; Darroch, Landry & Singh, 2000; Donovan, 1998; McKay, 2000; National Guidelines Task Force, 1996; Song & Pruitt, 2000). McKay (2000) articulated an effective educational approach in the
prevention of HIV, Acquired Immunity Deficiency Syndrome (AIDS) and other STIs and recommended:

1. Programs aimed at reducing specific sexual risk-taking behaviours, that provide pertinent information, give students the opportunity to develop and enhance motivational, personal insight, and behavioural skills.

2. Programs aimed at providing informative, motivational and behavioural strategies to assist adolescents to delay first intercourse and consistent contraception/condom use (p.133).

Research indicates that Canadian parents and students want schools to deliver sexual health education programs (McKay, 2004; McKay et al., 1998). McKay et al. (1998) reported that parents approved of the provision of sexual health information on reproduction, puberty, abstinence, contraception, STI/AIDS prevention, healthy relationships, sexual orientation, and sexual abuse/rape. A study released from the Council of Minister’s of Education Canada (CMEC) concluded that adolescents view schools as their main source of information about sexual health (CMEC, 2003). McKay and Holowaty (1997) surveyed Ontario adolescents on their preferred source of sexual health information. Results of this survey showed that adolescents rated school as their preferred source of sexual health information, while the family was the second choice followed third by friends.

While these results indicate school as the preferred source for sexual health information, ironically, data generated by the 2002 National Survey of Family Growth reported that teens feel that their parents influence their decisions about sex more than their friends, the media or siblings (Suellentrop, 2006). This information is further
supported by a study conducted by Ipsos on behalf of the Canadian Association for Adolescent Health (CAAH) that reported that 63% of Canadian adolescents considered their parents to be a major source of information on sexual health and 43% of these teens felt that their parents are the most useful and valuable source of information (CAAH & Ipsos, 2006). Although school-based sexual health education plays a significant role in the promotion of healthy sexuality, the literature suggests that comprehensive sexual health education should incorporate multi-targeted approaches that include the parents and family (Jaccard et al., 2000; Hutchinson & Cooney, 1998).

Parent-based Sexual Health Education

As sexual development begins in early childhood, optimal sexual socialization which includes nurturing, the development of intimacy and trust, gender identification, and positive experiences of sexual feelings can have considerable effects on the achievement of optimal sexual and reproductive health throughout the lifespan (Health Canada, 1999). “Comprehensive sexuality education should be taught early in life, should be age and developmentally appropriate, and should promote a positive attitude towards sexuality” (PAHO & WHO, 2000, p.29).

Parents play a significant role in the sexual socialization of their children and can have a profound impact on their child’s achievement of optimal sexual health (Hickling, 1999; Hutchinson & Cooney, 1998; Woody, 2002). “Parents can guide their children toward independent and healthy adult lives, helping the children understand their own sexuality and adopting perspectives that lead to healthy sexual attitudes and orientations later in life are of central importance” (Leland & Barth, 1993, p.11).
Significance of Parent-Child Communication Related to Sexual Health

Parent-child communication is an influencing factor on promoting optimal sexual health in children and reducing adolescent sexual risk-taking behaviours. Effective parent-child sexual health communication is viewed as a multidimensional process consisting of various components (Dittus, Miller, Kotchick, & Forehand, 2004; Forehand, Miller, Armistead, Kotchick & Long, 2004; Jaccard et al., 2000; Kirby & Miller, 2002; Ward & Wyatt, 1994). The components of effective parent-child sexual health communication include the process, content and styles of communication.

The process of sexual health communication involves the frequency and timing of communication. Dittus et al. (2004) recommended that frequency of discussions related to sexual health in families should be ongoing as opposed to a one time occurrence; sequential, building on the child’s development; and time sensitive, addressing the needs of the child as questions arise and/or needs are anticipated. Frequency of discussion about a myriad of sexually topics related to the risks of engaging in sex has been associated with a decrease in sexual activity amongst African-American youth (Dittus et al., 2004). Timing of sexual health discussion is another important aspect in the process of effective sexual health communication. Many studies highlight the importance of timing in regards to parent-child sexual health communication (Dittus et al.; Jaccard et al. 2000; Jaccard, Dodge & Dittus, 2002; Kirby & Miller, 2002; Lloyd, 2004; Miller, Levin, Whitaker & Xu, 1998; Rosenthal, Feldman & Edwards, 1998). Much of the literature reports the importance of parents engaging in sexual health discussion with their children at an early age, prior to the potential onset of a behaviour or process such as puberty changes. A
study conducted by Miller et al. (1998) reported that maternal condom discussions prior to the sexual debut of their adolescent were associated with increased condom use.

Kirby and Miller (2002) stated that parents should provide information about sexual topics and express their values when discussing sexual health with their children. It is recommended that parents provide developmentally appropriate sexual health information (Rosenthal, Senserrick & Feldman, 2001; Teitelman, 2004). Important topics for sexual health discussion include anatomy, adolescent changes, reproduction, sexual behaviour, contraception, STI’s, teen pregnancy, and characteristics of positive relationships (Kirby & Miller, 2002; Teitelman, 2004).

Aspects of communication should be considered when defining effective parent-child sexual health communication. These aspects include communication styles, comfort level, and skill. Teitelman (2004) stated that parents convey sexual attitudes and information explicitly through verbal communication and explicitly through nonverbal communication. Whitaker et al. (1999) highlighted the importance of parents to be opened, skilled and comfortable when discussing sexual health information with their child. A study conducted by Rosenthal et al. (2001) surveyed teens and their parents on the frequency of parental sexual communication and the communicative style when discussing sexuality and in general. The authors’ findings resulted in the development of typology of basic source styles. These four basic source styles included “effective communicators”, “reasonable communicators”, disengaged communicators” and “problematic communicators”. Effective communicators can be described as parents who communicate the most frequently about sexual issues of all the four styles and possess a very positive sexual and general communication style. Reasonable communicators rated
moderately well on positive communication styles for both sexual and general issues. These parents also rated moderately on the frequency of sexuality discussions. Disengaged communicators communicate very infrequently on sexual issues and their communication style is regarded as more negative on sexual issues. The scores for general communication were relatively positive. The last style involves problematic communicators. They are described as parents who communicate infrequently about sexual issues and their style reflects difficulties with both sexual and general communication. Although the authors identify four parental communication styles in relation to sexual health discussion, further work is yet to be done in understanding parent-child sexual health communication.

There are numerous studies providing empirical evidence supporting the importance of parent-child sexual health communication (e.g., Dilorio, Kelley & Hockenberry-Eaton, 1999; Jaccard et al., 2002; Miller, Forehand & Kotchick, 2000; Miller et al., 1998). Correlations between parent-child sexual health communication and delayed onset of sexual activity have been documented (Dilorio et al., 1999; Whitaker & Miller, 2000). Studies support the contention that early sexual communication, before the onset of sexual activity, may be most effective for reducing sexual health risks (Hutchinson, 2002; Miller et al., 1998). Miller et al. (1998) and Hutchinson and Cooney (1998) both reported that parent-adolescent sexual communication is associated with increased condom use. In addition, parent-child sexual health communication has been described as decreasing the risk for STIs, including HIV and teen pregnancy (Blake, Simkin, Ledsky, Perkins & Calabrese, 2001; Kirby, 2002; Miller et al., 2000).
Parents play a pivotal role as educators of their children therefore, are in a unique position to assist in the development and enhancement of their child’s sexual socialization. Children learn about sexuality from their parents at an early age through overt discussion as well as through implicit messages (Teitelman, 2004). Parents teach their children through role modeling (Beausang, 2000). Parents can motivate and guide the behaviour of their children in regards to fostering responsible sexual decision-making (Jaccard et al., 2002). This can occur not only through the dissemination of information, but through the translation of cultural assumptions and conveyance of values and attitudes (Rosenthal et al., 2001; Teitelman, 2004). As school-based sexual health education programs operate on the premise of providing factual and value free-information, parents need to assist their child in learning values and beliefs around sexuality.

Woody (2002) and Hickling (1999) agree that talking to children about family beliefs and values around sexuality is an important, if not essential role of the parent. Possessing personal values and beliefs, in addition to having factual knowledge about sexuality are important to the adolescent sexual decision-making process (Woody, 2002). For example females who discussed beliefs regarding the timing of initiating sexual activity with their parents were less likely to be influenced by whether their peers were having sex (Hutchinson, 2002). This further supports the notion that parent-child discussion about values and beliefs around sexual activity, such as the example of timing of the initiation of sexual activity by adolescents, can positively influence sexual decision-making and potentially decrease sexual health risks.
Despite the evidence supporting the importance of parent-child sexual health communication, critics argue that parents may not always provide appropriate and accurate sexual health information to their children. Jaccard et al. (2002) stated that skeptics believe that parents have misinformation regarding birth control; that adolescents are peer-oriented versus parent-oriented therefore parents' influence is limited; and that sexual communication between the parent and child in dysfunctional homes may be ineffective as parents may have abandoned the traditional parental role.

Experts refute these notions claiming that although parents may have inaccurate information and knowledge about sexual health related content, education can be provided to parents (Jaccard et al., 2002). In regards to adolescents being peer-oriented with little influence coming from parents, a study conducted by the National Survey of Family Growth stated that parents do influence their adolescents' decisions (Suellentrop, 2006). Finally, regardless of the likelihood that parent/child sexual health communication may be ineffective in dysfunctional homes, teen pregnancy and STIs are not limited to dysfunctional families (Jaccard et al., 2002).

The literature states that parents often feel they need to provide “the big talk” once while their child is entering early adolescence and then believe their role in the sexual socialization of their child is complete (Jaccard et al., 2002). Hutchinson (1998) suggested that in order for sexual communication to be most effective, communication needs to start early, with children as toddlers, and be ongoing.

Some parents use fear tactics as a means to instill the negative effects of sexual activity. Social psychologists suggest that this may cause the child to have negative thoughts and feelings which may lead to unhealthy views towards sexuality (Jaccard et
al., 2002). Horner (2004) stated that parents who view sex as dirty and punish a child for normal healthy sexual behaviour may instill feelings of guilt or shame in the child.

There are a small number of studies that failed to find a relationship between parent-child sexual health communication and sexual risk behaviour (Jaccard et al., 2002; Miller, 2002). In fact, one study reported a negative relationship between parent-adolescent communication and sexuality (Widmer, 1997). Jaccard et al. (2002) claimed that many of these studies used poor measurements, inappropriate conceptual models and inadequate research design. A significant number of studies conclude that parent-adolescent communication is associated with a decrease in adolescent sexual risk-taking.

Parent-based sexual health education initiatives can be one means of assisting parents to help their children to achieve optimal sexual health. These initiatives are aimed at providing parents with knowledge, skills and strategies to enhance parents’ abilities to support their child’s sexual development and socialization.

Approaches aimed at supporting parents and their families with sexual health have many advantages. Jaccard et al. (2002) stated that these approaches allow parents to discuss sexual health in a manner that is consistent with their values, enable the parent to tailor the information to the developmental age and stage of their child taking into consideration the social and familial context of the child, and finally, parents can affect other areas of their child’s life such as the monitoring and supervision of activities occurring on weekends, after-school and nighttime, aspects that are unreachable for schools and clinics. Parent-based sexual health approaches may have a positive impact on increasing sexual health communication, a factor that has been empirically proven to have enhancing effects on decreasing adolescent sexual risk-taking.
Although there are numerous studies supporting parent-child sexual health communication, recent literature yielded results indicating that many families are not engaging in sexual health discussions (Hutchinson & Cooney, 1998; Jaccard et al., 2000).

Children’s Perspectives on Sexual Health Communication

To assist in better understanding the significance of parent-child communication about sexual health, it is important to view both children’s and parent’s perspectives on the subject. A paucity of literature in this area indicates that children’s and parental perspectives regarding sexual health communication have been understudied. A lack of research may reflect a gap in understanding the dynamics involved in parent-child communication about sexual health and is an important issue to address.

The findings from two New Brunswick-based studies (Byers et al., 2003) indicate there remains a gap in students receiving sexual health education at home. Slightly more than half of middle-school and high-school students (53% and 54%, respectively) reported wanting more information about sexual health. Furthermore, the majority of students in both groups reported that their parents rarely encouraged them to ask questions about sexual health (76% of middle-school students and 80% of high-school students).

A comparative study by Duberstein Lindberg, Ku and Sonenstein (2000) also confirm some of the findings from the previous studies. This study examined changes between 1988 and 1995 in American male youth reports of the prevalence, content and timing of their SHE from school-based curriculum and their parents. The data for this research were derived from the 1988 and 1995 National Survey of Adolescent Males
The results of the study indicated there was limited change in the level of communication between parents and their sons from 1988 to 1995. Approximately half of teenage males reported having discussed sexual health topics with his parents. The study did report an increase in communication between parents and their sons on the topic of unplanned pregnancy, increasing from 49% in 1988 to 56% in 1995. The topics of AIDS, sexually transmitted infection’s and birth control did not show any significant increases.

**Parental Perspectives on Sexual Health Communication**

Understanding parental perspectives on parent-child communication about sexual health is also important and may enhance nurses’ understanding of factors that influence parent-child sexual health communication. As mentioned previously, a recent project completed in New Brunswick examined parental attitudes and experiences of sexual health education at school and home (Weaver et al., 2002). One of the study’s goals was to elicit suggestions regarding what could be done to support parents’ efforts to provide SHE at home.

A total of 4206 questionnaires were completed by parents with students in 30 New Brunswick schools in the spring of 2000. A vast majority (95%) of parents surveyed felt that both parents and schools play a role in providing sexual health education. Almost the same number of parents (94%) supported school-based SHE. Parents rated personal safety, puberty, abstinence, reproduction and sexual decision making as extremely important to cover in SHE and wanted most topics covered by grades 6-8.
Only 38% of the parents reported that they felt they did an excellent or very good job of providing SHE to their children. This result closely matches the responses of the middle and high school students participating in this same study (Byers et al., 2002). According to this research, parents and their adolescents have indicated a gap in parents’ ability to provide SHE for their children. Parents’ responses on how their efforts to provide SHE at home could be supported included such strategies as informing parents of school-based sexual health curriculum content their child is receiving and by providing educational sessions for parents focusing on strategies for approaching and discussing sexual health topics with their children at home. The outcome from this research identifies important strategies to include when developing SHE programs that foster parent-child communication about sexual health.

Another study supporting the need to provide parents with strategies to foster communication with their children about sexual health is reported by Miller, Kotchick, Dorsey, Forehand and Ham (1998). The authors examined communication between parents and adolescents on ten sexuality topics. Results of the study indicated that more than half of mothers and their adolescent children reported parent-child communication on the ten sexual topics, in particular, on such topics as HIV/AIDS, sexually transmitted infections, condom use, and pressures to have sex. However, a sizeable proportion of the sample had not discussed many of the sexuality topics.

The findings from this study also suggest that gender of adolescent influences the gender of the parent with whom discussions occur, that is, that mothers are more likely to discuss sex with their daughters and fathers are more likely to discuss sex with their sons. Much of the research conducted on parent-child sexual health communication describes
the influence of mother-child sexual health communication on sexual health risk-taking.

To develop a deeper understanding of factors impacting parent-child sexual health communication, more studies need to be conducted on father-child sexual communication.

An Australian study also described the results of a qualitative study conducted to determine Australian parents' approaches to sexuality education in their homes and the messages they deem important to convey to their children (Berne et al., 2000). The results of the study concluded three common beliefs prevalent amongst the parent participants. Firstly, most parents believed it is unethical and pointless to dictate sexual decisions of their children; they felt it was better to provide their children with skills and knowledge to assist them to make informed choices. Next, Australian parents value relationships over casual sex and encourage their youth to protect themselves and their partners if they are sexually active. Finally, these parents place great trust in school-based sexual health curriculum to provide SHE that enables a developmental approach to sexual behaviour and sexual responsibility, emphasizing protection of self and others.

Nurses' Role in Supporting Parent-Child Sexual Health Communication

Despite the abundant literature available on the importance of supporting and promoting optimal sexual health, there is limited published research on nurses' role in fostering parent-child sexual health communication. Of the research reported, most of the literature identifies nurses' role, community health nurses in particular, in the provision of sexual health education to be primarily involved with providing sexual health education programs to children and youth in the school-setting (Baraitser, Dolan
Cowley, 2003; Barnes, Courtney, Pratt & Walsh, 2004; Hickling, 1999), the work they do with adolescents in health clinics (Baraitser et al., 2003) and the care and teaching that is given in the communicable disease clinics (Stamler & Yiu, 2005). Gamel, Davis and Hengeveld (1993) stated that the professional associations of nursing, nurse educators, other disciplines have identified that sexuality and sexual problems are considered components of nursing care.

