

THE LIVED EXPERIENCE OF REGISTERED NURSES CARING FOR PATIENT
LIVING WITH HIV/AIDS IN BROWARD COUNTY, FLORIDA:
A PHENOMENOLOGICAL INQUIRY

DISSERTATION

Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy in Nursing

Barry University

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2016

THE LIVED EXPERIENCE OF REGISTERED NURSES CARING FOR PATIENTS
LIVING WITH HIV/AIDS IN BROWARD COUNTY, FLORIDA

DISSERTATION

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2016

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Abstract

Background: Vulnerability, opportunistic infections, and infection-related illnesses, caused by the human immunodeficiency virus (HIV), progressively overwhelms the human immune system resulting in acquired immunodeficiency syndrome (AIDS). The HIV/AIDS epidemic continues to slowly and non-discriminately spread continentally with dramatic consequences on the life expectancy of anyone who develops this pervasive illness/disease. The virus, HIV is well documented and is commonly transmitted through risky behaviors of human contact, and if left unattended and untreated, leaves a path of destruction and devastation of monumental proportions. HIV/AIDS dramatically leads to long struggles and concerns for human rights and end-of-life (EOL) care.

Purpose: The purpose of this research study was to gain an in-depth epistemology of registered nurses lived experiences in caring for people living with HIV/AIDS in Broward County, Florida.

Philosophical Underpinnings: The philosophical underpinnings that directed this study were buried in the interpretivistic paradigm to investigate the meaning of a particular sample of registered nurses using a qualitative research approach.

Method: This study employed a descriptive/interpretive paradigm navigated by Max van Manen's phenomenological method. Purposive and snow-ball sampling were utilized by the researcher to recruit registered nurses (RNs) for the study. Data collection was acquired using digital voice recorders to conduct semi-structured face-to-face interviews with a maximum of 12 elected participants.

Results: Four major related themes were conclusive from the findings of the study, as

unknowing, incapacitating, dejecting, and nurturing, and five sub-themes of swimming in deep waters, exasperating, dreading occupational exposures, feeling of emptiness, and emotional and physical support through this phenomenological descriptive/interpretive exploration. These themes and sub-themes showcased registered nurses experience in providing care to patients living with HIV/AIDS in Broward County, Florida. Margaret Newman's (1978) grand theory of Health as Expanding Consciousness was the theoretical framework applied to the themes/sub-themes for further understanding.

Conclusion: This phenomenological research inquiry coupled with Max van Manen descriptive/interpretive methodology exhibited the complexity registered nurses endure when providing care to patients living with HIV/AIDS in Broward County, Florida. The results of the study emphasized the quintessence of nurse's experiences by illuminating the fear of the unknown dealing with the disease HIV/AIDS, in which they displayed courage, resilience, empathy, and nurturing while caring for this fragile population. The experiences described in this study by the participants caring for patients living with HIV/AIDS in Broward, County Florida, highlighted the numerous effects of the disease on healthcare and nurses alike. There is a necessity for a comprehensive approach to make it possible to provide appropriate nursing care that can also address the new threat of HIV infection in Broward County, which has developed rapidly than expected. Participant's enthusiasm in sharing their life world experience on caring for patients living with HIV/ADS culminate the general purpose of this phenomenological study.

ACKNOWLEDGMENTS

After an intensive period of three years three months and 24 days, today is the day that the Lord has made, I shall rejoice and be exceedingly glad in it. This note is written anxiously to place the finishing touch on my dissertation. It has been a period of intense learning for me, not only in the scientific arena, but also on a personal level. The Lord has given me the ability to write this dissertation, which has left an everlasting effect on my intellectual well-being. In the ring of fascinating things, the obligation takes precedent to reflect on the people who have supported and helped me through this cumbersome period of my life. No one ever said attaining a PhD was an easy task, this certainly was not, and my life was dedicated to this torturous pathway.

Overtaken by the spirit of humility with a penitent and contrite heart the time has arrived to thank a few people who have made life so much easier on this journey. First and foremost I must first give thanks to the Almighty God and ruler of my life for sparing and preserving me with the courage to undertake this brave journey in my delicate life. I also would like to express my sincere thanks and gratitude to all the participants who dedicated their time and patience in letting me in their lives to comprehend their experience caring for patients living with HIV/AIDS in Broward County, Florida.

The very elite and courageous doctoral committee deserves to be recognized at this time for their kind, unselfish, diligent, and supportive expertise offered to me through this marathon was indispensable and matchless. They were there in living colors as a torch that light my pathway in guiding my foot steps on this journey and culminating this

degree.

Dr. Claudette R. Chin, my committee chair. To whom I am deeply indebted for her unselfish love and unwavering devotion, always there at the drop of a hat in my darkest hours of need. It is really a pleasure to have you as my chair, which I consider myself very blessed and fortunate to have you in my life, your faith, confidence, and trust that you placed in me, and the support and guidance delineated to me when I needed it the most word cannot express. From the delicate fiber of my being, I simply want to say a joyful thank you from the bottom of my heart.

Dr. Jessie M. Colin and *Dr. Ferrona Beason*; both of my committee members. Sincere thanks and kudos to both of you for being there for me every step of the way with your special words of encouragement. It is incumbent on me to also compliment you both on the tireless effort of reading and reading this dissertation over and over again; God knows I really do not know how you all do it. There is a special place in Heaven for this committee.

To my family and friends; let it be known “you are simply the best.” Special arrangements were made for me to study without disturbances, how considerate, my wife make sure I am fed, clean, and ready to go at all times, insanely matchless a priceless act.

This acknowledgement would not be resolute without offering gratitude and recognition to a few of my very dear friends Vedete Llewellyn-Borde, David Anthony Harris, Marie Nestant-Brown, Garfield Young, Georgia Peart-Jackson, and my very supportive cousin Michelle Smith-Blair who have all been there for me every step of the way cheering me on. Always relentless in wanting to know my academic status and

requesting an updated and even a grade card as if they were my professors or guardians.

Kudos to you guys friends for life. Memories to cherish for a lifetime.

Special tribute goes out to my cohort, a dream team of three, namely, Betty Bogart and Jamela Morton sergeants who does not take “no” for an answer. We have been through thick and thin together, sweet and bitter moments, but held on tightly to get this degree completed together. A dream team with memories for life. How must I forgotten my adopted sister Dezma Blair who is a tower of strength, and an excellent resource person who is invaluable, generous, a real dedicated public relations officer any one would be obliged to have on their team.

DEDICATIONS

To God be the glory, honor and strength who kept me in shape and reminded me every hour of the day that the race is not given to the swift nor the strong, but to he that endures to the end (Ecclesiastes 9:11 and Matthew 24:13).

In humility I would like to share this moment with my wonderful family; wife Arlene, son; Anthony, and daughters; Elisia, Deirdre, Shanice, and Jodi-Ann. Grandchildren; Kayhlia, Shania, Alyssa, O'dain, Amy, and Jordan who all adore me, and shower me with love unconditionally on this road, even when I have forgotten precious family get together. I love you all from the deepest part of my heart.

This dedication is centered securely on my dear grandmother Eva Dora (Doris) Coke, (1910 to 1995) gone but still not forgotten, always in my heart as I traverse this universe. She has nurtured and cherished me from the tender age of three months old through to young adulthood, placed the mantle at my feet always telling me education is the poor man ticket out of poverty. Insisted that I do well in school and was able to pull an accountant out of me as the fruit of her labor. I want to close by saying she was my inspiration I can fly higher than an eagle because she was the wind beneath my wings, the rock of Gibraltar who inspired me that I could be everything I wanted to be. This leaves me to quote the scripture "I can do all things through Christ who strengthened me."

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CHAPTER ONE

The twilight of the early 1980s heralded a precarious instability on the global landscape with plausible reactions. This instability was manifested in the discovery of an unknown virus impartial and unkind to humans. The rapid proliferation of this virus had the world's reaction on edge, confused, troubled, and nervous anticipating a name for an investigation. The impact of this disease had healthcare in a quandary, and found registered nurses (RNs) sitting on the edge of their seats trembling with sweaty palms, and emotional instability for fear of the unknown. Although major strides have been made to combat this disease since its discovery; no attempts were forthcoming in understanding nurse's day-to-day engagements, and relationships in the provision of care to patients infected with this unknown disease. Rosenberg, Taliaferro, and Ercole (2012) inferred that RNs are an important population to study to better understand their current awareness of the disease from actual clinical experiences and observations.

Actual clinical experiences and observations yielded several names to this unknown infectious disease, such as gay men cancer, Kaposi's sarcoma, and gay related immune deficiency syndrome (GRID) (Centers for Disease Control and Prevention [CDC], 1982). Pragmatism oversaw the legal name assigned called human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS). The advent of HIV/AIDS enacted guidelines and proliferated numerous studies in the battle to inhibit, stabilize, care, and to find a cure for this disease. The metaphor that alluded to experience as the precursor of wisdom and wisdom as the brainchild of knowledge is an exceptional, phenomenal, and unique way in understanding the care and treatment of

patients infected with HIV/AIDS. The discovery of HIV/AIDS has created an impact globally with severe restrictions, shortages, and scarcities in resources on the healthcare continuum. This disease is viewed as an unstable phenomenon heading in the 21st century ripping homes, families, and healthcare communities to threads with its force.

Researchers have long concluded that HIV/AIDS is a health crisis and that the virus is carried from an infected person to a healthy person by blood, semen, vaginal fluids, and breast milk. Recent report infers that an estimated 1.7 million persons in the United States are infected with HIV/AIDS and an estimated figure of 1.2 million people are living with the disease (UNAIDS, 2011). The frontline workers handling this health crisis are registered nurses (RNs) in a bid for care and support. The daunting effects of this notorious pandemic have created an unstable environment in the medical community at large, including nursing.

RNs are considered to be the largest group of healthcare providers straddled with the daily responsibility of providing intimate and personalized care for patients living with HIV/AIDS (PLWHA) to date. Even though it is the nurse's responsibility to provide care for PLWHA, challenges and problems still remain. These issues require serious and immediate attention in recognition of nurses lived experiences managing this disease on a daily basis as the infectious rate keeps climbing the ladder. One of these challenges in managing this disease that is significant to mention is the fear of contracting the disease. This may influence the unwillingness of nurses to provide care to PLWHA. To understand the plights of nurses, this study employed a phenomenological perspective, a qualitative method of inquiry to gain an understanding of the lived experiences of RNs

providing care to patient living with HIV/AIDS in Broward County, Florida.

Problem and Domain of the Inquiry

Background of the Study

HIV/AIDS is a serious and critical problem that has enacted a paradigm shift on the global landscape in recent years. The discovery of HIV/AIDS in the early 1980s ushered in a serious climate that overtook the world by surprise. This illness/disease, with the help of human behavior, primarily has no reservation for border crossings or boundaries. Without further advances in wisdom, knowledge, and understanding HIV/AIDS and related illnesses are destined to wreak havoc, destroy, and kill mankind; meanwhile, draining needed resources locally, nationally, and globally.

Recent estimates have shown that in 2013 there were greater than 35 million people globally living with the virus of HIV (UNAIDS, 2013). Relatively, opportunistic infection proliferates contributing to countless secondary illnesses and complications. These piggybacking effects accounted for the death of more than 1.7 million people through 2011. Another pivotal point to address is the stagnation of life and barriers to positive outcomes. PLWHA encounter stigma, discrimination, stereotyping, negative attitudes, fears, and inappropriate judgments associated with this pandemic.

The recent reporting of a staggering rise in the number of HIV/AIDS cases gives pause to those who are managing and caring for PLWHA. It is frightening to RNs in communities, such as Broward County, Florida and other regions in the United States that were relatively low impacted by the HIV/AIDS epidemic, are now experiencing a proliferation of new cases on the national landscape for that matter. The scientific

community, including nursing, has made leaps and strides in the management of this illness/disease, still there are much more to be done and to be understood. Accordingly, it is extremely important to understand the litany of negative attributes associated with HIV/AIDS in today's society.

In the world in cases of PLWHA the United States is one of the well-developed nation in the universe, albeit, the country is one of the hardest hit and affected society with the HIV/AIDS epidemic geographically. Destruction and erosion of the community's safety nets are significantly impacting the healthcare delivery system (HCDS). The magnitude of this self-destruction is seen in structural and financial resources, and behavioral responses. Structural resources are hospitals, primary care centers, clinics, community outreach programs, and nursing shortages. Behavioral responses are exhibited by negative attitudes associated with (a) stigmatization, discrimination, marginalization, and fear; and (b) stereotyping, inadequate nursing support, lack of compassion, disbelief, and panicking.

According to UNAIDS (2006), HIV/AIDS-related stigma and discrimination are the most technical barriers to the HIV/AIDS epidemic. Parker, Easton, and Klein (2008) inferred that macro-structural barriers should be used to understand how stigmas and discriminations are created. Several factors contribute to human ignorance in relation to the means of transmission. For instance imposed poverty, and gender inequality create social contexts in which HIV/AIDS stigma is cultivated and released on the human rights of PLWHA. This evidence of stigma leads to self-worthlessness, poor self-esteem, and loss of status, discrimination, and failure to use healthcare services (Deacon, 2006).

Even after 40 years, HIV/AIDS continue to inflict fear, instability, and anxiety in many people, including nurses. This should not come as a surprise. We are primarily only in our second decade of the 21st century, and still we are a long ways to a cure for HIV/AIDS. Anti-retroviral therapies (ARVs) remain an iatrogenic destructive force to the human immune system (Hodgson, 2006). The lack of control of our quality of life (QOL) and end of life (EOL) is driving many of the negative responses with the tendency of attributing stigma and blame. This is especially strong when an illness is mysterious and apparently out of control (Nelkin & Gilman, 1988). As reported in many research studies, HIV/AIDS has claimed millions of lives, and has permanently transformed the landscape of life in multifarious ways unimaginable. Consequently, healthcare workers, especially nurses, continue to find it extremely difficult to provide essential care to PLWHA on the continental landscape.

The science of nursing and the devoted nurse scientists have provided evidence-based research (EBR) in voluminous quantities. In an effort to share critical knowledge with nurses on HIV/AIDS, as an illness/disease in the provision of care, nurses must advocate worldwide for affordable access to health plans in the healthcare market-place. It is a paramount role for nurses to understand that they are saddled with the daily responsibility in caring for people diagnosed, and those living with this illness/disease. The negative attributes associated with HIV/AIDS continue to create a significant amount of stress, anxiety, fear, and duress among this body of frontline workers in the fight against this disease.

The delivery of appropriate and evidence-based nursing care for PLWHA is

influenced by many critical factors, such as fear, stress, pain, discomfort, stigma, attitude, or intimidation experienced emotionally at the point of care. The talk and action of nurses leaving the profession to avoid direct contact with PLWHA is astounding. This demise contributes fundamentally to the nursing shortages of all-time here in the United States, globally, and on the continental landscape. As a result, advancement in nursing practice requires nurses to comprehend, anticipate, recognize, and decipher how to respond and address these unique factors. In addition, nurse scientists are needed to explore and address these unwelcomed attributes. Subsequently, information generated through these EBR processes may be applicable for evidence-based nursing practice globally.

HIV/AIDS on the Continental Landscape

The challenges of HIV/AIDS on the continental landscape continues to progress in both size and multiplicity, and has exceeded all possible potentials since its embarkation and recognition 40 years ago. As a result of its strength the dares of this phenomenon will be briefly addressed on six continents with the exception of the Antarctica, which has no human inhabitants. It is imperative to mention that HIV/AIDS rapid proliferation has created significant stressors on population, structure, economic growth, social, and capital gains in *Africa, Asia, Europe, Australia, North and South America*, in particular the *United States, Florida, and Broward County* the site chosen for this study.

Africa. The art of caring for persons diagnosed with HIV/AIDS presents similar concerns, issues, and challenges. We share in the blockade of problems and barriers experienced in many countries, including the continent of Africa. The continental regions of Africa (see Figure 1) have had one of the hardest hit of HIV/AIDS cases (see Table 1). From shore to shore, some of the poorest countries on the planet, such as those in Africa and the Sub-Saharan regions, are encountering insurmountable calamities.

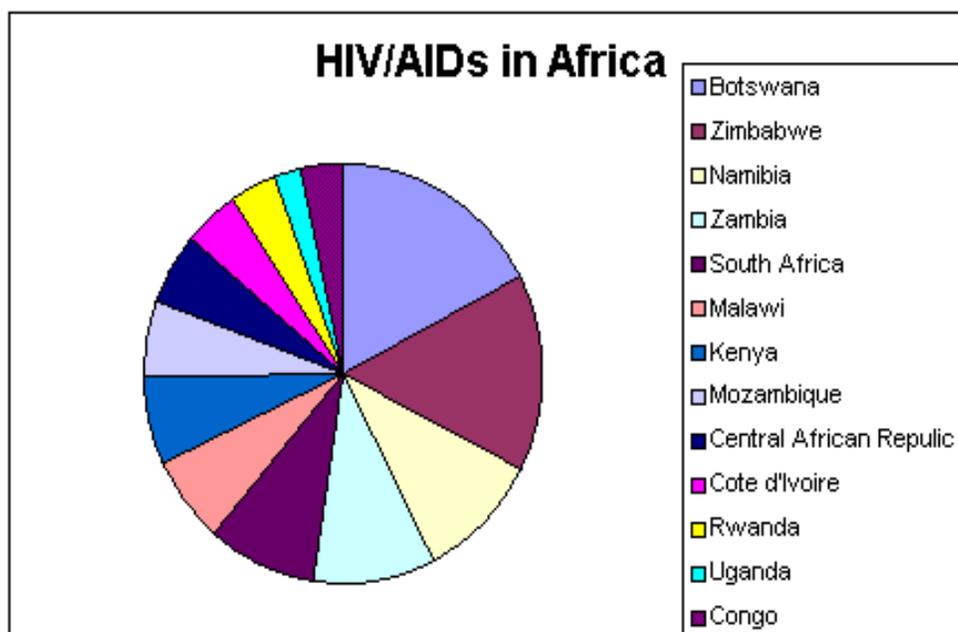


Figure 1. UNAIDS World AIDS (2012). Figure 1 illustrates the number of people in the continent of Africa infected with HIV/AIDS. The graph visually connects HIV/AIDS data with regions in Africa with the millions infected in the region.

The illustration in Table 1 displays that the country with the highest percentage of adult populated cases of HIV or AIDS infection on the continent of Africa is Botswana, and the country with the lowest percentage is Uganda. In contrast, the country with the highest number of adult populated cases of HIV or AIDS is the Democratic Republic of Congo and the two countries with the lowest number of adult populated cases of infection

with HIV or AIDS are found in Botswana and Namibia respectively (UNAIDS, 2012).

Table 1
Estimated Number of HIV/AIDS Infections in Sub-Saharan Africa

Country	%	N
Botswana	38.8	2,000,000
Zimbabwe	33.7	13,000,000
Namibia	22.5	2,000,000
South Africa	20.1	44,000,000
Malawi	15.0	11,000,000
Kenya	15.0	31,000,000
Mozambique	13.0	18,000,000
Central African Republic	12.9	4,000,000
Cote d'Ivoire	9.7	17,000,000
Rwanda	8.1	8,000,000
Uganda	5.0	23,000,000
Democratic Republic of Congo	7.2	54,000,000

Note: Data provided by United Nations Autoimmune Disease Syndrome Organization (UNAIDS 2012).

According to the UNAIDS Organization (2013), Global AIDS Response Progress Reporting, there is currently an estimated 35 million people infected with HIV globally with 1.7 million AIDS-related deaths, and 2.5 million new HIV infections (see Figure 2).

A point of interest; Africa has cut AIDS-related deaths by one-third in the past six years. Research findings suggest that this dramatic decline may be connected to the statistical data of improved life expectancy of the PLWHA due to a decrease in the number of AIDS-related deaths in the region.

Adults and children estimated to be living with HIV | 2013

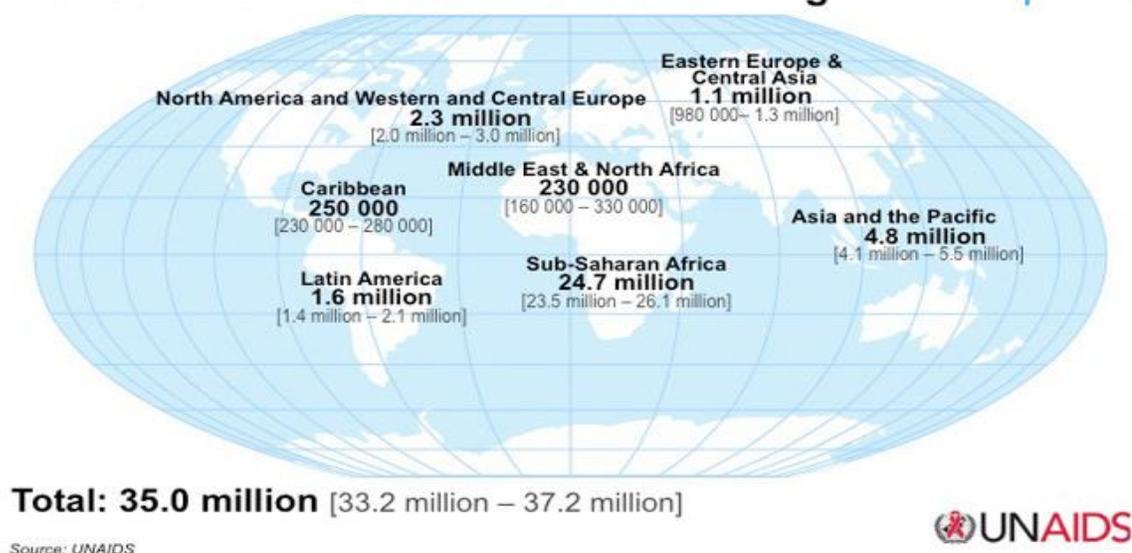


Figure 2. Wright, A. A. (2015). Adopted from *Global Surveillance: People Living with HIV/AIDS (PLWHA)*. Adopted from UNAIDS (2013).

Asia. The Asian Diaspora UNAIDS (2009) reported that of the more than 34 million adults and children living with HIV/AIDS worldwide, an estimated 4.8 million people living with this disease live on the Asian continent. Therefore, a collage of diverse structural challenges account for the vulnerability of each country in the region relative to the spread of HIV/AIDS. This is due in part to stigmatization, marginalization, cultural drawbacks, and discussion of sexual behaviors. Hence, high rate of sexually transmitted infections (STIs), limited condom use, a large defined sex-work industry,

poverty in combination with low social status, gender biases against women, inequality and illiteracy, interstate and cross-border migration, and men having sex with men (MSM) are some of the potent factors for the rapid proliferation (Haacker & Claeson, 2009).

Europe. According to the World Health Organization (WHO) in 2011, approximately 1.6 million people were living with HIV in 2001. It is now suggested that there is an estimated increase of 2.3 million people living with HIV/AIDS in Europe. It is further suggested that the count is still rising. It is believed that the number of people living with this disease in western and central Europe grew from 640,000 in 2001 to 900,000 in 2011, and an estimate of 30,000 new infections were reported in 2011. The three predisposing factors to HIV infection in Europe are illicit drug uses, sharing of contaminated needles, and risky sexual behaviors. In 2011, the fatality of the disease had claimed the lives of 7,000 adults and children.

Australia. The Australian Federation of AIDS Organization in 2012 reported that an estimated figure of 31,645 cases of HIV and 10,446 diagnoses of AIDS. In 2011, a report of 6,776 AIDS-related deaths occurred since the first diagnosis in 1982. A reported estimate of 24,000 people are living with HIV/AIDS (PLWHA); of that number, 22,000 are men. Subsequently, the increase in diagnoses in 2011 is considered to be the result of an increase in newly acquired HIV infection among gay men and MSM, risky behaviors, increased HIV testing, and illicit drug users with needle sharing. HIV/AIDS response is evidence-based and reports on an annual basis of the developmental strategies to minimize HIV/AIDS transmission, and to support people living with the disease (The

Australian Federation of AIDS Organization, 2012).

North/South America. UNAIDS (2011) reported that in comparison to western and central Europe, the number of persons living with HIV/AIDS in North America continues to grow reaching a staggering total of 1.5 million in 2011, which includes 4,500 children. During this reporting period of 2001, there were 58,000 newly infected cases; fewer than 100 children in the region became infected. An estimated figure of 20,000 people died of AIDS-related causes. In 2009, North American women comprised about 26% of the people living with this disease, which leaves men as the dominant force.

UNAIDS (2009) suggested that the HIV/AIDS epidemic has changed a little in recent years in South America. An estimated figure of 1.7 million people living with HIV/AIDS with a growth spurt in that region in 2009 has been reported. This region has seen an increase from 1.1 million in 2001. New infections occurred in 2009 with an estimated figure of 92,000, and 63,000 AIDS-related deaths. The primary modes of transmission on both North/South American continents are concentrated around networks of MSM. However, social stigma has kept many of these infections among MSM hidden and unacknowledged. There is also notable burden of infection among sex workers, clients of sex workers, and illicit drug use with needle sharing (UNAIDS, 2009).

According to the CDC (2012), on the continental plains of North America lies the United States of America, which is a strategic player in the HIV/AIDS epidemic. Statistics has shown that there are 1.2 million people living with HIV/AIDS infection, and almost one in seven (14%) are unaware of their infection, which is translated into 168,300 individuals. The number of persons living with HIV/AIDS has seriously

increased, while the annual figure of new HIV/AIDS infections has remained relatively stable. However, since 2010, the stride of new infections continues particularly among certain subpopulations. There is an extremely high level related to an estimated number of new HIV infection in the United States. MSM is the most affected subpopulation (CDC, 2012).

Centers for Disease Control and Prevention (2012) acclaimed that in recent years, the projected occurrence of HIV/AIDS remains constant at 50,000 new HIV infections per annum. The estimate has seen some groups affected more than others. Thus, MSM continue to bear the full force of HIV infection, among races and ethnicities, while African Americans also continue to be disproportionately affected. An estimated 47,352 persons in 2013 were diagnosed with HIV infection, and 26,688 were diagnosed with AIDS. This has garnered a total of 1,194,039 persons in the United States diagnosed with AIDS.

In spite of advances in combating the disease hundreds of thousands have already died with AIDS a total of 13,712 persons in 2012. At the end of 2010, an overall cumulative total of 658,992 people have died in the continental United States. The effect of the epidemic varies across the country and it continues to have a disproportionate influence on certain populations, particularly racial and ethnic minorities and gay and bisexual men. Even though medical developments and programs aimed at prevention and care have reached many people with or at risk for HIV/AIDS; looking across the spectrum at HIV/AIDS diagnoses to viral suppression, revealed missed opportunities for addressing the epidemic. The population profoundly affected by HIV/AIDS is gay,

bisexual, Men having sex with men (MSM) of all races and ethnicities (see Figure 3).