Bastable (2003) stated that client education is a major component in the work of nurses and has been dated as far back as the days of Florence Nightingale. In fact, expectations of nurses include teaching within the scope of nursing practice to provide information and education to health care consumers to assist them in maintaining optimal health, preventing disease, managing illness, and developing skills necessary to provide supportive care to family members (Bastable, 2003).

Nurses, particularly community health nurses are in a prime position to assist in the development and provision of holistic services, which includes addressing sexuality (Evans, 2000). Community health nurses provide a wide variety of services to a broad population on one-to-one, group and community bases. Community health nurses work with clients and families from preconception, teaching prenatal classes spanning across the lifespan to the aging population during flu clinics. Lewis and Bor (1994) commented that nurses are ideally placed to discuss sexuality with their patients due to the intimate nature of the nurse-client relationship.

Nurses' Role in Health Promotion

Health promotion is commonly viewed as foundational in contemporary community health nursing (Stamler & Yiu, 2005). There are various definitions of health
promotion. O’Donnell (1987) defined health promotion as “the science and art of helping people change and their lifestyle to move toward a state of optimal health” (as cited in Edelman & Mandle, 2002; p. 16). In 1986, the Ottawa Charter for Health Promotion was adopted and served as a widely accepted approach in the new era of health promotion (Stamler & Yiu, 2005). The Ottawa Charter outlines five health promotion strategies: (a) strengthening community action; (b) building health public policy; (c) creating supportive environments; (d) developing personal skills; and (e) reorienting health services.

Since the development of the Ottawa Charter, the area of health promotion has evolved to the population health concept. Health Canada (2001) defines population health as follows:

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.

As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.

In 1996, the Population Health Promotion Model was developed by Health Canada to integrate the concepts of the Ottawa Charter and population health (Hamilton & Bhatti, 1996). The model is a combination of the health promotion strategies from the Ottawa Charter, the determinants of population health and levels of intervention. Community health nurses are in a position to play a strong leadership role in health promotion and population health (Stamler & Yiu, 2005).

One means in which community health nurses have taken a leadership role in health promotion and population health is through the adoption of a macroscopic
approach in their practice. Butterfield (1997), in her critique of traditional nursing practice, suggested that community health nurses needed to integrate a macroscopic or "upstream" approach versus a microscopic or "downstream" approach in their nursing practice. Butterfield's recommendation was based on McKinlay's (1979) "upstream-downstream" analogy of the dissatisfactions with medical practice. McKinlay (1979) used the example of a swiftly flowing river to represent illness. In his representation, McKinlay described how physicians get so caught up in rescuing victims from the river (thinking downstream) that they are unable to see who or what is causing their patients into the hazardous waters. Thinking upstream would enable the health care professional to see where the real problem exists. Furthermore, Butterfield (1997) urged nurses to examine interfamily and intercommunity themes in health and illness, whilst investigating social, economic and environmental precursors of illness (p.70).

Community health nurses and the programs they provide are clearly thinking upstream or utilizing a macroscopic approach as many of these programs are considered primary prevention. Much of community health nurses' work is considered primary prevention, a level of health promotion. Primary prevention programs reduce the risks for potential problems as it precedes disease or dysfunction (Edelman & Mandle, 2002). Primary preventative interventions include education such as providing sexual health education and protection such as immunization for Hepatitis B.

Supporting families in communicating about sexual health is clearly a macroscopic approach to health promotion as it may have a positive impact on healthy child development and personal health practices as these children become adults. Community health nurses can play a unique role in this health promotion initiative as
they influence and guide families in opening up sexual health discussion (Smith, 1993). However, nurses’ involvement in this health promotion strategy has been understudied.

**Factors Influencing Nurses’ Provision of Sexual Health Communication with Clients**

Although the literature identifies nurses as being in a prime position to assist families with sexual health communication, there are few studies exploring why nurses may or may not be carrying out this health promotion initiative. The lack of research in this area indicates that further investigation on this topic is warranted. Much of the limited research conducted on examining factors influencing the provision of sexual health communication with clients involves studies completed with health care provider’s collectively (McKelvey, Webb, Baldassar, Robinson & Riley, 1998; Meerabeau, 1999; Skelton & Matthews, 2001).

Gamel et al. (1993) explored nurses’ provision of teaching and counselling on sexuality. The researchers reviewed literature and the results identified five influencing factors impacting nursing care behaviours related to sexual teaching and counselling. These factors included level of sexual knowledge, attitudes towards sexuality, opinion about professional roles and tasks, comfort with sexuality and participation in continuing education activities.

McKelvey et al. (1998) similarly identified sexual attitudes and level of sexual knowledge and skills as factors that may influence medical and nursing students practice related to sexual history taking and counselling. This study also found that background and sociodemographic variables impacted sexual attitudes amongst the student participants.
Another study by Lewis and Bor (1994) revealed that nurses' practice regarding discussion of sexuality with patients was influenced by the degree of sexual health knowledge and attitudes about sexuality held by nurses. Results of this study indicated that nurses with greater sexual health knowledge had more liberal attitudes on the subject and were more inclined to discuss sexual health with their patients. Furthermore, the authors highlighted the importance of education in decreasing nurses' reticence and discomfort related to providing sexual health teaching and counselling.

Summary

The literature presented attempts to place the current study within the context of available research on nurse's involvement with parent-child sexual health communication. In this chapter, literature on the significance of sexual health education was described initially. Next, literature reviewing the implication for parent-child sexual health communication was explored. Research elucidated in this section provided justification that parent-child sexual health communication is a factor influencing adolescent sexual risk behaviour. To give a broader picture on aspects of parent-child sexual health communication, literature reviewing both children's and parental perspectives was provided. Finally, nurses' role in supporting parent-child sexual health communication was discussed.

In summary, despite the evidence supporting the significance of parent-child sexual health communication, there is a paucity of nursing literature describing nurses' involvement in parent-child sexual health communication. Therefore, the study
examining nurses' involvement with parent-child sexual health communication may provide insight into this question.

Chapter Three will describe the research method used to gather and analyze data to investigate nurses' involvement in parent-child sexual health communication.
CHAPTER III
RESEARCH METHODOLOGY

The research question for this study is "What is nurses' involvement in parent-child communication related to sexual health and what are the factors that influence this involvement?" The qualitative method of ethnography was chosen. Qualitative methods are an acceptable research approach to employ to explore a phenomenon where there is a dearth of knowledge (Guba & Lincoln, 1994). Qualitative methods allow for exploring the depth, richness and complexity inherent in the phenomena and to learn from the participants in the setting the way they experience it (Morse & Richards, 2002).

According to Spradley (1979) "ethnography means learning from people" (p.3). The people, in this case, were nurses working with families. The use of ethnography allows the researcher to understand the cultural perspective of members of a group including their beliefs, values and behaviours (Morse & Field, 1995; Spradley, 1979). In a culture, the members usually share a language that categorizes and gives meaning to the ideas, values, norms, and systems around them (Morse & Field, 1995). Nursing is a part of a distinct culture that has shared values, meaning, language and practices.

Focused ethnography was used to elicit information on a special topic or shared experience (Morse & Richards, 2002, p. 53) and conducted with a cultural group such as nurses who provide sexual health education. As traditional ethnography involves at least one year in the field, focused ethnography was employed for this study as the research was undertaken in a shorter period of time and with a specific focus (Harrison, 2005).
In this chapter the participant selection process, data collection procedures and method of data analysis are discussed. Conclusion of this chapter includes the strategies the researcher used to ensure rigor and a description of ethical considerations.

Selection of Participants

As ethnographical methodological inquiry attempts to describe the relevant experience representing the phenomena, selection criteria were consistent with the requirements of this research method. Guidance for selecting appropriate study participants was taken from Spradley (1979). Spradley stated that it is important for the informant to have thorough enculturation and current involvement. Thorough enculturation is dependent upon education and experience. "In general, an informant should have at least a year of full-time involvement in a cultural scene" (Spradley, 1979, p.48). The participants selected all had relevant experience representing the cultural scene and were currently working in the area explored. The participants were representative of nurses working with families who may or may not provide SHE to parents and/or children. Purposeful sampling was used. Purposeful sampling is a sampling technique whereby the researcher selects participants because of their characteristics such as knowing the required information, having the ability to reflect on and articulate the phenomena of interest, and having the time and willingness to participate (Spradley 1979).

Selection criteria of study participants included community or Public Health Nurses working in the Central Vancouver Island region of the Vancouver Island Health Authority (VIHA) who have worked with families for at least one year. Because a
majority of the nurses working with families work in the Community or Public Health Agency settings, participants were recruited from Public Health Units. The geographical area in which participant recruitment took place was in the Central Vancouver Island area of the VIHA. This area included Duncan, Nanaimo, Parksville and Port Alberni. The Health Units located in the aforementioned cities were chosen because although they are different health units with unique population needs, they share common philosophies, policies and programs.

Sample

Upon receiving approval from the University of British Columbia and VIHA Ethical Approval Committees, access was formally obtained through VIHA. The researcher met with Managers for VIHA Central Vancouver Island Region to obtain their assistance in recruiting nurses to participate. The researcher attended staff meetings which provided an opportunity for the researcher to discuss the purpose of the study, participant selection criteria, trigger questions to be used during the interview process, and to answer questions pertaining to the research. At that time, A Letter to Nurses (Appendix A) was given to the Community or Public Health Nurses. The researcher displayed information posters in pertinent clinical areas to explain the study and recruit participants. The posters explained the study and provided contact information, such as a phone number and email address, for those individuals interested in participating in the study.

If the nurse was interested in participating in the study and was a suitable candidate, the researcher scheduled a mutually agreed upon interview time and location.
A Study Participant Consent form (Appendix B) was signed by all participants prior to commencement of the interviews. Twelve Public Health Nurses (PHNs) were interviewed. All informants were between 25 and 65 years of age. Each participant had been employed in the area of Public Health Nursing for more than one year. Three PHNs had greater than 20 years working in the area of public health nursing. All participants had between 1 and 26 years of experience working with families.

Data Collection Procedures

Data collection techniques in focused ethnography involve informant interviews and field notes (Morse & Richards, 2002). In order for the researcher to understand the shared meaning and practices around parent-child sexual health communication, interviews with informants of the culture and journal reflection of the researcher are means to ensure ethnography is holistic, reflexive, and is able to present from the emic or insider perspective (Morse & Field, 1995).

Interviews were conducted in a mutually agreed upon location that promoted a comfortable, quiet and non-threatening environment for the participants. The locations included Health Units, participant’s homes and on one occasion, the home of the researcher. Each interview session ranged in length from 45 minutes to 90 minutes. The researcher used open-ended questions during the interview (Appendix C). The conversations were audiotaped, with consent from the participant, and transcribed verbatim. A confidential secretary transcribed the interviews. The researcher checked the transcription for accuracy. Field notes were used to document data such as participant’s
nonverbal communication, session environment and setting, and the researcher's impression of the interview.

At the beginning of the interview, it is important for the ethnographer to explain the purpose of the interview, obtain consent, and then ask questions, keeping the conversation friendly and casual (Spradley, 1979). The researcher employed these techniques to assist in developing rapport, which is critical in promoting a comfortable environment for the participant. If the participant is comfortable, this will encourage use of the usual language of participants describing the phenomena (Morse & Field, 1995; Spradley, 1979).

Ethnographical questions used during the interview (Appendix C) were descriptive, structural and contrasting (Spradley, 1979). Descriptive questions assist in eliciting the participant’s use of language to describe an event. An example of a descriptive question used asked the nurse to describe his or her current practice related to parent-child communication about sexual health. Structural questions complement descriptive questions as they function to explore how participants organize their knowledge which assists the researcher in discovering the domains of the cultural knowledge (Spradley, 1979). “If you provide strategies to help families talk about sexual health issues, what are some of these strategies?” is an example of a structural question used during the interview process. Contrast questions can be used to discover the values placed on a set of symbols such as words. In this circumstance, the contrast questions identified meaning of language used by the participant. Rating questions are an example of contrast questions. During the interviews, the researcher asked the participants to
identify sexual health communication topics parents could or should discuss with their children at the child's various developmental milestones.

Another important data collection strategy employed was the use of field notes. Condensed field notes were taken during actual interviews. These included single words or phrases used by the participant. The researcher used expanded field notes to document a deeper version of the condensed version of the field note. These notes included salient points or thoughts that occurred to the researcher after the interview. The researcher journalled her perceptions about the interview and the nurses as she knew many of them. Although the researcher knew these nurses, she did not fully know their practice around parent-child sexual health communication. The researcher also added reflections about her own previous experiences in regards to her nursing practices working with families. These reflections enhanced reflexivity in the study design (Hammersley & Atkinson, 1995). Expanded field notes were documented as soon as possible after each interview. These expanded field notes and journal perceptions were documented in a word processing format using the researcher's lap top computer. The expanded field notes and journal were kept in the same confidential manner as the taped interview.

Data Analysis

Analysis of the data occurred concurrently with data collection and is consistent with the research method of ethnography (Morse & Field, 1995). A process of content analysis was initiated after the first interview. The process of analyzing the data concurrently allows for the raising of new questions for further data collection. Data analysis began after the initial session with the participant and continued throughout the
To analyze the data, the researcher reviewed the interview, field notes and journal transcripts. The researcher read and reread the data to better understand and identify patterns to develop thick description. Constant validity checking was employed by the researcher. Constant validity checking is a process of switching back and forth between the etic perspective (the researcher’s viewpoint) and the emic perspective (participant’s viewpoint) and testing the first against the second (Boyle, 1994, p. 181). The researcher continued this process with all the transcripts.

All data were coded. As the same questions were asked of all study participants, question analysis was employed. Coding of the data involves identifying significant words, phrases, themes or concepts from the data and subsequently labelling the data descriptively (Morse & Field, 1995; Morse & Richards, 2002). The codes were listed in a column to the right of the data on the transcript. These descriptive codes or units of meaning were derived from significant statements, phrases, or sentences extracted from the transcriptions that exemplified the phenomenon studied (Streubert Speziale & Carpenter, 2003). The initial sorting of the codes was organized by the broad questions for example ‘What enhances your ability to support parent-child sexual health communication?’

The next phase of data analysis involved examining the data carefully to assist in identifying recurrent patterns. After the descriptive codes were identified, the researcher reread the codes to uncover commonalities and discrepancies amongst the data, assisting the researcher in identifying recurrent patterns. The patterns could be tacit or explicit examples of the culture (Streubert Speziale & Carpenter, 2003). To assist in organizing the patterns, coloured highlighter pens were used to distinguish between the various
meaning units. For example, the recurrent code of comfort with sexual health discussion was identified as a common code or meaning unit and was highlighted with a yellow highlighter pen.

Once data saturation was reached, the researcher arranged the codes into broader categories or themes. Data saturation is defined as the collecting of data until a repetition or redundancy of data is obtained or identified (Polit & Hungler, 1999; Streubert Speziale & Carpenter, 2003). Theorizing began by establishing linkages through the identification of beliefs and values embedded in the data. These etic-emic distinctions were then linked with established theory as suggested by Morse and Field (1995). At this point, the researcher met with her faculty advisors to discuss the salient themes from the content analysis and further deepen the analysis. Once themes and patterns were identified, the researcher invited the participants to review and reflect on the analysis results to validate the findings and ensure the emic or participant’s perspective is represented.

Morse and Field (1995) describe the final step of analysis to be recontextualizing the interpretation and implications of the findings to other settings. This was accomplished through the comparison to relevant studies. Although there is paucity in the literature in relation to nurses’ involvement with parent-child sexual health communication, the preliminary findings may suggest that public health nurses’ beliefs and practices may be similar in other health authority areas in British Columbia.

Strategies to Achieve Rigor

Rigor in research is imperative to the development of trustworthiness of the result (Morse & Field, 1995). Strategies to achieve rigor in this study include those criteria
outlined by Sandelowski (1986). These criteria include credibility, fittingness, auditability, and confirmability.

Credibility

Sandelowski (1986) defines credibility as the truth value or internal validity of the study. This was ensured throughout the study by means of the participant selection process, participant validation participation and bracketing by the researcher.

Steps were taken by the researcher during the participant selection process to ensure the PHNs interviewed had sufficient enculturation and cultural scene involvement. This enhanced the researcher’s ability to capture a variety of participants’ experiences and practices working with families.

Credibility was strengthened when the researcher invited the participants to verify her findings to ensure it was representative of their emic perspective. Two experienced researchers, the University of British Columbia School of Nursing Faculty thesis advisors, were asked to confirm the data analysis process to ensure that the “decision trail” was easily followed.

The researcher recognized her own knowledge and experiences with the topic and her previous working relationships with some of the participants as a potential bias. She addressed these issues by bracketing her thoughts during the data collection and data analysis phases. Bracketing involves setting aside one’s prior knowledge, experience and theories about the phenomenon to enable the researcher to view the data as it was described (Morse & Richards, 2002, p. 146). This was accomplished through journaling her feelings, personal impressions, and ideas that occurred after each interview. She also discussed her feelings with her faculty thesis advisors. Bracketing also prevented the
researcher becoming enmeshed with the participants despite having an emic perspective. Hammersley and Atkinson (1995) describe this as ‘over-rapport’ with participants.

**Fittingness**

Fittingness or applicability refers to the degree to which findings from a study can fit into the experiences of others who are not within the context of the study situation (Guba & Lincoln, 1994; Sandelowski 1986). To enhance fittingness, the researcher chose study participants representative of the particular group studied. In this case, participants included public health nurses working with families. Sandelowski (1986) describes the importance of avoiding elite bias to achieve fittingness of the study. Elite bias has been described as the overweighting of one participant’s contributions and attributes over another participant’s. The researcher avoided elite bias by including quotes from all participants in the analysis thereby equally weighting their contributions to the study.

**Auditability**

Sandelowski defines auditability as the ability of another researcher to follow the “decision trail” of the investigator (1986, p.36). The researcher’s audit trail was comprised of journal entries, field notes, and memos to record ideas arising from the data analysis. To enhance auditability, the researcher requested that experienced researchers, in this case, her thesis advisors, assist with data analysis. The advisors verified emergent themes from the data.

**Confirmability**

Confirmability refers to the objectivity of meaning or relevance of the data and is considered to be achieved when two or more independent people confirm this meaning (Polit & Hungler, 1999; Sandelowski, 1986). Guba and Lincoln (1994) suggest that
confirmability occurs when adherence to credibility, fittingness and auditability are accepted. Confirmability was achieved when the researcher returns to the participants to confirm accuracy of the interpretation of data and findings. The researcher kept a reflexive journal consulted with her faculty advisors to discuss any biases.

Ethical Considerations

The study was approved by both the University of British Columbia Behavioural Research Ethics Board (Appendix D) and the Vancouver Island Health Authority Research Review and Ethical Approval Committee. The following steps were taken to protect the nurse participants in this investigation:

1. All potential participants were informed verbally and in writing, of the purpose of the study, the data collection procedure and that their participation was voluntary (see Appendix A).

2. The participant contacted the researcher voluntarily to take part in the study. Mutually agreed upon meeting dates and locations were designated.

3. At the time of the interviews, all participants were told verbally and in writing that participation was voluntary and withdrawal from the study could occur at any time.

4. A written consent was obtained from all study participants (see Appendix B). The voluntary nature of participation was emphasized.

5. Tapes, disks, transcriptions, and documents were coded to remove any identifying characteristics. Access to the tapes was limited to the researcher, a confidential transcription secretary and her thesis committee. Tapes, disks, transcriptions are
kept in a secured and locked file when not in use and all electronic copies of the
data are stored on a password protected computer.

6. Tapes and transcriptions will be destroyed when all scholarly work is completed.

Summary

The methodology of focused ethnography was selected to guide this investigation.
In this chapter, focused ethnography was described and the rationale for using this
method to address the research question was elucidated. This qualitative research method
enhanced in the development of rich description of the experiences, process and culture
of nurses working with families and their involvement in parent-child communication
related to sexual health. Selection criteria, sampling, data collection and analysis,
strategies to achieve rigor, and ethical considerations were outlined in relation to this
study. Results of the study findings are presented in Chapter 4.
CHAPTER FOUR
FINDINGS

Throughout the conversations, participants shared stories about their nursing experience in relation to the research question. The nurse's experiential knowledge provided rich descriptions reflected in the findings reported in this chapter.

The organization of this chapter reflects the emergent themes from the data analysis process. The findings are presented under the following headings: nurses' involvement with families including strategies used with families; values and beliefs around parent/child sexual health communication; and factors that enhance or hinder nurses' ability to support families with sexual health communication.

Nurses Involvement with Families

Programs delivered by public health nurses working in the central island region of VIHA did not specifically include a program that supports families with sexual health communication. Despite the absence, nurses described their involvement with families in relation to sexual health communication during the interviews. Although this involvement was not an everyday occurrence, nurses were able to provide rich descriptions of examples of this taking place in their practice. Nurses' involvement with families is placed into two contexts. These two contexts include nurses' involvement with families on formal and informal bases. Nurses' formal and informal contact with families are elucidated. Two themes emerged through thematic analysis regarding nurses' work with families. The themes are: (1) Nurse as Resource; and (2) Helping Parents Initiate the
Conversation. Strategies used by nurses to support parent/child communication are discussed within the realm of these two themes in regards to nurses’ work with families.

**Formal Contact**

Formal contact refers to nurses’ involvement with families vis-a-vis the work they carry out delivering the programs as mandated by VIHA Central Island. These programs include those under the auspices of early childhood health which includes maternal health, school-aged health, youth health clinic, and communicable disease and travel. Some of the nurses interviewed for this study stated that they worked on specific teams such as early childhood health team or school-aged health team, however, a few of the nurses interviewed worked across the spectrum of teams providing care to a diverse population base.

Nurses working on the early childhood/maternal health team provided prenatal teaching, maternal/newborn postpartum assessments, breastfeeding counseling, well-baby clinics, and immunizations. In the central Vancouver Island region of VIHA, prenatal classes are offered free of charge to parents. Public health nurses teach a series of prenatal classes both outside and in the hospital setting. These classes include information related to healthy nutrition, newborn development, child safety, breastfeeding, and labour pain management. Once the mother has delivered her child, a public health nurse contacts the family within 24-48 hours to complete maternal and newborn postpartum assessments and assist with any questions or issues that may arise. The family is seen by the nurse either in the health unit or a home visit is scheduled. The new family is followed up for at least eight weeks postpartum or longer if required. At two months of age, the infant is scheduled for its first well baby clinic visit. Assessments
are completed on both the infant and mother at this time. The first of a series of free immunizations is given to the child as directed and funded by the British Columbia Centre for Disease Control (BCCDC). The child will be subsequently seen for growth and development assessment and ongoing immunizations at four months, six months, one year of age and eighteen months. During this time, the mother is also contacted to complete postpartum depression screenings. Nurses also provide breastfeeding support and counseling. The early childhood teams of public health nurses also see children prior to starting kindergarten for their next assessment and immunizations. The nurses are available to answer questions that parents may have pertaining to the health and well-being of themselves and/or their children.

Nurse participants working on the early childhood/maternal health team acknowledged that they do not specifically see families related to sexual health communication. However, these nurses did state that they do get questions from parents related to the sexual health of their child. Many of the questions received pertained to circumcision decisions and appropriate sexual behaviours for example genital exploration and masturbation particularly with parents of toddlers. Nurses also described providing sexual health information to expectant parents during prenatal classes. When asked what they might do in their practice that might help families talk about sexual health issues with their child, in particular with families of infants, one nurse replied:

In the first home visit you’re dealing with the baby’s body and proper hygiene and sometimes if it’s a female child like pseudo menses or a little bit of breast tissue engorgement in the baby from mom’s hormone. Sometimes you’re dealing and at that visit too you’re talking about birth control for mom and dad...if it’s a boy quite often there’s a circumcision discussion and trying not to put your own personal viewpoints in there...But helping them get accurate information...Then in future visits, sometimes you have masturbation questions...So sometimes you’re answering those at home visits for the first bit because a sibling is that age.
This example describes how nurses working with families with infants answer questions around the normal sexual health and development of their child. Nurses interviewed spoke about the opportunities at these visits to “introduce parents to their child’s sexual health” and some nurses agreed that this is a role that public health nurses could be doing more of in their practice.

The school-aged health team of public health nursing provides immunizations, delivers health promotion programs, and provides support to families, schools and the community. Nurses working on this team provide free immunizations to school-aged children, primarily those entering kindergarten, grade six and grade nine as recommended and funded by the BCCDC. When a child receives his kindergarten immunization, a health review assessing growth and development is completed. Referrals may be made to other health care providers if necessary. School health promotion programs include classes taught to students on topics such as tobacco and drug prevention, tobacco cessation, and sexual health. At some health units, the public health nurses teach the content to the students in the classroom setting. In other areas, a team of youth health educators provide the teachings. The youth health educators are high school students who are trained by public health nurses to deliver health promotion programs to elementary and junior high school students in the classroom setting. These health promotion classes include topics such as tobacco prevention, drug prevention, and sexual health education. Nurses are available to answer questions from the public pertaining to school-aged health issues such as childhood diseases and concerns.

Nurses working with this population described receiving questions from families mostly related to puberty and how to talk with their children related to these changes.
Sometimes, parents would ask the nurses how to talk to their child about sex. Often parents would contact the nurses via the telephone or in person at the health unit or while the nurse was at their child’s school. The following quote provides an example:

I have had parents come in and ask me about ways they can bring up puberty changes or even sexual, like sex, how do they talk to their child about sex. Like encouraging them to talk to their child and not to kind of ignore the whole issue...more puberty than anything. But I think I have had one or two phone about or come in about sex and how to start that whole conversation around the dynamics of it... I have also encouraged them (parents) to also go by their child’s cue.

Many of the study participants talked about parent education sessions that had been done in the past. These educations sessions were developed to provide an opportunity for public health nurses to meet with parents of school-aged children, to discuss sexual health classes that their children would be receiving at school. The public health nurses or youth health educators (under the guidance of the public health nurses) would be teaching this content in the school classroom setting. Parents could ask the nurses questions about the sessions such as content taught, and in some cases, the parents would also ask questions pertaining to sexual health or how to communicate with their child about sex. The nurses all stated that these sessions were not well attended by parents, especially once the parents became more knowledgeable and comfortable about knowing what their child would be learning. After a while, the sessions were stopped and not provided again.

All of the health units located in the central Vancouver Island region of VIHA offer youth health clinic services. Public health nurses provide reproductive health education, counseling and services to youth. The age of the youth vary depending upon the health unit area and the needs of the population within that geographical area. Youth
access the youth health clinics services during specific hours set by the health unit. Youth may be seen outside clinic hours if necessary. Nurses provide sexual health education, counseling related to sexual decision making which includes contraception management and sexually transmitted disease prevention, testing and treatment, pregnancy testing, counseling and referral, and Papanicolaou testing. A physician is, in most circumstances, available to see youth clinic clients that fall outside the scope of practice of the public health nurse.

Nurses often see youth only accessing the services, however, many of the nurses described working with the youth and their families (most often the mother). Youth clinic clients may bring their parent in to the youth clinic during their visit. Some nurses described parents bringing their adolescent youth to the clinic, sometimes against the youth’s wishes. In other situations, parents would call or come into the health unit to ask questions pertaining to their child’s sexual health or for strategies to talk to their child about sexual health. Nurses stated that they have talked with youth about strategies on how they could talk to their parents about sexual health as evidenced by this nurse’s experience:

If we get a youth in who is pregnant, you always have to have that discussion “Have you told anyone else that you think might be pregnant?” And maybe offering some strategies on how they could tell their parent...and we always have to have that discussion too about birth control pills. Sometimes we will see a girl, for example, “Well gee you came in a couple of months ago and you got some birth control pills but you haven’t been back” and “Well my mom found the pills and threw them out”. So having that discussion with her about that so that she can, ‘cause she’s still engaging in sexual practices, so having that discussion about how you can talk to your mom about this.

This nurse provided a vivid description of the circumstances when nurses explore and discuss strategies for youth to initiate the conversation about sexual health between
the youth and her parent. Many of the nurse participants who worked in the youth clinic setting concurred that they encourage youth to communicate with their parents about their sexual health.

Nurses who work on the Communicable Disease and Travel team provide a number of services to a broad population including working with families. Care provided by public health nurses include sexually transmitted infection testing, counseling and treatment, contact tracing of reportable communicable diseases, tuberculosis testing and treatment, and travel immunizations and safety information as mandated by the BCCDC.

Nurse participants working on the communicable disease and travel team reported parents coming to the health unit or calling to ask questions about sexual health, in particular, sexually transmitted infections (STIs). One nurse described how she has received calls from parents who were asking her how they could talk with their adolescent about contraception and sexually transmitted infections, prevention and testing. She also described receiving calls from parents of adolescents who had experienced a sexual assault and wanted information that would help them support their child. When asked to identify her involvement with families related to sexual health communication, this nurse reported:

We'll get phone calls from, um (parents) because we also deal with STIs...if they phone in, if they have concerns about their child-if the child-if the teenager or young adult has been sexually assaulted. Or, um, you know, has quite open communication with the parent. If the parents phone me about birth control. Or pregnancy testing. Or just sexually transmitted infection testing. That's usually the type of contact that we have with parents...often our services.
Informal Contact

Not only did the nurse participants discuss their involvement with families on a formal basis but they also identified the informal contact they had with families supporting parent/child sexual health communication. Nurses described this informal contact as the involvement with families outside of their work environment and hours. Also, nurses spoke about individuals seeking them out outside their work hours because they identified them as an expert in the content due to the work they complete as a public health nurse. Some of the nurses discussed being approached by friends, parents of their children’s friends, and by strangers during non-working hours. Individuals asked these nurses questions pertaining to sexual health and sexual health communication and often looked to these nurses for advice on strategies to address questions, issues and concerns that had arisen within the family. One nurse described a particular encounter with a friend:

And the mom and I, we’re friends, she knew ‘cause she knew this is what I was doing. Talking about it in schools. So she asked me questions. And I, you’ve got to find out what’s going on through her head to know what this change means to her. Some things can be the same; some things are going to be different. So, like, you just need to find out what things are different, and then deal with them again differently.

This participant recounted a conversation that had occurred with an old family friend. The parent had come to the nurse outside the work environment to discuss approaches on how to talk about puberty changes that were beginning to happen to her daughter. The nurse highlighted the importance for the mother to find out her daughter’s thoughts and feelings about the puberty changes as a starting place for discussion. The
parent had identified the nurse as a resource for this information and felt comfortable talking with this nurse about her questions and concerns.

Another nurse spoke about being approached by parents of her children’s friends outside of her work at the Health unit:

I find that lots of parents will ask me questions given my background with youth clinic days and having kids at the same age group. Parents of my kids, you know the friends, right... Friend’s parents... On an informal basis.

As in the case with the previous nurse participant, this nurse also described being identified by others as having knowledge of the topic because of her title as a public health nurse and, therefore, was considered a trustworthy resource for parents. In this circumstance, the individuals who approached this nurse were parents of her children’s friends therefore some were acquaintances. This nurse went on to explain that these contacts with families occurred outside of her nursing role while attending her children’s soccer games and during other community events.

A nurse participant commented about complete strangers approaching her with questions about sexual health and sexual health communication while she was out in the community. This nurse explains one incident:

So I just went, actually, to the bank...You know, a safety deposit box, really...Anyways, the lady that was letting me in said, you know, I’ve got a fifteen-year-old daughter, ‘cause they know- it’s a small town. One of the lady’s in the bank, her son has been a (name) educator. So she said, my daughter’s fifteen, and she said, um, I think she should really have a pap smear. And I said, well, here’s the criteria. So she’s been sexually active and it’s coming up to a year after she began. She said, oh, I can’t find that out. And I said, well you don’t need to find it out, but you can just share that with her. She said, yeah I don’t really want to know that information. That just, you know, just, well you’d be interested to see what she shares, and that’s good... You just have those little questions because of your role, what you do.
This nurse’s statement highlights how through her role as a public health nurse, in particular, her work with youth health educators, she is identified by others in the community as someone they can ask sexual health questions and share personal information to assist in meeting the needs of their family. By sharing this information with the mother, the mother may now be able to initiate the conversation regarding her daughter’s sexual health potentially opening up the lines of sexual health communication.