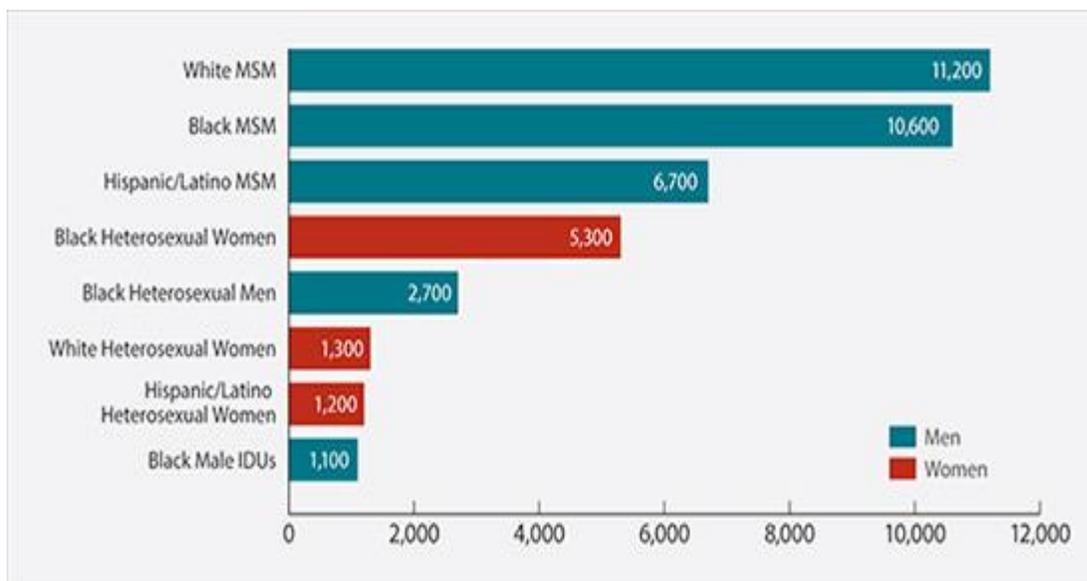


Figure 3. Wright, A. A. (2015). *Estimated Numbers of New HIV Cases in the United States*. Adopted from the CDC (2012).

Figure 3 depicts that MSM has the highest prevalence in the Caucasian population as to other gender-based groups. Data of estimated numbers of new HIV cases in the United States is furnished by the CDC (2012). This group makes up gay, bisexual and combinations of other men engaging in sex with men. The challenges here are to modify lifestyle behaviors and focus on prevention.

Florida. The reason for focusing on Florida is that the HIV/AIDS epidemic is no stranger to the health, wealth, resources, and well-being of the State. Subsequently, it is important to denote the statistical implications on the State's ranking, population, and healthcare maneuvering to effectively manage those PLWHAs. This State has been heavily impacted and continued to rank third in the nation in cumulative number of AIDS

cases of 126,581 in 2012, and second in the cumulative number of HIV cases of 49,058. It is estimated that there are approximately 130,000 PLWHAs in Florida. The estimated subpopulation breakdown of those living with HIV/AIDS is 49% Blacks, 29% Whites, and 20% Hispanics. Men accounted for 70% of the cases, while individuals represent 60% over the age of 45 years. To prevent the spread of HIV/AIDS, the Florida Department of Health has developed comprehensive programs for providing care and treatment to those infected (CDC, 2012).

Broward County. Broward County is a Metropolitan center with a population of 1.84 million people nestled between West Palm Beach and Miami-Dade Counties. It is considered the second most populous County in Florida, and the 18th in the United States (Florida Department of Health, 2012). It is on a fast track occupying second place in Florida with the most number of new HIV/AIDS cases in spite of all the resources that are available for prevention and treatment. New statistics have shown that HIV infection has risen by 25% and half of the new cases are among gay and bisexual men. This is a community where the virus has been on the rise in recent years. The basic statistics for 2012 saw 879 new HIV diagnoses with 59.4 diagnoses per 100,000 persons, 726 HIV without AIDS, and 149 (17%) HIV cases concurrent with AIDS (Florida Department of Health, 2012).

There were 377 new AIDS diagnoses with 149 concurrent HIV/AIDS diagnoses, and 17,051 persons living with HIV/AIDS, which is 1.2% of the population of Broward County. The year 2012 saw Blacks over-represented among the AIDS and HIV infection cases accounting for 58% of adult AIDS cases, and 42% of adult HIV infection cases, but

only 25% were of the adult population. Further indications show that the age range of 40 to 59 males and females combined accounts for 64% of all those PLWHA. MSM contact has also accounted for 61% for living HIV cases among males, and heterosexual connection represented 70% of living HIV cases among female (Florida Department of Health, 2012).

In light of these statistics concerning HIV/AIDS in Broward County, the call for nurse's action is paramount in the field of education, counseling, prevention, treatment, collaboration, and holistic care regarding people living with HIV/AIDS. Morgan (2014) noted that holistic care should be stimulated by nurses in implementing innovative, community-oriented, and tertiary preventative programs within associated healthcare delivery systems directed at this vulnerable population in Broward County. Furthermore, the wealth of nursing and medical research provided the groundwork for evidenced-based training and supported the ideals of harmonizing therapy, as well as, each individual holistic performance.

In other words, nurses who are involved in holistic wellness program for this population are best aligned in direct partnership with patients, as well as, community, faith-based, or local university nursing holistic programs. Education and training play a significant role in holistic care directed in the management and prevention of HIV/AIDS. Subsequently, HIV/AIDS organizations require supporters to develop solid holistic wellness-centered individual, and community plans in implementing the most effective holistic interventions available to people living with HIV/AIDS in Broward County.

Problem Statement

HIV/AIDS has created a significant paradigm shift across the globe in the last four decades in testing, diagnosing, implementing, caring, and treating persons infected with this virus. This paradigmatic shift has propelled healthcare and its workforce of registered nurses (RNs) to be steadfast and proactive. RNs are considered front-liners in healthcare. Currently the healthcare delivery system (HCDS) was in a state of uneasiness, panic, and turmoil, while having to provide direct care to this vulnerable population. Due to significant misunderstandings of equal and human rights, the discipline of nursing was left with insurmountable challenges in knowing that HIV/AIDS requires educated and competent caretakers and caregivers.

Although important scientific innovations have been created in the treatment and care of this disease trajectory, a gray area of negativity circumvent society at large and almost every community, including Broward County. Nurses face agony, bewilderment, and conflict in practice where there was not much hope. Notably, these behaviors were also encountered in caring for individuals with HIV/AIDS. Likewise, the fear of occupational infection, the lack of physical and emotional support, and the negative attributes that shroud RNs daily duties instigate inappropriate and less than quality nursing care rendered to people living with HIV/AIDS (PLWHA). Consequently, the lived experiences of nurses were without an expression, platform, or voice. There was an enormous gap in the nursing literature surrounding this phenomenon hence, a critical investigation was warranted.

Purpose of the Study

The ultimate purpose of this study was to gain an in-depth epistemology of registered nurses lived experiences in caring for people living with HIV/AIDS in Broward County, Florida. The aim of this study was to provide registered nurses with a medium in which they can voice their concerns about their interactions with people living with HIV/AIDS in their daily practice. Moreover, the intent of this research undertaking was to showcase not only the scarcity of phenomenological studies in the United States with striking reports of Broward County rising new HIV/AIDS cases, but to also obtain an evocative explanation with elucidation of this phenomenon. The ultimate purpose was to gain an understanding of the lived experience of RNs providing care for PLWHA.

Research Question

The central research question that instructed this research study was: “What is the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida?”

Philosophical Underpinnings

The philosophical underpinning that guided the phenomenon under review for this study: The lived experience of RNs caring for PLWHA in Broward County, Florida was to employ a qualitative approach to disseminate and interpret nurses lived experiences. A qualitative approach was generally related to the social constructivism/interpretivism paradigm that accentuated the socially constructed nature of reality. This approach further involved inductive and systematic collection, organization, and interpretation of textual material derived from talk, or observation. Moreover, a qualitative approach

entailed recording, analyzing, and attempting to uncover the deeper meaning and significance of human behavior and experience.

Subsequently, the researcher was interested in gaining a rich understanding of person's experience, and not in obtaining information, which can be generalized to other larger groups. This design is a form of scientific research that explicated answers to life world questions, utilized systematic predefined procedures to answer these questions, collected evidences, and produced results that were not procured in advance. The design infrastructure is strongly effective in attaining culturally specific information about opinions, values, social contexts, and behaviors of a specific population.

The strength of qualitative research is its capability to deliver intricate textual descriptions of how people experience a given research issue. The bases of the research provided information about the human side of the role in caring. Multiple behaviors, emotions, opinions, beliefs, and relationships of the RN to intense situations and settings were explored. Qualitative methods of inquiry were also fundamental in detecting intangible factors, such as socioeconomic status, social norms, ethnicity, religion, and gender roles, which may not have been visible (Mack, Woodsong, MacQueen, Guest, & Namey, 2005).

A qualitative research emphasizes that an individual is a holistic system engaged in the world of others by interacting and sharing experience. The arbitration to investigate, study, describe, ask questions, and seek clarification in nursing research necessitates the need to collect and analyze some form of data in order for a researcher to derive at a conclusion or interpretation (Martin, 2013). Another crucial element of a

qualitative study design is its underpinning which places importance on holism yet describes the constraining grips of objectivity as a myth. This issue is taken under review and exploration.

Munhall (2012) indicated that philosophical underpinnings of qualitative research do require a shift in perceptions from the positivist perspective. It emphasizes that an individual is a holistic system that engages in the world of others by interacting and sharing experiences. Qualitative inquiry does not practice reductionism nor reduce human beings or experiences to parts, which would require separate investigation. The philosophical underpinning to guide this study with the phenomenon under review: The lived experience of RNs caring for PLWHA in Broward County, Florida was positioned in a phenomenological approach, and the theoretical perspective was buried in the interpretivism paradigm. This paradigm coupled with any qualitative approach gave cohesion in disseminating and interpreting meanings to any particular perspective under investigation, such as nurses lived experiences.

According to Crotty (1998), theoretical perspective is being taken here to mean the philosophical stance lying behind the method. It provides a context for the process involved, a basis for its logic, and its criteria. In other words, whenever a researcher investigates a particular method of inquiry, it provides the researcher with discovery of an array of assumptions buried within. It is these assumptions that constitute this researcher's theoretical perspective. Assumptions are largely the situation that the qualitative method is trying to unravel. Therefore, the qualitative axis is constructed on the following five basic philosophical assumptions frequently interacting with the

phenomenology tradition. These assumptions are *ontological, epistemological, axiological, rhetorical, and methodological*.

Ontological Assumption

According to Creswell (1998), ontological matter addresses the nature of reality for the qualitative investigator. This is translated in that realism is subjective and is fashioned by the participant's involvement in the investigative process. Therefore, many realities occurred involving the investigator, participants, readers, and the target audience construing the study. Furthermore, the ontological assumption required the qualitative investigator to report these realities, rely on voices and clarifications of the participant's statements through broad quotations. This assumption comprised themes that mirror arguments used by informants and advanced evidence of diverse viewpoints on each theme. In reality the main emphasis of ontological assumptions in a phenomenological research study is that the researcher is commissioned to report every possible argument representing the various perceptions on the phenomenon being discovered (Moustakas, 1994).

The application of ontological assumption was crucial in accentuating the overall effect of reality along the pathway of this study in determining the phenomenon being investigated and the nature of its existence. On the other hand, the investigator was cognizant that reality was subjective, which formed the basis of participant's initiative in the investigative process. Therefore, the investigator in this study was mindful that the phenomenon being studied was connected to human beings who had cultivated their own thoughts, meanings, and interpretations on the nature of reality. The researcher's

investigation of the phenomenon was set apart through the research method, and techniques that clearly interpreted participant's feelings and embedded thoughts for a rigorous outcome.

Epistemological Assumption

This assumption courted a strong relationship between the investigator and that, which is being investigated. The idealism was that qualitative researchers intermingle with those they study. This interface assumed the form of living with or detecting participants over an extended period of time or actual association. The significance of this assumption in short was that the investigator avoided distance or objective distinctiveness among the participants being studied. In retrospect, the claim to epistemological assumption was that the researcher or investigator interacted with what was being researched (Creswell, 1998). Munhall (2012) implied that to know nursing phenomena, the expressions are founded in the language of qualitative epistemology. Max van Manen (1990) briefly summed it up that epistemology is the realization that the lived experience is saturated in its entirety with language.

The use of epistemology in this study was to gather facts and findings in understanding and explaining things known through interaction between the investigator and the participants. Therefore, epistemology set the philosophical stage in contributing to the kind of knowledge base available, and determined its adequacy and legitimacy. The epistemological stance in action in this study was positioned on the constructivism paradigm which was to acquire and view knowledge and meaningful reality on the basis of human initiatives through interactions, development, and transmission within an

essentially social context. In this study it was paramount for the researcher to grasp the complexity of the experience and its wholeness for knowledge synthesis.

Axiological Assumption

Axiological assumption mediated the role of values in a research study. Subsequently, in a qualitative study the investigator acknowledges the value-laden environment of the study and actively reports his or her values and biases as well as the value-laden nature of data collected from the research setting. Therefore, the distinctive role of this assumption was value-laden and that biases were present. This indicated that values were personally relative which needed to be understood and the critique of ideologies promoted needed social change (Creswell, 1998). Research paradigm is a concept crafted by Thomas Kuhn as a pathway that summarizes a researcher's belief in creating and enhancing knowledge in a research study (Morgan, 2007).

Subsequently, axiology is one of those assumptions of the research paradigm used in this study to expedite and generate knowledge in a value-laden environment such as this one. Axiological assumption placed the burden on this researcher's subjective values, intuition, and biases as important elements in the construction of social dialogue and interpretation of reality. Value is considered a scholarly reflection on human beings and their life world in different scientific disciplines, such as nursing, philosophy, sociology, and linguistics. It has become a basis and inspiration for analyses of the relationship between this researcher's system of values and his personality and social functioning both in attitude and behavior (Sekowski & Lubianka, 2014).

Rhetorical Assumption

Rhetorical assumption in a qualitative study implies that an investigator employs explicit languages, personal and literary descriptions in the study. This is characterized by the researcher writing in a literary, casual flair using the personal voice that sometime speaks qualitative terms and limited definitions. This assumption evolved during the study rather than being defined by the researcher at the start of the study. The highlight of this assumption allows a researcher to use attractive style of narration and the use of the first person pronoun, which engages the language of qualitative research (Creswell, 1998). In other words, the research is frequently written in the first person domain demonstrating an intricate and even zealous investigator.

The interplay of rhetorical assumption in this research study was to engage, persuade, and convince the reader that what was being investigated was worth something. Therefore, for impression to be effective, the researcher reported truthfully what reality was from the lens of the participants. Evidently, the use of the linguistic approach was carried out by writing thoroughly in a humanistic way; conveying the study's findings in a descriptive and interpretive format. The characteristics of writing skillfully in the first person domain, formal, informal, or in the personal voice indicated a strong, passionate, and involved investigator.

Methodological Assumption

Walshaw (2012) stipulated that it is the combination of ontological and epistemological determinations that lead to a researcher's selection of methodological assumptions. This assumption becomes the process by which researchers understand,

interpret, critique, and identify potential of the study. Moreover, the process is mutual, simultaneous; context bound, and uses an emerging design. A rigorous research approach was shaped by the investigator's experience in collecting, analyzing, and communicating the data. The importance of this assumption in research methodology was that it allowed investigators to work with detailed specifics before generalization, provided a comprehensive perspective of the study, and frequently asked questions from experiences and occupational on-the-job learning from the field (Creswell, 1998).

The use of methodological assumption as a research strategy in this study was to extract the meaning of reality through close relationship between the participants and the investigator through a phenomenological approach. This approach provided entry to the participant's inner most subjective experiences. Methods used for extracting meaning of reality or participant's inner most subjective experiences were data collection through in-depth face-to-face interviews, observations, member checking, and content analysis of the data. However, in order to achieve this milestone the researcher worked toward constructing a social ambiance that was conducive to the participant's experiences.

Scientific assumptions are used in the exploration of meanings of social phenomena as experienced by individuals themselves in their natural context. Moreover, qualitative research methods are founded on an understanding of research as a systematic and reflective process for the development of epistemological studies. For this reason, scientific assumptions can be both contested and shared. This implies ambitions of transferability of the findings beyond the study setting as clinicians and practitioners integrate the implications of study results into EBP. Drawing on these assumptions, the

researcher was prepared to use strategies for questioning, findings, and interpretation instead of taking them for granted (Malterud, 2001).

Munhall (2012) indicated that qualitative research method has the power to liberate biases and prejudices. Hence, in so doing, biases and prejudices stigmatize, discriminate, ostracize, and oppress people. Indeed, there is no stronger evidence than what can be witnessed in caring for PLWHA. Meanwhile, when research studies are done with rigor and trustworthiness, the results can expose the dark side where a need for change is illuminated and a call for action is the responsible outcome. The results from qualitative research raise consciousness to what is not known; the unbeknownst becomes known, and the concealed becomes seen. The format for acquiring consciousness can be achieved through these different traditions of qualitative inquiry, namely, grounded theory, case study, ethnography, historical, action, and phenomenology (Creswell, 2013).

Grounded theory is a qualitative method of inquiry that is based on symbolic interaction and pragmatism. Theory in this method was developed after data was collected and analyzed. Case study examines and describes in-depth experience of a person, people, or groups of people. Ethnography is another qualitative tradition that investigates and describes cultural groups. Historical research explores and describes events of the past to relate the events to the present and the future. Action research investigates and seeks action to improve practice and study the effects of the action that will be taken, and phenomenology describes the uniqueness of the individuals' experience as they are lived. Hence, each individual has his or her own reality and it is subjective looking from a phenomenological perspective (Nieswiadomy, 2008).

Charalambous (2008) communicated that phenomenology incorporates all the essential features for conducting a successful qualitative study based on the lived experiences of the participants.

Phenomenology

Phenomenology is a philosophical viewpoint, which was first identified and described in the early 18th century through works of philosophers, such as Immanuel Kant, Georg Wilhelm Friedrich Hegel, and Ernst Mach. Sometime later, the philosopher Edmund Husserl formally introduced it in the 20th century. Phenomenology is considered both a philosophical discipline in nature and an approach to human research science. Meaning it is both a philosophy and a research method.

The philosophical work of Edmund Husserl (1859-1938), a phenomenologist and the transcendental philosopher, *Logische Untersuchungen* (Logical Investigations, 1900-1901) uniquely approached phenomenology. As a mathematician Husserl became dissatisfied with the fundamentals of the natural sciences as means of understanding human experiences. As a result, Husserl is accredited with presenting the study of the “lifeworld” (*Lebenswelt*). He described phenomenology as the science of pure consciousness and a discipline that seeks to define the manner in which the world is instituted and experienced through conscious acts (van Manen, 1997). The dissatisfaction of natural science allowed Husserl the insight of coining the transcendental arm of phenomenology. He related to the way knowledge is perceived into being in consciousness and is seen as the rigorous human science of all conceivable transcendental phenomena.

Husserl (1970) further studied, amended, and developed the concept of phenomenology by other philosophers and scholars, such as Heidegger, Gadamer, Merleau-Ponty, Levinas, Satre, and Derrida. It was outside the scope of this study to review the intricate works of each of these philosophers in detail, but rather in this study their work was acknowledged, and contribution to scientific research collectively was reviewed. The works of Husserl, Heidegger, Gadamer, and Merleau-Ponty is well explicated in discussing Max van Manen scholarly approach (Earle, 2010).

The foundation of transcendental phenomenology hinged on crucial concepts, such as *intentionality*, *eidetic reduction*, and *constitution of meaning*. Intentionality is considered the human capability for awareness of things as well as their background features, which permits humans to reason about entities in the world, and interconnects with others. Husserl believed that intentionality is strategic in comprehending human experience and an inseparable connection to the world (Earle, 2010). The theme eidetic reduction related to transcendental phenomenology emphasizes the bracketing of an individual's normal approach toward a specific object or phenomena. Such action is needed in order to filter human consciousness and to learn the essence of a precise phenomenon. Thus, an individual's experiences should not be convoluted by preconceptions, presuppositions, or theoretical ideas.

The theme constitution of meaning denotes recognizing the principles or constructions of transcendental phenomenology. The premise of this theme creates consciousness and perception of the human lifeworld (Earle, 2010). In 1990, van Manen, a contemporary social scientist, introduced specific guidelines for conducting human

science research in hermeneutic phenomenology. The four key constructs of phenomenology consist of consciousness, embodiment, perception, and experience.

Consciousness as it is experienced from the first person's viewpoint is considered a major construct of the study of phenomenology. It is the sensory awareness of and response to the environment as it is perceived (Munhall, 2012). In other words, the basic intentional structure of consciousness can be found in reflection or analysis, which entails other forms of experience. Husserl (1963) explained that the intentional process of consciousness is called *noesis*, while its ideal content is called *noema*. Hence, the noema of an act of consciousness is characterized by Husserl both as an ideal meaning and as the object as intended.

Therefore, the phenomenon or object as it appears become the noema or as an object as it is intended. Moustakas (1994) further explained that consciousness is deliberate and is directed toward objects containing contents that are intentional. He further concluded that objects can appear in one's consciousness in a hollow manner and experience will move toward filling them by virtue of observation and verification. Nonetheless, no matter how frequent or from what hierarchy a physical object is presented with embodiment, there is always space for further reasoning, meaning, and clarification.

Embodiment, another construct of phenomenology elucidates that through consciousness awareness, individuals are being in-the-world and gaining access to the world cannot be done without the body. Therefore, the body offers human beings the opportunities for using the five created senses wisely and effectively through seeing,

hearing, feeling, smelling, and tasting to consciously discern the world. The individual's use of the body allow for any point in his or her life that specific perception or consciousness abound that is based on history or knowledge of the world they traverse. The responsibility of human science is to focus on the individual, and on meaning events may have that will reflect recognition through the openness of the world. Moreover, the world as experienced and interpreted by past generations is delivered in succession, teaching a great deal about reality in the process (Munhall, 2012).

Perception is also another construct related to consciousness. It takes place through the body (embodiment), which is the individual's access in experiencing reality in the world. Perception of experience is also described as what matters, not what in reality may appear to be contrary or to be more truthful. On the contrary, if an individual perceives pain when in fact there is none, the reality of that individual's lived experience is that there is going to be pain. The interpretation of the experience from the individual's exclusive perception of an event is crucial in discerning reality. What is significant about this worldview, however, is not what is occurring, but what is perceived to be going on.

The talk of *experience* as one of the derivation of consciousness is inexcusably significant to the individual in a phenomenological world. To solidify this statement and bring it into reality it is considered one of the acts of consciousness. Moustakas (1994) argued that experience integrates a real content and an ideal content, in and through which human beings abide in thought, perception, memory, judgment, and feeling in order to understand its principles. Therefore, every intentional experience can be protracted in a chain of meanings and fundamentals, and contains avenues for further

experience.

On account of Moustakas (1994), there is no complete or concluding reality in experience. Creswell (1998) took the experience hither by indicating that a phenomenological report terminates with the audience comprehending better the crucial, invariant structure of the experience, and recognizing that a single unifying meaning of the experience exists. In other words, this means that all experiences have an underlying cause in reality or the world inhabited by humans. Munhall (2012) summed it up perfectly; an individual who indicated that the purpose of phenomenology is to describe lived experience may be describing his or her own or other's perceptions of that lived experience.

Subsequently, this is the reality or experience for concern, as the individual perceives the event. Max van Manen (1990) alluded that phenomenology refers to an individual's perception of an event's meaning as opposed to the event as it exists externally to that person. His method of conducting phenomenological scientific research provided a significant landmark for EBR. It is important to mention that his methodological approach forms the fundamental infrastructure in the investigative designs of research studies. Max van Manen's phenomenological stance is explicitly credited for steering professional disciplines in education, clinical psychology, law, and nursing (Earle, 2010; Munhall, 2012).

On the other hand, Martin Heidegger (1859-1938), a philosopher, was a protégé of the recognized Edmund Husserl. Husserl was known as a revered father of phenomenological study by peers of his era in the phenomenological scientific

community for the work he did and contributions made to phenomenology scientific research. Heidegger's persuasive writings, *Being and Time* (1927, 1962), are singled out as a fundamental movement away from traditional philosophical approaches to human beings. Notably, a specific section of the text directed Heidegger's attention toward ontological principles instead of the epistemological emphasis of his predecessor Husserl.

Heidegger later (1962) deposed the idea of intentionality composed by Husserl (1970) in favor of an existential phenomenological justification of *Dasein*, or the situatedness of being in the world. The justification of *temporality* by Heidegger explicated the horizon of all possibilities of being or existence, which make sense in terms of time, past, present, and future. In contrast to Husserl, Heidegger excluded the notions of bracketing and phenomenological reduction, and adopted the view that understanding is never without preconceptions and presuppositions. In addressing this matter, Heidegger reestablished the idea of the hermeneutic circle. This circle or loop permits for mutual activity between pre-understanding and understanding (see Figure 4).

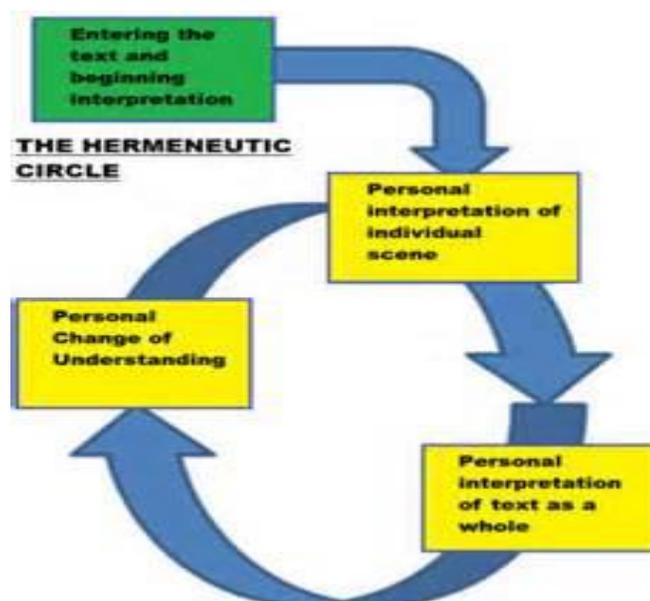


Figure 4. Wright, A. A. (2015). The Hermeneutic Circle. Adopted from The Literary Lens (2012).

The hermeneutic circle and its environment make use of the un-limitedness of worldly activities and events. The framework promotes inquisitiveness to investigate and engage in learning opportunities. The conceptualization gives clinicians' clinical reasoning and strategies to use in communicating, validating, and understanding issues in health professional practices of importance (Literary Lens, 2012).

Hermeneutic (Interpretive) Phenomenological Approach

Phenomenology is frequently considered paramount to the hermeneutic (interpretive) paradigm. One of Husserl's successors, Heidegger (1962), sought to explicate the meaning of *being* in his writings, which he believed that humans are hermeneutic beings proficient in finding importance and significance in their own personal lives. Here lies the line of demarcation that is drawn between descriptive and hermeneutic phenomenology. Husserl (1970) believed context is of peripheral importance, while Heidegger profoundly believed context is a central concern. Therefore, the Heideggerian phenomenology is strictly grounded on the perception that the understanding and knowledge of an individual cannot occur in isolation of their culture, social context, or historical period in which he or she lives (Wojnar & Swanson, 2007). Charalambous (2008) indicated that through the essence of hermeneutics beliefs, values, and commitments, understanding and reasoning can become known, understood, and clarified.

In understanding human experience, hermeneutic (interpretive) phenomenology is far-reaching beyond knowledge of central concepts and principles. In 1962 Heidegger presented the notion of "*dasein*" describing the individual way of being in the world.

The thought here is that by emphasizing that humans cannot free themselves from various contexts that influence their choices and give meanings to lived experience. The constructs of *dasein* and *situatedness* formulate the foundation for *preunderstanding* or in other words, *forestructure of understanding*.

The assumption of *forestructure* is meticulously connected with how an individual understands and interprets the world. Heidegger (1962) claimed that the interpretive process is circular, moving back and forth between the whole and its part and between the investigators *forestructure of understanding* and what was learned through the investigation. Heidegger called this the *hermeneutic circle of understanding*. Therefore, its incumbent on the hermeneutic researcher to reflect on his or her past experiences of caring or being cared for, preconceptions about issues of caring, and biases about what is meant to be a nurse or patient (Wojnar & Swanson, 2007).