**Nurses Work with Families**

Through thematic analysis of the data, it became evident that nurses work with families in regards to fostering parent/child sexual health communication involved two distinct roles. These roles included nurse as a resource for families and nurses helping parents and children to initiate sexual health conversation within the family. These two themes will be discussed. Specific strategies that nurses use to enhance these two roles will be elucidated and verified with the data.

**Nurse as resource.**

Although nurses’ involvement with families varied dependent upon which team the nurse worked on, identification of acting as a resource for families was similar. All of the nurses interviewed described that one of their roles as a public health nurse was to be a resource for clients and families including acting as a resource for sexual health education and supporting parent/child sexual health communication.

Throughout the interviews, nurses acknowledged that families come to them in person or via the telephone with questions, issues and concerns relating to sexual health and parent/child sexual health communication. Although this does not occur on a daily basis, nurses were able to provide examples of this occurrence. Contact with public
health nurses ranged on both formal and informal terms. Parents often would ask nurses sexual health questions while they were at the Health unit or other community agency, participating in one of the many services the health authority offered, or merely out in the community as a lay person. The parent may not specifically come to the nurse with a sexual health related question but often the question would arise as an aside. The parent would ask the question they had pertaining to sexual health education and/or communication. In other circumstances, parents would call or come in to the Health unit specifically with a sexual health question. One nurse commented on one example of this occurrence:

Frequently parents will come into the health unit and say, you know, “I have a child that’s starting to go through puberty and I need some information about what to, what kind of materials to use” or they want to rent a video, so we have videos available for them to use. We have some educational materials available and we have some specific books that we, that we have available and recommend for children.

Nurses would answer the question or concern the parent had to the best of his or her knowledge. Strategies implemented by nurses to assist parents included the provision of resources available at the health unit such as pamphlets, books and videos to assist in answering the families’ questions. If the nurse did not feel she had the knowledge base to provide support, the nurse would refer the parent or family to another nurse at the health unit with expertise in this area. If the family required more support than the health unit could provide, the nurse would refer the parent or family to another community agency who may help them with their questions or concerns. Many of the nurses spoke about providing a list of references available for parents to use to support parent/child sexual health communication as another supportive strategy such as this nurse described:
One of the things that we do too is we have a business card that we printed up that has some really good resources in the public library that you can order. So Meg Hickling books and things like that, so if parents are calling, and wanting to know how do you start these discussions with your kids, you know there’s lots of resources out there that can help you do that and here is a list through the public library even.

This participant mentioned a specific author, Meg Hickling as a resource that is often recommended to parents. Nurse participants also mentioned other specific books and videos that they specifically recommend for parents to use to support parent/child sexual health communication.

Many of the participants interviewed agreed that acting as a resource to families was a key component in the health promotion and illness prevention work that they do. They felt that many public health nurses possess the knowledge, expertise and opportunities to be able to provide sexual health support to families. Another reason for nurses providing this information and support to families was due to the trust the public has in nurses as articulated by this nurse:

...they [public health nurses] are looked to by the public as having some sort of expert knowledge in this area. Two, they do have lots of knowledge in this area. They’re working with people across the life span. They are very familiar with sexuality in many ways and I think that, that they have a, a level of trust that lots of other professionals may not sort of have. That inherent trust. So it places them in a position that’s really important. I also think that they have a comfort level, for the most part, about speaking about physical issues...and certainly about sexuality, that places them in a great position to speak to, to parents. I think parents find them approachable.

As a result of these factors, nurses are a huge resource for families. Public health nurses can and do play a pivotal role in supporting families with sexual health communication although nearly all of the nurses interviewed felt there is more work that could be done in this area.
Helping families initiate the conversation.

Another prevalent theme that emerged from discussions with nurse participants was that nurses work with families to initiate sexual health communication. Although many of the nurses interviewed did not state that they actually brought up the topic of parent-child sexual communication with families, nurses described how they worked with families to assist in opening and maintaining the lines of communication between parents and their children related to sexual health discussions. This was accomplished through their practice with large groups such as children and parents during the delivery of puberty classes, by working with parent and child dyads, or by working one-on-one with the child.

Many of the nurses spoke about the positive impact that inviting parents to puberty classes had on initiating and assisting sexual health communication within families. In most of the health units located in the central Vancouver Island region of VIHA, public health nurses provided puberty classes to grade five and six students. In one particular health unit, letters of invitation were sent home to the parents by the schools on behalf of the nurses before puberty classes were scheduled to commence.

Some participants felt that by inviting the parents to the puberty class, parents heard what their child heard and subsequently, was then able to discuss and reinforce this information after the class. In some cases, the family had not had this discussion thus far and the class apparently facilitated this process. Nurses also knew that parents have experienced puberty and this experience may be something they can share with their child therefore assisting in normalizing this life change. Some nurses explained how during the class, they would ask parents questions that encouraged parents to share their
experiences of puberty such as asking fathers when they remember their voice changing or asking mothers to share, if they felt comfortable, when menarche began. By using this technique, the nurse not only involved parents in the discussion but also modeled to the children in the class how they may be able to initiate the conversation with their parent.

In many cases, nurses said that the parents learned almost as much as the child was learning for example, the mother of a son may not have been aware or understood the male puberty process, as she had not experienced it herself. The class aided in the provision of knowledge in this area, enabling her to be a resource to her son and potentially fostering sexual health communication. At the end of the class, the children were given an information pamphlet on puberty for future reference and to reinforce their learning after the class. Some of the nurses stated that they encouraged the children to go home and share the pamphlet with their parents, which may be another strategy to initiate sexual health communication.

Although nurse participants stated that not all of the parents attended the puberty classes, those parents who attended had provided positive feedback in regards to evaluation of this strategy. One nurse shared the following comment:

We also did a satisfaction survey one year, too. For the parents and students after the puberty class. And we had just amazing comments back. The parents were so pleased at how comfortable and relaxed the students felt and you’ll get phone calls with them [parents] saying...or they will see you next time, in the store, whatever, they had been in the class and they will just say “how communication had just opened up after they [parent and child] had been in the puberty classes”.

Another example of how public health nurses initiate sexual health communication in families is through the collaborative partnerships with the youth health educators program. One participant described how she felt the youth health educator
program provided a "ripple effect" that promoted learning for families and influenced family discussion about sexual health. She described this phenomena stating that the youth health educators would go home and study the information they needed to know to teach the sexual health class. While preparing to teach their class, family members such as parents and/or siblings would overhear the youth or see written information and this would stimulate learning and subsequently, conversation about sexual health topics. This nurse provided her perceptions about this occurrence:

So when we were creating some of the learning activities, one of the coordinators [senior youth educators] said you know, my mom can sew and she'll make this game or whatever. So she took it home and before she knew it, her younger brother was, they thought they were just cards, right, so they were playing cards, and mom was sewing and going, what? A vagina’s how long? One testicle hangs lower in boys, I didn’t know that. So I think what you, we get very, very important to have all these measured effects, but actually what happens is the ripple effect.

Another example of nurses initiating sexual health communication between families is the work they do with parents and their children when they come to the health unit specifically asking for support. Although this is not a common occurrence, a few of the nurses commented on how parents have brought their child to the health unit for support in the discussion of sexual health issues or concerns. Nurses described parents bringing their youth into youth clinic because they either thought their adolescent was sexually active or considering becoming sexual active. In some cases, the youth were willing to attend the clinic with their parent. In other circumstances, nurses spoke about teens being “dragged into the clinic”. This nurse described some of her experiences with this:

Sometimes I’ve had parents bring in their kids, and it’s more trying to invoke fear in them of what can happen. So maybe not always the best way of going about
things, but, I try not to approach it from a fear, fear-based perspective. I would be honest about things. And this is what, you know, your risks are when you decide to become sexually active...I think, you know, be honest with them, but not, I don't want to make it sound so fearful they'll, you know, be afraid of their sexuality. Or to be sexually active.

Nurses also described working one-on-one with a child, usually a youth, to initiate sexual health communication with their parents. In most of the situations, the youth had come to the youth health clinic for birth control or pregnancy testing. Participants discussed how they talked with youth about strategies they could use to initiate the conversation with a parent about a specific sexual health decision or issue. For example, some of the nurses role-played with the youth to give them ideas of how they could broach the topic with their parents. Another nurse described how she provided ideas to youth about appropriate times and places to start discussions about sexual health with a parent:

We spend a lot of time talking about that [youth/parent sexual health communication]. I think it depends, sometimes, on the teens and their abilities. To try and find out what their abilities are to speak to parents. I often ask them to not wait until it becomes, um, not until their birth control pills are found...to speak to parents a little earlier to find a time when parents are available to hear them...I encourage them to speak to their parents... that parents may seem unapproachable but, in fact, they really would love to talk to the child but sometimes we forget to bring it up.

Many of the nurses interviewed spoke about the importance of encouraging sexual health discussion between families as demonstrated in the previous quotes. Nurse participants felt that initiating sexual health communication amongst families was not a primary role in their practice, but as illustrated in the data, is a health promotion initiative that occurs.
Values and Beliefs around Sexual Health Communication

Values and beliefs play a role in our day to day conceptualization of our world and the context we place it in. Values and beliefs can guide the importance nurses place on particular health promotion strategies or the significance of attaining knowledge in a certain area of focus. Public health nursing base their programs on population health and health promotion models. It is under these premises that nurses develop programs, under the mandate of their health authority, that meet the health promotion needs of a population. Throughout the interviews, the nurse participants spoke about values and beliefs inherent in their practice in relation to parent/child sexual health communication and nurses' involvement.

All of the nurses believed that parents play an important role in their child’s acquisition of sexual health information and should be communicating with their children about sexual health. Many of the nurses believed there were many parents who were not currently communicating with their children about sexual health. In analyzing the data to answer the research question, three major beliefs emerged: (1) Parents are the primary educators; (2) Education should start early; and (3) Families’ comfort level influences sexual health communication within the family. These themes are illustrated below.

Parents are the Primary Educators

Nurses spoke about their belief that parents could play and in many circumstances, do play an important role in regards to their child’s sexual health. Many nurses identified parents as being the number one educators of their children. Parents are the first people children interact with and children learn from the first interactions they have together. The nurses described these parent/child interactions
including the various components of bonding and attachment. Many nurses identified that children learn even as young as infancy about sexuality through touch, verbal and nonverbal communication and care they receive from their parents. As the child grows, they learn from their parents through a variety of ways such as verbal and nonverbal communication, role modeling, and also, by what they do not do. The nurses remarked that parents are the most influential people in their child’s life and that children take cues from their parents therefore, it is the responsibility of parents to act as role models for their children. One nurse explained:

So, my perspective on that is that...that parents play a tremendously important role and probably should actually be the primary educators for...for children in regards to their sexual health. I think that one aspect is that parents are with their kids all the time and they bring their own morals and values and thoughts to it, so they are... they have this wonderful opportunity to, um, work with their children as they’re growing and developing and providing age-appropriate and stage appropriate education. They are the primary providers in my perspective.

Some of the nurses elucidated the point that parents are role models for their children. Not only do children learn through verbal and nonverbal communication but they also learn from the role modeling by their parents. According to the nurses, parent role models a variety of communication techniques, relationship practices and beliefs around sexuality. During the conversations, nurses discussed how parents’ use of language can affect their child’s perceptions around healthy sexuality. For example, if parents substitute names for the actual names of the genitals, children may feel that they should not use the correct terminology when they do indeed find out the accurate name for the genitals. Also, if parents do not model examples of healthy relationships such as use of appropriate communication with his or her partner or the inability to show
affection, the child may feel that this is an example of how he or she should act within a relationship.

Many of the nurses described the importance of parents being open in their communication meaning that they should be able to communicate with their children about all subjects including sexual health. The nurses felt that families need to develop a rapport that includes openness, trust and respect of each other. Parents should instill a sense of openness that says to the child they can talk to their parents and ask questions about all things, including sexually related topics. This sense of openness should not only be evident in verbal communication but also from nonverbal communication. Some of the nurses discussed the importance of parents being aware of their nonverbal forms of communication such as facial expressions. The nurses believe that children pick up on parents' nonverbal cues which may be telling the children that parents do not feel comfortable nor open to discussing this information.

Many nurses alluded to the ability for parents to be “askable parents”, an important trait for parents to possess to enhance parent/child sexual health communication. If children have a sense of security and are comfortable with their parents, they will be able to ask parents questions pertaining to sexual health as explained by this nurse:

I think the thing that would be most important for parents that we really try to tell them is that you don’t have to know it all, it’s trying to set up that whole thing of being an askable parent and saying “I don’t know but let’s go find out together, I think I know who to ask.

This nurse highlighted not only the importance of parents being “askable” but also the notion that parents did not need to have all the answers to the questions, but a
willingness to find the answers together. On the contrary, the nurses believed that if parents have created an environment of discomfort or lack of openness around communicating about the topic of sexual health, the child will feel they cannot ask questions nor openly discuss this topic.

The following quote fully captures the previously mentioned beliefs:

Uhm, well parents, I believe are the number one educators of their child. So that’s always, and they’re even educating by how they look at somebody. When they’re changing their baby’s diaper. How they approach and the words they use for body parts. How they educate their child about their bodies and make their child feel about their bodies. Role modeling relationships that if a parent’s open and role modeling trust and being honest and approachable. I think that’s really important and to refer when they don’t know the answer. So sometimes it involves a third party in there too. And respecting privacy and teaching their child, you know, that their body belongs to them. And that their child has the right to be respected for that privacy or whatever issue happening there.

Education Should Start Early

When asked what parents could or should do to promote parent/child sexual health communication, it was abundantly clear that nurses felt parents should start sexual health communication and education at an early age. Nurses felt that parents could be implementing strategies and initiating sexual health communication with their child earlier than what parents may be currently doing. They believe that many parents wait until the child becomes a teenager before beginning sexual health discussions, which according to the nurses interviewed is too late. By the time the child has become an adolescent, he or she has more than likely found sexual health information from others sources such as from school, peers, other adults, the media such as television, movies, radio, books and magazines, and finally from the internet. Although the nurses identified that there are reputable sources that children can access to learn sexual health information, there were some concerns. They stated that the concerns with children
researching and learning about sexual health from others sources were threefold. First, the information received from other sources may not be factual, second, the information may not be congruent with family values, and last, the child has now established that they can not discuss this information with their parents. Therefore, participants felt that parent/child sexual health communication can be a positive attribute enhancing family health and well-being.

When asked at what age parents should start communicating about sexual health, this nurse responded:

From birth through onwards really. You know, and then 'cause it – I just think it leads to less confusion as the child gets older. Um, just with body parts. I mean, that’s their body. They have to know what their body parts are at some point, so they’re not twelve and confused about different things. And just being really open. And I think that needs to change going through the lifespan. I mean, I think you adjust it to how, um, you know, what’s appropriate for that particular age group. I don’t think that at two years old you need to be having a discussion about sex. But just, um, you know, especially if there’s another child being born into the family. That’s well, this is how – without getting into all the details, but not saying that, oh I have a baby growing in my stomach. To use proper terminology. And just being open from that sense. So when it does come time to have an open discussion about sex and sexuality, that, you know, the groundwork has been laid...if the groundwork has been laid in that manner, and you can have that open conversation...hopefully the child will come to the parent and feel comfortable enough that they can look to them for support.

This participant’s response echoed many of the other nurse participant’s belief about the significance of starting sexual health communication early. By providing age appropriate information from an early onset, the child not only learns pertinent sexual health information, as stated by the participants, but also parents begin “laying the groundwork” thereby, assisting in the establishment of open lines of communication which may enhance parent/child sexual health discussion throughout the family lifespan.
Throughout the conversations with the nurses, it became evident that nurses viewed sexuality in a broad context as stated by this nurse:

One of the most incredible things that happened in terms of this education, which of course has had a sexual health part, where does sexual health start and end? You know, it’s… self esteem is part of sexuality. You know, I don’t find sexual health just about intercourse and how to do it safely or not do it, it’s about many facets of being sexual.

Further, nurses viewed sexuality as not only discussing aspects such as the reproductive system, puberty changes and sexual decision making, but also the importance of bonding, attachment, personal safety, self esteem, body image and healthy relationships. One participant described sexuality as being “part of our personality”. Sexuality is part of what makes us who we are. Therefore, nurses felt it was important for parents to build the child’s self-esteem, provide age appropriate information, engage and use language that honours healthy sexuality and to teach their children about healthy relationships through dialogue and role modeling to their children from the outset.