In essence, hermeneutic (interpretive) phenomenology is an integral component of lived experiences. The hermeneutic context was employed in the current undertaking of this study to discern, understand, express, give meaning, process, and explicate the life world of the lived experiences of registered nurses caring for PLWHA in Broward County. This interpretive process was displayed through the lens of the four-life world existentials interconnected with van Manen (1990) six activities. The four life world existentials described by van Manen (1990) was proven significantly as helpful conductors for reflection by which nurses' experience the world denoted through this research process. Munhall (2012) affirmed that existential inquiry was not possible without *being-in-the-world*, and this was only accomplished in the life worlds of both the

researcher and participants. According to the philosopher van Manen (1990), lived experiences are categorized into the following four existentials: (a) *lived space* (spatiality), (b) *lived body* (corporeality), (c) *lived time* (temporality), and (d) *lived other or relation* (relationality, see Figure 5).

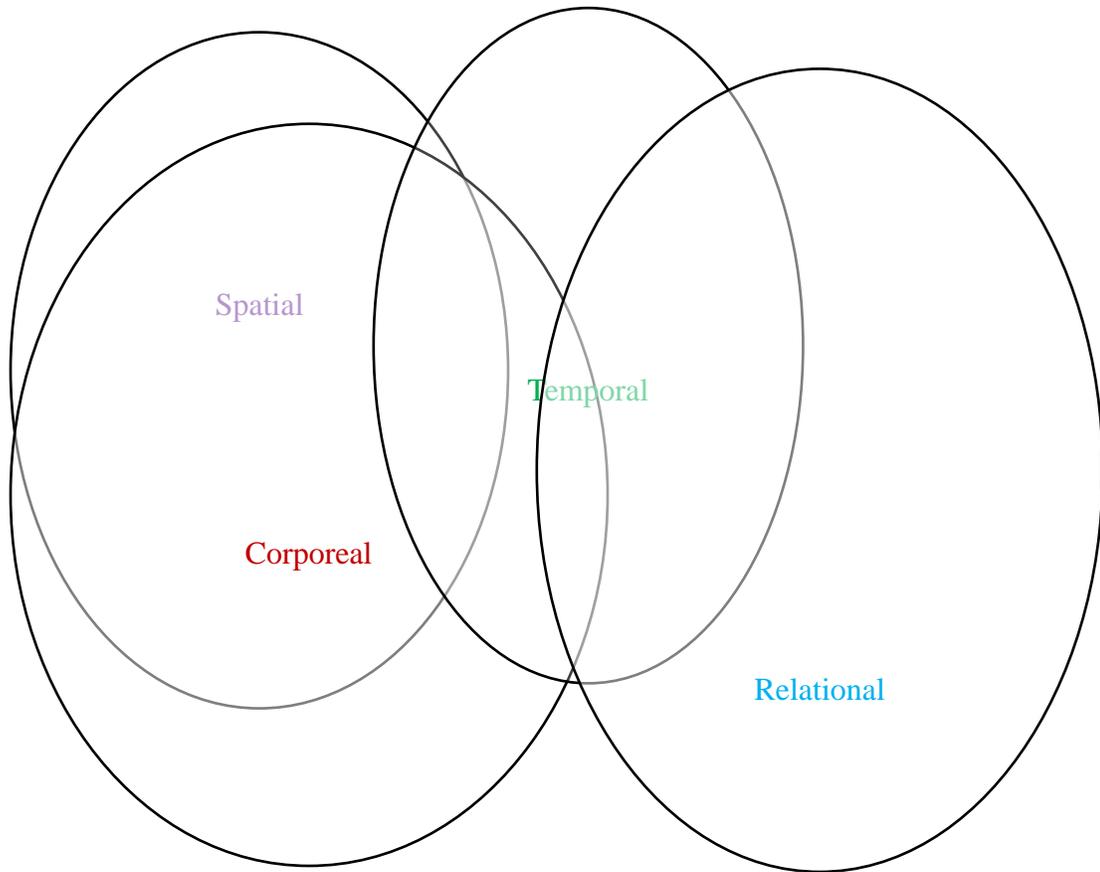


Figure 5. Wright, A. A. (2015). Four Existential Life Worlds: Interconnectedness. Adapted from Munhall (2012).

Lived space (spatiality) is defined by van Manen (1990) as felt space. It is the subjective nature or experience of the infinite space conceptualized by an individual at any given time. The exploration of lived space can affect feelings, and can conversely affect the experiences of the space occupied. In other words, lived space is an element for probing into the ways a person experiences the activities of his or her daily existence.

Moreover, it can account for discovering significant meanings of the lived experience or lived life (van Manen, 1990).

Lived body (corporeality) is interpreted as physical body or bodily existence in the world through feeling, revealing, concealing, and sharing of an individual's life world. Hence, "lived body" is where, how, why, when, one meet and greet another in his or her surroundings or life world. In addition, humans are always present in the world on account of the lived body. Therefore, through the methodology, this medium of communication, feeling, interaction, and experience are shared with each other either consciously, deliberately, self-indulgence, or on account of an individual sharing their experiences freely (van Manen, 1990).

Lived time (temporality) is considered subjective as one experience it. In essence, it means lived time is of the essence which can move swiftly or slowly whether one is having fun or not; it is the experience of the lived world on a temporal level. Lived time differs significantly from objective, factual, or clock time. In universality, feelings can influence the experience of time and moments, and conversely constraints, paralyze freedom, and place demands and restrictions on the life world. The temporal dimensions of lived time, whether it is previous, current, or imminent, constitute the prospects of an individual's temporal landscape (van Manen, 1990).

Lived relation (relationality) is the relationship an individual makes and maintains with others in the interpersonal space shared in his or her life world. In other words, human relations are based on communication and relationship experiences with others through shared spaces and interactions through the life world allowing humans to

transcend his or her self. In the broader existential intellect, human beings seek out the experience of each other on a collective and social stratosphere for determinants to life, and grounds for existence in the life world (van Manen, 1990).

Although each of the four life world existentials offers different points of view, they are not independent of each other; rather they are interconnecting, intersecting, and interacting with each other in the exploration of the lived experience of the life world. In cooperation with these four life world existentials, many suggestions make reference to how experiences can be better understood and characterized in simple tone. On the other hand, the four life world essentials present and promote helpful guides through which to investigate any phenomenon of interest by phenomenological researchers (van Manen, 1990). Therefore, this researcher aimed to use the hermeneutic approach with the four life world existentials embedded in its framework, and subject to the criteria for research rigor and trustworthiness as fundamental structures supporting this research endeavor.

Another well-known contemporary German philosopher Hans-Georg Gadamer (1900-2002) was also conceptualized by the extensive work of both Husserl and Heidegger even though the central notions in his writing *Truth and Method* are more closely associated with the thoughts of Heidegger. Gadamer (1960) vetoed the idea of phenomenological reduction and bracketing and claimed that understanding arose only in and through one's prejudices (Moran, 2000). He used the term prejudice in a positive sense to interpret preunderstanding of the lifeworld, which occurs by an individual's existence of being in the world. Gadamer's two key concepts are *prejudgment* and *universality* in his seminal work *Truth and Method* (Moran, 2000). The reference of

prejudgment is one's preconceptions, prejudices, or horizon of meanings that is part of one's linguistic experience. Universality, on the other hand, relates to a linking that is fashioned by shared human consciousness between persons who express themselves and persons who understands (Ray, 1994).

In practicality, Gadamer's (1960) research concurs with Heidegger's (1962) notion of being in the world, which is concerned mostly in making sense of and interpreting the lived experience. He also purported the need for a hermeneutic circle, but takes this paradigm a step further by suggesting that a dialogical progression occur within the hermeneutic circle such that there is a fusion of horizons between the interpreter and the phenomenon being deliberated (Dowling, 2007). Particular emphasis was placed on language by Gadamer and its affiliation to understanding of "being in the world." It embraces the interpretation that language not only replicates human "being," but it is language that really makes humans who they are and it brings about human existence as communal understanding and self-understanding (Moran, 2000).

The scientific phenomenological work performed by the contemporary philosopher, Maurice Merleau-Ponty (1908-1961), is an influential display and dedicated disciple of Husserl (1959-1938) from the same phenomenological school of thought as Sartre and Heidegger (1889-1976). Merleau-Ponty (1945) classical writing *Phenomenology of Perception* was converted into English in 1962 by Colin Smith. In this piece of writing he posited a phenomenological elucidation of what is meant by "being-in-the-world" (*etre au monde*) and placed specific importance on the dialectical relationship between subject and object. According to Baldwin (2004), the philosophical

connection between Merleau-Ponty and Husserl is ultimately decisive; this does not come as a surprise as he immersed himself in the works of Husserl in the early years of his career. In comparison to Husserl's transcendental phenomenology, Merleau-Ponty acumen was attached to existential phenomenology.

Merleau-Ponty (1945) conceded to the philosophical community to the idea of descriptive phenomenology as opposed to interpretive phenomenology, which is in sync with Husserl thoughts. However, he castigated empiricism because of its inaccurate interpretation of experience. Merleau-Ponty defined a type of phenomenological reduction, which is different to Husserl idealistic interpretation in that he recognized the irreducibility of the real world. He further suggested a special kind of reduction that is a return to the perceptual pre-conceptual experience of the child with the aim of being to re-experience *an element of being and a type of knowledge in which man forget in his normal attitude*. In addition, Merleau-Ponty further acclaims that the goal of phenomenology is to rediscover the supremacy of perception (Besmer, 2007; Racher & Robinson, 2003). Merleau-Ponty concluded that phenomenological description has the possibility to remind every individual of the nature of one's pre-reflective experience prior to philosophical and scientific misrepresentations (Besmer, 2007; Moran 2000).

The contemporary social scientist and educational philosopher Max van Manen is currently a professor of education in the Department of Secondary Education at the University of Alberta, Edmonton, Canada. Van Manen's (1997) writings revealed that he has his introduction to the human sciences, phenomenology, and hermeneutic in the Netherlands while studying pedagogy. The chief difference in his approach to

phenomenology in contrast to his predecessors is that he proposes more specific methodological guidelines for investigators engrossed in conducting phenomenological inquiry.

Relationship of Phenomenology to This Study

Although van Manen draws from the work of the aforementioned philosophers his exact approach is considered more action sensitive than philosophical. Furthermore, he clarified the distinction between phenomenology and hermeneutics; explicating that phenomenology is a wholesome description of the lived experience, while hermeneutics is an interpretation of experience through some writing or symbolic form. Max van Manen (1997) admitted that there are contradictions in the literature, and thus he chose the concept description to include both the interpretive and descriptive mechanisms. He further elaborated that as for pedagogy, the same hold true that RNs require phenomenological sensitivity to the lived experience (i.e., RNs realities and lifeworld). Therefore, RNs yearning for hermeneutic ability is a requirement in making interpretive sense of the phenomena of the lifeworld in order to see the significance of the situations and relations of caring for PLWHA. Moreover, he defined his approach to human science research as an active and ongoing interplay of six distinct research activities (van Manen, 1997).

Max van Manen (1990) showed how lived experiences add value and relevance to the qualitative research approach. Hermeneutic (interpretive) phenomenological paradigm is anchored in the design on the descriptive foundation drawn on the design of the six activities displayed. These activities commonly form the foundation of many

research studies and their success to expected outcomes. Thus, the guide to this research study was immersed strongly in van Manen six activities to improve clinical reasoning and health care decision making for PLWHA and nearing the end of life (EOL). Balancing interpretation and meaningful dialogues prevent circumventing best practices in preventative care and services in PLWHA. It was critical to help keep these healthcare providers and caregivers engaged in their passion and compassion caring for PLWHA.

Significance of the Study

The significance of this study was to bring to the table important information to the science of nursing, nursing education, nursing practice, nursing research, and the aim for healthy working policies tied to HIV/AIDS in healthcare. Information contributed from nurses working with HIV/AIDS patients as a career specialization helped in the identification of special needs for nurses, and consequently ways in which appropriate support, encouragement, and stability could be provided. Relative information extraction was also essential in designing undergraduate and graduate nursing curriculum or program for future nursing students, and educators alike in HIV/AIDS care. The ability to study this area of the HIV/AIDS experience was paramount to nurses and the science of nursing here in Broward County, Florida, and around the globe on the preponderance of social support, strength, and care to this delicate population. Another pivotal concern was for policy makers to formulate policies geared at HIV/AIDS care through the study findings. The anticipation of this proposed study's findings led to fundamental changes in nursing, education, practice, health/policy, and provided advance knowledge in the care of PLWHA.

Significance to Nursing

This study's intention for the science of nursing had significant implications in the hierarchy of practice, research, education, policy building, curriculum development, and health care. Research endeavors were fundamental to the science of nursing in comprehending the phenomenon of interest, and its contribution to the health care delivery system on the premise of HIV/AIDS. Intricately the ability to study this area of the HIV/AIDS experience was paramount to nurses and the science of nursing here in Broward County, Florida, and around the globe on the preponderance of social support, strength, and care to this delicate community. Hence, comprehending the effects in providing care to patients infected with HIV/AIDS has attributable significance for the discipline of nursing encountering this delicate population.

Implications for Nursing Education

Nursing education is the backbone of the discipline of nursing anywhere in this globalized world. The ability to endow education appropriately in the discipline of nursing whether here in Broward County, or elsewhere around the universe is paramount in the care of any disease; thus, this study guided practice to evidence-based knowing, significant to this vulnerable population. The influence of nurse's reactions in telling their stories caring for PLWHA through this medium staged the platform for changes in educational curriculum development, and practicum arenas. The art of nursing education was to disseminate the rich knowledge available in provoking the understanding of theories, frameworks, models, and concepts applicable to the discipline of nursing through this study's emergence.

This also enhanced continuation of leadership development where a nurse grows in depth experience, education, and maturity (Fagin & Lynaugh, 1972). The inclination of comprehending HIV/AIDS pathophysiology could have direct implications on nursing education in Broward County. In comprehension of this educational orchestration, faculty, and nursing schools may have a stage to dance on in advancing knowledge to young minds in the care of PLWHA. The anticipatory influence of nurse's reactions through this medium may stage the platform for changes in curriculum development, practicum areas, and how nursing day-to-day businesses are conducted and operated.

Implications for Nursing Practice

Nursing practice is the runway of patient care significant to the science, and discipline of nursing. Nurses are considered the chief frontline fighters in practice; providing care and support for this high risk group of people and most vulnerable to the phenomena of interest. According to Munhall (2012), there are no values in nursing research unless it is influential in the clinical practice arena. The unique aspect of nursing practice is for nurses to make their contribution in a meaningful and positive manner in coordinating and enhancing care for the common good of mankind instigated by their code of conduct. This research study was intended to bring to light significant data relevant to nursing practice on the way members of the discipline of nursing cope with phenomenon of this magnitude. On the other hand, through evidence-based practice nurses exhibited unique clinical skills and experiences geared at improving better patient's relationship and liberation of HIV/AIDS. Nurse's responsibility through practice was to provide assistance without impunity for the benefits and well-being of

every patient that require care.

Implications for Nursing Research

Nursing research has a profound influence on current and future professional nursing practice, thus, rendering it an essential component of the educational process. On the other hand, it is necessary for continuing advancements which may promote optimal nursing care through knowledge attainment for the practice environment. This study's contribution to nursing research added another dimension to evidence-based nursing care (Tingen, Burnett, Murchison, & Zhu, 2009). Durham and Lashley (2010) emphasized the importance of using best practices by reviewing selected evidence-based interventions that have been recommended by the CDC, and the WHO as models for specific population, such as HIV/AIDS. Therefore, the advancement of research in this arena instigated changes in caring for PLWHA. Research endeavors were fundamental to the science of nursing in comprehending the phenomenon of interest, and its contribution to the health care delivery system on the premise of HIV/AIDS care. Subsequently, through exposure, experience, and diligence, an individual may understand the concept, and importance of nursing research in the care of PLWHA.

Implications for Health/Public Policy

Health and public policy refers to resolutions, procedures, and arrangements that are undertaken to achieve specific healthcare goals within a society. According to Penny, Campbel-Heider, Miller, Carter, and Bidwell-Cerone (1996), public policies are a course of action developed by officials or government bodies for handling matters of public concern. Healthcare policy is one type of social policy, which refers to policy statements

related to the health and healthcare of people and communities stricken with the disease HIV/AIDS. The appropriate and timely implementation and development of health policies, programs, and activities related to HIV/AIDS, and other infectious diseases of public concerns are significant in the treatment and outcome of the disease. Therefore, an explicit health and public policy can achieve several things: It defines a vision for the future which in turn helps to establish targets and points of reference for the short, medium, and long term. It also outlines priorities and the expected roles of different groups; and it builds consensus and informs people.

Nursing has the strategic ability to direct health policy issues through public policies; enacted by governmental bodies for the benefits of patients entrusted in nurse's care. The experience achieved through this study allowed nursing leaders to engage in credible health policy activities through accepted innovations. This study influenced these two major issues galvanizing effective health and policy making articulated by nurses in the direct care of PLWHA. Health and public policy statements are enacted daily to put into place significant guidelines to regulate the provisions for human survival. Another aim was for policy makers to formulate policies geared at HIV/AIDS care through the study's findings. Hence, comprehending the perception of caring from the viewpoint of nurses in this study influenced strategic benchmark for public policies to set aside resources to meet the needs of this delicate aggregate.

Scope and Limitation of the Study

The centrality of this study was to uncover data relevant to the proposed research question under review, in exploring the lived experience of registered nurses in Broward

County, Florida caring for PLWHA. This ambition involved registered nurses in the direct practice arena caring for patients living with HIV/AIDS. The vehicle of choice tailored to investigate this phenomenon was a phenomenological descriptive interpretive approach. This approach was used purposefully and voluntarily to elicit rich responses that would not have been permissible by any other means of investigation.

Furthermore, it provided an avenue for the researcher to redirect his thoughts and experiences, and capture deeper meaning and understanding of the lived experience of registered nurses caring for patient with HIV/AIDS. According to Wojnar and Swanson (2007), phenomenological investigations in nursing are descriptive and interpretive. These two approaches are concerned with understanding phenomena foundational to nursing. The directions of these paradigms provide interpretation of the structures of experience, and with how things are understood by people who live through these experiences and by those who study them.

Limitations in this study were related primarily to design, setting, transferability, data collection, and inexperience on the researcher's premise. Another key component to limitation in this process was influenced by the researcher's nursing background. Interviews for this study were done in Broward County, Florida; however, participant's non-commitment may play a pivotal role in data collection. On account of unforeseen limitations, directions from experts in this field of research study were sought for directions.

Chapter Summary

The advent of HIV/AIDS in the early 1980s has created significant instability on

globalization. This instability has placed healthcare in a dilemma alluding to the fear of the unknown, which awakens all disciplines from a daze, including nursing trying to make sense of this phenomenon. The presumptuousness of this 21st century plague has enacted guidelines, standards, programs, and policy making through research initiatives.

Evidently, this study was not differently positioned in a phenomenology approach, and the theoretical perspective buried in the interpretivism paradigm sought to uncover the lived experience of registered nurses in Broward County, Florida caring for PLWHA.

Significant undertakings as it pertained to nursing were highlighted in the background of the study to showcase the criticality of the problem throughout the continental landscape with an annexation to the problem statement. Consequently, there was an enormous gap found in the nursing literature as it pertained to this phenomenon, which instigated a purpose for an investigation. Thus, the purpose of the study was to acquire an in-depth knowledge through RN's experience caring for PLWHA. Other significant points of interest were embedded in the research question and the philosophical underpinnings aligned with the four assumptions of the phenomenological tradition.

This was then followed by an overview on the philosophical viewpoints of phenomenology which in turn gave way to the introduction of the hermeneutic interpretive phenomenological paradigm to show the effectiveness of how human experience and behavior can be understood and clarified. The interpretive process was displayed through the lens of the four-life world essentials interconnected with van Manen's six activities, which also distinguished the relationship of phenomenology to

this study. On the other hand, further nursing obligations were centralized education, practice, research, health, and public policy. The scope of the study was mentioned, and limitations were also addressed. Chapter two will follow with a review of the literature.

CHAPTER TWO

Review of the Literature

Literature review plays an intricate and vital part in the development of any new research study. This step provides readers with a background on a topic and illuminates the interest of the new study. Therefore, on the premise of this qualitative study; literature review was conducted to explicate the understanding of RNs caring for PLWHA in Broward County. The ultimate purpose of this research study was to gain an in-depth epistemology of registered nurses lived experiences in caring and communicating with people living with HIV/AIDS. In preparation of this literature review for the intended study; computer navigation through various search engines were used to access Barry University, and University of Phoenix online libraries. Surfing various databases, such as EBSCO host, PubMed, ProQuest, Medline, SAGE, and cumulative index to Nursing and Allied Health Literature (CINAHL) were used for article selection. Peer-reviewed journals published in English were the literature of choice in addressing the effects of registered nurses caring for PLWHA.

Literature published between 2003 and 2014 were reviewed in an effort to understand the problem at hand. It was imperative for literature to be reviewed beyond the usual five year period, as the need existed for seminal work disposition geared toward this phenomenon. Keywords used in these searches were attitudes, care, experience, fear, stigma, knowledge, discrimination, nurses, education, occupational, exposure, infection, and HIV/AIDS. Key categories noteworthy of addressing in this literature review are historical context, knowledge, attitude, and education in HIV/AIDS care, related stigma

in the care of HIV/AIDS, fear of occupational exposure to infection and transmission in HIV/AIDS care, and nursing in the context of HIV/AIDS care. An experiential context also was highlighted.

Historical Context

HIV/AIDS is one of the most talked about infectious disease to have descended on civilization in the past century, and it continues to be one of the most severe public health intimidations of the 21st century. HIV/AIDS became noticeable in the dawn of the early 1980s, and more than 40 years later 35 million people globally are infected with the disease with a death toll of 1.7 million reported at the end of 2013 (Peeters, Mundeke, Ngole, & Delaporte, 2010). Since the debut of this pandemic, a staggering 78 million people have been infected with the virus, and approximately 39 million people have died from it (WHO, 2013). On account of other incipient infectious diseases, HIV/AIDS is of Zoonotic derivation and originated from two strains of simian immunodeficiency virus (SIV), which is transmitted from primates to humans (Peeters et al., 2010).

The two strains that comprised the deadly SIV is made up of a strain from the red-capped macabey and the other is from the greater-spot nosed monkey. The crossbred SIV has infected the Pan Troglodytes Troglydytes chimpanzee in Central Africa, and is passed on to humans from blood-to-blood contact or the ingestion of bush meats (Peeters et al., 2010). Therefore, the circumstances surrounding the culture and origin of HIV/AIDS are devastating to the global environment in many ways. This pandemic is on a fast tract of death and destruction creating severe environmental and societal changes.

According to Talman, Bolton, and Watson (2013), environmental changes are seen

through migration because of poverty, global climate change, inequality, conflict, human capacity and conservation, natural resource management and land use, and human displacement as a result of natural disasters or food shortages. These environmental attributes played a significant role in nourishing, strengthening, and sustaining this pandemic. The relationship between the culture of HIV/AIDS and the environment strategically influences the lived experience of RNs caring for PLWHA in Broward County, Florida. Therefore, even after four decades the culture of HIV/AIDS and its effect has the globalized world seeking clarification of the disease through exploration, and investigation on the delineation of care to unfortunate individuals infected with this disease.

Nursing scientists explicate research initiatives to make sense of the disease; on how care and treatment should be extenuated to HIV/AIDS patients seeking assistance for their affliction. However, the complexity of this phenomenon instigated a climate of fear, contagion, and anxiety on the domain of registered nurses caring for this high-risk population. HIV/AIDS initiatives through multifarious educational modalities on the premise of the researcher's quest may enhance the provision of care to PLWHA. On the other hand, despite educational penetrations, standards and guidelines the co-conspirators stigmatization, attitude, marginalization, and discrimination poses a threat to quality care in the healthcare arena.

Knowledge, Attitude, and Education in HIV/AIDS Care

Scientific literature emphasizes that a precise broad base knowledge and educational awareness about HIV/AIDS along with an in-depth comprehension of

patients' needs help in the alleviation of fear, anxiety, and stigma related with the care of PLWHA. Knowledge and understanding through education could foster a positive relationship toward judgment and the quality of care provided to these patients. On the contrary, a deficit in knowledge and educational attainment on HIV/AIDS could seriously complicate the coordination of care to PLWHA. Moreover, it is nurse's professional deportment to shun biases when executing care to these patients, but they are overcome by personal attitudes projected on the nursing issue they are faced with in their daily practice.

A qualitative study with an ethnographic design by Harrowing (2011) in Uganda explored the impact of education on nurses' lives in escaping or allaying the progression of compassion fatigue. The fundamental question that the study sought to answer was: What is the impact of an HIV education program on the lives of Ugandan nurses and nurse-midwives? The researcher has worked with 24 female RNs to achieve a greater understanding of the effects of the education program and process on their personal, professional and social lives. Subsequently, exploring the concept and consequences of compassion practice involving nurses and nurse-midwives providing care to HIV-infected and affected people in Uganda is the study's purpose. Data collection was done through interviews, observations, and focus group discussions. Data was analyzed by transcribing tapes and field notes verbatim which was entered into a qualitative data management program (NViv07); simultaneously thematic coding occurred with data collection.

The results indicated that things were changed drastically on the arrival of HIV/AIDS. Capitals hastily became insufficient, levels of fear and uneasiness rose

quickly, and a suffocating blanket of stigma and distrust developed over Uganda.

The study's findings also alluded to compassion as an important element of professional nursing practice as it relates to HIV/AIDS. It represents commitment by nurses to recognize, validate and ease the suffering of the infected patient. The work of fulfilling that commitment can be overwhelming to nurses, particularly when they labor in complex, resource-challenged context. It is important to understand that compassion fatigue has effects that extend beyond individual nurses who struggle to find personal resources that will allow them to connect with their patients and in the meantime providing efficient evidence-based care (Harrowing, 2011).

Other findings showed that in addition to the challenges nurses faced in high-income countries, Ugandan nurses faced serious barriers that add a layer of complexity to their roles in the workplace and the community. Consequently, the nursing profession comprises mostly women who are at increased risk for infection with HIV in the sub-Saharan region. It is reported that that women accounted for 60% of all people living with HIV in sub-Saharan Africa. The themes generated in this study are integrating, dis-integrating, and re-integrating with subthemes, namely, called to service, impact of HIV, public tragedy, personal suffering, expanding and engaging, context and community, and strategies for coping (Harrowing, 2011).

There were a number of recommendations offered in this study. The researcher believed it is not realistic for compassion fatigue to be reduced in a country where everyone has been affected by HIV/AIDS. Therefore, it is not possible for organizations to provide a better environment, including opportunities for retreats and counselling in a

resource-challenged country such as Uganda. The study suggested that the first step in avoiding compassion fatigue is for nurses to be aware of their own limitations. It is imperative for nurses to identify the strengths, weaknesses, and assets that they can use in their day-to-day practice for changing attitudes, improving patient care, and crafting the beginnings of a critical frame for achieving change (Harrowing, 2011).

Hassan and Wahsheh (2011) conducted a quantitative study using a cross-sectional design in exploring the knowledge and attitudes of Jordanian nurses toward patients with HIV/AIDS. There were a total of 1,260 nurses invited to participate in the study with 922 who completed the questionnaire. Three objectives were tabled for this study (a) to determine HIV/AIDS knowledge level; (b) to identify the sources of information and education about HIV/AIDS, and nurses' fear of getting HIV/AIDS; and (c) to determine the attitude of nurses towards patients with HIV/AIDS. Data analyses were carried out using Statistical Package for the Social sciences (SPSS), version 16 for Windows (Hassan & Wahsheh, 2011).

Examination of the data through descriptive analyses was generated from all the subsections of the knowledge and attitude scales. To describe the demographic variables, sources of HIV information, knowledge, and attitudes subsections, percentage and frequency distributions was performed. The researchers used a level of $p < 0.05$ to determine the statistical significance. The study found Jordanian nurses expressing negative attitudes towards PLWHA and their knowledge level of HIV/AIDS was extremely weak (Hassan & Wahsheh, 2011).

Over two-thirds of the participants (84%) refused to provide care for patients who

tested positive for the disease. Respondents (81.4%) indicated that current HIV/AIDS information and resources were inadequate. The nurses (96.5%) were interested in support groups for staff nurses. Jordanian nurses (52.7%) received majority of their HIV/AIDS information through the Internet. The fear of getting HIV/AIDS from their nursing practice was ranked (96.2%) overwhelmingly, and (84.3%) of the respondent showed negative attitudes (Hassan & Wahsheh, 2011). There were no further psychometrics reported in this study.

The study findings further concluded that correct knowledge about HIV/AIDS along with in-depth understanding of patient's needs will help to ease much fear, anxiety, and stigma related with caring for PLWHA. Nurses are on the frontline of HIV/AIDS prevention, care, and advocacy; therefore, it is essential that they are equipped with adequate knowledge to decrease the danger of occupationally-acquired HIV/AIDS infection (Hassan & Wahsheh, 2011). Multifarious research study illustrated that education on HIV/AIDS is a crucial vehicle for reducing the fear of contracting the disease when providing nursing care. The study recommended that the first step to increase HIV/AIDS knowledge as well as promoting positive attitude of nurses toward PLWHA, is that all aspect of HIV/AIDS should be covered in the nursing curriculum (Hassan & Wahsheh, 2011).

The recommended areas of choice are pathophysiology, prevention, medical treatment, nurses' role, patient's bill of rights, caregiver support, general precautions; as well as specific precautions necessary in the healthcare environment. On the other hand, basic HIV/AIDS counselling skills should be employed in the scope of nursing practice,

and also be included in the nursing curriculum. A universal approach should always be the foundation for all HIV/AIDS epistemology acquired. Educators in nursing should develop strategies to support nursing students in allaying their fear of contagion while providing care to PLWHA. Another recommending point of interest is that all undergraduate nursing students should be trained on how to deal with PLWHA to further increase and instil positive attitudes caring for this delicate community. There is a call for nursing administrators to appraise the usefulness of their HIV/AIDS education programs, while there is a need for further research in exploring the fundamental elements of nursing students' attitudes toward PLWHA (Hassan & Wahsheh, 2011).

Martin (2013) conducted a qualitative inquiry embedded in the phenomenological interpretivism paradigm on the lived experience of Jamaican nurses caring for PLWHA; the only study on this side of the hemisphere among a purposive sample of 25 RNs. Data were collected by face-to-face semi-structured interview with each participant through open-ended questions, which facilitate in-depth responses from the participants using audio-tapes for recording. Data analysis was carried out by using van Manen's six activities immediately after each interview by transcribing verbatim participant's responses. Following transcription the transcripts were reviewed to confirm accuracy. In ensuring credibility of data analysis and interpretation the act of member checking was done to capture rigor and trustworthiness. The result of the study found that it is essential that education for HIV/AIDS and its effects is needed for the provision of quality care.

Furthermore, nurses are under duress with expressive stress and faced several components aligned with human suffering caring for PLWHA. The study maintains that

knowledge attainment is extremely important in spanning the deep waters between stigma, attitude, discrimination, and fear of the disease. Further findings indicated that HIV/AIDS education for the general public is overwhelming, and nurses should be educators for governmental bodies in creating programs for prevention and treatment. The interpretive analysis of the findings found related themes parallel to the major concept of the theory, such as *fear of infectiveness, transitioness, powerlessness and anger, and compassioness* (Martin, 2013). The study's recommendation is for more qualitative studies to be done to capture the greater understanding of the lived experience of nurses caring for PLWHA. Also future studies should examine the meanings placed on this phenomenon of interest by a population of diverse nurses. A critical point is the call for more investigations in the quest to develop strategies and knowledge in assisting nurses to the call of duty.

A quantitative study was carried out by Stavropoulou et al. (2011) using a descriptive design to explore 100 nursing students' perceptions about caring and communicating with HIV/AIDS patients. The researchers used a questionnaire comprising of 21 opened and closed ended questions, and a purposive sampling for recruiting the participants in the study. There were three areas of investigation (a) attitudes towards HIV care, (b) communication with people with HIV and their relatives, and (c) education and communication with people with HIV. A descriptive statistical analysis was employed for data interpretation. The study found that 60% of the participants seemed confident caring for patient with HIV/AIDS. Another 40% sighted that they were afraid of providing care for these patients.

Further results revealed that attitudes on providing care and communication with HIV-infected clients have been reported in the literature to be influenced by stigma, discrimination, and prejudice as elements that impede communication. Health care providers recognize HIV-related stigma and discrimination as key barriers to the delivery of quality services. To discover the hidden truth about the problem for investigation Pickles et al. (2009) confirmed that ferocious attitudes of nurses toward PLWHA have long been scrutinized. It is obvious that some nurses have negative attitudes and are reluctant to provide care to people with HIV/AIDS resulting in poorer quality nursing support and evidence-based nursing care. There were no further psychometrics to be found in this study except for percentages and frequencies.

Several recommendations were made through this study, such as the urgency for further education to be placed on HIV/AIDS to dispel misconceptions in overcoming negative attitudes toward PLWHA. Educational programs developed for nursing students should be assessed for their influence in the clinical practice area on the knowledge, and attitudes in providing HIV/AIDS care. The issue on communication skills, risk of infection and prevention, interprofessional provision of care, interpersonal skills development, prevention of stress and burnt out, ethics, attitudes and stereotypes, infection control and privacy may be some of the constructs to be incorporated in future training manual. Furthermore, a methodological assessment on the efficacy of current educational programs and the use of advanced teaching techniques may be used for readdressing educational goals and to promote training programs focusing on HIV/AIDS care.

In the fight against HIV/AIDS epidemic Davhana-Maselesele and Igumbor (2008) conducted a cross-sectional quantitative study in Limpopo Province in sub-Saharan Africa of 174 participants from a total of 1,687 nurses employed in the Province. The formulation of a structured questionnaire was used for data collection incorporating the AIDS Impact Scale (AIS), Maslach Burnout Inventory (MBI), Beck Depression Inventory (BDI) and the participants' demographic and professional profiles. The sample comprised 89 (51%) qualified professional nurses, and 85 (49%) auxiliary and enrolled nurses. Participants were females (92%) with an average age of 37 years ($SD = 9.2$).

One out of three participants had two to four years of working experience and over 10 years respectively. Significant to the study, the average years of experience was seven years ($SD = 7$) and ranged from one year to 32 years. The instrument AIS has a Cronbach's alpha of 0.78 that measures its reliability. Instrument with a reliability of 0.70 and over is considered reliable. The study was done to assess the impact of caring for HIV/AIDS sufferers on the mental health of nurses. Data analysis were performed using the Statistical Package for the Social Sciences (SPSS), version 15 for windows.

To describe the variables in the study frequency tables were utilized; means and standard deviations were used to describe the distribution of the variables selected. Chi-square and t -tests were executed to equate the frequency of the variables on account of participant's average scores. Results of the study found that a higher percentage of nurses without professional training agreed to identify strongly with patients when equated to qualified nurses that agreed ($p = 0.037$). A significant percentage of qualified nurses agreed that they had trouble coping with the number of deaths ($p = 0.045$), and

that their friends recognized that the work they provided in the area of HIV care is valuable ($p = .005$).

On the other hand, nurses without professional training agreed that they suffered stigma and discrimination from colleagues at the hospital; as a result of the unit they work ($p = 0.039$). The study findings also concluded that two-thirds (63%) of the nurses felt that they would end up like their patients. Seventy percent of the respondents believe that they have a lot in common with the patient. Another (68%) of the respondents claimed that the patients' lives remind them of their own. The majority of the nurses (80%) and greater reported that they formed excellent relationships with their patients with HIV/AIDS and felt a responsibility to help deal with the impact of HIV/AIDS on society respectively.

The study's results also highlighted the resilience of nurses despite the high HIV/AIDS burden, staff shortages, heavy workload, and human and material resource inadequacies. Higher measure of sadness, fatigue, fear, and low energy among nurses were also noted. It is indicated that high proportions of nurses formed good friendships with their patients, and felt responsible for dealing with the impact of AIDS in the South African society. The continued fear of casual transmission: HIV/AIDS is seen as a life threatening disease, perceived as contagious, and threatening to the healthcare community (Visser & Forsyth, 2009).

The review of the literature acknowledges knowledge, attitude, and education in HIV/AIDS care. Research is replete in thoroughly using quantitative and qualitative approaches to explicate the collective obstacles in providing needed care to PLWHA.

The qualitative study done by Harrowing (2011) discussed the exclusive aspects of experience on compassion among nurses in Uganda providing care to people with HIV/AIDS. It also illustrated the barriers nurses faced in competent care and the liberating effects of education, new knowledge, and skills in caring for PLWHA. Furthermore, nurses engaging in meaningful patient relationships, maintaining optimistic attitudes and support for the profession were found to convert and assert nurses' approach toward their work and augment their experiences of compassion satisfaction. Subsequently, nurse's educational experience was the means for changing their attitudes and practices, and for re-discovering themselves in representing the nursing profession on the grounds of evidence-based care.

The quantitative studies done Hassan and Wahsheh (2011) and by Stavropoulou et al. (2011) found that accurate knowledge about HIV/AIDS care along with an in-depth comprehension of patient's necessities can help alleviate fear, and anxiety when providing care for PLWHA. Indications were made that nurses should have sufficient information, knowledge, and educational backing in the exploration of emotional issues so that they can become more aware of their own attitudes, as well as the educational needs of others. Significant insight was given that nurse's support and participation in educational program planning is extremely important in providing a structural environment beneficial to learning, and trusting the knowledge presented. Moreover, both studies add to the current nursing knowledge, and that the findings may be of interest to clinical nursing faculty and nurse educators in order to advance the theory and practice of care within HIV/AIDS context. Davhana-Maselesele and Igumbor's (2008)

quantitative study echoed the call for the development of psychological support programs for nurses caring for PLWHA and the establishment of social incentives and acknowledgment of the role of nurses in HIV/AIDS care.

The qualitative study done by Martin (2013) contributed meaningful information in the thorough investigation of the lived experience of Jamaican nurses practice of care in HIV/AIDS context. The findings of this study and related searches provided information significant in comprehending knowledge, attitude, and education in HIV/AIDS care. It is important to mention that there are just a few qualitative studies done in the hermeneutic (interpretive) paradigm to address the lived experience of RNs caring for PLWHAs and Martin (2013) is one of those few, especially in this Western hemisphere. Furthermore, the use of hermeneutic (interpretive) phenomenological design by qualitative researchers like Martin allows the prospect of understanding and synthesizing the rich description of participant's expression through exploration of data collection.

This in turn gives the researcher evocative information about each participant's contribution and position toward his or her life-world, and how he or she conceptualize and interpret his or her experience (Smith, Flowers, & Larkin, 2009). However, in defense of Martin (2013) as the lone rider on the hermeneutic phenomenology trail, most of the studies addressed this category in the statistical sense. Therefore, in light of the findings generated by these studies it is noteworthy that there are no studies done here in the United States to address the lived experience of RNs caring for PLWHA using a phenomenological approach, hence, this warrants an investigation. This proposed study

may further add rigor, trustworthiness, and further exposed the mitigating circumstances that may be deterrents in the provision of care to PLWHA through a hermeneutic interpretive process.

Related Stigma in the Care of People with HIV/AIDS

Intricately, stigma is dominantly alive and well in the healthcare industry today in-as-much as affected ones will receive support, or rejection of the reality. Therefore, health related stigma is vehemently an inherited component from pre-human ancestors. The effect of stigma is conveniently complimented by its co-conspirators discrimination, marginalization, stereotype, prejudice, attitude, and fear in the circle of disease management, health, and wellness. The concept of stigma commonly occurs in diseases chiefly progressive, incurable, and unconcealed. Second, little is known and understood by the public for which the infected person is portrayed as the guilty party responsible for possessing the disease (Brimlow, Cook, & Seaton, 2004; Deacon, 2006).

Using a cross-sectional pilot design Rosenberg et al. (2012) conducted a quantitative study exploring Cameroonian nursing students' awareness of HIV/AIDS related-stigma within the context of two elements: stigma disseminated by nurses and stigma experienced by nurses. Indicator and demographic variables were collected to comprehend vital differences in stigma. A total of 353 participants were recruited from five nursing school for the study. These nursing students were verbally invited by the principal researcher to complete a 10-item Likert-scale questionnaire. The ages of the participants were between 18 to 44 years old with 39 (9.9%) from Biaka, 31 (8.8%) from the University of Buea, 169 (47.9%) from INSAM, Douala, 37 (10.5%) from

NKongsamba, and 81 (22.9%) from Bonaberi.

There were 268 (75.9%) females and 77 (21.8%) males. Ethnicity saw Blacks overrated with 349 (98.9%), and Hispanic origin 5 (1.1%). Participants HIV status was drafted among the demographics with 270 (76.5%) uninfected, 2 (0.6%) infected, and 81 (22.9%) missing. Sexual orientation was also mentioned with 319 (90.4%) heterosexual, 3 (0.8%) homosexual, 7 (2 %) bisexual, and 24 (6.8%) missing. Three questions were asked of the participants: Question 1 is have you known someone with HIV infection, 299 (66.2%) yes, 130 (28.8%) no, and 6 (1.3%) missing; Question 2 is have you known someone who died of AIDS complications 318 (70.4%) yes, 128 (23.3%) no, and 23 (5.1%) missing. Question number three was asked of the participants if they have ever knowingly given nursing care to someone with HIV, 187 (41.4%) yes, 237 (52.4%) no, and 28 (6.2%) missing (Rosenburg et al., 2012).

Data management and analysis for this study was carried where univariate information was produced as summary, mean, and frequency measures for demographic and indicator variables. One-way analysis of variance (ANOVA) and student *t*-tests were used to compare mean age by demographic and indicator variables. Thus, indicator variables and demographic of independence by nursing school was assessed using Pearson's chi-square statistic and when small cell size was present Fishers exact test was employed. To examine the distributions of stigma questionnaire responses by a number of demographic and indicator variables of interest the Kruskal-Wallis one-way ANOVA and Mantel-Haenszel chi-square tests were used.

Using reliability and confirmatory factor analyses performed analysis of the

questionnaire item data. The two underlying factors nurses stigmatizing patients and nurses being stigmatized were calculated for the entire study as well as measures for Cronbach's alpha, eigenvalue, and explained variance. Windows version 9.2 by SAS (Statistical Analysis System), (SAS Institute, Cary, NC) was used to compute Fisher's exact test. However, Windows version 17.0 (IBM Corporation, Somers, New York) by SPSS was performed for all other analysis.

The study's results found that single participants (23.33) were younger than married and partnered participants (25.75) $t(57) = 3.5; p < .001$. Nursing students in the Bachelor's program (24.27) were quite older than those students in the diploma program (23.11); $t(345) = -3.1; p = .002$. Students who have known someone that died from an AIDS-related condition (23.92) were much older than those who did not know (22.62; $t(341) = -2.3; p = .021$). Nursing care provided by students to patients with HIV infection (24.16) were older than those who had not provided care (23.34; $t(318) = -2.1; p = .039$). The study also found that stigma existed between nurses and patients alike (Rosenburg et al., 2012).

Specific stigma items response distributions indicated that student nurses who did not have direct contact with PLWHA were less likely to have any stigma towards these patients. Further findings showed that knowingly having given care to PLWHA or someone who died from AIDS-related condition helped to decrease stigmatizing behaviors and attitudes. Results further indicated that the perceptions of HIV/AIDS-related stigma could influence training in the educational process for nurses globally. In addressing the varying levels of stigma among Cameroonian nursing students, peer-to-

peer intensive workshops on HIV will be overseen as ongoing partnerships between Cameroonian nursing schools, and the Goldfarb School of Nursing in the United States (Rosenburg et al., 2012).

The study is recommending that any future research should include examination of stigma and nursing students in other parts of the world, involving both industrialized and unindustrialized countries. There should be an opportunity existed in observing the effect of sensitivity training and cultural education on reported stigma by nursing students. As nurse educators it is imperative to examine present level of HIV/AIDS-related stigma among nursing students, and the ability to recognize destructive attitudes toward PLWHA. The study warned that undesirable attitudes, principles, and feelings by healthcare providers, including nurses toward PLWHA cripple the effectiveness in providing nursing care in a beneficial and reasonable fashion.

Another study by Li et al. (2007) titled *Stigmatization and Shame: Consequences of Caring for HIV/AIDS Patients in China* using a quantitative approach with a cross-sectional design assessed the impact of the HIV/AIDS epidemic on medical care systems and service providers in China. A total of 1,101 participants were randomly selected from 3,579 eligible healthcare providers. The proposed question for participant's selection was "have you ever treated or interacted with any HIV/AIDS positive patients in the hospital or clinic?" Participants chosen for the study were doctors, nurses, and lab technicians who have given favorable reply to the question (n = 478).

The sample was made up primarily of female (72.8%) and Han ethnicity (68%), the racial majority in China. Approximately 23% of the participants were younger than

30 years of age and 31% were 41 years and above. Roughly one-third of the sample worked in regional hospital and about 45% were doctors, 42% nurses, and 13% were lab technicians. The SAS statistical software version 9.1 was engaged to execute all analyses. First, descriptive analysis was done using the distribution of age, gender, education, care facility, and profession of the sample.

To investigate the relationships between age, gender, medical degree, HIV knowledge, stress, perceived institutional support, perceived societal stigma, effect of working with HIV/AIDS, and internalized shame were calculated using Pearson correlation coefficients. Respectively, two multiple regression analyses were conducted with the Impact Scale and the Internalized Shame Scale controlling for the immediate effects of participants HIV knowledge, perceived institutional support, perceived societal stigma, stress, as well as demographics. Reported stigma and discrimination experienced by working with PLWHA was associated with internalized shame ($r = 0.32$), stress ($r = 0.14$), age ($r = 0.14$), and perceived societal stigma ($r = 0.10$). The study's results found that negative consequences reported by healthcare providers were both at institutional and individual levels (Li et al., 2007).

The primary focus of the study deals with healthcare provider's feelings of being stigmatized, and discriminated against, while working with PLWHA. Further findings of the study indicated that respondents reported negative consequences of caring for PLWHA. The study elucidates clear indications that institutional support is paramount in reducing healthcare providers' perceived negative consequence of caring for PLWHA. One of the fundamentals of this study is that excellent institutional support will foster and

promote a positive psychological state, avoid burn out and departure from the workplace. The study's recommendations are for healthcare executives to recognize the crucial need to entice, train and retain health care personnel to meet the challenges of the HIV/AIDS epidemic. It is also fundamental for policy makers and healthcare administrators to identify and respond to the support needs of the healthcare workforce.

Wong and Nur Syuhada (2011) generated a qualitative study investigating the public's perceptions of HIV/AIDS-related stigma, and discrimination toward PLWHA to better understand the root cause of HIV/AIDS-related stigma and discriminatory attitudes. In this study an interview guide with semi-structured questions was used for a focus group discussion. A purposive sample was used to recruit respondents from the public at-large with a total of 14 focus group discussions (n = 74) carried out between March and July 2008. The participants in this study had a mean age of 24.0 years old ranging from 18 to 60, 60% were female.

Data was collected from each participants using Glaser and Strauss methodology. Mechanism for data analysis was done using qualitative research software (QRS) NVivo (QRS International, Doncaster, Victoria, Australia). Using a grounded theory approach transcripts were analyzed where open, axial, and selective-coding procedures were adapted. Coding commenced by categorizing extensive theoretical themes and was polished as more data was analyzed.

The study found that the cause surrounding HIV/AIDS-related stigma and discrimination toward PLWHA was astounding. Most respondents exhibit discriminatory attitudes showcasing a disturbing degree of uneasiness with PLWHA. Critical reactions

by participants indicated uneasiness toward PLWHA in two ways. The first was fear of the lethal nature and harmful effects of HIV/AIDS infection, and the second involves fear of contagion.

Consequently, participants refused taking unnecessary risks, which could result in HIV/AIDS transmission through occupational infection (Wong & Nur Syuhuda, 2011). The study recommends a hasty and effective campaign to curb the HIV/AIDS epidemic, which should highlight the stigma of HIV/AIDS, and integrate messages in its narratives to diminish HIV/AIDS-related discrimination toward PLWHA. Moreover, the public should adopt a constructive attitude toward people infected with or affected by HIV/AIDS. The compilation of outreach programs should mobilize and educate the public that HIV virus is not spread by casual or social interaction.

Curious observation has shown that stigma directed at PLWHAs and their caregivers has coexisted with the global spread of the disease for over four decades, therefore, negative penalties of stigma has instigated a secondary psychosocial pandemic. A participatory research study was carried out by Mill et al. (2013) using a qualitative approach to explore the nature, context, and influence of stigma on nursing care provided to PLWHAs in four countries, namely, Jamaica, Kenya, South Africa, and Uganda. A purposive sampling method was used to recruit 84 registered nurses in individual interviews, and 79 in 11 focus groups. The researchers in this study used an inductive process to iteratively identify themes and relationships among themes in the interviews and focus groups.

A comprehensive analysis was guided by Morse's taxonomy (1994), which

included synthesizing, comprehending, re-contextualizing, and theorizing the data. In assisting with the management of the data and coding of the transcripts qualitative research software (QRS) NVivo 8 (QRS International, 2008) was used. During the analysis process the coding structure was refined to reveal new insights about the data and relationships among themes. It was interesting to know that the themes that emerge from the data across the four involved countries were the same. However, there was some distinction in the specific examples that nurses used in highlighting their approaches to the care of PLWHAs.

Findings of the study also revealed that stigma was a major factor that prejudiced nurses' ability to provide care for PLWHA. Consequently, the fear of stigma and discrimination also inhibited patient's decision making in revealing their HIV/AIDS status, which in turn thwarted nurses' ability in the delivery of basic nursing care. The study also found that nurses in reality made strategic decisions about nursing care that was based on the appearance of the patient or knowledge of his or her status. Significant to the findings the degree to which nurses acquire support from employers may offer evidence for understanding the portrayal of stigma.

The category that was addressed in this section; related stigma in the care of people with HIV/AIDS by selected qualitative and quantitative studies demonstrated the effectiveness of rigor and trustworthiness of the study's outcome. Rigor and trustworthiness were noticeable through the findings, limitations, implications, and recommendations. However, the quantitative study done by Rosenberg et al. (2012) plainly identifies mishaps in the data analysis, which means that analysis was

confirmatory rather than exploratory. The size of the sample in this study was a critical factor analytically, which pose a threat to generalizability.

On the contrary, these studies discovered severe impediments on how stigma is perceived by healthcare providers, especially nurses in the care of PLWHA. It is imperative to denote that literature review plays an integral part in research study with the sole purpose of sharing significant information relevant to nursing in any proposed study, worth investigating universally. Therefore, this proposed study may reveal whether or not stigma has any influence on the way care is provided to individuals suffering from this dreaded disease. Moreover, data collected may provide the researcher valuable knowledge on how healthcare should be delivered to PLWHA.

Fear of Occupational Exposure to Infection and Transmission in HIV/AIDS Care

The fear of occupational infection of HIV/AIDS is disconcerting among RNs in the practice setting. The effect of occupational infection in HIV/AIDS care is extremely rare but poses a potential risk for RNs in the care of PLWHA. The CDC recommends proper use of safety devices and barriers to prevent infection of HIV/AIDS on the healthcare continuum. For healthcare workers who are exposed such as RNs, the CDC has mandated strict regulations and guidelines coordinated by State's health agencies to minimize the risk of HIV/AIDS infection. It is interesting to know that fewer than 60 cases of occupational transmission of HIV/AIDS have been reported in the United States to date. As of 2010, 57 documented cases of HIV/AIDS transmissions, and a possible 143 transmissions was reported. In other words, three out of every 1000 such occupational exposure will result in infection (CDC, 2010).

An analytical cross-sectional study done by Amoran (2013) titled, *Occupational Exposure, Risk Perceptions and Access to Prophylaxis for HIV/AIDS infection among healthcare workers in Northern Nigeria, Nasarawa State* from January to February 2009. This study highlighted the technicality of occupational infection. The researcher utilized multistage sampling technique to obtain a representative sample and a structured self-administered questionnaire to collect relevant data. A total of 1,680 prospective participants as of December 2007, which comprised 1,357 in public and governmental healthcare institutions and 323 registered health workers in private hospitals/clinics throughout the State. Among the total prospective participants there were 401 nurses/midwives (78%) from public healthcare institutions, and 109 (21%) from private institutions.

There were a total of 421 healthcare workers interviewed 284 (67.5%) were males and 137 (32.5%) were females. Nurses were 18.5% (78) of the sample interviewed. Data analysis was done using SPSS statistical software version 15. Detection of errors or data editing were generated by frequencies. Patient's characteristics were described by calculating proportions. For comparing proportions chi-square tests were influence for categorical variables, and when suitable Fisher's exact test was mobilized. To determine the association between categorical variables and a p value of less than 0.05, which was considered significant, chi-square was utilized.

The study found that 5.2% of healthcare workers reported percutaneous exposure to HIV/AIDS infected blood or body fluids in the workplace in the last six months. Consequently, healthcare providers mostly at risk were the nurses/midwives with 9%.

Several retrospective studies and surveys have shown higher rates ranging between 12% - 87.4% of blood contact among healthcare workers in different patient care settings. The study implies that the Nigerian healthcare system should encourage voluntary counseling and testing in order to ascertain and prevent HIV/AIDS infection due to occupational exposure. The study suggested that the lack of medication for prophylaxis and other supportive materials needed to treat and prevent the spread of HIV/AIDS, and the high risk perception of being infected among healthcare workers may contribute to discriminatory behavior toward PLWHA. First, two distinct points of interest were made by the researcher that future research with a longitudinal approach was necessary and would be valuable in assessing occupational exposure. Second, it would be plausible for a follow-up study to be done to acquire knowledge and understanding on the premise of how disease state could transpire from these occupational exposures.

Another scholarly work completed by Beyera and Beyen (2014) titled *Epidemiology of Exposure to HIV/AIDS risky conditions in Healthcare Settings: The Case of Health Facilities in Gondar City, North West Ethiopia*. This study employed an institutional quantitative cross-sectional design conducted from April first through 20th, 2014 to determine epidemiology of healthcare workers exposure to HIV/AIDS risky conditions and associated factors in healthcare settings. The study's sample size was determined using the formula for single population proportion by considering 50% prevalence of exposure to HIV/AIDS risky conditions, 95% level of confidence and 5% margin of error. By adding 10% non-response rate the final sample size was 422 healthcare workers of which 401 participated in the study giving a 95% response rate.

Data collection for this study was done through interviewing healthcare workers using structured and pre-tested questionnaire. The sample was made up of 224 (55.9%) males and 177 (44.1%) females. Data processing and analysis were carried out using epidemiology information (EPI INFO) version 3.5.3 statistical software and was then transferred to and examined through SPSS version 20.0. Percentages, means, and standard deviation known as descriptive statistics were processed for most variables in this research study. For controlling the possible effects of confounders after bivariable logistic regression analysis was done in defining exposure to HIV/AIDS risky conditions; multivariable logistic regression analysis was the primary initiator. Variables, which have important association with exposure to HIV/AIDS risky conditions were identified, based on adjusted odds ratio (AOR) with 95% confidence interval (CI) and P-value <0.05.