Nurses also believed that parents should be instilling their family values in their children at an early age. This nurse described her views on the significance of parents sharing their values with their children:

Making sure that the child understands what their family’s belief system is. And working with sexual decision making with their youth when they reach into the teenage years is really important… the family’s beliefs on when it’s appropriate, what makes things appropriate, what are some worries and concerns. And when that parent wants to be approached. Like some parents want to know before their child becomes sexually active, other parents don’t want that piece of information.

Some of the nurses articulated what information they felt parents should be providing to their children. The nurses stressed the importance of parents providing age-appropriate information dependent upon the developmental stage of the child. Nurses also
felt that parents should take their cues from their children for example, answering questions when the child asks. The interview participants emphasized that parents do not necessarily need to give the full details, dependent upon the age of the child, nor do they always need to have the answers, although it would be beneficial for them to be willing to find the correct answer for their child.

As many of the nurses described parents starting sexual health communication when their child is an infant, a few nurses elaborated on how parents actualize this process. Nurses highlighted the importance of parents using touch, cuddling, eye contact, smiling and other bonding and attachment techniques with children as newborns to initiate a sense of love, trust, security and therefore, develop healthy sexuality. The child begins to learn the basics of communicating feelings of love, trust and security from the care the parent provides as affirmed by this nurse:

I think they get taught as newborns babies about how they feel about themselves. Touching is, is really, really important and touching is part of sexuality...The whole aspect of, yeah, caring for your baby and interacting and cuddling and tickling and laughing and touching them is important.

Many of the nurses described the importance of parents using correct terminology for body parts and teaching personal hygiene as children become toddlers. A number of nurses felt that it is imperative to teach children the accurate names for body parts for knowledge of their body. This participant stated:

So, I think the sooner parents begin, the better it is. I think, actually, you should be doing it, um, with young children as soon as they are learning to speak and even speaking about body parts so when you’re, you know, washing your kids in the bath so that they can learn their body parts. That type of thing.
As the parents teach the proper names for body parts, nurses believed they should also teach about private and public parts of the body, places and behaviours such as self exploration, an activity toddlers often begin to partake in and is part of developing healthy sexuality.

As toddlers become preschoolers, nurses felt that parents should teach their children about reinforcing personal hygiene, personal safety, and answering questions children have about their own bodies and “where do babies come from?” Often, preschoolers are experiencing the addition of a new sibling and often have questions about pregnancy. Nurses believed it was important for parents to give accurate but simple answers to children in this age group. Parents should also be teaching and reinforcing information to children about appropriate and inappropriate touch, an important personal safety strategy.

Nurse participants all felt it was important to teach children about the body changes that occur during puberty before this process begins. This age group would include those children in grades three to six, ages’ eight to twelve. Pubertal changes include the physical, emotional and social aspects. Nurses felt that parents should be providing accurate and honest information and to look for resources when needed. When asked when parent should cover the topic of puberty, this nurse responded:

Well I would think it is somewhere around grade three or grade four. We talk about it in grade five but some of the students, the girls in particular have already developed breasts. They are already menstruating. So, for some, it could be anywhere between grade three and five. Depending on, I guess the parent really needs to be aware of what’s happening with their children. They need to watch for the signs that the child might be developing faster than their peers.
This participant provided sexual health teaching related to puberty to students in grade five within the school classroom setting. She recognized that there are students, primarily girls, who have already started the puberty process by grade five and felt that parents should be able to recognize these changes to initiate discussion with the child about these sexual changes.

Many of the nurses felt it was important to give preteens information about healthy body image, healthy relationships, and to explore media influences on children. Encouraging healthy body image includes reinforcing a positive self esteem with the child around body image and debunking media influences related to weight and body shapes and sizes. Educating children about healthy relationships involves teaching preteens about characteristics of a positive relationship through discussions and role modeling. Nurses reported the importance of parents being aware of the impact of media influences children are exposed to and discuss these influences together. Parents should look for the “teachable moment” with their children.

As the child enters their teen years, nurses felt that parents should be teaching healthy relationships, personal boundaries, respecting their body and others, reinforcing the impact of media influences and being open to answering questions related to sex. Parents should be instilling their own family values around aspects of sexual activity. This nurse articulated her thoughts around sexual health information parents should provide to their adolescent children:

I think ideally it would be good if parents can be open about it. And just say, you know, that I think it’s human nature to be sexual. And that, um, maybe to invoke the family’s values within the, or, you know, this is what we see, or would like, expect of you as our child. But also, to be aware that, you know, things might happen. And that, if that child is going to become sexually active, then these are the things that you need to think about before you do so. And thinking about who
your partners are. And what risks you’re taking—may be taking. And how you can protect yourself if you do decide to make that decision.

As this nurse outlined, education should include information about sexual decision-making, pregnancy, sexually transmitted infections, and prevention. Many of the nurses felt that parents should discuss contraception including strategies to postpone sexual activity with their child; however, not all of the nurses believe that teens should be taught birth control information. One nurse described the importance of including discussion around sexual orientation and resources that would be helpful and useful for dialogue.

Families’ Comfort Level Influences Sexual Health Communication within the Family

The concept of comfort was a prevalent theme that emerged from all of the participants’ conversations. The nurses described the impact of comfort on parent/child sexual health communication.

Parental comfort.

Most of the nurses felt that parents required a level of comfort to discuss the topic of sexual health with their children. Nurses described the importance of parents feeling comfortable to bring up sexual health topics for discussion with their children. The nurses identified parents’ ability to be comfortable with discussing the topic as an enhancing factor fostering parent/child sexual health communication. For example, when asked what could or should be parent’s role in regards to parent/child sexual health communication, one participant stated:

Parents could play the defining role as far as their children’s sexual health. If there is a relationship set up, and a comfort level set up within that family or those individuals in which they could speak openly and comfortably about sexual development, I mean physical and sexual development.
Another nurse stated:

Hopefully having parents feel comfortable enough about their own sexuality that they in turn can feel comfortable talking with their kids about not only names for body parts but you know, feelings and appropriateness of behaviours.

Furthermore, a number of nurses supported the importance of parents feeling comfortable with their own sexuality in the enhancement of their ability to conduct sexual health related conversations with their child.

Another factor which may impact parents’ comfort around sexual health communication was the importance of the family instilling their values into the dialogue:

So I think that, for parents, sometimes it’s not just knowing the questions to ask, but, how do you answer that question? Or how do you answer it in a way that you’d feel comfortable with that supports your values and also provides the information to me about that and you’d never know about that.

Many of the participants elucidated the implication of parents providing information to their child that supports their family values and beliefs. The nurses interviewed agreed that talking to your child about family beliefs and values around sexuality is an important, if not essential role of the parent and may have a positive impact on adolescent sexual decision-making process.

Generally, nurses commented that most parents are uncomfortable talking to their children about sexual health. There was a consensus by the nurses that parents were uncomfortable with the topic of sexual health and with discussing this content with their children, as in this quote, where a nurse described what a parent had voiced to her:

It makes me so uncomfortable to talk about birth control or pregnancy or oral sex or any of that. You know, ugh, I don’t want to even think about it.
Nurses felt that many parents did not speak to their child about sexual health due to a lack of comfort, knowledge and in some instances, because it was embarrassing. When nurses had conversations with parents, parents often had a difficult time saying the word sex. Another nurse described what parents have told her when asked if they talked to their child about sexual health:

I could never talk to my kid about that. Meaning sex, or sexual health I should say.

This comment brings us back to the point that parents need to process their own thoughts and feelings around sexuality to be able to communicate effectively with their child about sexual health. Many of the nurses discussed the importance of parents examining their own fears, attitudes and values toward sexuality to assist in creating a safe and comfortable family environment in which sexual health communication could occur.

Child's comfort.

Some of the nurses talked about how parental lack of comfort with the topic of sexuality may have a negative impact on their child’s feelings and comfort in talking to parents about sexual health. If a child feels the parent conveys a message of discomfort with the subject matter, the child may be less willing to ask questions or discuss sexual health related topics. Nurses consistently spoke about this point:

It needs to be given in a comfortable manner and that, if the parents feel awkward, shy, or uncomfortable, then the child picks that up and they don’t hear the information.
During the interviews, other nurses concurred with the belief that if discomfort with the topic is conveyed by the parent, children may begin to feel that sexual health discussion is taboo and something that should not be talked about.

Nurse participants also agreed that children needed to have a relationship with their parents that promoted a feeling of comfort and open communication. Many of the nurses believed families whom developed a relationship that included open communication about sexual health positively enhanced teens ability to feel comfortable with their bodies and the choices and decisions they made.

I've seen quite a diversity in regards to parents' capability of having communication. I've had experiences with girls that have come in that said right from the dinner table of when I could remember my mom and dad talked about healthy relationships and what that looked like and when to know when you were ready for having an intimate relationship. And they felt quite comfortable when they started that relationship in regards to coming in for birth control and even feeling comfortable enough to share that.....how their parent relationship actually helped to impact on them on regards to when they were actually going to make that decision. And they were very comfortable with their sexuality.

Factors that Enhance or Hinder Nurse’s Ability to Support Families

Factors that enhance or hinder nurses’ ability to support families became evident through content analysis of the interviews. Nurses interviewed described enhancing factors which included: (1) Nurses’ interest in the health topic; (2) Access to education; (3) Support of others; and (4) Being a parent. Nurses also elucidated factors that hinder nurses’ ability which included: (1) Lack of resources; and (2) Lack of comfort.

Enhancing Factors

Enhancing factors can be defined as those factors that augment or improve nurses’ ability to support parent/child sexual health communication.
Nurses' interest in the health topic.

Many of the nurses reported that having an interest in the topic of sexual health promoted nurses' ability to support parent-child sexual health communication. They felt that by possessing an interest, nurses were more inclined to talk with families about sexual health topics or issues, and perhaps more inclined than nurses who were not interested in discussing sexual health topics. Nurses believed that nurses who were more inclined to discuss sexual health topics with clients seemed to be more comfortable, approachable, and open in regards to discussing and answering questions pertaining to sexual health content. A large number of the nurses reported an interest in the topic and in some circumstances, commented further stating that they were quite passionate about the topic. One participant stated:

Well, I think that some nurses probably do that really well and I think some nurses aren’t comfortable with doing that. So, for me, it…it’s just part of…it’s such an important part of my practice and a great deal of what I work on my….one of my passions is sexual health education so, for me, it’s naturally embedded in what I do.

This nurse described being passionate about sexual health education which may make her more willing to provide this information with her clients. It is interesting to note that many of the participants, who reported sharing an interest or passion in the area of sexual health, work with school-aged children or with youth health clinic clients.

Providing sexual health education to school-aged children and youth health clinic clients is a part of these nurses’ roles within their practice.

Access to education.

A large number of nurses interviewed commented that having access to education is an important factor to enhance their ability to support parent/child sexual health
communication. Nearly all of the nurses indicated that they did not receive education in their undergraduate nursing education that would support their practice in sexual health today. Therefore, nurses reported learning this information upon graduation from their basic nursing training. Much of this learning occurring post basic nursing training, although supported by management, was self-driven or motivated. The nurses felt a need to obtain this knowledge and often independently met this requirement. One nurse identified her experience of learning to support parent/child sexual health communication as "flying by the seat of your pants". Her experience illustrated an increasing need to meet a self-identified knowledge deficit to help meet the needs of her clients. This sentiment was shared by other nurse participants.

The nurses reported that access to up-to-date sexual health related information and education on how to support families with sexual health positively impacted their work. The nurses felt that possessing pertinent information was imperative for their practice in that it promoted an increased body of knowledge, development of skills and strategies, and enhanced their comfort level in the topic of sexual health and sexual health communication with their clients. The nurses discussed attending post-basic nurse training courses, accessing relevant and accurate websites, reading peer reviewed professional journals, watching videos and attending sexual health related conference and workshops sponsored by various organizations. One nurse commented:

And then there were opportunities to go to some really good conferences. That's really helped. And finding resources like Meg Hickling and they're becoming more widely known maybe because you are in that circle that you find more resources.
This nurse also mentioned the name of a nurse author as a resource for providing sexual health education and working with parents. Meg Hickling was mentioned numerous times throughout the interviews by many of the nurse participants. The nurses felt that she has provided a sound body of information in her books and workshop.

Nurses also reinforced the importance of using research based evidence acquired from peer reviewed journals and articles and accessing relevant internet websites to enhance their practice in the area of parent/child sexual health communication. One nurse described the availability of resources on the internet positively impacting her ability to remain current and up-to-date on the latest sexual health information.

A recurrent resource identified by the nurse participants was Planned Parenthood of British Columbia now known as Options for Sexual Health. Nurses cited this non-profit agency as a necessary source for information to enhance their practice. Many nurses described attending training sessions, workshops, and conferences as well as reading educational materials sponsored and developed by Options for Sexual Health as indicated by this participant:

“And the ones through Planned Parenthood have in the past they’ve been quite helpful in terms of updating information, practical information. I haven’t been to one for a while but the couple that I went to, they were great. Especially kind of synthesizing the information and kind of reminding you what’s current and that kind of stuff.”

Support of others.

Another enhancing factor identified by numerous nurse participants was the importance of having support from others. The nurses defined ‘others’ as work colleagues, regional committee members and management. Nurses stated that support
included the ability to dialogue with work colleagues about practice questions, debriefing about practice situations, networking with others, and the provision of professional development opportunities.

Nurses highlighted the significance for occasions to dialogue with work colleagues about practice questions, issues and/or practice situations that arose. Nurses felt it was valuable to be able to ask other nurses questions in order to assist them in trouble shooting a complex situation or identifying a strategy or plan for the client. The occasions to dialogue with other nurses were generally identified as informal, occurring within their regularly scheduled work time, usually during or after contact with a client. This nurse outlined thoughts about the support received from colleagues:

It's my peers that would, just talking about what my peers talk about or questions they deal with and how they answer them. Just to get different ideas, and how to answer the question. And to listen to actual language used....And I want to know specific words they use. And not just try, I want to also understand the idea they're trying to get across. And why they chose this.

Nurses also discussed the task of debriefing with colleagues as another aspect of receiving support from others. Debriefing with others allows nurses to discuss issues or situations that have occurred in order to assist the nurse in working through a practice problem or dilemma. Debriefing enables the nurses to reflect on their practice and share the experience with others which may help to answer practice questions. This nurse articulated how supportive colleagues enhance her ability to work through practice problems:

If I ever felt like I didn’t know how to address a situation. Or deal with a particular parent, or child that there was always good resource in the staff that we could depend on as a whole, I think, talk about a situation. And, you know, debrief, or come up with a plan that is suitable for that parent or that client.
Some of the nurses discussed how if they were experiencing angst or dissonance over a particularly troubling client interaction or situation, debriefing with colleagues allowed the nurse to work through the process of coming to terms with the situation, assisting the nurse to develop another strategy or method to deal with the situation or question as it arose in her practice again.

Nurse participants referred to opportunities to network with others as being supportive to their ability to foster parent/child sexual health communication. Networking occurred when the nurses were able to attend team and regional meetings as well as workshops, seminars, or conferences. Networking enabled nurses to discuss practice programs, strategies or issues with other nurses working in the area of sexual health. This nurse offered her perspective on the importance of networking with others:

Supportive mentors and the conversations we have. We get together once a month for School Health and the dialogue that goes on, doesn’t matter if it’s coffee, lunch or whatever. You know what, it’s really valuable. You walk away and you feel like you’ve got something out of that. It’s the content that you carry from the meetings... it changes your thinking. Like you never want to think in a box. And it’s like okay I never looked at it from that perspective before. Now I look at it differently and it changes your practice.

Finally, nurses identified the support of management as another factor that enhances their ability to foster parent/child sexual health communication. Nurses discussed the importance of management sharing the same philosophy as an important facet. They felt that management needed to value work in the area of sexual health in order for nurses to devote time and energy to this aspect of their practice. As nurses identified being essentially self-educated in sexual health, management was required to support nurses with this educational endeavor. They felt that management needed to support nurses taking time to attend conferences, seminars, workshops and to spend time
researching education through reading peer-reviewed journal articles and searching relevant and credible internet websites as indicated by this nurse:

And just having a supportive management staff that will let you go to these in services and things that will specifically support communication.

On a whole, the nurses interviewed described feeling supported by management to do work with families to support parent/child sexual health communication.

Being a parent.