The findings of the study showed that 162 (40.4%) healthcare workers reported at least one history of accidental exposure to HIV/AIDS risky condition in the last one year. One hundred and two (62.96%) of the exposures were mentioned by males, while 60 (37.04%) by females. Forty seven percent (47%) of the exposed healthcare workers experienced the exposure more than once, while 53% just once. Majority, 92 (56.79%) of the exposure episodes occurred through percutaneous injury followed by 90 (55.56%) through contact of mucus membranes and non-intact skin with blood. The leading cause of exposure is heavy workload followed by failure to use protective gears, and lack of knowledge on standard precautions. The most common reasons given by healthcare workers for not reporting their exposure were busy workload, fear of stigma and discrimination, lack of management support, reporting is too time consuming, and lack of

awareness about reporting procedure. The study also implied that work environment; available resources, inadequate staffing, insufficient training, duty overload, and fatigue may lead to occupational infection.

In understanding the fear of occupational infection of HIV/AIDS where nurses are concerned, Chan, Rungpueng, and Reidpath (2009) conducted a qualitative inquiry; *AIDS and Stigma of Sexual Promiscuity: Thai Nurses' Risk Perceptions of Occupational Exposure to HIV/AIDS*. The study scrutinizes the traditionally shaped meaning of HIV/AIDS awareness of accidental occupational exposure among a group of 20 nurses in Bangkok, Thailand. There were 20 semi-structured in-depth interviews carried out among qualified and student nurses studying at a Bangkok nursing college. Fifty percent (50%) of the participants were student nurses completing the final year of their undergraduate studies, and the other 50% were well-rounded nurses pursuing postgraduate study.

An independent Thai-English translator who is not involved in the research project translated this study's transcripts from interviews from Thai to English. The second researcher for this study oversaw the translation for consistency. Analysis of the data was steered primarily from the English transcript by the first researcher using NVivo in which transcripts were coded and evaluated for emergent themes. Narratives were organized into distinct concepts and categories utilizing open coding. During the analysis phase axial coding was promoted to refine main categories and themes into sub-themes, and interrelatedness between the many themes and sub-themes to be reconnoitered.

Suggestions from the study identified the fear of occupational infection in the

practice arena as one of the fundamentals of HIV/AIDS stigma among nurses, and that HIV/AIDS-related stigma is a vicious element in the provision of care to PLWHA. Furthermore, research has denoted that in the healthcare setting the fear of HIV/AIDS infection on account of accidental exposure instigates nurse's negative reactions toward PLWHA. The study also found that accidental occupational exposure to HIV/AIDS infection happened frequently as a result of needle stick injury, and is a well-documented occupational risk for nurses. A significant finding of this study shows that the fear of HIV/AIDS infection remains an important occupational stress for many nurses and a stipulation for early retirement for many. Nurse's descriptions had shown that in spite of acknowledgment of low probability of occupational exposure to HIV/AIDS, the fear of contracting HIV/AIDS infection remained, and largely motivated by the enormity of the predicted social penalties of being tested positive.

To further examine the fear of contracting HIV/AIDS, Ncama and Uys (2003) navigated a qualitative study using a phenomenological approach. The title of the study was "*Exploring the Fear of Contracting HIV/AIDS among Trauma Nurses in the Province of Kwazulu Natal.*" Participant's selection was done using purposive sampling technique on the premise of category (registered nurses), workplace (level one trauma units), and work experience (six months experience in a trauma unit). There were 12 nurses who participated in the study from public and private institutions. The purpose of the study was to interpret the lived experience of RN's fear of contracting HIV/AIDS, its consequences on their personal and working lives, and on their coping skills.

Undertaking for data collection was done through the development of an

interview guide, which direct the researcher to react to participant's responses on the progress of the interview. It also gave the researcher the autonomy for probing or following up of important information that came to the forefront. There were two interviews per participants. The second interview called member checking was carried out based on data earlier obtained on the initial interview. This second interview in the analysis process was to clarify misunderstandings, misconceptions, and to ratify suggestions and solutions from participant's own opinion, and to exit the interview based on the principle of data saturation. Hence, data analysis was done with short summaries made from participant's responses, which was then referred back to the participants for validation. Trustworthiness and authenticity of the data was achieved mainly through member checking.

The study's findings revealed that trauma nurses perceived themselves to be at risk of contracting HIV/AIDS from their practice area in spite of universal precautions. Nurses also purported that percutaneous injury, such as needle sticks are the key source of fear, and that diverse coping skills and defense mechanisms were used efficiently to cope with the fear of contracting HIV/AIDS. Study's results showed that there were no emotional crisis exhibited among nurses who employed different coping skills and defense mechanisms in daily practice. To decrease the fear of contracting HIV/AIDS, education on every level and support network development was recommended as key strategies in examining this phenomenon. Further findings indicated that improvements are required in quality and availability of protective equipment and materials. Suggestions were also made for HIV/AIDS to become a notifiable disease, as well as

improving universal and explicit beliefs that would increase coping skills.

The category fear of occupational exposure to infection in HIV/AIDS care addressed the qualitative and quantitative stance on this phenomenon. These studies uniquely divulged sensitive information that is of importance to the lived experience of RNs caring for PLWHA. Therefore, the presumption of nurse's fear in contracting HIV/AIDS in the practice setting is common place singled out by the researchers in the articles reviewed. Although the hazard of occupational exposure is quite low, statistics and narratives of the articles show that fear loomed over participants through their responses.

The study conducted by Ncama and Uys (2003) found a significant gap in literature to support the notion that fear of HIV/AIDS infection through occupational exposure caring for PLWHA goes beyond nurses working environment to include their families. Chan, Rungpueng, and Reidpath (2009) study raised concern that accidental occupational exposure as a function of the extent of nurse's genuine exposures to PLWHA is a matter that merits further investigation. However, the studies mentioned that HIV/AIDS exposure in the United States is generally through occupational exposure, while in other parts of the world it is through heterosexual transmission. Furthermore, these studies invoke within their narratives that support development networks are key strategies to decrease fears.

This proposed study's aim is to add cohesion and expand knowledge on the effects occupational exposure has on the lived experiences of RNs, and whether it has any repercussion on the well-being of PLWHA. In other words, information derive will

further assist the researcher in identifying if this category merits further exploration, and ways of improving care for PLWHA in light of RNs concerns. However, in order to improve care for PLWHA, effective ways of modifying RNs perceptions of occupational risks must be addressed promptly, and this study may provide an understanding of the plight of RNs as they deliver care to this vulnerable population.

Nursing in the Context of HIV/AIDS Care

HIV/AIDS is one of the most severe impediments to have graced the nursing profession in recent years. Studies have shown that nurses have always conjured a range of feelings and concerns about providing care to PLWHA in daily practice. Consequently, some of these feelings and concerns for nurses to refuse caring for PLWHA are the fear of infection, fear of putting spouses and children at risk, and fear of condemnation from others. Presently, there is no known cure for HIV/AIDS infection, and given the high incidence of HIV/AIDS cases globally, and with the use of antiretroviral therapy PLWHAs are living longer lives. Therefore, nurses are more likely to provide care for PLWHA in the context of HIV/AIDS care for a considerable long time to come.

Dilorio (2008) provided the body of nursing with a study done on neuroscience nurses' intentions to care for people with HIV/AIDS. The study's purpose was based on Ajzen's theory of planned behavior, which was to define the degree to which personal attitudes, subjective norms, and perceptions of behavioral control influence the intentions of nurses to care for PLWHA. A quantitative design was employed using a systematic sampling technique to select every fourth name on the list of prospective participants.

This procedure generated a sample size of 740 individuals in which 368 nurses completed and returned the surveys accounted for 50% that made up the final sample.

The participants in this study ages range from 23 to 66 years with a mean age of 39.3 years ($SD = 8.1$). Respondents were predominantly female (94.8%), married (60.6%), and 41% of the sample has a baccalaureate degree in nursing. Master's degree in nursing accounted for 28.3%, associate degree 14.4%, diploma 14.1%, and doctorate 1.6%. Participants worked an average of 15.5 ($SD = 8.2$) years in nursing, 10.4 ($SD = 6.4$) in neuroscience nursing, and 7.5 ($SD = 7.6$) years with PLWHA.

A hierarchical regression analysis was used to determine if nurses' intentions were predicted by their attitudes and subjective norms, and if perceived behavioral control would add to the prediction. Participants accounted for 65.8% who had not cared for a person with HIV/AIDS within the week prior to filling out the survey. However, 45.6% had cared for at least one person within the month prior to the survey completion. The study conveyed that 88% were presently working in an acute care setting, such as medical centers, or hospitals, and the remaining participants were practicing in diverse healthcare institutions.

The result of the study showed that the means for the intention and predictor variables are in sync with a study done by Laschinger and Goldenberg on a sample of practicing nurses in Canada of 4.5 on a seven-point scale. This finding has revealed some distinction on caring for PLWHA. The respondents expressed positive beliefs about caring for PLWHA as evidenced by the relatively high mean score on the attitude scale of 32.38. Consequently, participant's approval rating on the beliefs about caring for

PLWHA by others was less positive than their personal attitude. Perceived behavioral control mean (36.58) on beliefs by participants were slightly higher than attitudes (32.38), and subjective norms (23.74).

This indicates that higher levels of control suggest that nurses have access to resources, and they believe that it makes it much easier for them to care for PLWHA. The study suggested a different approach should be taken in promoting nurses' intentions to care for PLWHA by shifting from a focus on nurses to one on the environment in which nurse's practice. The intentions of nurses were influenced by perception on the availability of resources and supports. Therefore, it would be beneficial for nursing administration and staff to attend to the environment where care is provided. It is also noted that the intricacies to the care of PLWHA present challenges to nurse's competency, professional and personal values, ethical principles, and willingness to care.

Introducing the willingness to care for patients with HIV/AIDS, Valimaki et al. (2008) conducted an international cross-sectional study of nurses working in medical, surgical, and gynecology wards in Finland, Estonia, and Lithuania addressing this challenge. The study's purpose was to describe and compare nurses' willingness to provide care for PLWHA and influences related to this issue in three countries. There were two research questions used to address this issue (a) "Are there any differences among Finnish, Estonian, and Lithuanian nurses' willingness to care for PLWHA? And (b) what personal-level factors are associated with nurse's willingness to care for PLWHA in Finland, Estonia, and Lithuania?"

A purposive sampling technique was used to ensure a possible standardized

working environment. Questionnaires were distributed to nurses in Finland ($n = 427$), Estonia ($n = 221$), and Lithuania ($n = 185$). The return rates on these questionnaires were; Finland 75% ($n = 322$), Estonia 54% ($n = 119$), and Lithuania 86% ($n = 160$). In each country nurses' working experience is different with Finland accounting for 0-42 years, (mean 14.94; $SD = 10.38$), Estonia 1-47 years (mean 21.25; $SD = 11.21$), and Lithuania 1-50 years with a (mean 18.69; $SD = 10.28$).

In this study, data analysis was supported by using SPSS for windows version 11.5. Demographic variables and items about nurses observations related to their willingness to provide care for PLWHA were scrutinized using descriptive analysis. Individual items comparison between countries were led by initiating cross-tabulation and chi-squared analysis. Average scores for the scales were obtained by summing up the willingness scores for each nurse, and the end product divided by the number of items. Consequently, the greater the average score, the less willing a nurse would be in providing care for the population under review.

A non-parametric Mann-Whitney U-test or a Kruskal-Wallis test was used to determine the association between the nurses' background variables, and their average score on the willingness scale. To examine the correlations between the willingness scale and the numerical background variables; Pearson's product moment correlation coefficients were employed. The 13 items for all participants and by countries were calculated to examine the relationships among continuous variables using Spearman's correlation coefficients. In addition, P -values of less than 0.05 were construed as statistically significant.

The study found that in Finland 29% of the nurses had known someone with HIV/AIDS, Estonia 26%, and Lithuania 14% ($p = 0.001$). Of the total number of nurses asked to care for PLWHA the study revealed that 81% of Finnish nurses, Estonia nurses 42%, and Lithuanian nurses 7% ($p < 0.001$). There were 88% (Finnish), 59% (Estonian), and 19% (Lithuanian) nurses who had cared for PLWHA in their practice. The majority of Finnish nurses (81%) and half of the Estonian nurses (54%) were directly willing to care for PLWHA, while in Lithuania only 9% of the nurses were willing to provide care ($p < 0.001$). However, nurses' refusal to care for PLWHA found 1% in Finland and Lithuania, and 2% in Estonia ($p = 0.226$).

There were 13 specific nursing activities used to describe and compare nurses' willingness to care for PLWHA. Of these activities only two items; willingness to give bed bath and to clean up vomitus, 9% to 23% disagree or strongly disagree, nurses in all three countries exhibited the willingness to perform nursing activities for PLWHA. However, associated factors on the willingness of nurses' to care for PLWHA are overwhelming in performing activities to fictional patients in this population. This means that nurses have shown charisma and responsibility in safeguarding and promoting the well-being of PLWHA which can be measured on their mental level. Generally, sharing of the same value base and goal setting in daily experience, nursing education, ethical responsibilities, and cultural tendencies in nursing may vary among nurses in all three countries.

The study also discovered that in all three countries nurses are different in background variables, such as advocacy, HIV prevention, and their willingness to care for

PLWHA. The study recommended that future studies should use a data collection method that will diminish the risk of the Hawthorne effect. In support of the healthcare environment, mobility of the workforce, patients and families, and to ensure high-quality nursing care; cultural sensitivity should be prioritized. However, the improvement of nursing curriculum that recognize prejudicial thinking, biases, and xenophobia with respect to marginalized groups would help decrease fears, and intensify nurse's willingness to provide culturally proficient healthcare. Priority should be given when designing HIV/AIDS educational material on account of nurses' national and personal differences.

As a beacon of hope nurses have always been on the forefront of HIV/AIDS epidemic, prevention, care, and advocacy. Consequently, nurse's opportunity in working with PLWHA may lead to stress, burnout, and even resignation, especially when physical contact with HIV/AIDS patients provokes misinterpretations and circumvention among nurse's social world, connections, and families. Hamama et al. (2013) initiated a study called *Nurses Job Satisfaction and Attitude toward PLWHA in Ekaterinburg, Russia*. This was a quantitative study with a cross-sectional design. Hamama et al. examined the connection between job satisfaction and nurse's attitudes toward caring for PLWHA in two settings, nurses that work regularly, and nurses who rarely work.

The study included 168 nurses employed in six HIV/AIDS clinics combined which accounted for 21-35 nurses in each clinic, 76 nurses participated from this setting. The second sample had 371 nurses working in the largest hospital in the State, which accounted for 75 nurse's participation. The sample altogether made up almost 90% of all

the nurses who were approached from both settings that decided to participate in the study. In examining the differences between the two groups (nurses who regularly cared for PLWHA, and nurses who rarely cared for PLWHA) in job satisfaction and in attitudes toward PLWHA; a univariate one-way multi-variate analysis of variance (MANOVA) was carried out. Two demographic variables age and education were controlled that differed between the two settings in the analysis. Statistics showed 69 participants from the HIV/AIDS clinics regularly worked with PLWHA and 66 from the general hospital who rarely worked with PLWHA.

The study's findings indicated that the mean age was 41.3 years overall ($SD = 9.88$) of nurses who regularly work with PLWHA. These are significantly younger nurses (mean = 39.58; $SD = 8.61$) than those who rarely worked with PLWHA (mean = 43.15; $SD = 10.81$), $t = 2.13$, $p < 0.05$. The mean years of professional experience for nurses was 19.65 ($SD = 10.00$) with no significant difference between the two groups. Avoidance in care was significantly different between the groups toward PLWHA. This means that nurses who work in HIV/AIDS clinic exhibit a lower avoidance in care toward PLWHA in comparison to their colleagues in the hospital settings.

There were no significant differences in job satisfaction between the two groups. A possible justification for the less avoidance in care among nurses in these specialized HIV/AIDS clinics may be interpreted that their personal contact with PLWHA and their AIDS-specific training acted to dissipate fabrication. On the other hand, nurses who work in general hospitals rarely have contact with PLWHA and may experience paucities in AIDS-specific training, resulting in insufficient and inadequate knowledge regarding

HIV/AIDS care, leading to avoidance toward PLWHA. However, nurses are expected to give quality and evidenced-based nursing care to every patient irrespective of their diagnosis, demographics and diversity. Moreover, nurses are expected to practice ethically and act indiscriminately toward all patients for the common good of humankind (Smit, 2005).

To further explicate the context of nursing in HIV/AIDS care Williams et al. (2006) generated a quantitative study called effectiveness of an HIV/AIDS educational program for Chinese nurses. This study engaged a pretest, post-test, one group, experimental design with 208 nurses across seven Chinese provinces. The purpose of this study is the effect of a multifaceted HIV/AIDS educational intervention on the knowledge, attitudes, and willingness of Chinese nurses caring for PLWHA. The setting was a five day workshop intervention embracing educational lectures interposed with events intended to stimulate discussion of participants' values, and personal feelings about HIV/AIDS care.

Theoretical underpinnings of this study were guided by Bloom's Taxonomy. Essentially, this study sought to examine principles of efficient HIV/AIDS educational practice through applied education intervention to learning. The outcome variables were HIV/AIDS knowledge, attitude, and the willingness to provide nursing care toward PLWHA including, compassion for and the desire to avoid these patients. While HIV/AIDS epidemic in China continues to climb the infectious ladder, healthcare workers; including nurses display misperception, unawareness, and anxiety in the provision of care to PLWHA.

A member of the research team organized hard copies of the questionnaires from the four workshops instituted and supervised data cleaning, entry, and analysis. Data analysis was piloted using EPI INFO 6.0 (Centers for Disease Control, Atlanta, Georgia). Descriptive and comparative statistics were also done to analyzed data collected. Scores for mean, median, standard deviation and range was calculated on knowledge, attitude, and willingness to care.

The assumptions of normality and constant standard deviation for dependent *t*-tests were evaluated and met. To describe the association between the number of years of nursing experience and HIV/AIDS knowledge Pearson's coefficient of correlation was used. In examining the relationship between the numbers of patients with HIV/AIDS for whom the nurses had previously provided nursing care and pre-workshop HIV/AIDS knowledge, empathy, avoidance, general attitude, and the willingness to care Spearman's Rho rank correlation was imported. On the other hand, pre/post workshop scores were assessed for statistically significant differences using paired *t*-tests.

The study found that 75% of participants believed that the risk of contracting HIV/ AIDS through occupational exposure is greater than 1% as opposed to 80% before the workshop. There was no suggestion between the number of PLWHA for whom participants reported having previously provided nursing care, and the willingness to care for the same patient in the future. However, nurses who had experience in caring for PLWHA scored higher on the knowledge section of the questionnaire. The study projected that the more HIV/AIDS patients a nurse cared for the better his or her knowledge score will be.

In order to achieve a successful response to the HIV/AIDS epidemic in China, including clinical care, delivery of antiretroviral medications, and effective prevention; it will require a major overhaul to strengthen the HIV/AIDS capacity of the Chinese healthcare. The study also emphasized that it would be strategic to conduct careful and controlled appraisals of the efficiency of different clinical models of education to combat the epidemic in the Chinese society. It is imperative that the intensive workshop evaluated in this study is time consuming, and therefore, require experienced nurse educators. In justifying the financial obligation, time, and effort of this project; imminent studies should scrutinize not only the usefulness of the program in changing attitudes and willingness to care in the short term, but also the strength of its influence. The study also recommended that it is crucial for future studies to observe the association between enhanced scores on educational appraisal measures and actual clinical and patient care behaviors. An important suggestion was made for the AIDS Attitude Scale (AAS) used in this study to be further tailored to explicate the correlation between changes in the scores and behavior.

On the contrary, experience with PLWHA was not associated with a more positive or definitive attitude toward those patients, or with an increased willingness to provide nursing care to them. Nurses in the United States of America alluded that feelings of preparedness and favorable attitudes about personal safety are associated with willingness to care for PLWHA (Preston et al., 2000). The fact that nurses are on the forefront of HIV/AIDS prevention, care, and advocacy it is imperative that they receive education both to decrease the risk of occupational acquired HIV/AIDS infection and to improve

the quality of care delivered to PLWHA.

Nursing in the context of HIV/AIDS care is addressed thoroughly by review of the overwhelming quantitative studies as opposed to the limited qualitative studies on this particular phenomenon of interest. In the action of this revelation a serious gap has been detected raising the consensus that more qualitative studies are required to explicate this crucial area for knowledge attainment. The opportunity to peruse and analyze these articles proved that nursing in the context of HIV/AIDS care is essential to promote the quality of life and restoration for PLWHA. The authors of these articles proclaimed that as the epidemic of HIV/AIDS widens in its 40-year history no corner of the globe is immune from its tentacles. Hamama et al. (2013) summed it up beautifully by articulating that maintenance, management, and innovation can be used as strategy for commitment and involvement when providing care to PLWHA.

Dilorio (2003) implied that personal attitudes were noteworthy in nurse's willingness to care for those infected with HIV/AIDS, and that conditions under which nurses practice can influence their intentions. Valimaki et al. (2008) strengthened the argument by saying that cultural sensitivity should be maintained in supporting the mobility of nursing workforce and patients to ensure high-quality care. Williams et al. (2006) exercised the claim in supporting the need for comprehensive professional education programs that will expedite attitude change in addition to providing didactic experience for the willingness of care to PLWHA.

Each article selected has the theme for *support* on the premise of nursing context in HIV/AIDS care. Recommendations were also made for future research endeavors

through qualitative and quantitative designs to address this phenomenon of interest. Therefore, this study is attempting to uncover a systematic presentation of knowledge whether or not there is any problem related to the care of PLWHA. The indispensable background of this study is to make the reader aware of the context of nursing in HIV/AIDS care, as contentious as it is for the researcher noted in the experiential context.

Experiential Context

Nursing was never on the list of to do things while growing up on this researcher's tiny island of Jamaica in the 1960s. Furthermore, it was not encouraged, instigated, or customary for men to become nurses in the Jamaican culture. As a gender-biased job, nursing was, at one time, not considered a profession at all, and was scorned upon if a male even considered nursing as a job opportunity. In Jamaica, this chosen professional field was not gender-neutral as it was in America for some time. Entering nursing was definitely considered a female skill subset. However, the opportunity of migrating to the United States of America changed the dynamics of things in many ways, and nursing is one of such changes. Nursing has become a central focus of my life equipping me with valuable experiences from every angle on the nursing spectrum.

The experience of caring for patients diagnosed with HIV/AIDS created a vacuum of distress, attitude, hate, prejudice, fear, discrimination, stigmatization, and rejection on my path purported by the literature reviewed. Significant to these concepts were the poor care extended to a close family member diagnosed with HIV/AIDS, which eventually took his life. This catastrophic loss aroused this researcher curiosity and interest to work with this phenomenon. The ability to work with this phenomenon both in the hospital

and home-care settings advances the drive to investigate care in practice, seen through the lens of registered nurses caring for PLWHA in Broward County, Florida. Nurse's characterization of HIV/AIDS through their lived experiences is an important phenomenon to understand in the provision of care to PLWHA.

To understand and explicate nurse's lived experiences of this phenomenon would be derived from their personal platforms, stages, and through their voices. Husserl (1970) who is considered the father of phenomenology believed that the implication of the lived experiences might be unraveled only on a communal ground between the researchers and the respondents. Thus, the art of accomplishing communal understanding on this matter, the process of *bracketing* or total *epoche* must be settled by the researcher. Bracketing is the consciousness of removing prior experiential knowledge and personal bias or suspending all preconceived notion about the phenomenon under review. On the other hand, epoche is another concept for bracketing in mathematics, but in the phenomenological perspective it is the ability of the researcher to suspend all judgments and attitudes about what is real until they are established on a more definitive foundation (Creswell, 1998).

Clearly, for the researcher the art of not having any prior knowledge of the phenomenon being investigated is extremely difficult to conceptualize in a phenomenological context. However, Heidegger (1962) saw an opportunity to bridge the gap in understanding the world and to use such understanding to interpret reality in this logical reasoning. Heidegger suggested that it is absurd for a researcher not to reflect on his or her past experiences in the dynamics of caring, alluding to preconceptions and

biases in the interpretive process to clearly access participant's forestructure of understanding in the study (Benner, 1994). Max van Manen (1990) went a step further indicating that in any phenomenological endeavor the investigator and the respondents are considered stakeholders in the research process, and it is insane to achieve complete bracketing or total epoche. However, he warns that it is better to make clear our understanding, beliefs, biases, assumptions, presuppositions, and theories when taking hold of the phenomenon in a qualitative research study.

Another critical aspect of taking hold of a phenomenon in a qualitative study is through *reflexivity*. The inference on the interconnectedness of bracketing and reflexivity holds true that a researcher must be reflective to bracket. Murray and Holmes (2013) indicated that in qualitative research and other ethical decision-making process reflexivity is generally understood as a technique for self-awareness. It is used to promote the eminence of the research, validate ethical research practices, and to guarantee the practicality and ethicality of the decisions.

Guba and Lincoln (2005) defined reflexivity as a conscious experiencing of the self within any research project. In other words, it exhibits the dominance of the researcher over the process. Therefore, it is cognizant of the researcher to be reflexive skillfully in three domains of a qualitative research study. First and foremost be thorough about the phenomenon to be investigated, secondly, be aware of the knowledge, experience, and perceptions of the participants, and thirdly, know the population who will be benefited from the results of the study (Gilgun & Sands, 2012).

In practicality, the researcher must lay aside all unwanted baggages when crossing

the threshold of the participant's life world. This means that all unwanted baggages, such as beliefs, biases, presuppositions, judgments, preconceptions, assumptions, and theories must be stripped away to facilitate the voices of participants as they share invaluable experiences of their life-world. Furthermore, as a medium in this study, it is the ambition of this researcher to thread softly around the process, and embrace self-reflexivity as a strategic measure to cast aside all unwanted baggages that will be detrimental to the outcome of the project. Pagis (2009) interestingly coined self-reflexivity as the conscious turning of the researcher toward themselves, simultaneously being the observing subject, and the observed object; a process that includes self-knowledge, self-monitoring, and self-reflection.

Evidently, in a qualitative study the tool for self-reflection documentation is called a *field journal*. This mechanism is extremely important in transcribing unfinished business, events, guilts, perceptions, principal and poor techniques, ideas, conceptions, questions, and problematic attenuations encountered along the study's trajectory. The action of journaling allows the researcher to be fully aware of shortcomings, such as biases, preconceptions, negativities, presuppositions, and impure thoughts that can derail the process. The epistemology attained from this reflective-interpretive process will give the researcher the autonomy to revise aspect of the study that will deliver a well-balanced and finished product. Moustakas (1994) remarked that the reflective-interpretive process includes not only an explanation of the experience as it appears in consciousness, but also an examination and shrewd elucidation of the underlying circumstances, historically and aesthetically which provide justification for the experience.

Chapter Summary

HIV/AIDS is a serious delinquent threat to the stability of this universe and requires immediate attention for its demise or containment. Therefore, understanding the disease; its background, and its significance are fundamental in the provision of scientific care. The amplification of the literature review gave the researcher a synopsis of HIV/AIDS care as it related to nurses and their experiences. It is imperative from an epistemological perspective to understand nurse's point of view; if negative or positive responses have any bearings on the care of PLWHA. This was accomplished by addressing the following content areas; historical context, knowledge, attitude, and education in HIV/AIDS care, related stigma in the care of people with HIV/AIDS, fear of occupational exposure to infection and transmission in HIV/AIDS care, and nursing in the context of HIV/AIDS care. The experiential context was also presented. Chapter three followed with the methodology that was utilized in this study.

CHAPTER THREE

Methods

The ultimate purpose of this research study was to gain an in-depth epistemology of registered nurses lived experiences in caring for people living with HIV/AIDS in Broward County, Florida. Hence, it was paramount to understand from the frontline worker's point of view; what it is like caring for this super sensitive group of patients with this 21st century disease. Comprehending the lived experiences of RNs caring for PLWHA in Broward County, Florida; Munhall (2012) explicated that nurses own personal experience gives voice to their experience through language attainment made available to others. However, the insight gained through the eyes and experiences of these extra special frontline workers; through interviews and other methods of communication provided important themes from which specific actions may be developed. Therefore, investigating these themes may eventually provide, and foster a better understanding of the special humanness required in caring for PLWHA. In addition, the examination of this problem used a qualitative method of inquiry in conjunction with Max van Manen hermeneutic (interpretive/descriptive) phenomenological approach for the explication of the concerned problem.

Furthermore, the researcher's action in employing these approaches exhibited concrete epistemology suitable in the care of individuals diagnosed with HIV/AIDS and PLWHA. The study's duty was to uncover RNs lived experiences and procures an expression of their emotional world caring for PLWHA in Broward County, Florida. The voices of RNs has been hidden and ignored for quite sometimes, and it was fundamental

that a platform be given to them to tell their stories as indicated by the enormous gap in literature seen on this side of the Western Hemisphere.

Methodology

Speaking of a qualitative method of inquiry and a phenomenological approach, this study drew on an interpretive paradigm navigated by van Manen's (1990) hermeneutic approach. Max van Manen has no definitive standards, rules, or guidelines, but discussed phenomenology research as a dynamic interplay among six research activities. These six activities were used to explicate, investigate, explore, recognize, express, and expose the significance of the lived experience of registered nurses caring for PLWHA in Broward County, Florida. Through the lens of van Manen's approach, phenomenology was not only a description, but an interpretive process in which the researcher made an interpretation between different meanings of the lived experiences (van Manen, 1990).

Research Design

Max van Manen's (1990) hermeneutic phenomenological approach was the reliable vehicle of choice in spearheading this study in explicating, scrutinizing, and determining the lived experience of RNs caring for PLWHA. Berg and Lune (2012) have indicated that the researcher use an assortment of complicated measures to ensure confidentiality, but perhaps the most effective and fundamental strategy was to think through the project carefully during the design stage. It is paramount that during the design stage of the study, the researcher considered what action was implemented to protect the identities of participants as well as data collection, and van Manen's research

approach was the most feasible in directing this study.

Polit and Hungler (1995) called in to question the number of problems that could arise during the design phase, such as research problem, and ethical dilemma. According to Munhall (2012), research design should be clearly and explicitly tabled to meet two strategic criteria for quality research. First, the researcher appraised the congruence between the purposes of the study and subsequent sampling, data collection, and analysis. Second, the researcher determined if something was learned from the participants that went beyond initial assumptions, understanding, and interpretation.

Rationale for Qualitative Inquiry

Qualitative inquiry of any proposed study is considered a scientific research design. This paradigm helped the researcher to interpret and to better understand the complexity of the lived experience of RNs caring for PLWHA in reality. In other words, the advantage of qualitative inquiry was to allow the researcher to seek and explore the given phenomenon of interest. Its intended action was to facilitate and field open-ended questioning and probing, and give respondents the opportunity to explain their experience in their own words.

On the other hand, qualitative inquiry gave leverage to heights and depths of information sharing between participants and researchers alike. Qualitative inquiry fits well for the phenomenon under investigation because it allowed the researcher to gain an understanding of the experience of RNs caring for PLWHA. This phenomenon was one of importance using a qualitative design with the backing of van Manen's approach that provided the researcher with thick and rich description of the phenomena. Through the

interaction with the participants the researcher was able to get close to the participants, probe further into their experience, and to arrive at the essence of what it meant to be a RN caring for PLWHA.

Rationale for Phenomenological Inquiry

Phenomenology is an inductive process that occupies two distinctive methods: descriptive (transcendental) and interpretive (hermeneutics). The interesting act of phenomenology research was the discovery of implications to the lived experience of one's everyday life as in the case of RNs caring for PLWHA in Broward County. Phenomenology was often considered integral to the interpretivism paradigm. Central to the interpretivism paradigm, the lived experience of registered nurses in Broward County caring for PLWHA was evaluated to uncover the true act of caring. Relevant to hermeneutic (interpretive) phenomenology inquiry was the specific method designed by van Manen (1990), called the six activities. These activities have been used frequently to drive many research studies to success. Thus, the researcher was immersed thoroughly in van Manen's six activities (see Figure 6).

These six activities gave the researcher the autonomy of seeking knowledge by turning to a phenomenon that seriously interested the researcher meaning that the project on the lived experience of RNs caring for PLWHA engaged a phenomenological inquiry. This project was motivated by a serious commitment of moving expeditiously on a long-lasting concern of interest that merits an investigation to inspire and bring about change. This activity turning to the lived experience was categorized as a mission of someone; a physical person, who was in the situation of a specific individual, social, or historical life

conditions that sets out to acquire wisdom of a certain aspect of human survival.

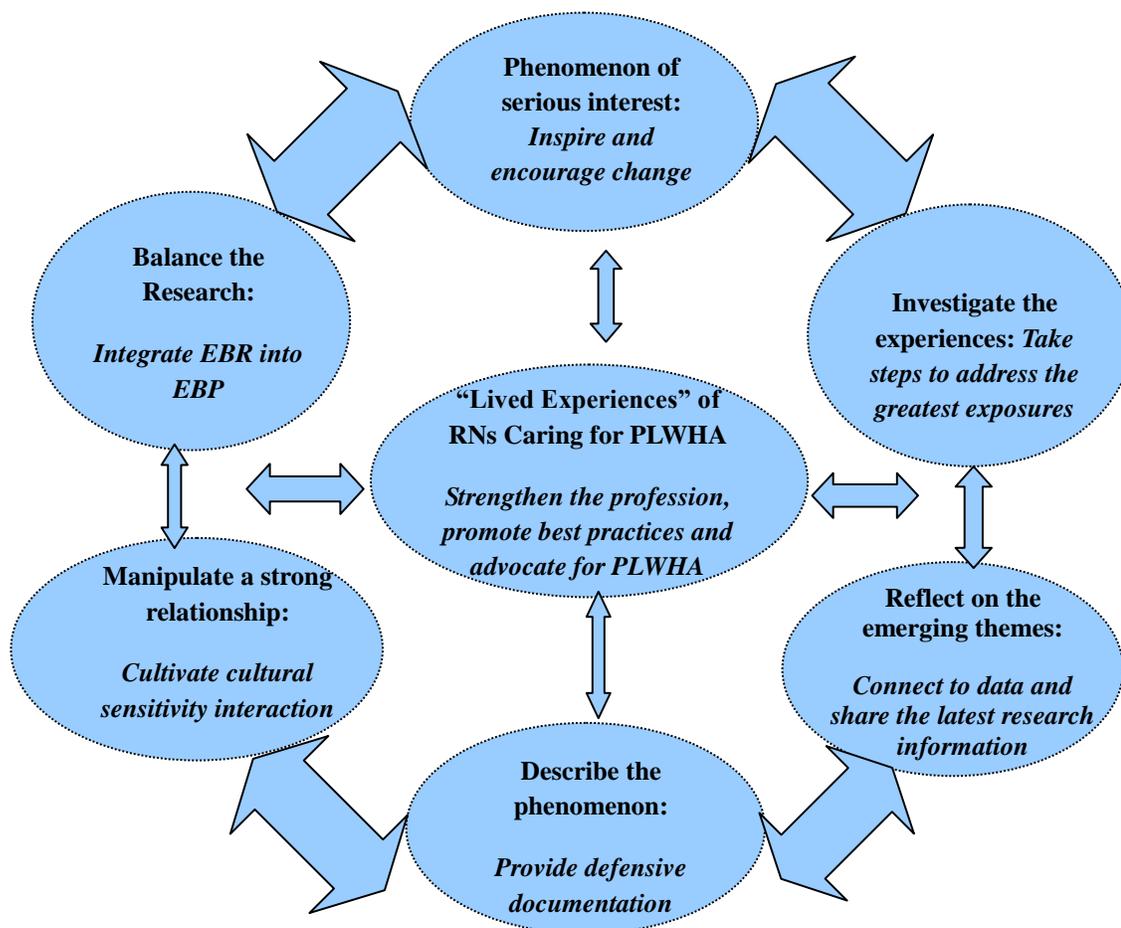


Figure 6. Wright, A. A. (2015). *Hermeneutic (Interpretive) Phenomenological Paradigm of "Lived Experiences" of RNs Caring for PLWHA: Six activities; Drivers of Human Research Success in the Management of PLWHA*. Adopted from van Manen (1990).

Analyzing description of this phenomenon with a phenomenological touch was always looked at as a single explanation, and no other interpretation of human experience ever depleted the opportunity of yet another complimentary or even potentially richer or deeper description obtained through exploration.

The researcher who investigated the experience as one, lived it in a phenomenological study; the sole purpose was to establish a renewed contact with unique

experience of this phenomenon in taking steps to address the greatest exposures of the lived experience. Hence, it was the art of procuring valuable knowledge and comprehending the nature of the lived experience itself in the eyes of RNs as they lived it providing care to PLWHA. In other words, it empowered the researcher to aggressively explore the category of the lived experience of RNs caring for PLWHA in all its fullness. To reflect on the emerging or essential themes in this study paved the way for the researcher to analyze a true reflection on the lived experience of RNs as a thoughtful and reflective grasping of what gave this specific experience its unusual meaning.

This activity also allowed the researcher to reflectively bring into view what experience was unclear, and what tendency to elude the lucidity of one's ordinary attitude of everyday life situation. Moreover, reflecting on emerging or essential themes assisted the researcher in connecting and sharing the latest research information. In describing the phenomenon with the ability of writing and rewriting was to bring to speech uniquely something that was thought about, such as the lived experience of RNs caring for PLWHA. Evidently, it was in the realm of letting that which is spoken about to be visible through the provision of defensive documentation as in this study.

The investigation of this phenomenological study allowed the researcher to manipulate and establish a strong relationship between the paradigm and the phenomenon. However, there are many obstacles, temptations, unhealthy speculations, preconceived notions, and narcissistic reflections that could cause conflict within the study that could require the researcher to hold steadfast to his or her conviction. To court a strong relationship with this phenomenon in question, the researcher could not afford to

accept an attitude of professed scientific partiality. For the researcher to be strong in his or her orientation or conviction dealing with this project, it signified that there was no outlet for trivialities and inaccuracies. It was paramount for the researcher to cultivate and promote cultural sensitivity interaction throughout this endeavor.

Speaking of the activity balancing the research context by examining parts and whole clearly dictated that the researcher needed to continually examine and measure the study or text against the importance that each segments play in the total textual structure. Phenomenological (van Manen, 1990) research approach (hermeneutic/descriptive) was fundamental and versatile in explicating meanings and assumptions on the participant's lived experience in caring for PLWHA. Each of the six (6) activities designed by van Manen (1990) contributed to a credible and rigorous interpretive research approach between design and outcome. The methodology applied to this study collected data to ensure understanding and meaning from data about RNs caring for PLWHA. The research was presented to health professionals derived from the complexity of health outcomes and practices encountered in clinical and nonclinical setting in the healthcare delivery system on the lived experience of RNs caring for PLWHA.

Max van Manen (1990) showed how lived experiences add value and relevance to the qualitative research approach. Hermeneutic (interpretive) phenomenological paradigm was anchored in the framework of the descriptive foundation drawn on the design of the six activities displayed. These activities commonly form the foundation of many research studies and their success to expected outcomes. Thus, the guide to this research study was immersed strongly in van Manen's six activities to improve clinical

reasoning and health care decision making for PLWHA and nearing the end of life (EOL). Balancing interpretation and meaningful dialogues prevent circumventing best practices in preventative care and services to PLWHA. It is critical to help keep these health providers and caregivers engaged in their passion and compassion caring for PLWHA.

Sample and Setting

The goal of hermeneutic phenomenology with a qualitative method of inquiry was to develop a rich and thick description of the phenomenon that was investigated. Therefore, in the development of any phenomenon sample and setting are strategic components of the research project. According to Patton (2002), purposive sample is a dominant sample selection method in qualitative research and is consistent with the interpretivism paradigm. Evidently, this study sought a fair share of purposive sample, which included RNs from a cross-section of health care centers, HIV/AIDS Websites, Seminars, Conferences, and religious organizations throughout Southern Broward County in Florida, and also included snow ball sampling. This sample represented nurses in current practice working with PLWHA showcasing their lived experience. The sample size for recruitment was a maximum of 25 participants who met inclusion criteria or until saturation was reached.

In the research phase of this study, the researcher identified a rationale for using a particular setting as a data-collection site for capturing meaningful information. In practicality, it was important to select a site or setting that was conducive in size, ambiance, and complexity to enhance the study's completion and liberate financial constraints. The setting were locations where entry and access was possible, and the

appropriate participants were likely to be available. These locations included HIV/AIDS clinics, nursing care centers, community healthcare and rehabilitation centers, and homecare agencies where care was being provided to PLWHA throughout Broward County.

Access and Recruitment of the Sample

The participants in this study were RNs with qualification and specialization attending to the care of PLWHA in Broward County, Florida. Access letters providing permission to carry out the research project in institutions, such as HIV/AIDS clinics, nursing care centers, community health and rehabilitation centers, and homecare agencies throughout Broward County will be obtained. Upon the Barry University Institutional Review Board (IRB) approval, the recruitment process began. Potential participants were accessed through the following two methods: (a) flyer postings in selected institutions, and (b) snow-ball sampling. The first recruitment initiative was flyers (see Appendix C) that were posted in strategic areas of the selected institutions, such as nursing stations, bulletin boards, lobbies, lunch and waiting rooms for potential participants to read and choose whether to participate. The purpose of this flyer was to provide information, which facilitated recruitment of participants. The flyers (see Appendix C) used in the recruitment process provided information on the study and the researcher's contact. The second recruitment initiative employed was snowball sampling where participants were asked to refer other nurses who have met the inclusion criteria and were interested in the study.

Preparation for the study initiation was planned and established for the benefit of

potential participants. It was expected that participants were briefed and provided with written and verbal instructions on the study's requirement denoted by Barry University IRB. During this session all participants who responded to the two recruitment initiatives were provided with explanation on the study and made aware of how critical information was collected, used, and maintained indefinitely by the researcher. Informed consents (see Appendix B) as it entailed human participation, was given to participants for their signature before any interview initiation.

Participants were made aware that they would be participating in a voluntary capacity, and that they could withdraw from the study at any given time or refuse to answer any question(s) or participate in the study. Therefore, nurses who were interested in participating in the study were directed to contact the researcher via email or telephone displayed on the flyer. A maximum of 25 nurses who have the experience of caring for patients living with HIV/AIDS were recruited for the proposed study. For their participation in the study a monetary token of \$25 US dollars in Visa gift card was given to the first qualified 25 participants who signed the informed consent in appreciation; even if they refused to continue to be involved in the study.

Inclusion Criteria

Inclusion criteria for this study was to be a registered nurse with more than one year working-experience residing in Broward County, Florida, and be an English-speaking registered nurse who was willing to participate in the proposed study. In addition, the nurse had to possess current experience working with PLWHA on the healthcare continuum for a (minimum of one year), was willing to speak openly about

their experience, and had access to a telephone or the Internet. Participants were required to complete a demographic questionnaire.

Exclusion Criteria

The exclusion criteria for this study included nurses, who were not presently in practice, had no experience working with PLWHA, and had a poor command of the English language. In addition, nurses who possessed less than one-year working experience with PLWHA were excluded from the study.

Ethical Consideration/Protection of Human Subjects

This study approval was incumbent on Barry University Institutional Review Board (IRB). The IRB was the governing body that carried out the guidelines of the United States Department of Health and Human Services (HHS) in the Protection of Human Research Subjects in conjunction with the National Institute of Health (NIH) locally (National Institute of Health, 2013). On account of the NIH statues, principles, and guidelines, the researcher has completed the Web-based training on the protection of human subjects in a research study. This means that the researcher complied with the core principles adjudicated by the NIH on the protection of human subjects. Therefore on the IRB's decision to grant permission for the study's initiation, each potential participant was given detailed information about the study and allowed time to consider their options before signing the consent form. Participants were not interviewed until consent forms were read, acknowledged as understood, signed, returned, and verified. Their identity and confidentiality was protected to minimize risk for harm both physically and psychologically for participation in this study.

Participants were advised of their confidentiality, and that it was maintained in strict confidence throughout this study. Appropriate forms and written documents were stored in separate lock compartments monitored by the researcher. Destruction of audio-tapes was planned once accuracy of data transcription was confirmed by the researcher. Instructions were given to participants to choose a pseudonym to further enhance confidentiality, and were also told that there will be no known risks associated with the study. Participants were told that their participation was voluntary and the study had no known direct benefits to the study participants except to bring aggrandizement to the science of nursing in promotion of education, practice, health and policy statements in HIV/AIDS care.

The participants will also be furnished with research contact information, and the IRB representative if concerns or questions arose. They are further given the autonomy to withdraw from the study at any time deemed necessary in the event they develop feelings of uneasiness associated with aspect of the exposition to their experience in the study. In simplification, participants could have chosen to withdraw from the research study, and declined to answer any question(s), without any penalty. Therefore, in the event that a participant could have chosen to withdraw from the research study, the data they provided would not have been included in the research study and data would have been destroyed. For their participation in the study, a monetary token of \$25 US dollars in Visa gift card was given to the first qualified 25 participants who signed the informed consent in appreciation; even if they refused to continue to be involved in the study.

Data Collection Procedures

A qualitative method of inquiry situated in the interpretive paradigm, navigated by Max van Manen's hermeneutic and phenomenological approach was utilized to conduct this study. The commencement of data collection began once approval was obtained from Barry University IRB. A letter to access (see Appendix F) the sites for the study was used to secure permission to post the recruitment flyers at the various study sites on account of gaining permission to these study sites. Participants who met the inclusion criteria and who contacted the researcher were offered an interview at a mutually agreeable time and place. Instructions about the study were given including the purpose, and the participants were asked to sign an informed consent form denoted by Appendix B, and to complete a demographic questionnaire (see Appendix D).

Data collection for this study was carried out through two interviews. The first interview was to collect data with each participant lasting between 45 to 60 minutes in a location conducive for this face-to-face engagement. Participants were asked to choose a pseudonym to maintain confidentiality. They were asked to complete a demographic questionnaire for approximately 15 minutes. A total time of 105 minutes was required for each participant. The open-ended interview questions (see Appendix E) were used to gather data. Digital voice recorders were the medium of choice that was used to capture detailed encounters by each participant. A transcriptionist who signed a third party agreement for confidentiality was employed to transcribe audio recordings (see Appendix G). The transcription of the data was completed within two weeks of the initial interview. The researcher carried a handy journal and ruled pad to make entries and memoing of

events that added significance.

A second interview for member checking was completed face-to-face to clarify and confirm data obtained three weeks after the first interview. The lived experience presented orally through the interview process was transcribed and returned to the participants for verification and accuracy called *member checking*. This second meeting lasted no more than 45 minutes. Thematic analysis occurred from the writing, and rewriting of data from the verbal interview process. For their participation in the study, a monetary token of US \$25 dollars in Visa gift card was given to the first qualified 25 participants who signed the informed consent in appreciation; even if they refused to continue to be involved in the study.

Interview Questions

Interviews are key components of any research initiative. Interviews were scheduled between the researcher and participants at a time and place conducive for each other. A potential meeting place was decided upon in public view, but away from the hustle and bustle of metropolitan life. This was important in the interview process to avoid noise, discontent, and distraction that could have created a pitfall for the research study.

Qualitative research design can be complicated depending upon the level of experience a researcher may have with a particular type of method. The researcher had an affinity to aspire, grow, and expand his knowledge base and experiences with qualitative design in order to better utilize a variety of research paradigms. One of the more popular areas of interest in qualitative research inquiry was the interview protocol

(Turner, 2010). Therefore, interview questions in qualitative inquiry were integral in retrieving data derived and enhanced as substance for the study. The aim of the interview questions was to obtain thick, rich data utilizing a qualitative investigational perspective. Developing effective research questions for the interview process was one of the most crucial components to interview design. McNamara (2009) suggested that research questions be open-ended and neutral as possible.

According to Mack, Woodson, Guest, and Namey (2005), open-ended questions in this project had the potential to induce responses meaningful and culturally salient to the participants, unanticipated by the researcher, explanatory, and rich in nature. Qualitative inquiry helped the researcher to listen attentively to what participants verbalize, engaged in probing to elicit further in-depth information on their individual personalities, capabilities and styles, and used inquiries most of all to discuss the essence of the lived experience of caring for PLWHA. Effective formulation of the main research question was the fuel that drove the research study to success. Moreover, it helped to trigger crucial follow-up questions. The question of choice for this study was: "Tell me what your experience is in caring for patients infected with HIV/AIDS." Appendix E contains the questions for use in this qualitative study.

The researcher empowered participants by explaining that they have the autonomy to withdraw from the study at any time if they become uncomfortable without measures of impunity. Permission was requested from participants to commence the interview and audiotape recordings that aided in data collection. The interview was conducted in a setting that had access to the outdoors and other amenities, and an

atmosphere of ambiance cultivated for both the participants and the researcher to court an open and free relationship. The researcher had the responsibility to facilitate open-ended questions in the interview to enable participants to verbalize their experience in their own words.

The researcher requested for follow-up meetings and confirmed contact information for scheduling, and offered phone or email availability if any questions arose. Assurances were given to participants that all communication was done through a secure, confidential, and password-protected email account with a selected phone number solely for the purpose of this study. Participants were briefed that a second interview would follow to confirm and clarify the data given. This process is referred to as *member checking*.

Demographic Data

Demographic data is an important part of the research study. Researchers routinely collect *demographic data* to describe the sample of people or organization in the research study (see Appendix D). These demographic data are written in narrative and sometimes table format with frequencies used for qualitative and quantitative research projects. The researcher's aim was to select carefully which demographic data was to be collected for the study for cautious examination and scrutiny. Data was collected on variables that would aide in describing the sample. A demographic data questionnaire designed by this researcher for this study included age, sex, years of experience as a nurse, marital status, educational background, ethnicity, and exposure working with patient diagnosed with HIV/AIDS and can be found in Appendix D.

Data Analysis Process

The processes of data analysis were in sync with van Manen's (1990) analytical process or thematic analysis of reading and re-reading the data to capture the theme or themes that evolved from the study. Data analysis followed van Manen's stated six activities. Consistent to the phenomenological principle, if the true structure of the phenomenon under investigation was identified, then participants who had experienced the phenomenon should have been able to identify his or her own experience in the proposed description highlighted through data analysis (Wojnar & Swanson, 2007). Data transcription began verbatim within two weeks after the first interview. The transcriptionist completed data transcription verbatim of the audio recordings within two weeks upon completion of each interview. The researcher then listened to the audio recordings while reviewing each transcript to ensure the credibility of the data. Data were returned to the participants for member checking by the researcher. The second interview was scheduled for member checking.

Research Rigor

The relevancy of research rigor and trustworthiness are two important domains of any qualitative study. These two concepts were pillars supporting the research process. A major role of the researchers' focus was to address daily concerns inherent to human life and open themselves up to critical assessment from peers to ensure clarity and precision (Pollio, Henley, & Thompson, 1997). In simplification, research rigor and trustworthiness key components that added magnet status to qualitative research design were integrity, competence, and legitimacy. Guba (1981) identified four criteria of

trustworthiness relevant to qualitative research studies: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality.

In the first criterion, the researcher used *truth-value* questions and established confidence in the truth of the findings for the subjects, or informants, and the context in study's undertaking. *Applicability*, the next criterion, refers to the degree by which the findings were applied to other contexts, and settings or with other groups; it was the ability to generalize from the findings to a larger population. The third criterion was consistency. *Consistency* of the data, examined whether the findings were consistent if the inquiry was replicated with the same participants or in a similar context. The final criterion of trustworthiness was neutrality. *Neutrality* is the liberation, which was derived from biases in the research procedures and results (Krefting, 1991).

Each of the aforementioned four criteria identified by Guba (1981) and later transformed by Lincoln and Guba (1985) prompted a renaming of each as follow: (a) credibility, (b) dependability, (c) confirmability, and (d) transferability. According to the investigators, Lincoln and Guba, the basis of name changes resulted as an appraisal on the merit of a qualitative research study. These fundamental statutes set in motion what rigor and trustworthiness can best accomplish in a qualitative designed study. According to Morse, Barrett, and Mayan (2002), without rigor and trustworthiness the research study could have been worthless, futile, becomes fiction, loses its utility, and centrality.

Credibility

This criteria refers to the believability of the findings and is enhanced by evidence, such as, confirming evaluation of conclusions by research participants,

convergence of multiple sources of evidence, and control of unwanted influences. On the other hand, maximum confidence in the believability of those conclusions came from support provided by participants' agreement, analysis of multiple sources of data, other's interpretations and predictions based on relevant philosophical underpinnings. The art of maintaining reflective bracketing by journaling was integral in this process by documenting presuppositions, biases, feelings, assumptions, preconceived notions, and ideas of the investigator. To achieve credibility it was the responsibility of the researcher to report data through the lens of the participants. The essence of credibility laid in the truth of the findings through continued observations, engagements, and relationships with the participants, member checking (verification of data), peer debriefing, and the dissertation committee reviewing the data analyzed to ensure precision and trustworthiness of the study. Lincoln and Guba (1985) indicated that member checking is one of the most influential maneuvering for instituting credibility in a qualitative research study. This was completed by having the participants evaluate the investigated data for correctness.

Dependability

This domain was where the researcher gathered evidence to support the assertion that related findings attained were replicated if the study was repeated. This strategy was further enhanced by common qualitative criteria, such as audit trail, dense description of the research method, replication, triangulation (verification), peer examination, and code-recode procedure. Dependability's purpose was to appraise the data so that clarification and assumptions were supported by the information conjured. Other strategic ways of

validating dependability were delineated through accurate record keeping of the study's materials, such as field notes, summaries, and thematic analysis. According to Higgins and Straub (2009), dependability is the most common term occupying the extent to which an experiment, test, or any other measuring procedure or tool produces the same results on recurrent trials. Audit trail coupled with accurate record keeping through journaling or diary accounts were maintained throughout this study to accomplish dependability.

Confirmability

Confirmability refers to objectivity (neutrality) and the control of researcher bias. *Bias* in qualitative research was an ever-present factor; *unbiased* interpretations were more likely to emerge once the researcher's self-reflection recognized them. Therefore, it was paramount to establish that the investigator's bias had no bearing on the study's outcome. Therefore, it was imperative for the researcher to lay aside all preconceived notions, ideas, presuppositions, and biases about the provision of care delineated to PLWHA through journaling, diary entry, or memoing to secure tangible results pertaining to confirmability.

The use of these gadgets aided the researcher in identifying, bracketing, and suspending any feelings or impure thoughts that eroded accuracy of the research process. For instance, this allowed other investigators the privilege of distinguishing and endorsing the accuracy of the study on account of the presenting experience. The term confirmability dictated whether the conclusion or findings of the study would be consistent if the investigation was repeated with the same subject matter or in a similar circumstance (Lincoln & Guba, 1985).

Transferability

Transferability is the evidence supporting the generalization of findings to other contexts across different participants, groups, and situations. It was carried out expeditiously when the researcher gave adequate information about the self, the research context, processes, members, and research participant's connections to make it possible for the reader to decide how the findings could have been transferred. For the comprehension of this study, the concept was generated by the use of rich thick meticulous description of the data in describing the experiences, settings, perspectives, and lifeworld of the participants.

The increase in this criterion was seen in comparison across cases, and unit of analysis that yield similar findings. Therefore, at the conclusion of this study, the results or findings were shared and communicated with colleagues and experts in the field of nursing to enhance transferability. In other words, the epistemology derived from this study was of importance to other research endeavors.