While interviewing nurses on factors that enhance nurses' ability to support parent/child sexual health communication, being a parent was identified by nurses as a positive attribute. When one participant was asked where she learned to support parent/child communication she responded:

Right now, probably being a parent. It's really changed a lot of things. Oh yeah. And I think some of the things that I really expected from parents before...what was I thinking? I only have one, I can't imagine trying to be able to have all these skills to be able to deal with three kids that might have different issues that, you know, and different developmental stages. So that has really helped a lot. And I think, probably just experience has really helped a lot.

Another nurse described how she needed to research information on tools and strategies for the direction to go with her own children hence giving her a sound knowledge base to be able to discuss the same with other families she works with in her nursing practice. One participant identified sharing the names of resources that she used with her own children to families that have come to her requesting strategies to help them with parent/child sexual health communication.
Hindering Factors

Nurses identified hindering factors as those aspects that impede or negatively impact their ability to support parent/child sexual health communication. Lack of resources and lack of comfort were two themes identified by nurse participants.

Lack of resources.

Nurses described a lack of resources as a hindering factor that negatively impacts their ability to promote sexual health communication in families. These resources were identified as time and money. Lack of time to provide support to families with sexual health communication was frequently reported by the nurse participants as an impeding factor. This factor includes feeling a lack of time to work with families and a lack of time to enhance nurses' educational needs in this area of practice.

Supporting families with sexual health communication was not a clearly defined outcome or program component of their public health nursing practice. Although nurses felt providing support to families was an important health promotion strategy, many of the nurses described providing support to families with this information as something that occurs off the side of their desk. Participants described that they were extremely busy meeting the everyday requirements and deadlines outlined under the expectations of the core programs of public health nursing. Nurses discussed how they did not want to turn away or not assist families who have questions pertaining to sexual health communication, but regretfully felt that they did not have adequate time to provide families with the information or resources they need as indicated by this nurse:

Time is a huge factor in hindering my ability to work about sexual health. 'Cause often you’re dong it and then parents are dropping in at ten minutes to quitting and it’s sort of “Okay, here’s sexuality in a nutshell and a book to go with it” and
there you go. “If you have any questions, give me a call”. So, I think time is a big factor and, you know, you have lots of things on your plate.

Another resource nurses felt is insufficient to support their ability to assist families with sexual health communication is a lack of time to meet educational needs. Nurses felt ill-prepared upon graduation from their basic nursing training in the area of sexual health, and particularly, supporting parent/child sexual health communication. Nurses also reported that researching and learning pertinent information requires time and energy, often time that is over and above time allotted in their regular work schedule.

If a nurse wishes to research educational sexual health related resources, or attend conferences, seminars or workshops aimed at providing sexual health education, she needs to be replaced in her job for that period of time required. This requires having the staff to replace her, which in many circumstances, is not an option due to a lack of staff available to replace her or lack of funds to cover paying for a casual nurse. In most cases, if the nurse is granted time to research or attend the educational session, the nurse is not replaced and therefore the nurse still needs to complete the work that she has missed in her absence. When asked whether management encouraged staff to attend educational workshops, this nurse described her experience:

Yep, yep, as long as there is someone around and available. That is what I found. There isn’t really anything around here and as long as they are fairly local. Like if they’re in (name of metropolitan city) it takes a bit more persuasion to be able to go... because of cost....and probably staff shortage.

In order to increase nursing time to permit nurses to meet educational learning needs that will enhance nurses’ ability to support parent/child sexual health communication, money is required. However, due to current fiscal restraints, allocating
funding to increasing nursing hours and professional development in areas that have not been identified as core programs is challenging. Nurses feel that management needs to recognize the significance and long-term impact nurses have on the potential for enhancing parent/child sexual health communication.

Lack of comfort.

In this study, many of the nurse participants frequently remarked about the importance of being comfortable with the topic, their comfort level and/or the comfort level of other nurses in regards to sexual health communication. Most of the nurses interviewed stated that they felt comfortable with the subject and in turn, were comfortable talking to families about sexual health as conveyed in the following quote:

I also think that they (nurses) have a comfort level, for the most part, about speaking about physical issues and certainly about sexuality, that places them in a great position to be able to speak to parents.

Some of the nurses described their comfort with the topic of sexuality stemming from an interest or passion they feel for this area of their practice. The nurses with a higher level of comfort also reported that they did feel that they had attained some expertise in this area and that other nurses working in their health unit often referred clients to them or to other nurses who had a level of sexual health knowledge. The following quote provides an example:

There are some nurses who don’t like the topic so they don’t bring it up but at that point if they weren’t comfortable delivering that information they are professional enough to refer to someone who will have that discussion.

Nurses identified a lack of comfort as an impeding factor that hinders nurses’ ability to support parent/child sexual health communication. A lack of comfort may be on
the part of the parent, child or nurse. There are a variety of reasons why people may experience a lack of comfort with the topic of sexual health. These reasons include: feelings of embarrassment with the topic, lack of knowledge and incongruence with personal values and beliefs.

Individuals experiencing feelings of embarrassment with the topic of sexual health often are uncomfortable discussing aspects of sexual health education with others. They may exhibit embarrassment or discomfort in a few ways. They may avoid the topic at all costs, changing the subject when it arises, or they may become visibly uncomfortable as exhibited by verbal and non-verbal communication cues. Verbal cues include stuttering or stammering conversations, changing the topic, or by blatantly stating that they are uncomfortable. Non-verbal communication cues may include a change in facial expressions or colour, avoiding eye contact, closed posturing such as crossing arms, and the use of paralinguistics such as using the verbal words “um” and “ah” or changing the tone of the voice for example, the voice becoming very soft when speaking about sexual health.

Throughout the interviews, some nurses would exhibit some of the nonverbal cues of discomfort. This became evident in particular, when nurses were asked what strategies they used to support parent/child sexual health communication and when asked what role they thought parents could or should play in regards to their child’s sexual health, when they increasingly used “um” and “ah” in their responses. During one interview, one nurse’s voice would become very soft when she discussed aspects of sexual health but stated she felt fairly comfortable supporting parent/child sexual health communication.
Nurse participants indicated that if a nurse was uncomfortable with the topic, she would refer the client to a colleague who was more comfortable with the subject matter.

Feelings of embarrassment may stem from a lack of knowledge of sexual health and sexual health communication. Nurses felt that this may be a result of a lack of education in their undergraduate nursing training program. In some circumstances, there are some public health nurses who still have not had formal post nursing program sexual health education most likely due to fact that it is felt that education related to sexual health is unwarranted as they are not working with school aged or youth populations. As one participant stated:

Well, it’s really, I mean when I think of that area I tend to think more of the (name of youth clinic) and the work that they do there, which is more directly with youth and parents who have older children than what we see here. So, yeah I, there’s probably different degrees of comfort, isn’t there, amongst different, even on the Early Years team I know there’s some nurses who would be more comfortable than others talking about the topic with parents.

Nurses identified a conflict in personal values and beliefs as factors that may hinder comfort level with sexual health communication. Conflicting personal values and beliefs may result from a lack of education, own experiences with parents and religious views.

Some of the nurses felt that people may not believe in providing sexual health information to children due to a lack of education. Individuals may lack research information about the significance and importance of providing sexual health information and the important role parents’ play. Nurse participants identified that some parents and nurses still believe that providing sexual health information encourages teens to become sexually active.
Nurses recognized that individual’s own experiences growing up impacts personal values and beliefs around sexuality and sexual health communication. For example, a person’s own experience with their parents can play a role in how they approach sexual health communication with their own children. In some cases, people parent in the manner that they were raised, which may include continuing on with the same discomfort around sexuality. This nurse provided a vivid example of her own experience with sexual communication with her mother:

Because I grew up in a home where my own mother said nothing to me. Even though my mother was a nurse. And I joke in the classes and I tell them how my mother gave me this book and I told them that book was still in the drawer that I left it in when I was in grade eight. And in fact, two weeks ago, I went and pulled the books out of my drawer, and in fact they were in that same drawer in my home that I grew up.....So I think that’s part of it. Is that I didn’t want anybody else to go through some of the misinformation I did.

Religious beliefs may also impact an individual’s values around providing sexual health communication. Nurses described that there are some families and nurses who do not believe in providing sexual health education to children due to their religion. Therefore, these individuals do not support providing their children with sexual health information.

Summary

Despite the absence of a specific program or mandate outlined by VIHA to promote parental/child sexual health communication, some public health nurses are supporting families with sexual health communication. The nurses described strategies they use within their practice and the context within the core programs and these strategies are provided. Although the nurse participants identified and articulated how
they support parent/child sexual health communication, they also illuminated the need for more work to be completed in this area.

The nurses interviewed for this study identified values and beliefs around sexual health communication. The themes include: (1) Parents are the primary; (2) Education should start early; (3) Families' comfort level influences sexual health communication within the family.

There were several factors that nurses believed could assist or impede their ability to support parent/child sexual health communication. The enhancing factors include: (1) Nurses' interest in the health topic (2) Access to education; (3) Support of others; and (4) Being a parent. Factors that hinder nurses' ability to foster parent/child sexual health communication include: (1) Lack of resources such as time and money; and (2) Lack of comfort due to feelings of embarrassment with topic, lack of knowledge, and incongruence with personal values and beliefs.

In Chapter Five, the findings will be discussed and nursing implications for nursing practice, education, and research will be suggested.
CHAPTER 5
DISCUSSION OF THE FINDINGS AND NURSING IMPLICATIONS

The purpose of this study was to explore nurses' involvement with parent-child sexual health communication and the factors that influence this involvement. Chapter Two identified the plethora of literature available pertaining to the importance of sexual health education and implications of parental-child sexual health communication. However, the literature review acknowledged a dearth in research related to nurses' involvement in parent-child sexual health communication.

Interviews with nurse participants provided rich data in the following areas: (a) information and insight into the current nursing practice related to parent-child communication about sexual health; (b) an understanding of how nurses foster communication at the different developmental stages of children; (c) nurses' current beliefs and values about supporting parent-child communication about sexual health; (d) how nurses learn to provide and promote parent-child sexual health communication; (e) educational needs to support nurses in their ability to provide parent-child sexual health communication; (f) and other factors that enhance and hinder nurses' ability to foster parent-child communication about sexual health. The nurse participants' accounts were rich in detail and candid in nature. This chapter discusses the findings arising from the study as reported in Chapter Four. Limitations of this study are also described. Finally, as a result of the findings, implications are proposed for nursing practice, education, and research.
Nurses' Involvement

Nurses described their involvement with parent-child sexual health communication as limited. Nurse participants stated that providing support to families related to sexual health communication was not specifically a task they performed on a daily basis. Nor was it part of a specific program provided within the realm of public health services. Many of the nurses described the health strategy as something that occurs "off the side of their desk". Nurses highlighted their frustration at the number of programs they deliver making it challenging to be able to provide all services to everyone. Despite this fact, nurses articulated having some contact with families in regards to sexual health communication.

Nurses described working with families in relation to sexual health communication on two levels: (1) Formal; and (2) Informal bases. Thematic analysis of the data related to these two levels of nurses' contact with families revealed two distinct roles of the nurses. The roles are Nurse as resource and Helping families initiate the conversation.

The literature supports the notion that nurses are in a prime position to provide sexual health education to clients (Evans, 2000; McKelvey et al., 1999), and that nurses can contribute positively and facilitate parent-child sexual health communication (Doswell et al., 2003; Lloyd, 2004; Sharpe, 2003; Smith, 1993). Reasons for this include: nurses' close contact with clients and families through the programs they provide; the knowledge they possess related to sexual health; their population health promotion perspectives; and the inherent trust the public feel about nurses. Nurse participants' echoed these views during their interviews. Some of the nurses felt that more work in the
area of supporting families with sexual health could be done. Participants described how nurses could start talking with parents about sexuality and communication when parents come in for post partum assessments by discussing their sexual health issues with them to promote a feeling of comfort with the topic and also letting the parents know that public health nurses (community health nurses) are health professionals they could talk to about sexual health or sexuality issues. This strategy could influence parents to begin thinking about sexual health for their children and ways in which they can support their child. As nurses are involved with families across the lifespan, nurses could open the door for conversations with families about sexuality and sexual health.

Findings also indicated that some of the nurse participants felt they do possess sexual health knowledge that allows nurses to be a resource for families and is similar to what has been noted in the literature (Edelman & Mandle, 2002; Evans, 2000; Sharpe, 2003; Smith, 1993; Stamler & Yiu, 2005). Although participants identified that not all nurses working in community health possessed expert knowledge in the area of sexual health, there appeared to be at least one or two expert nurses or “champions” within the health unit with whom the other nurses could refer families to or nurses could go to themselves to ask questions. Experienced nurses can provide support to novice nurses or those nurses with less knowledge or experience in this area (SmithBattle, Diekemper & Leander, 2004).

Although the nurses recognized the importance of having an expert or champion in the area of sexual health communication with whom other nurses could refer families to, it is important to consider the impact this may have on the health promotion strategy to normalize sexual health education and communication. As noted in the literature,
health promotion is a central tenet of contemporary community health nursing (Edelman & Mandle, 2002; Stamler & Liu, 2005). This tenet was an underlying philosophy described by all nurses interviewed. All of the nurses confirmed that supporting families with sexual health communication is a valuable health promotion and illness preventative strategy. Many of the nurses felt that it was “incumbent upon us” to offer support to families in relation to sexual health communication and other aspects of sexual health therefore, possessing knowledge in this area would enhance nursing practice.

**Formal Contact**

Nurse participants in this study reported the formal contact they have with families in regard to parent-child sexual health communication. Nurses described contact in relation to working on programs including maternal/child health, school-aged health, youth health, and communicable disease. Many of the nurses stated that questions related to sexual health sometimes arose while they were completing other services with families. In analyzing the data, it became apparent that families or family members often initiated the conversations related to sexual health and communication as opposed to nurses bringing up the topic during client interactions. This finding suggests that the nurse participants did not include discussion related to sexual health or sexuality as a common aspect of their practice but did address the topic when asked.

Although the evidence from this study suggests that families often bring up the topic of sexual health and communication, there were instances when the participants discussed assisting families with this process. Nurses working with the school-aged population spoke about inviting parents to puberty classes to enhance parent-child sexual health communication. They also described receiving feedback from families suggesting
that attending the puberty classes fostered parent-child sexual health communication. This example reinforces the point that parental attendance at puberty classes can enhance and potentiate the possibility of opening the lines of sexual health communication between parents and their children.

It must be noted that not all parents participated in the puberty classes; therefore access to families using this strategy is limited. Furthermore, parents who did attend may already be communicating with their child, therefore they are preaching to the converted, yet the parents who did not attend may be the families that really need to be accessed. As there are no formal studies conducted in this area, further review into parental attendance is warranted.

Youth clinic nurses described talking with both parents and their adolescents about sexual health issues and communication strategies. This occurred with parent-adolescent dyads, parent only, and adolescent only. A study conducted by Doswell et al. (2003) stated that nurses should conduct reproductive health counseling to families and this could occur in the youth clinic setting. Nurses stated that families, usually the mother and adolescent female would come into youth clinic together to discuss reproductive health issues with the nurse usually pertaining to contraceptives, pregnancy testing and options, and STI testing. This finding is similar to what is noted in other studies (Doswell et al., 2003; Hutchinson & Cooney, 1998; Lloyd, 2004) that described that it is often the female parent who discusses sexual health with their daughters.

On other occasions, parents would call or come in to the health unit independently to ask questions related to sexual health and communication and their adolescent. Youth clinic nurses talked about working with adolescent females to open up the lines of
communication with their parents, usually their mother related to sexual health concerns. Nurses described providing strategies and at times, role-playing with the youth to assist commencing sexual health communication. These health promotion strategies are particularly relevant for enhancing sexual health and sexual health communication amongst families and the findings from this study are supported by a study conducted by Doswell et al. (2003).

**Informal Contact**

Not only did nurses discuss their formal contact with families, but they also illustrated examples of informal contact they had with families related to sexual health communication. The informal contact resulted from these nurses being identified as trustworthy resources in the area of sexual health. Nurses provided examples of how friends with children would ask them sexual health questions as well as having acquaintances and strangers approaching them while they were out in the community, not working as a community health nurse. Individuals felt comfortable enough to approach these nurses to ask questions related to sexual health and communication. Despite not working at the time, the nurses provided the information as requested.