Chapter Summary

In this chapter valuable information was explicated to generate important methods used to channel this study situated in van Manen's hermeneutic (interpretive/descriptive) phenomenological paradigm. This chapter invoked narratives explaining the methodology for transmission of the study through research design pathway covering the rationale on qualitative and phenomenological inquiries with the employment of Max van Manen's six activities. In order to acquire rich thick data extraction, the researcher laid the groundwork in showcasing the sample and setting benchmarks with discourse given

on access and recruitment of the sample. The study's inclusion and exclusion criteria were also addressed. Much emphasis was placed on ethical consideration and protection of human subjects as governing principles instituted by the NIH for the study's undertaking.

On account of these adjudicated principles by the NIH, the researcher had challenged a Web-based course on the protection of human subjects for compliance. Strategies were laid out explicitly in data collection procedures and data analysis processes on the ways in which the researcher described, analyzed, and interpreted themes generated. Research rigor of the study was addressed extensively through the four criteria mentioned by Lincoln and Guba (1985) seen in credibility, dependability, confirmability, and transferability. These relevant criteria embedded in this qualitative research design judiciously discussed rigor and trustworthiness as supporting pillars for the study. Both rigor and trustworthiness were given confidence to the authenticity of the study's outcome. Chapter four will summarize the findings of the inquiry.

CHAPTER FOUR

Findings of the Inquiry

This chapter argued the important findings of this phenomenological inquiry exploring the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. Discussion in summation was carried out narratively on demographic depiction and physiognomies of all participants individually, who has participated in this research project. Explicitly, thematic analysis was extracted through data analysis, which was contingent on participant's in-depth feelings, thoughts, and actions relevant to the experiences they shared through this phenomenon. On the other hand, important findings generated from collective argumentation with each participants were summarized in detail. Connection to nursing theory was also included.

This phenomenological inquiry titled the lived experience of registered nurses caring for people living with HIV/AIDS in Broward County, Florida was completed to explore the care provided to this fragile patient population affected by this disease aligned through nurse's experiences liberated by their voices. According to van Manen (1990), the basic epistemology of phenomenology in research is always to question the action in which an individual experience the world, and wanting to know the world in which one lives as a human being. Munhall (2012) exercised the notion that the basic premise of phenomenology is to uncover the quintessence of participant's life world related to the phenomena experienced in their everyday reality. According to Kuhn (1962), on account of this scientific paradigm this researcher was able to adopt van Manen's methodology to transcribe, analyze, describe, interpret, translate, and summarize the puzzle through the

participant's individual experience caring for people living with HIV/AIDS in Broward County, Florida.

Kuhn's seminal work, *The Structure of Scientific Revolution* (1962), emphasized paradigm as a unique way of criticizing previous scientific ideas as well as a way of developing new concept of how phenomenon functions in science today. The dynamics of science in Kuhn's understanding is the concept of paradigm, which he defined as the universally recognized achievements that provide model problems and solutions to a community of researchers. In other words, paradigm is the foundation of methodology, theoretical and practical obligations, and principles of solution recognized by the scientific communal. Hence, as paradigm is wholly acknowledged and implemented by researchers, it emerges as the normal science that directs the puzzle solving activities of any phenomenological inquiry (Kuhn, 1962).

The trajectory of phenomenological inquiry is to procure an in-depth fore-structure of understanding of the lived experience of individuals in everyday situations. Max van Manen (1990) claimed that the central focus of phenomenological inquiry is to establish a transformed connection with innovative experience. Merleau-Ponty (1962) further balanced the phenomenological scale by showing that turning to any phenomena of the lived experience means re-learning to examine the world by re-emerging to the basic experience of the world. In essence, every project of phenomenological inquiry is motivated by a commitment of turning to an abiding concern, which will make sense of human existence. Therefore, making sense of human science or experience is the centrality of phenomenological inquiry. The meaning that lies in human science or

experience notions, such as truth, method, understanding, objectivity, subjectivity, valid discourse, description, analysis, interpretation, writing, and text are always to be comprehended within certain lucid perspective (van Manen, 1990).

Subsequently, from a lucid perspective Max van Manen's (1990) phenomenological flagship, the six research activities, is the vehicle used for collecting and analyzing data surrounding this puzzle. This framework gave the researcher the autonomy and opportunity to draw on the implication and description of the lived experience of registered nurses caring for people living with HIV/AIDS in Broward County. The implications and descriptions attained through this phenomenological methodology enabled the researcher's sense of understanding, while engaging in the lived experience of the participants as they voiced their concerns. The ambition of the researcher was to be deeply immersed in all tributaries of each participant's life world as they experienced it.

It is understood that phenomenological approach begins with the return to an experience with the sole purpose of obtaining inclusive descriptions that provide the foundation for a philosophical fundamental analysis that depicts the substances of the experience (Moustakas, 1994). Moustakas (1994) further indicated that the evidence from phenomenological research is derived from an individual report of one's life world experiences. In compliance with phenomenological ideologies, scientific exploration is effective when the knowledge sought is arrived at through descriptions that make conceivable an understanding of the importance and cruxes of the experience. Consequently, obtaining accounts of each participant's life world experience was the

gateway in solving the intended puzzle. The process of gaining traction into participant's life world was through data collection. The unique phase of this puzzle solving activity allowed the investigator to approach this realm with an open mind and make all biases known with the intention of hearing the report of each participant's experience with the phenomenon under review.

The undertaking of data collection was through face-to-face interaction of semi-structured interviews conducted in an ambiance conducive for confidentiality and for promoting trust on the path of the researcher and all participants involved. Fostering a climate of neutrality between researcher and participants set the stage for a trusting romance of collaborative interaction in deciphering the meaning of each participant's experience associated with this phenomenon. Participants efficaciously voiced their experience caring for patients living with HIV/AIDS in Broward County, Florida, which mesmerized the researcher in comprehending the phenomenon through the everyday life world experience. This casual collaboration swung open the window of the world for the researcher to look deep into how caring for people living with HIV/AIDS was carried out.

Collaboration of this magnitude continued through data collection and analysis until the same report was given by participants over and over again with the surfacing of no new material of interest. The repetitive occurrence of the same material heard signified to the researcher that saturation had been met. The concept *saturation* in phenomenological inquiry was indicated when the collection of data reached a point where a sense of cessation was achieved because new data produced redundant

information (Polit & Beck, 2012). Saturation or redundant effect was noted after the eighth interview with the discovery of no new material. Confirmatory signaling of saturation was definitely obvious when an additional four more interviews were conducted.

Speaking of the interview process, this was conducted immediately after each participant sign an informed consent, chose a pseudonym, and completed a demographic questionnaire. These interviews were carried out inherently in non-threatening environments conducive for promoting trust, confidentiality, and easiness on the path of both participants and researcher alike. Interviews were audio-taped by the researcher and transcribed verbatim by a third party transcriber who signed a third party agreement form in compliance with Barry University Institutional Review Board (IRB) under the guidelines of the National Institute of Health (NIH). The researcher listened and re-listened to the audio tapes, while reading and re-reading the transcriptions for underlying meanings, and to ensure that participant's experience was captured correctly as was told.

On the other hand, participant's reactions and gestures seen through body languages, emotions, tone of voice, and non-verbal prompts, while being interviewed provided the researcher with an opportunity in grasping any concealed meanings from unexpressed words in description of the lived experience. Information garnered in this fashion enabled the researcher to be more inclined with the data and personal stories associated with the participant on a whole. In the interim, journal entries were made by the researcher to document post interview reflections, thoughts, biases if any, and non-verbal hints of participant's action. The researcher chose to make his experiences,

opinions, thoughts, and feelings detectable, and an accredited part of the research process through reflective journaling with the sole purpose of using them in the writing of the research.

The ensemble courted by the researcher and each participant in the interview arena allowed for the primary question to take center stage without hesitation. This effective relationship allowed each participant the opportunity to assimilate the question asked, “Tell me about your experience as a nurse caring for people living with HIV/AIDS.” The laying of this foundation set the stage for each participant to concentrate and digest the question that was propagating the exploration of the phenomenon or problem in laymen term that was under review. At a time like this, it was in the interest of the researcher to be quiet, open minded, listen attentively, and cultivate an atmosphere of non-intrusion unless it is absolutely necessary. The recommended method of intrusion used occasionally was “probing” which was to dissect and promote clarity of the emerging distinctions and advents of the phenomenon. Understanding this simple unique process in the puzzle solving activity helped the researcher to comprehend the lived experiences shared by each participant revealing the substances of the life world or in other words the phenomenon.

According to van Manen (1990), promoting transparency of the subject matter, the researcher openly indulged actions, such as self-reflection, writing, and rewriting to further understand participant’s experience of the life worlds. However, he cautions researchers that this cannot be achieved without first making one’s understandings, beliefs, biases, assumptions, and theories known. In essence, actions like these afore-

mentioned promote and enhance the interpretive process by clearly accessing the forestructure of understanding held by participant's exposition of the lived experience of the phenomenon (Benner, 1994). Tymieniecka (2003) lay claim to the lived experience itself, as described by participants as a way of providing universal description and interpretation of the phenomenon accentuated through the inclination of reflection and writing. The art of serious reflection, writing, and rewriting had the researcher situated in a position to acquire and synthesize knowledge gained through each participant's experience, and to understand the reality of the phenomenon.

Data acquired through the interview process led the researcher to evaluate the research findings, comparing and contrasting with other pre-existing ones to conclude whether or not there are parallels or variances depicted in each interview. The redundancy of participants spoken words were chronicled and arranged as a result of universality and extraordinary crux of the experience shared. The implementation of this arrangement placed emphasis on the researcher to listen attentively to the audiotapes contents, reading and rereading of the transcriptions to solidify that every little detail was captured and nothing of importance went undetected. In relation to understanding the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida, emerging themes were analyzed to conclude the factual essence of the phenomenon. The associated emerging themes sifted from data analysis up for discussion based on experiences expressed by the participants are as follows: *Unknowing*, *incapacitating*, *dejecting*, and *nurturing* followed by the sub-themes under certain themes, such as *swimming in deep waters*, *exasperating*, *dreading occupational exposure*

feeling of emptiness, and lacking emotional and physical support to discover hidden meanings (see Figure 7).

Sample Description

The study population included registered nurses living and working in Broward County, Florida. The sample size for recruitment was tabled at a maximum of 25 participants who met inclusion criteria or until saturation was reached. A purposive sample of 12 registered nurses was selected to participate in the study because of saturation accomplishment. Inclusion criteria were for registered nurses with more than one-year working-experience, English-speaking registered nurses willing to participate in the proposed study. In addition, they would possess current experience working with PLWHA on the healthcare continuum for a (minimum of one year), willing to speak openly about their experience, and have access to a telephone or the Internet. Participants were required to sign an informed consent and complete a demographic questionnaire.

Demographic physiognomies of the sampled participants varied: the mean age of the participants was 51.4 years (range 38-67), one participant was between the ages of 30 to 39, two participants were between the ages of 40 to 49. Seven participants were between the ages of 50 to 59, and two participants were between the ages of 60 to 69. The mean number of years for all 12 nurses having experience caring for patients with HIV/AIDS was 10.2 years (range 3-30). There was one participant practicing for three to nine years, six participants practicing for 9 to 15 years, three participants between 15 to 23 years, and two participants practicing between 23 to 30 years.

Sample selection saw five participants from the recruitment flyer, and seven

participants from snowball sampling. These 12 participants indicated that they have cared for patients with HIV/AIDS for almost their entire career in New York, Texas, and Florida. One participant reported she practiced in Trinidad, New York, and Florida, two practiced in New York and Florida, and one practiced in New York, Texas, and Florida, and eight made claim to practicing in Florida only. The birth places for these 12 research participants varied with four born in Haiti, one in India, five in in Jamaica, one in Trinidad, and one in the United States.

Marital representation for all 12 participants revealed eight being married, two being single, and two divorced. Reported educational level for all 12 research participants varied: two participants with Associate degrees, nine participants with bachelor's degrees, and one with master's degree with a tract in education. All 12 participants have specialized training with certification in other areas of the nursing profession. These 12 participants' areas of practice varied: six nurses practice in a nursing care and rehabilitation center, two practice in the hospital, three practice in home health, and one in hospice care. The study's participants claimed that they have cared for patients of heterosexual, homosexual, and bisexual orientations, and children who are infected with the HIV/AIDS.

Physiognomies of the Participants

To maintain confidentiality in this study, participants will be presented by pseudonym chosen by them prior to the interview commencement. The act of using a pseudonym to identify research participants was to give them the autonomy to reverberate their cause by expressing their true inner humanness without exposition. In

other words, hand them the tool to tell it as it is without reservation, and in the interim without exposing their identity. The physiognomies of each participant was tabled from the interview narratives, which highlighted their actions, precepts, thoughts, belief, values, and cruxes through the liberation of their lived experiences.

Cohesive collaboration between participants and researcher was unintentionally appealing, and passionate as voices were raised solemnly releasing their inhibitions. Participant's deportment through every stage of the research study was remarkable with grace and poise. There were no disparaging undertones, which leaves the researcher's questions about caring for patients with HIV/AIDS a receptive mantle for the study's trajectory. Along the interview pathway some of the participants exhibited periods of grief, choking up, and teary eyes, while expressing their lived experiences, and requested a pause in tape recording. Sequentially, written below in pseudonyms is an outline indicating participant's current status.

Nurse Fire

Nurse Fire is an African American female professional registered nurse who has over 25 years of nursing experience in the hospital and long term care facilities. She possessed a bachelor's degree in nursing, and is currently pursuing a master's degree in nursing at one of the local universities. Nurse Fire has over 10 years of working experience caring for patients living with HIV/AIDS. She is between the ages of 50 to 59 years old and is divorced with two grown children.

Nurse Fire informed the researcher that she has been providing care to patients with HIV/AIDS for almost her entire career as a nurse. Presently, she is one of the many

charge nurses on the north wing of this long-term care facility that she has worked for the past 12 years, which housed patients living with HIV/AIDS. Interestingly, Nurse Fire pointed out in her interview response frequently, “Uh, for me it’s like just a regular person, you know I don’t see them as any different. They have needs that have to be met, and they have values just like us. However, at times the care can be challenging and emotionally disconcerting in many ways than one.”

Nurse Lila

Nurse Lila is an African American female registered nurse and is between the ages of 50 to 59 years old. She had her nursing training at Miami-Dade College with an Associate degree in nursing, and is a married woman with two children. At this point in time Nurse Lila indicated that she has no plans of returning to school for higher education. Nurse Lila made claim that she has cared for patient living with HIV/AIDS since she became a nurse for about 20 years. She has worked in this long-term care facility for over 11 years where she has the opportunity of caring for patients living with HIV/AIDS. Nurse Lila is also one of the many charge nurses on the north wing of this long-term care facility that housed patients living with HIV/AIDS. She mentioned in the interview, “I remember I was working in this nursing home where they were starting to get HIV/AIDS patients, and automatically I told my boss I don’t feel comfortable taking care of them.”

Nurse Joan

Nurse Joan is a professional female registered nurse between the ages of 50 to 59 years old and practicing for over 16 years. She is married with four children, and her

highest level of education is a bachelor's degree in nursing. Nurse Joan is an Asian American, born in India and received her education there. She is currently working in a nursing and rehabilitation care center for the past 16 years where she reported taking care of patients living with HIV/AIDS for the last 10 years. Nurse Joan highlighted during the interview session, "at the beginning you know I was kind of really concerned about working with HIV/AIDS patients, you know I was afraid and scared of treating them."

Nurse Chloe

Nurse Chloe is female of African American heritage and is between the ages of 50 to 59 years old, a practicing registered nurse with more than 25 years with excellent working experience. She was born in Haiti and migrated to the United States at the age of 16 years old. Nurse Chloe spent nine of her teenage and young adult years in New York; then moved to Texas at the age of 25 and lived there for 14 years. During this time period she went back to school and became a Licensed Practical Nurse (LPN) where she worked for some time in various nursing settings. Nurse Chloe further migrated to Florida and worked for 17 years in long-term care, and has worked for 10 years caring for patients with various comorbidities, including patients living with HIV/AIDS.

In the interview session she mentioned that five years ago she went back to school and have received a bachelor's degree in nursing and her registered nurse license. She is married for 37 years with one grown son, and currently works in a long term care facility that specializes in the care of people living with HIV/AIDS. Nurse Chloe exhibited in the interview narratives many concerns giving strong feeling of apprehension, helplessness, hopefulness, and avoidance. She made clear in her statement and I quote, "before caring

for HIV/AIDS patients I was uncomfortable, it is like a death sentence. I know some people like myself resent those people and feel like it's a punishment, but now I am comfortable caring for them, they are like any one of us.”

Mr. Banah

Mr. Banah is a registered nurse of African American decent with over 22 years working experience under his belt. He is between the ages of 50 to 60 years old and has worked in many areas of nursing, such as public health, hospital emergency and operating rooms, and currently with Vitas hospice care in the hospital units and patient's home for the last 14 years. Mr. Banah's birthplace is in Jamaica, but in 1981 he migrated to the United States and settled in New York City. He received his associate degree in nursing education and training at Long Island School of Nursing, and has worked in the hospital system in New York for a number of years.

During the interview session Mr. Banah mentioned that he became tired of the extreme cold weather in New York, and migrated to South Florida settling with his family in Fort Lauderdale, Broward County since 1991; a tradeoff he boasted vehemently about making consciously. He went on to further broaden his horizon by crediting the University of Phoenix (UOP) for his bachelor's degree in nursing (BSN), which he acquired in 2009. Another milestone that he has accomplished is the stewardship of being a prominent figure in the public health department caring for people living with HIV/AIDS in many community health centers across Broward County. Mr. Banah is married with an only child who is 18 years old. Expressive emotions were displayed as Mr. Banah exclaimed, “HIV/AIDS crisis for nurses is likened to someone swimming in

deep waters, having a fear of the unknown. I have been there first hand while serving this population in public health and saw the devastation it brought about on the lives of nurses.”

Nurse Bella

Nurse Bella is an African American female from Haitian background, and is an experienced registered nurse who is between the ages of 40 to 49 years, and has about 23 years of working experience in every area of the nursing profession. She is a graduate nurse with a diploma from Jackson Memorial Hospital School of nursing since 1993. Nurse Bella has worked in medurg, telemetry, home healthcare, psychiatry, crisis unit, the prison system, HIV/AIDS clinic, and has worked with various age groups, and different diseases. She is single, has three children, and is currently working in the homecare setting for the past eight years, and has over 12 years working experience with patients living with HIV/AIDS.

Nurse Bella made it clear during the interview sitting in her statement, “caring for a . . . can be . . . starting off, it can be an emotional type of experience, particularly for me. When you care about someone with that particular disease, knowing that it’s a terminal disease. I’m happy with some of the research that has progressed up to this point, even though I feel that we still have work to do in that area. At this point, I can see that there are times where people are living a little bit longer with HIV positive depending . . . it seems to be with my experience. The health benefits either with their environmental factors, the prevalence of available treatment for them, their compliance, the emotions plays with it, and family support plays into that factor also.”

Nurse Eula-Lee

Nurse Eula-Lee is an African American female with Jamaican background, and an experienced registered nurse with 23 years of nursing experience. She is between the ages of 60 to 69 years old, and has retired from Jackson Memorial Hospital, but is currently working in home healthcare since her retirement in Broward County. Nurse Eula-Lee is married and has raised four children who are now grown. She has an Associate Degree in Nursing (ADN) and has no plan of going back to school for further nursing studies.

Working experiences for Nurse Eula-Lee is mainly in the intensive care unit (ICU) and homecare. She brags that she gained her experience working with patients from different cultures, diversity, and backgrounds and has seen many different diagnoses. Nurse Eula-Lee informed the researcher that she likes to teach and is currently working in home healthcare, which she enjoys a lot, especially discovering things that she did not know existed outside of the hospital. She took credit for working with a large diversity of HIV/AIDS patients and this is what she has to share.

“It is very interesting what’s going on out there, but I am learning from the patients and I am learning a lot as I go day-to-day. Working with HIV/AIDS patients, to me, I treat them just like any other patients. I am very empathetic. Much . . . we’ve come a long way, as far as HIV/AIDS patient care. Initially, at Jackson, we used to get so many HIV/AIDS patients and the end result was not always what we wanted, but over the last 10 years, it’s been much improvement. We have sent home a lot of patients that prior to that may not have gone home, especially patients with pneumocystis carinii pneumonia

(PCP). Those were, I think, the largest groups of HIV/AIDS patients . . . pneumonia and we have them with the . . . what's the brain, eye, gastrointestinal disorder now? Cytomegaly virus (CMV).”

Nurse Lulu

Nurse Lulu is a female registered nurse with over 30 years nursing experience, and is between the ages of 50 to 59 years old. She is single and the mother of two children. Nurse Lulu had her nursing training at Iona College formerly Elizabeth Seaton College in New York City, where she received her associate degree. She worked many years in New York in various nursing facilities and boast about caring for numerous amount of patients living with HIV/AIDS for the past 30 years. Eventually she moved to Florida in the year 2010 and has worked at the Memorial Healthcare System in the homecare department for the last six years. She went on to further her nursing education at the University of Phoenix and graduated with a Bachelor's of Science Degree in Nursing (BSN).

Nurse Lulu plan is to return to school to further her nursing education working on her Masters of Science Degree in Nursing in the future. Nurse Lulu has contended, “Well, I would say my first experience taking care of patients with HIV/AIDS was in the ‘80s when the disease . . . I would say just was detected. I worked in a hospital this was my first year . . . my first experience as a new nurse and I was nervous. I was anxious, but as I . . . the more I work with them, my fears was decreased, because I had a great mentor.”

Nurse Thelma

Nurse Thelma is an African American professional female registered nurse from Jamaican background, who informed the researcher that she has been living in Broward County for the last 20 years. She is between the ages of 50 to 59 years old and has worked in a hospital system in Florida for the last 15 years caring for patients from various cultures and backgrounds. Nurse Thelma is married with two grown children. She has her nursing education done at Miami-Dade College where she earned an Associate Degree in nursing (ADN). Her Bachelors of Science Degree in Nursing she earned from Nova Southeastern University. Nurse Thelma categorically refused to further her nursing education at this time when asked if she has any plans of returning to school in the near future.

Her response to the question is this, “all I want to do now is to drink some porridge.” For those of us who do not know what porridge is, it’s a staple from English origin around the 16th century consisting of oatmeal or another meal or cereal boiled in water or milk and sweetened with condiments? Nurse Thelma indicated that porridge from any source is a wonderful staple to nurse any patients back to health. She further went on to say, “my primary experience with, um, HIV/AIDS patients is that, um, they’re very scared and likewise the nurse, anyway as a nurse you have to be compassionate to be taking care of these patients. My experience with, um, they’ve been ostracized by other people and that, um, you know make them vulnerable.”

Nurse Vanilla

Nurse Vanilla is an African American female from Trinidadian background and is

in practice for over 30 years where she has cared for patients with various comorbidities, including those patients living with HIV/AIDS. She is between the ages of 60 to 69 years old and has her college and nursing education completed in Trinidad and Tobago where she has practiced her craft before migrating to the United States in the early 1980s. Nurse Vanilla is married with no biological children of her own, but has raised one adopted child who is now grown. She has a master's degree in nursing with a tract in education (MSN/ED). Nurse Vanilla is currently working in a long term and rehabilitation center for the past 18 years.

Nurse Vanilla stated, "I am very satisfied with all my accomplishment and I have no intention of going back to school to further my nursing education, I am now looking forward to retirement." On the issue of caring for patients living with HIV/AIDS she has a few choice words of her own. This is what she told the researcher during the interview discourse, "HIV/AIDS patients more than anything else, do need our empathy." "After all they are human beings and more than anything else, people do treat them as though they are the scourge of the earth. I do not do that, and I would never condone to that sort of behavior from the nurses I work with. It is unacceptable and it is totally immoral, as well as it's a dignity issue for these residents and patients."

Nurse Sophie

Nurse Sophie is an African American female of Jamaican background who is between the ages of 40 to 49 years old. She is registered nurse with nine years working experience, married with one grown son, and a Seventh - day Adventist by religion. Nurse Sophie has her college education in Jamaica before migrating to the United States

in the late 1990s. She has her nursing education completed at Kaiser University, and went on to the University of Phoenix where she gained her Bachelor's Degree in Nursing and has plans on working on her Masters of Science Degree in Nursing in the near future. Since gaining her registered nurse license, she has worked in homecare for a short while, and has spent nine years in her current place of employment where she credits herself on working with patients living with HIV/AIDS. Nurse Sophie has this to say to the researcher, "you know, this takes me back to my days in nursing school. It would seem like all my patients in the clinical area had HIV/AIDS. And believe me, at first I was terrified. I was, I was petrified, and I'm telling you."

Nurse Petal

Nurse Petal is an African American female of Bahamian background who is between the ages of 30 to 39 years old. She is registered nurse with three years working experience, is divorced with two daughters ages 16 and nine years old respectively. Nurse Petal has her college education in here in the United States. She has her nursing education completed at Dade Medical College, and went on to the University of Phoenix where she completed her Bachelor's Degree in Nursing and is currently working on a double Masters in Nursing Science and Hospitality. Nurse Petal expected graduation date is in 2017. Since gaining her registered nurse license, she has worked in the hospital setting for a year, and has spent the last two years in homecare. Nurse petal credited herself on working with patients living with HIV/AIDS both in the hospital and homecare. She lounges over and chuckle, "um, this field, we're open . . . in nursing . . . we're open to everything, and even though we are caring for these patients, it is an

industry where any day you as a nurse can come down with any of these disease process.”

The 12 nurses who were selected to participate in the study gave up their time unselfishly to share their life world experiences with the researcher on the matter of caring for patients living with HIV/AIDS during the interview session. These participants were very outgoing in telling their stories, which mesmerized and interest the researcher in understanding and giving deeper meanings of the phenomenon under review. These descriptions allow for the researcher to identify emerging themes and sub-themes that represent participant’s meanings of their experiences.

Emerging Themes and Sub-Themes

Max van Manen’s (1990) thematic analysis was used in this study during the data analysis process and four themes and five sub-themes emerged. The silhouette of these profound actions seen through these emerging themes and sub-themes mirrored participant’s disposition in displaying their true feelings, thoughts, and experiences during the narrative interview session. The dramatizations of these phenomenological actions according to van Manen (1990) were to be understood as the structures of experience. In other words, the researcher was attempting to describe the lived experience because this could not have been apprehended in conceptual abstractions. Hence, this aided the researcher in the clarification of the methodological implication reflecting on concrete situation, such as participants’ experiences through the idea of themes and sub-themes, while ratifying through the interconnectedness of the essential life worlds of lived space, body, time, and human relation (van Manen, 1990).

For this researcher to arrive at the structures of meaning, data collected were analyzed through reading and rereading, writing and rewriting of the emerging or essential themes, which gave control, and provided direction for this research and its writings (van Manen, 1990). Moreover, these scientific activities deliberated by van Manen (1990) paved the way for the researcher to analyze true reflection on the lived experience of RNs as a thoughtful and reflective grasping of what gives this specific experience its unusual meaning. The emergence of unusual meanings was denoted in the identification of four significant related themes: (a) *unknowing*, (b) *incapacitating*, (c) *dejecting*, and (d) *nurturing*. The five sub-themes are (a) *swimming in deep waters*, (b) *exasperating*, (c) *dreading occupational exposure*, (d) *feeling of emptiness*, and (e) *lacking emotional and physical support*.

These themes and sub-themes illustrated in Figure 7 gave a clear indication of the researcher's interpretation of the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. The results discussed here were based on the lived experiences expressed by registered nurses caring for people living with HIV/AIDS in Broward County, Florida. In addition, these themes and sub-themes blended with the four life worlds existential of (lived body) nurses who had experience caring for patients with HIV/AIDS, (lived time) giving their time unselfishly in care provision, (lived human relation) nurses interaction with colleagues, patients, and family members, lived space which is denoted by nurses working environment in various patient care arenas (van Manen, 1990).