Some of the nurses described being identified as sources for sexual health information secondary to the work they provided. In particular, nurses who provided sexual health programs in the schools were highly recognized by parents as sources for information and therefore, were most often the nurses who described being approached. As there are no studies that report these findings, further research in this area is warranted.
Nurse as Resource

Nurse participants in the study described one of the ways they support parent-child sexual health communication as acting as a resource for families. The nurses discussed providing answers to questions that parents had related to sexual health and sexual health communication. Stamler and Liu (2005) recognized that the role of the community health nurse included primary prevention strategies such as acting as a resource to the community for sexual health education.

Nurse participants outlined providing resources to families such as literature, lists of literary references, and videos related to sexual health education. On numerous occasions during interviews, nurses identified Meg Hickling as a resource they often recommended to families. Meg Hickling is a British Columbian sexual health educator who is well-known within the community health nursing environment for providing sexual health content for parents in the forms of family-education nights, three sexual health related books and a series of videos for parents to support parent-child sexual health education. The nurse participants stated that they often recommended one of Meg Hickling’s books as a resource for parents to read to assist them in parent-child sexual health communication.

Nurses in this study also commented that if they were unable to provide parents with the support they needed, they would refer them on to other nurses with the required expertise or to other community agencies who provided this type of support. This finding suggests that there are nurses working in this area who do not have knowledge in the area of sexual health communication and that there is a need for further professional development on this topic.
Helping Families Initiate the Conversation

Through the thematic analysis of the data, it was evident that nurses’ role in supporting sexual health communication was through assisting with helping families initiate the sexual health conversation. Although the findings suggest that nurses often wait for families to bring up the topic, there was evidence that nurses help families get the conversations started. Nurse participants identified strategies they implemented to foster parent-child sexual health communication. These strategies involved the work these nurses do teaching puberty classes, coordinating youth health educators, and working in the youth clinic setting. For example, nurses felt that inviting parents to attend puberty classes was a positive means to open the door to communication of sexual health between parents and children. The classes provided an opportunity to learn the content their child was receiving which assisted them in being able to reinforce the information with their child at a later date. The child would know that the parent heard the same information and could potentially ask the parent questions pertaining to the content. A number of studies also support the inclusion of parents in sexual health education (Ball, Pelton, Forehand, Long & Wallace, 2004; Jaccard et al., 2002; Kirby & Miller, 2002; Tingle, 2002; Wacket & Evans, 2000). Nurses received positive feedback from parents stating that the classes were a positive influence on sexual health communication and the classes did assist the family with sexual health communication. Unfortunately, the nurses identified that not all parents attended the classes; therefore the program did not access all parents of these children. To assist in addressing this gap, nurses provided literature related to puberty and encouraged the students to take the information home and share it with their parents. Encouraging students to go home and discuss information as well as
providing take home assignments has been supported by other research studies (Kirby & Miller, 2002; Tingle, 2002). Kirby and Miller (2002) stated that it is possible to reach large numbers of parents through student take home assignments which do increase parent-child communication.

Nurses working with youth health educator programs also identified the work they do as fostering sexual communication within families. One nurse described the ripple effect the youth health educator program had on promoting sexual health education and communication within families. Her experience with the program was that students, who were working as youth health educators providing sexual health education classes in the elementary and junior high schools often went home and discussed the content with family members. This program not only provided important sexual health education to elementary, junior high and high school students (youth educators themselves), but the information also reached family members and subsequently initiated and enhanced parent-child sexual health communication. This example emphasizes how public health nurses and the programs they facilitate stretch further than they had initially intended and result in broader health promotion outcomes.

Nurse participants working in the youth clinic setting provided rich examples of how they often assisted in opening the lines of sexual health communication within families. Nurses gave examples of how they worked with families, usually mothers and daughters. Nurses would model effective communication techniques to initiate sexual health communication between family members, which could be used in later conversations. The nurses said that they often provided examples to the youth on how they could approach the topic with parents, including ideas on how to broach the subject
and what to say to their parents. In some circumstances, nurses stated that they would role-play with the youth to help them feel more comfortable and confident in having the conversation with their parents. Doswell et al. (2003) also support the pivotal role nurses can play in health promotion interventions and discussion in the clinic setting. The authors stated that nurses can provide support, information, and open up discussion around sexual health topics.

**Nurses’ Values and Beliefs**

Throughout the interviews, nurse participants alluded to and spoke directly about their values and beliefs around supporting families with sexual health and sexual health communication. These values and beliefs included: Parents are the primary educators; Education should start early; and Families’ comfort levels influence sexual health communication within the family.

**Parents are the Primary Educators**

The findings of this study have confirmed what other sexual health educators have pronounced regarding parents being the primary sexual health educators for their children (Hickling, 1999; Kirby & Miller, 2002; Woody, 2002). Nurse participants also believe that parents are the primary educators of their children and further, recognized that parents play an important role in the sexual socialization of their children. The nurses believed that parents are role models for their children and is supported in the research (Miller, 1994; Smith, 1993). Parents begin to educate their children about sexuality from as early on as infancy through bonding and attachment. Smith (1993) stated that parents
teach their children about love and trust through the relationships they have with their parents and other family members.

Parents also educate their children through verbal and nonverbal communication. Nurse participants described how parents educate their children about sexual health and sexual health communication by what they say or not say and also by means of their nonverbal communication techniques. Beausang (2000) recognized that children learn about values and beliefs about sexuality from their parents both explicitly and implicitly.

Parents who do not discuss sexuality or sexual health convey the message that sexuality discussion is something that is taboo and should not be discussed. Nurse participants agreed that parents should strive to be an “askable parents”. An “askable parent” is considered to be a parent who is open to sexual health discussion and has instilled a sense of trust and respect with their children that enables their child to approach them to ask questions, including those related to sexual health. Nurses can play a role in assisting parents in developing their skills to become “askable parents”. Nurses could provide parents with education in the forms of workshops and literature to assist them in developing skills in this area. At the time this study was conducted, there were no workshops or literature that was provided to parents specifically assisting parents in this area.

Nurse participants also illuminated the importance of parents teaching their children about family values and beliefs related to sexuality and sexual health. Woody (2002) and Hickling (1999) agree that talking to your child about family beliefs and values around sexuality is an important, if not essential role of the parent. Possessing
personal values and beliefs, in addition to having factual knowledge about sexuality are important to the adolescent sexual decision-making process (Woody, 2002).

Another interesting finding of this study was that although the nurses believed that parents are the number one educators of their children, it is felt that many parents are not communicating with their child about sexuality and sexual health. This notion is supported by numerous research studies (Hutchinson, 2002; Hutchinson & Cooney, 1998; Jaccard et al., 2000; Lloyd, 2004). This finding implies that support and education for parents in this area is warranted. The nurses believed that community health nurses are in a prime position to support families with sexual health communication but because of factors that hinder this process, such as lack of education, time, or comfort with the topic; this health promotion strategy is not widely taking place.

Education Should Start Early

Nearly all of the nurses interviewed believed that sexual health education and communication should start early. Some nurses supported starting as early as the infancy or toddler stages. These findings are consistent with other research conducted (Hickling, 1999; Miller, 1994; Smith, 1993). Many of the nurses felt that parents wait too long before commencing sexual health discussion, often waiting until their child is teenager. These nurses felt that parents who wait until their child is in their teen years to begin sexual health discussions has missed the opportunity as the child has already gone on to find other sources for sexual health information. Although nurse participants recognized the importance of starting sexual health education and communication early, it was evident that nurses working with young families do not reinforce this information. Nurses
working with young families are in a prime position to promote this health promotion initiative and have implications for nursing practice.

Some of the nurse participants articulated what information parents could or should be providing to their children related to sexual health. These findings are similar to what has been noted in other studies (Hickling, 1999; Hutchinson & Cooney, 1998; Lloyd, 2004; Miller, 1994; Smith, 1993). It is interesting to note that not all nurses interviewed were able to express their thoughts about what sexual health information parents should provide to their children. This may be indicative of a decreased level of knowledge related to sexual health topics, decreased understanding of age and stage appropriate sexual health information to provide or a reflection of nurses own values and beliefs around what sexual health information should be taught to children.

Families' Comfort Level Influences Sexual Health Communication within the Family

The findings of this study affirmed the notion held by other researchers that comfort level impacts sexual health communication (Baraitser, Elliott & Bigrigg; 1998; Beausang, 2000; Gamel et al., 1993; Kirby & Miller, 2002). All nurse participants interviewed recognized that comfort level with the topics of sexuality and sexual health contributed to whether sexual health communication occurred. The nurses described the impact of varying comfort levels on families.

Beausang (2000) described the importance of parents feeling comfortable to bring up sexual health topics for discussion with their children. Kirby and Miller (2002) outlined comfort with the topic as a factor that increases frequency of parent/child sexual health discussions. Nurse participants confirmed that comfort with the topic is an
enhancing factor fostering parent-child sexual health communication. If parents are uncomfortable, sexual health communication usually does not take place.

Most of the nurses interviewed felt that most parents are uncomfortable with sexuality and sexual health communication. Nurses felt that parents need to process their own thoughts and beliefs around sexuality to assist in being able to effectively communicate with their child about sexual health. Hutchinson (2002) also described the need for parents to examine their own fears and attitudes toward sexuality to foster the creation of a family environment that normalizes sexuality and promotes communication (p.246). This finding suggests that nurses could play a role in assisting parents through values clarification discussion and exercises.

Some of the nurses believe that parental lack of comfort with the topic negatively impacts the child’s comfort level. This occurs through messages conveyed by the parents both verbally and nonverbally. Nurse participants felt that parents who do not talk about the subject convey the message that sexuality and sexual health discussion is taboo, a finding supported by research (Beausang, 2000).

A few of the nurses reported seeing a correlation between family relationships where sexual health discussion occurred and an increase in adolescent’s comfort with their bodies and sexual decision making. Numerous well-designed studies support the fact that parents’ sexual communication with their children has a positive influence on sexual attitudes, initiation of sexual activity, use of contraceptives and sexually transmitted infection prevention (Hutchinson, 2002; Jaccard, Dittus & Gordon, 2000; Lloyd, 2004).
Factors that Enhanced or Hindered Nurses’ Ability to Support Families

As discussed in Chapter 4, nurses described distinct factors that enhanced or hindered their ability to support parent child sexual health communication. Enhancing factors included: Nurses’ interest in the topic; Access to education; Support of others; and Being a parent. Factors that appeared to hinder nurses’ ability to support parent-child sexual health communication were Lack of resources and Lack of comfort.

Nurses’ Interest in the Health Topic

Nurse participants interviewed who stated that they had an interest in the topic were more inclined to discuss sexual health and sexual health communication with families and described themselves as approachable, open and possessing a sound knowledge base. A few nurses stated being passionate about the topic and that supporting sexual health communication was part of their practice philosophy. An interesting finding from this study was that nurses who described themselves as having an interest in the topic worked with school-aged and youth clinic populations. This may indicate that nurses working with this population are more inclined to assist families with sexual health communication.

Access to Education

Nearly all of the nurses interviewed felt that education enhances their ability to support parent-child sexual health communication. All of the nurse participants stated that they did not receive any education in their diploma or undergraduate nursing training that assisted them with supporting parent-child sexual health communication. This finding bears a striking commonality to other studies (Haboubi & Lincoln, 2003; McKelvey et al., 1999; Meerabeau, 1999; SmithBattle et al., 2004). This finding implies
a gap in undergraduate training in the area of sexual health education. As it is recognized that community health nurses can play an important role in supporting families with sexual health communication, the provision of related training and education is needed.

The nurses reported being self-educated in sexual health and accomplished this through researching peer-reviewed journals, accessing appropriate web sites, and by attending post basic nursing courses, workshops, and conferences related to sexual health. A few of the nurses described two particular sources for sexual health, Meg Hickling and Planned Parenthood of British Columbia, now called Options for Sexual Health. These two sources were quoted throughout the study by nurse participants.

**Support of Others**

This study revealed that nurses believe that support of others enhances their ability to support families with sexual health communication. Nurse participants stated that the opportunities to work collaboratively with other nurses provided the ability to debrief about situations, ask questions pertaining to practice related to sexual health, and troubleshoot issues or concerns related to working with families. This was of particular benefit when the nurse was more novice with the content or practice. This finding is supported by the research (Benner, 1984; Benner, 1999; SmithBattle et al., 2004). SmithBattle et al. (2004) reported that less experienced public health nurses learn from experienced colleagues to promote clinical learning and skill development. This reinforces the point that pairing novice nurses with seasoned nurses is an important strategy to foster and support learning for beginner nurses.

Some of the nurses believed that attending meetings with other community health nurses in the region allowed for networking and opportunities to discuss programs, issues
and concerns related to sexual health. Community health management could use these opportunities to help support nurses in developing their knowledge and skills in the area of sexual health and sexual health communication.

Many of the nurses felt that a supportive management also positively impacted their ability to foster parent-child sexual health communication especially if they shared the same philosophy and provided time for nurses to research or attend educational opportunities to enhance knowledge and skills in this area.

Being a Parent

Nurse participants highlighted the importance of being a parent as a factor that had a positive influence on their ability to support families with sexual health communication. Nurses stated that their phenomenological view of parenting reinforced the importance that sexual health communication plays on the family unit. Because nurses needed to have knowledge to be able to support their own family, they developed knowledge and skills to support families within their nursing practice. The finding from this study can not currently be supported in the literature and further research is warranted. It is important to note that this finding does not consider or take into account those nurses who are not parents yet but are knowledgeable, skilled and comfortable with providing SHE to families. Furthermore, nurses who have not experienced particular health challenges such as cancer, heart disease or diabetes can still be effective patient educators or counselors.

Lack of Resources

Nurse participants discussed a lack of two resources that negatively impacted their ability to support families with sexual health communication. These resources were
a lack of time and a lack of funding to support professional education. As has been reported elsewhere (Evans, 2000), nurses in the present study identified a lack of time as a barrier to fostering parent-child sexual health communication, in part because they had no formal mandate for this kind of health promotion in their roles. If the public health agency values this type of health promotion but does not make explicit room for it, competing priorities that are formally mandated will continue to fill available practice hours. Nurses also described a lack of time for educational needs required to stay current with the topic. Nurses recognized that life long learning is a commitment of the nursing profession but find it difficult to complete if they are not given the time to be able to do it.

Nurse participants also stated a lack of money for professional education as being a factor hindering their ability to support parent-child sexual health communication. In order for nurses to stay current with the topic or develop programs that enhance parent-child sexual health communication, nurses need to be able to have the time to do this. This means that they need to be replaced by other staff so they can dedicate time to do this. As there are still key programs that need to be completed, these nurses need to be replaced so that the key programs continue.

Lack of Comfort

The findings of this study affirmed that a lack of comfort on the part of parents, children and nurses impedes nurses' ability to support parent-child sexual health communication. In comparing the results of this study to the findings from other studies (Albaugh & Kellogg-Spadt, 2003; Baraitser et al., 1998; Gamel et al., 1993; Haboubi & Lincoln, 2003; Lewis & Bor, 1994; Meerabèau, 1999) commonalities have emerged.
Nurse participants identified that embarrassment with the topic may hinder discussion around sexual health communication. Meerabeau (1999) stated that embarrassment can incapacitate individuals from performing a role and it may deter individuals from adopting health protecting measures (p. 1507). Nurses in this study also described embarrassment as a factor contributing to lack of sexual health discussion with families.

One nurse described the importance of nurses being comfortable with the topic of sexual health when working with families on sexual health communication. She stated that individuals can “pick up cues” when nurses are uncomfortable with the topic thereby hindering effective communication to take place between the nurse and client. On the contrary, if individuals accessing public health services are embarrassed about sexual health topics, they will be less likely to discuss sexual health communication with nurses.

Nurse participants identified that a lack of comfort with the topic may stem from a lack of education related to the area of sexual health. Nearly all of the nurses stated they had no formal training in their undergraduate nursing programs related to sexual health. Nurses had to self-educate themselves with this information. Lack of education is factor described in the literature as playing a significant role in health professionals comfort level with sexual health. Haboubi and Lincoln’s (2003) study indicated that a poor level of training in sexuality issues was a barrier affecting health professionals’ decisions to discuss sexuality with their clients. A study completed by Skelton and Matthews (2001) concluded that teaching information related to sexual health history taking can enhance health care professionals level of comfort and decrease embarrassment.
Nurse participants highlighted the impact of personal values and beliefs on comfort level related to sexuality and sexual health. Nurses felt that conflicting personal values and beliefs related to sexuality, may result from a lack of education, own experiences with parents and religious views. These factors have also been identified in the literature. (Beausang, 2000; Gamel et al., 1993; Lewis & Bor, 1994).

Lewis and Bor (1994) reported that nurses with greater knowledge generally had more liberal attitudes towards sexuality and therefore discussed sexual health more frequently with clients than those nurses that did not. Beausang (2000) stated that individuals who grew up with parents who did not discuss sexuality or sexual health were less likely to feel comfortable about their own sexuality and tended to repeat the patterns of sexual health communication set by their parents. Nurses participating in this study also supported these findings from the research.

Lewis and Bor (1994) stated that nurses who provide sexual health counseling or education should be aware that they may have personal biases around sexuality and there is a requirement to bracket or separate these biases when providing professional care. Furthermore, nurse need to recognize that people have their own personal beliefs about sexuality and nurses should take this into consideration and provide non-judgmental care.

Personal religious beliefs were identified by nurse participants as a factor that may influence comfort levels with sexual health communication. Some of the nurses indicated that parents may not communicate with their children about sexual health because of their religious beliefs. A few nurses also recognized that there are nurses who do not provide family support with sexual health communication due to their own religious beliefs. These findings concur with the results of a study conducted by
McKelvey et al. (1999) reporting that medical and nursing students who attended regular religious services were significantly more likely to have lower sex knowledge scores and were more likely to express negative attitudes related to sexuality and sexual health. Although it is important for nurses to consider the values and beliefs of the clients they are interacting with, nurses must also be aware of how their own values and beliefs impact the care they are providing. Nurses need to examine and weigh their own values and how they may influence the health promotion of others (Edelman & Mandle, 2002). This could be accomplished by nurses completing value clarification exercises that may assist them in better understanding their perspectives and the perspectives of others.

Nurses’ comfort level with the topics of sexuality and sexual health communication was a prevalent theme identified by nearly all of the nurses. Level of comfort with sexuality has been studied as an influential factor on health care professionals’ behaviours on sexual health teaching and counseling (Gamel et al., 1993; Lewis & Bor, 1994; Baraitser et al., 1998). Subsequently, although nurses and other health care professionals recognize the significance of sexual health care as an important component of practice, it has been documented that health care professionals find sexual health consultations challenging and are often reticent to bring the topic up with clients due to discomfort with this subject (Gamel et al., 1993; Baraitser et al., 1998).

The findings of this study concurred with the literature that nurses who are comfortable with the topic were more likely to discuss sexual health and sexual health communication with families. Nurse participants who stated they were comfortable with the topic described having an interest in the area and possessed knowledge and skills enabling them to support parent-child sexual health communication. On the contrary,
several nurse participants believed that nurses who lacked knowledge and skills often had discomfort with the topic and therefore did not discuss sexual health communication with families. The nurses did state that the nurses who were uncomfortable discussing sexual health with families often referred them to other nurses who were considered experts or “champions” within the health unit. Although it is commendable that some nurses make the effort to find another resource, they may be failing to normalize sexual health education.

Limitations

Although the study was conducted at five health units in the Central Vancouver Island region of the Vancouver Island Health Authority, results may be less transferable to other settings around the province of British Columbia. Health care services in British Columbia are governed by one provincial and five geographic health authorities (British Columbia Ministry of Health Planning, 2002). Although these health authorities share the same mandate, the means to which they achieve their targets vary. Noted variables include the variability of health care programs, initiatives, resources, policies, and populations served.

Another limitation to the study may have been that the researcher had previously worked with a number of the research participants in the area of Public Health Nursing. The researcher’s relationship with the participants may have had a positive influence on participants’ willingness to share their experiences or may have impeded their willingness to disclose values and beliefs pertaining to sexual health education. Every effort was made to minimize the researcher’s influence on participants’ responses such as
providing a mechanism for participants to provide additional information directly and potentially anonymously to the thesis advisors.

Implications for Nursing

The findings from this study provide direction for nursing interventions directed at supporting parent-child sexual health communication. This section will describe the nursing implications for practice, education, and research.

Practice

Increasing parental awareness about the importance of providing sexual health information to their children at an early age is an important strategy for community health nurses to consider. This upstream health promotion approach could be accomplished by providing parents with this information in prenatal classes, well-baby clinics, and parent-tot groups and through public service announcements (PSA). Community health nurses are in a pivotal position to advocate for community support and the development of programs for families.

Nurses and other health care providers could play a significant role in increasing parental awareness about the importance of sexual health communication with their children as they often have access to new parents. Increased parental awareness could be accomplished by nurses or health care providers simply identifying to parents that sexual health is an important aspect to consider and by providing parents with information to include for the developmental stages of their child. This information could be given verbally and enhanced by the use of literature. Information pamphlets such as those distributed by Capital Health (2002) in Edmonton are excellent examples of how sexual
health awareness can be increased in parents. By including this information as part of the development of their child, discussion of sexual health is normalized.

As many community health nurses are involved in school-based SHE programs, parent education sessions or workshops for parents could be included. These education sessions or workshops should incorporate the sexual health curriculum components provided to their children. It is important for parents to have an understanding of the sexual health information their child is receiving as parents may then be better educated and equipped thus enabling them to reinforce this information at home. The opportunity to perform values clarification exercises is also important to include as this may assist parents to have a greater understanding of their own sexual health needs. The parent education sessions could also provide parents with important sexual health information, including examples of how parents could effectively communicate with their children about sexual health information.

Nurse participants in the study stated that they had previously provided parent education sessions but found them to be poorly attended and they ceased to provide them therefore, further evaluation of parental needs is warranted. It would be prudent for nurses to examine how past sessions were marketed and conducted to assist in developing a positive and effective implementation strategy.

Current school-based SHE programs could strengthen parent-child communication by the use of take-home assignments. Children would be required to bring assignments regarding sexual health education home to discuss with their parents. The purpose of the homework assignments would be to promote discussion regarding
sexual health information, which may potentially provide a window of opportunity for parents and their children to engage in conversations about sexual health.

In recognizing the significance of parent-child sexual health communication, nurses could work with community leaders to advocate for, develop, implement and evaluate services and programs aimed at supporting families with sexual health knowledge and communication. Nurses could use grass root approaches to determine the needs of families within specific communities.

Nurses also need to advocate increasing public’s awareness of the importance of sexual health communication within families. Public service announcements (PSA) utilizing a variety of media mediums would also assist in increasing parental awareness of the importance of providing sexual health education to their children. PSA’s could be run on television, radio, and in newspapers. Posters promoting parent-child sexual health communication could be placed in the offices of health care providers, at schools, community centres, and on the buses.

As it was recognized in this study that not all nurses supported families with sexual health communication, directives related to this area of nursing practice needs to be clearly defined. If the public health agency feels that supporting families with sexual health and sexual health communication is an important health promotion strategy, nurses needed to be supported and given opportunities to carry out this initiative. It is interesting to note that in the last few years, VIHA South Island has been developing and piloting a new program called Healthy Choices. This program was created in collaboration with school districts, parents, youth, public health nursing and community sexual health educators. Healthy Choices is a comprehensive curriculum-based school health program.
for children and youth focusing on sexual health. Lesson plans for classroom education were developed and piloted in the 2003/2004 school year for students in grade five and six. VIHA, as they state on their website, believe that sexual health information should be provided at an early age. VIHA also recognizes that children and youth want sexual health information from their parents but realize that parents are often uncomfortable discussing sexual health information with their children. Therefore, VIHA’s Healthy Choices program provides parents with access to information through print resources, website, lending library and resource links. Nurses interviewed for this study did not mention knowing about the Healthy Choices program. VIHA may want to provide education and information to community health nurses working in other areas of the health region so they are aware of VIHA’s viewpoint on the subject and so that nurses can provide these resources for families.

Education and Professional Development

Community health nurses working with families need to have a sound understanding of normal sexual development of children and strategies that assist parents in sexual health discussion with their children. As noted in this study, there are community health nurses currently practicing who may require further education and increased support to meet this need. Education can assist in increasing knowledge and comfort levels with the topic of sexual health.

Level of comfort with sexuality has been studied as an influential factor on health care professionals’ behaviours on sexual health teaching and counseling (Baraitser et al., 1998; Gamel et al., 1993; Lewis & Bor, 1994). Subsequently, although nurses and other health care professionals recognize the significance of sexual health care as an important
component of practice, it has been documented that health care professionals find sexual health consultations challenging and are often reticent to bring the topic up with clients due to discomfort with this subject (Gamel et al., 1993; Baraitser et al., 1998). Strategies that may assist community health nurses currently practicing within the realm of public health include attending post-basic nurse training courses, reading professional journals and participating in sexual health-care related conferences (Gamel et al., 1993).

Basic nursing education.

Findings from this study suggest that most basic nursing programs fail to adequately prepare nurses in the area of sexual health. Many nurses described not receiving any sexual health education during their undergraduate nursing learning experience. The results of this study are further supported in the literature (Gamel et al., 1993; Haboubi & Lincoln, 2003; Lewis & Bor, 1994; McKelvey et al., 1999; Miles, Penny, Power & Mercey, 2003).

Nurse educators teaching in the undergraduate nursing programs need to be aware of the importance of integrating the significance of meeting sexual health needs of all clients, including families and the community into current nursing curricula. They can play a major role in increasing nurses’ knowledge about sexuality and sexual health. Gamel et al. (1993) recognized that nurses often do not include sexuality as a component of nursing care due to a lack of knowledge, discomfort with the topic and personal attitudes towards sexuality. Nursing curricula should be aimed at increasing undergraduate nurses’ knowledge about sexuality and sexual health including promoting its inclusion as an important aspect in the provision of nursing care.
Courses that include increasing nursing students' comfort with the topic in collaboration with assisting nursing students with addressing their own values and beliefs around sexuality would be beneficial. These recommendations could be accomplished in a number of ways: (a) incorporating sexual development into course content related to growth and development of individuals across the lifespan from infancy to the older adult; (b) including values clarification exercises around sexuality and sexual health in nursing communication classes to assist in bracketing prejudices and biases; (c) integrating the inclusion of sexuality related questions when teaching nursing students about history taking and assessment; (d) and including sexual health promoting strategies as important aspects of achieving population health and health promotion.

One reason why sexual health education and strategies to support families with sexual health communication may not be included in basic nursing education may be due to the overwhelming amount of topics and information that needs to be covered to meet graduate nursing competencies as regulated by the College of Registered Nurses of British Columbia. There are compelling pressures around course content in the undergraduate curriculum therefore, it is difficult to specifically address all health promotion initiatives.

Lewis and Bor (1994) identified that the lack of adequate training and reticence to discuss sexuality in undergraduate nursing curricula may stem from the discomfort felt by nurse educators themselves (p. 257). Therefore, post graduate nursing and health education programs should also address sexuality and sexual health as components of nursing care to include in the development of nursing curricula.
Continuing education/professional development.

Community health nurses working in the area of sexual health described self-educating themselves on topics involving sexual health and feel that nurses need further education in this area, particularly around supporting parent-child sexual health education. Many of the nurses described attending workshops, in services, reading and researching information pertaining to this topic. Continuing education workshops or in services aimed at increasing nurses’ knowledge on normal sexual development of children could be delivered by community agencies such as OPTIONS for Sexual Health who employ sexual health educators to provide this education. Currently, OPTIONS for Sexual Health British Columbia has developed a program to certify educators delivering sexual health education. Work is currently being completed to add a component of this program that includes assisting families with sexual health education. Although this program may be costly, VIHA could send a nurse or nurses to obtain this certification and these nurses in turn, could develop and deliver a workshop addressing the learning needs of community health nurses in the area.

Research

As there is relatively no research addressing nurses’ involvement in parent-child sexual health communication, further investigation is warranted. Replication of this study in other health authorities could assist in determining if these findings are congruent and consistent with other community health nurses’ experiences working with families thereby strengthening the validity of this study’s conclusions.

Qualitative and quantitative research methodologies utilizing questionnaires and focus groups for data collection would be beneficial in gathering information pertaining
to nurses’ involvement with parent-child sexual health communication, nurses’ values and beliefs around parent-child sexual health communication, and factors that enhance or hinder nurses’ ability to support parent-child sexual health communication.

A need to conduct more research examining parental needs for providing sexual health communication with their children appears to be a prevailing issue identified in current literature and may assist community health nurses in developing programs aimed at supporting families. Questions that should be addressed are “How do we get parents and children talking about sexual health?” “How can we normalize parent-child discussion about sexual health?” and “What do parents need to support them in their efforts to provide sexual health education to their children?” Schalet’s (2000) study on adolescent sexuality in the Netherlands and United States describes different approaches parents take regarding the sexuality of their children. Parents in the Netherlands are accepting and normalize adolescent sexuality whereas their American counterparts tend to control or ignore their children’s sexuality. The Dutch parents’ philosophy may play a contributing factor to their country’s low teen pregnancy rate and delayed age of first sexual intercourse (17.7 years versus 16.3 years for American teens) (Mabray & Labauve, 2002). Therefore, it may be beneficial for nurse researchers, educators and community health nurses to take a closer look at the contributing factors underlying Dutch parents’ philosophy on sexual health communication with their children.

Parent participants for research regarding identifying parental needs for supporting parent-child discussion about sexual health could be recruited through school districts and public health programs. The use of data collection strategies such as questionnaires and focus groups could provide pertinent quantitative and qualitative data.
and the triangulation of this data could yield rich information to assist individuals developing and implementing SHE programs for parents.

It is also important to conduct research that identifies adolescents' perspectives on their needs regarding parent-child communication. As with parent participants, access to study participants may be recruited through school districts and public health programs. The McCreary Centre Society in British Columbia has yielded some extremely important and useful information regarding adolescent health through their Adolescent Health Survey III (The McCreary Centre Society, 2004). By including questions pertaining to parent-child communication about sexual health in their next survey, important adolescent perspectives could be uncovered.

Conclusion

In conclusion, the findings from study have contributed to our understanding of nurses' involvement in parent-child sexual health communication and the factors that influence this involvement. Community health nurses who participated in this study provided support to families with sexual health communication, however participants acknowledged that more work could be done in this area. As these nurses have competing priorities that are formally mandated, public health agencies that values the importance of supporting parent-child sexual health communication need to explicitly provide room for this to take place. Current undergraduate nursing curriculum could benefit from exploring avenues to increase nursing knowledge, skills, awareness and comfort with the topic of sexuality and sexual health.
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Re: Study, What is Nurses’ Involvement in Parent-child Communication Related to Sexual Health?

Dear Nurse,

My name is Sandy Alexander and I am a graduate student in the Master of Science in Nursing Program at the University Of British Columbia School Of Nursing. I would like to invite you to participate in a study I am conducting. I am interested in talking with nurses who work with families. My topic area is sexual health information across lifespan. This study is part of the requirements for my graduate studies education.

The purpose of this study is to explore and describe nurses’ involvement in parent-child communication about sexual health. The goal of this research is to provide a rich description of the experiences, process and culture of nurses working with families and their involvement with parent-child communication about sexual health.

Your participation in this research study will allow you to share your perspective and voice related to your work with families, which may potentially influence public health programs to better support your nursing practice, future nursing policy practice and nursing education.

To gain a better understanding of nurses’ role in parent-child sexual health communication, I will gather information from study participants through an interview process. In order to facilitate this research, study participants meeting the following criteria will be selected. This selection criterion includes: (a) Community or Public Health Nurse working with families (b) currently working in the Central Vancouver
I have received a copy of this consent form for my own records.

I consent to participate in this study.

__________________________  _______________________
Participant Signature        Date

__________________________
Printed Name
APPENDIX C

Potential Questions

1. How long have you worked as a nurse?

2. How long have you worked as a public health nurse?

3. What are your areas of practice in public health?

4. What client population do you work with in your role of public health nurse?

5. What kind of role do you think parents should play, or can play with regards to their children’s sexual health? How might this change over the child’s lifespan?

6. What kind of role do you think nurses can or should play with regards to helping parents do this?

7. What do you do in your practice that might help families talk about sexual health issues with their children?

8. How do you think other nurses help families talk about sexual health issues?

9. If you provide strategies to help parents and children talk about sexual health issues, what are some of these strategies? Do you do things differently when the children are at different developmental stages?

10. If applicable, how did you learn to support parent-child sexual health communication?

11. What do you need in relation to education to help you to support parent-child communication about sexual health?
12. What enhances your ability to support parent-child communication about sexual health?

13. What hinders your ability to support parent-child communication about sexual health?