Subsequently, the themes and sub-themes identified were not to be misconstrued

that participants were restricted to any definite theme or sub-theme, but was indicative of their responses through their experiences and was intertwined to form the cruxes of the themes and sub-themes. Therefore, themes and sub-themes revealed in this study were incumbent on each other, and each carry the exact weight of all participants involvement, none was in superior of the other. On the premise of this phenomenological inquiry, the four major themes of *unknowing, incapacitating, dejection, and nurturing* distinctly emerge from participant's experiences to formulate meanings. Included also are the representation of five sub-themes; of *swimming in deep water, exasperating, dreading occupational exposure, feeling of emptiness, and lacking emotional and physical support* as a derivative of the major themes as well.

The lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida was flanked by the four major themes and five sub-themes as portrayed in Figure 7. This represented the researcher's conceptual illustration as a covenant of participant's life world reality. In essence, these themes and sub-themes were not constrained or selective to any individual participants, as the merit of their experience could be very well documented across all major themes and sub-themes. On the other hand, it is obvious that all the major themes and sub-themes were extremely redundant in the experiences of most participants with slight variation. Interesting to note there were no major differences found between the themes or sub-themes. It was also eminent to differentiate a relating configuration between the themes anchored within the demesne of participant's lived experiences.

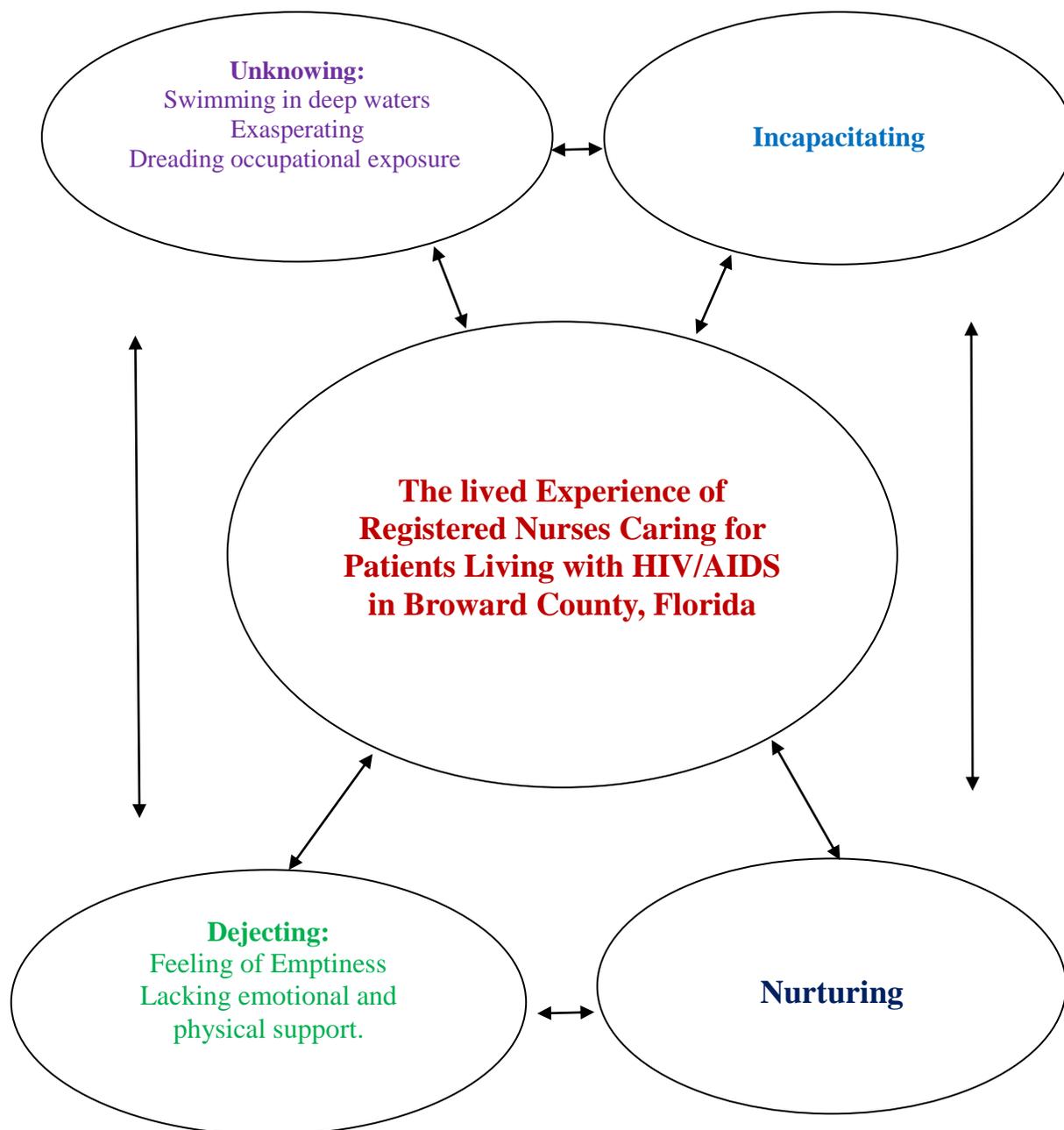


Figure 7. Wright's (2016) Conceptual illustration of the lived experience of registered nurses caring patients living with HIV/AIDS in Broward County.

Unknowing

The theme unknowing and its sub-themes were the first to overwhelmingly appear and be dissected from the presenting data as participants reacted to the primary question,

tell me about your experience as a nurse caring for patients living with HIV/AIDS. The trajectory of the disease HIV/AIDS on modern civilization is certainly in a class by itself with the action word *unknowing* written in every research narratives reactive to human intellect. *Unknowing* is an action word which is from the root word knowing. It was originated in the Middle English and was first used in the 14th century. Its meaning is not knowing, ignorant, or unaware, and in the post positive era lack of knowledge thereof (Random House Dictionary, 2016).

The issue of HIV/AIDS posed a serious and critical threat as narrated in the literature which signifies no end to its demise as in *unknowing*. This problem is highly demanding, distressing, and critically offensive, which carved the epitaph *unknowing* in the vocabulary of these research participants as they struggle to provide continuous care to infected individuals with HIV/AIDS. Participants instantaneously equate *unknowing* in regard to the disease HIV/AIDS experience as the act of *swimming in deep waters*, *exasperating*, and *dreading occupational exposures*. The advent of these special characteristics related to the disease HIV/AIDS posed a significant danger to patient care. Speaking of *unknowing*, Nurse Fire eloquently stated,

In the early years of the disease lack of knowledge was a serious altercation, we were not 100 percent sure of what is going on, we were all scared of the unknown especially about contracting the virus or what I will be taking home to my family. Even now at this stage of the disease *unknowing* is still a problem. To me the word *unknowing* is a very terrible word, which stimulate uneasiness, anxiety, and fear of the unknown.

Other participants resonated the same sentiments with their experience providing care to patients living with HIV/AIDS in Broward County. In light of these sentiments participants reacted conspicuously when an encounter is eminent in the provision of care. In the words of Nurse Lila expressing her experience:

Oh [laughs], ah, I remember that patient I had with HIV/AIDS. The patient came and was coughing and was also on isolation for tuberculosis (TB). Oh! My God, it was not easy for me, because I fear the unknown. To me I think if I go in there and by talking to the patient I would [laugh] have the disease. I had to speak with my manger first. My manger says, “No you don’t need to be scared as long as you wear your mask.” Lack of knowledge about anything is distressing, and it’s a terrible thing not knowing.

Interestingly, the shock wave of *unknowing* kept resonating with almost the entire sample of research participants in their experience shared. Nurse Joan expounded on her experience by indicating:

Yeah, the very first time I felt like I was kind of afraid of taking care of HIV/AIDS patients, because I did not know, I fear the unknown, we did not know how we were going to get the HIV/AIDS. You know, it’s just . . . even in the beginning, think it’s the . . . lack of knowledge . . . kind of feel awkward of touching HIV/AIDS patients, you know.

Nurse Chloe expressed her experience by saying:

Nurses and medical personnel, yeah, before we would avoid having such patient you know. The fact that we don’t know about the disease, lack the knowledge, we

would have to treat everybody as if it's a possibility. If we don't know about all the diagnosis, you know, we have to practice universal precautions because getting the disease is still to this day *unknowing*. Don't be fooled by all the rhetoric you heard and read especially in the press. We need research to say otherwise that is just my opinion. Otherwise I still remaining fearing the unknown.

Another member of the research participants Mr. Banah chimed in by making his voice heard echoing:

Just like tuberculosis (TB), when TB came about. Nurses were afraid to serve in that area. Even recently with that, um, African illness that came aboard or came ashore here called Zika virus, nurses were much afraid of caring for these individuals mainly because of lack of knowledge or fear of the unknown. Nurses in general will always fear the unknown. In one of our schools in Jamaica, we said knowledge liberates, ignorance enslaves. We sometimes are enslaved by our ignorance and I think with HIV/AIDS that was mainly the case. Again nurses were fearful as a result of *unknowing* as in what to do, and the lack of knowledge is what created the problem.

Nurse Bella was very solemn in getting her point across by suggesting:

Um, in the beginning, well, in the beginning, we didn't know exactly where the disease was coming from. There was a lot of misconceptions and speculations on where it was coming from a certain culture, a certain type of racial background at this time, where we were . . . what we were told. Some nurses like me were really

scared and thought you can get it by even touching the person, which, you know, now we've been educated enough that that is not so, which has been a good thing, because it's calmed down, you know certain fears. The anxiety for me was definitely lack of knowledge, not knowing, and what we thought back then, as far as the person with HIV/AIDS and how to contract it. And so to...so then to begin to approach a patient with the disease was kind of scary with fearing the unknown.

Nurse Lulu conveyed her descriptions on the transitive verb *unknowing* as it pertains to caring for patients living with HIV/AIDS; note what she had to talk about:

At that time, not only were we treating them with oral medications. We were also using the pentamidine, which was an aerosol treatment. This was kind of, you know scary . . . make you nervous, because we were not sure if we would inhale what they're putting out and become infected through . . . by the air. At that time, lack of knowledge was an obstacle, not too much was known about the disease. Well, we were told in that time that it could be . . . you could get infected by blood and body fluids. Some were saying you wouldn't be able to get infected by saliva, but they weren't sure, so fear of the unknown was a disaster. There were other . . . were saying it was strictly blood and body fluids, but as a nurse at that time, we weren't even sure how great our protective gears were giving those treatments. The weight of unknowing in providing care to HIV/AIDS patients was very startling and troubling. Because, as I said, aerosol treatment was big treatment during that time. Yes, we were wearing masks, gowns, and gloves, but even then,

we were still nervous, because we were not 100 percent sure we were protected, so unknowing was a problem for all nurses.

Nurse Thelma has this to say about *unknowing*:

In the beginning of the HIV/AIDS crisis it was likened to a tug-of-war for no one knows what to do, due to a fear of the unknown, it was called a death sentence, so who wants to care for them. Okay, as a nurse I did not want to take care of patients with this disease, because I did not know much about it. I was given a HIV/AIDS patient on an assignment one day and I felt, felt angry because I felt the other nurses were dumping on me because they didn't want to take care of this patient. They were scared, um, not knowing much about the disease, so they didn't want to have anything to do with the patient because they didn't understand too much about the disease. It was just lack of um, education, lack of knowledge pertaining to the disease. But once I got the assignment and saw how this person needed my care, you know, I said God put me here for a purpose to take care of this person. So I sit down and try to get a better understanding of this patient emotional point.

Nurse Vanilla's contribution to the theme *unknowing* is rather stern given by the tone of her voice. This is her sentimental sensation on the matter:

Initially, the disease HIV/AIDS was something that most people have a fear of the unknown. Most people including myself did not want to touch them for a lack of knowledge, and if you went to see them or do anything for them, you were dressed as though you were going to outer space. It was not in my comfort zone

caring for those patients because of not knowing what to expect while providing care. However, as people like myself becomes knowledgeable as to the disease process things have changed and then you just treat them as if it's any other patient who has an infectious disease.

Nurse Sophie has her contribution to theme *unknowing*, read what she has to say about it:

You know, this takes me back to my days in nursing school. It would seem like all my patients in the clinical area had HIV/AIDS. And believe me, at first I was terrified. I was . . . I was petrified, I'm telling you I was scared of not knowing what awaits me in caring for those patient, it was scary, fearing the unknown or the worst. Um, not knowing what to expect, because you read about it, you've seen people other people's experience, but it's just the thought that any day you could get a needle stick, and this happens every day in nursing. You could get a needle stick and then you could come down with the same disease process, and the medications you have to take, you know. It's . . . it's scary. It's like, uh, death penalty really. After a while, I became a little bit more comfortable with them, you know. And learning that this is just another disease process like any other disease process, and as nurses, we have to use universal precautions and take care of ourselves while we take care of everybody, 'cause we never know what's going on with people. Lack of knowledge is certainly a tall order to fill for me in those days, a really tall order indeed.

Nurse Petal had this to say about the theme *unknowing*:

At first it was taught that it was just a gay man's disease and if you . . . you can

get it from saliva, you can get it from body fluids and anything like that. Who knows, pure speculation, it is killing us, we are between a rock and hard place right now because of not knowing what to do about this curse. It is incurable and you may as well sign your death warrant, if you contracted it.

Swimming in Deep Waters

Through the stellar theme *unknowing* voiced by all participants sharing their experiences, the catchy sub-theme *swimming in deep waters* was able to be identified by the researcher. The redundancy of this saying was on the tongue of almost every participant comparing how they feel caring for patients living with HIV/AIDS. Literature has familiarized us with many expressions doubtless of nautical origin, which have become better known ashore than at sea, such as *swimming in deep waters* (severe tribulation) (Chase, 1942). *Swimming in deep waters* origin is probably metaphorical and related to the fact that deep water can be dangerous, especially if someone cannot swim. Meanings attributed to this term are seen in decline, despair, defeat, trouble, difficult to understand, very absorbed or involved, and in great danger or difficulty.

This is a term used metaphorically in every language and on every tongue. Participants compare the care of patients living with HIV/AIDS as swimming in deep waters, because they are not certain whether they are going to swim, sink, drown, bitten or eaten by sharks, or for that matter stung by sting rays. This they say is just to prove their point on the enormous fear of this disease. Basically, their interpretation is that they are not 100 percent sure how the disease is manifested, they are fearful, scared, and afraid of infection. To be frank they claimed they do not know enough about the disease, and

how well they can provide effective and safe care. Nurse Fire stated specifically:

We nurses are going to find ourselves *swimming in deep waters* if a cure is not found soon, life will never be the same with HIV/AIDS in our lives. We are really at a crossroad of deep trouble and destruction.

Nurse Lila voiced similar comment:

As nurses we are *swimming in deep waters*, and in over our heads with this disease on our hands. Oh! My God, nurses like me are afraid, scared, and in despair with fear of drowning as in the sense of being infected.

Nurse Joan shared her sentiments also by indicating:

HIV/AIDS has no boundaries, it is not really considered a gay man disease any more, and it felt like we are paddling in deep waters with no destination in sight.

Nurse Chloe made her contribution by voicing her concern in disgust:

Personally, I became very apprehensive, scared, and distressed at the beginning of the disease. Before, uh, I think we knew less about the disease. It was, uh . . . also, we used to hear a little about in the media and then it creates more fear. It feels stifling as if you are under water with no source of oxygen staring death in the face. That is just my opinion.

Mr. Banah was quite emotional about his story, he voiced discontent by saying:

I would very much equate fear of the unknown with the disease HIV/AIDS with swimming in deep waters. Oh! Most definitely, that is a very good example. If I am taught how to swim, there is no depth or treacherous water that I will not be able to swim in. But if I'm just struggling there to swim, I probably drown by it,

because of a lack of knowledge not knowing how to swim. So yes, taking a nurse that has no knowledge of HIV/AIDS, was never taught, never trained, and place that nurse to work in an HIV/AIDS clinic or setting is like throwing that person in the deep waters for sure to either sink or swim.

Nurse Bella was very opinionated in sharing her concerns:

Okay, like I remember when I first learned about HIV/AIDS, the first thing that came to my mind is that we are up a creek without a paddle, over our heads in deep waters, and in for a rude awakening. Speculation came in that the disease came from a certain country or a continent. Okay but that was in America and if you went to other countries they had different ideas of where it came from. So then, you were privilege with information that it wasn't true and you got the first one or two cases in the United States. You had to figure out where the disease came from or asked yourself the question did they go to that certain country to get the disease and that was not the case either. So, now you begin to . . . whether it's a certain socioeconomic that really gets it to the point where we are now. We are finding out now that HIV/AIDS is a disease that anybody can catch. What a royal mess this is? *Swimming in deep water* is an understatement in my opinion.

Nurse Sophie interestingly lamented in her interview homily about the metaphor *swimming in deep waters* as a blanket to HIV/AIDS:

The evil connotation attached to HIV/AIDS is wearisome in the fight against this disease. Nurses like myself believe that getting indulge in this disease is like swimming in deep waters with nothing to hold on to, is either you swim for your

life or you sink with it. When you think about swimming in deep waters many thoughts come running in your head, especially if you don't have any equipment to keep you afloat, you are definitely destined for death that is how I feel caring for patient with the disease.

Nurse Petal placed her assertion on swimming in deep waters with pragmatism:

The disease of HIV/AIDS is quite treacherous, at this time you don't know if you are coming or going where this disease is concern . . . it is like you are swimming in unknown waters with no chance of survival. Oh! My father I think it's a plague of the worst kind. Some people would say that, you know, it is a disease from God for those people who are doing the unthinkable. Because remember, it was considered a gay man's disease. But now, hey, anybody can get it, even the babies, what did they do to deserve it.

Exasperating

Another sub-theme identified to compliment the flagship *unknowing*, which is tied into *swimming in deep waters*, is *exasperating* noted on the impulse of most participants. The interrelatedness of *exasperating* implicated anger and frustration as each participant emotionally made their statements. *Exasperating* origin is from the Latin transitive verb "exasperates" suggesting galling anger and the arousing of extreme frustration (Random House Dictionary, 2016). In simplification, its intent is to cause irritation and annoyance, excite anger, and to make someone very angry and annoyed.

The fracas divulged by Nurse Fire is:

In the early years, because we were not 100 percent sure of what's going on, we

were all scared. I for sure was very angry, perturbed, and frustrated at the beginning of this HIV/AIDS crisis. That's a normal human reaction, but as, uh, we get more educated, we know about how to protect ourselves, and then we realize that after all they're human beings just like us and no one would wanna be infected with the HIV.

Nurse Lila puts her mouth in motion by saying:

I was afraid really of course to go . . . I would go to the room. You know, I would go to the room, I would talk to them but I was very afraid, scared, angry, annoyed, and frustrated with them. I think if I go in there, I'm . . . they get angry . . . especially if they get angry, they might hit or spit at me, and or they might, uh, stick me with something, you know stuff like that. But right now I'm used to them, you know . . . is the way you approach too . . . you know, you approach them. So I go into their room and I talk to them, and right now I am comfortable with, uh, taking care of an HIV/AIDS patient.

Nurse Joan implied:

At the beginning, you know, I was kind of, um, really concerned about working with HIV/AIDS patients, because I . . . you know afraid of . . . angry, frustrated, and annoyed you know because I don't know what to expect . . . when I have to treat the patient . . . patient now . . . but now I've worked almost 10 years working with HIV/AIDS patients. I don't feel much, um, different with other patients . . . towards the same patient like other patients. I'm with that.

Interestingly for these research participants, the sudden initializing of HIV/AIDS

on civilization ultimately send a shock wave into the heart of all healthcare disciplines and nursing was not immune. Moreover, as they hold their grounds, they contended that nursing was the first at the forefront of the crisis that threw them for a loop. Furthermore, they claimed that the advent of HIV/AIDS shrouds their daily duties instigating inappropriate and less than quality nursing care through exasperation. Participants also made mentioned that they felt guilty in practice, and that they should not have had their conscience seared by no means, while carrying out their oath of office. Then Nurse Chloe delivered her toast to the argument by implying:

I have read about many incidents of HIV/AIDS infection but the one that takes the cake, like, uh, years ago that haunt me to this day is the dentist that used the instruments that weren't clean properly and then, uh, some patients were getting the disease. I was over the top on this one, angered, bewildered, and infuriated by this act of carelessness and self-centeredness.

Mr. Banah made his contribution known and placed a twist on the argument in comparison to some of the other informants. He communicated,

I was extremely angry and infuriated by the lack of knowledge where HIV/AIDS is concerned. I was more angered infuriated, and annoyed because as I said before people were being looked down on with a lot of disdain as a result of . . . the HIV/AIDS. Many times I mean they would be regarded as homosexuals, especially the men. People were afraid to get closer to them because of the fact that they think that, I mean HIV/AIDS will be spread via direct contact. Initially, when the disease came about, no one understands it or no one understood how it

would be spread. As a result of that there came the stigmatization, which is what made me enraged.

Nurse Bella contribution to *exasperating* is quite simple as she delicately puts it into perspective:

Well! Like I said in the beginning, when I first started to see my first few HIV/AIDS patients I did feel annoyed, some resentment, anxiety, despair, frustration, and lack of motivation when providing care. However, this was because of the lack of knowledge in comparison to “unknowing” of the disease process and how it was really contracted. I felt at the time that everybody was coming at you with different opinions and different reasons and some of the reasons and opinions were really not even true at the time or not even accurate. Right now I mean you do have to approach carefully, but at the time, you can really, you know, treat that patient without making them feel like, you know, they’re isolated in some way or manner.

Nurse Vanilla has her comment for this area:

The frustration, annoyance, and anger comes from when you see somebody, I would not say mistreating them, but not treating them the right way. They’re not giving them the dignity that they so deserve, just like a normal human being. It is also frustrating when you try to tell them that you must take your medications, because if you do not, the disease is going to progress. And because of some sort of mindset that they have, they think somebody did them something that it was some sort of evil spirit or somebody put a curse on them that they have the

disease. Or some people will deny it to the end that they do not have that disease which is very perplexing. So people like that, you just have to try your best with them, because there's no way you could actually educate them, which is quite irritating.

Nurse Sophie has a fascinating story to tell about *exasperating*, and she claimed she is entitled to her opinion, this her take on the matter:

I am lost for words, quite angry, afraid, frustrated, scared, annoyed, and distraught about all the lies they are telling and want us to believe their follies about the origin of HIV/AIDS. I have to take a deep breath when I hear all those shenanigans about the disease came from the gay community. You want to know my suspicion; I think it came out of the lab as it is so widely said. It was, um, basically tested on black people in the first sense, and then it just started spreading rapidly like wild fire, you know, all over and they blame it on the gay community. For so long they've been researching this disease process and they can't figure out where it come from. So that kind of strengthened the, um, prognosis that it came from the lab, and they really don't want to say anything much about it. I am so very over their farce, that it makes me sick to my stomach over their inequities and innuendoes take it or leave it, just my personal assumptions.

According to study's participants the embarkation of HIV/AIDS since the early 1980s has had a profound impact on modern civilization. The receptive atmosphere of this disease was shrouded with stigma, marginalization, discrimination, frustration, animosity, disdain, negativity, pathways of unknown, misinformation, prejudices, and

misrepresentation, just to name a few. Consequently, there are many acts of impediment associated with HIV/AIDS, which caused participants to cringe, feel afraid, and feel scared.

Dreading Occupational Exposure

One such impediments is *dreading occupational exposure*. The action of dreading occupational exposure is the nucleus of participants wanting to resist providing care to patient living with HIV/AIDS in Broward County. Occupational exposure translates into getting injured accidentally on the job with any sharps, such as needle stick, and dreading is to be afraid. Nurse Fire spoke out loudly by inferring:

The nurses you know, they were more scared and afraid of contracting the virus themselves, especially getting stuck by needles, so we had to bring some educators here to really go over the . . . all the steps of putting yourself at risk and all that. I think that made us more comfortable. The person who educated us, she came and with her bare hands she was touching the patient, and it gave us back the . . . you know the human aspect.

Nurse Lila comments were almost the same as Nurse Fire. She flavored the argument in a loquacious tone indicating:

Okay, um, HIV/AIDS . . . at first at the beginning, I used . . . well . . . you know, the way people used to talk, it's like, uh, once you . . . have HIV/AIDS you must, um, get in contact with blood, you know. Um, the . . . yes, taking care of HIV/AIDS patient, as I told you at the beginning, it was a big problem for me. Um, I remember I used to work at this hospital and, um, got stuck with one of the

. . . a needle, but thank God the patient was from . . . it was not cancer. And, um, I couldn't sleep at all. I couldn't sleep thinking that something . . . I would get the disease, you know. But with . . . as I told you, with education . . . but, um . . . and also I got tested, the patient got tested also, but thank God everything was okay. But still I was afraid. I was afraid, um, after the needle stick. I was afraid to take care of them.

For Nurse Joan *dreading occupational exposure* is frightening and disabling. She contended:

I think you have to be, um, like, um, very personal . . . like the patient . . . HIV/AIDS patient, but it's when you . . . you have to be careful with the . . . when you draw the blood. So, I think that's about it, yeah. It means, like we have to be careful with needle stick, you know, and when you come in contact with the . . . body fluid . . . the blood and body fluid, you have to be careful overall with HIV/AIDS patients. So always use the universal precautions, always wear the gloves, gowns, and goggles to spear yourself the dread of a heart condition.

Nurse Chloe is a comical individual but serious as a heart attack in conveying her every day experience, this is what she had to say:

The *dreading of occupational exposure* is stifling; especially when it comes to needle sticks. You know I had some, uh, apprehensions about it. Um, I . . . I know, um, for example, to draw blood, I may be wearing, uh, instead of one [laugh], I wear, like, three or four gloves. Uh, I take, uh, extra precautions where occupational exposure is concerned. Um, but, uh, not that I . . . I take precautions,

so I don't get infected or take anything home to my family, but I still treat the HIV/AIDS patients like the rest of the other patients.

Mr. Banah castigation of *dreading occupational exposure* in his mind is universal as he lay his claim.

Education is the key in providing safe care where occupational exposure is concerned in the fight against HIV/AIDS. Primarily as research states, body fluid exchange is the culprit in transmission of the disease. Whether you are sexually promiscuous or you got injured on the job with someone who may be involved, and I mean you have an exchange of body fluid that is the primary route of getting infected with HIV. Again, I spoke about education. If we continue to educate and people are taught that HIV is a body fluid exchange disease process, and if we talk to them about self-use . . . individualize your needles, discard them appropriately, then of course it will reduce the possibility of HIV transmission. Therefore, the sleepless nights spent, and much confusion on the job during the day will lessen the dread of occupational exposure, well that is just my take on the matter.

Nurse Bella take on *dreading occupational exposure* is quite candid under a tearful situation, and this what she had to say:

The cause or factor associated with *dreading occupational exposure* in the transmission of HIV/AIDS is very well written. Well, we are understanding of course, you know, there are different ways through transfers, sexual . . . us as nurses, or anybody through use of different types of needles or sharps that allows us to contract certain disease process. HIV virus, like I said, either through any

blood borne transfer, any sexual contact. Most people, it's not like you . . . you know, you're kissing someone and you're getting the disease. It has to be a real inter contacts with some type of, you know, sharp object on the job. This is where you get it either punctured through your skin or some kind of open membrane where it's in the blood area or some type of mucus where that HIV is present in there to get into your system.

Nurse Eula-Lee present her case astoundingly on *dreading occupational exposure*, note her expression:

Nurses are really scared, scared, scared and afraid of needle stick on the job. It's a needle stick, nurses are afraid of needle stick, because that's one of the . . . because for you or the patient, taking care of the HIV patients. While treating the patient as nurses you don't want to get stuck by a needle from any patient . . . hepatitis, you know, or any of those other infectious disease. All nurses should protect themselves. You know, you protect yourself from all patients really . . . I mean, HIV/AIDS patient should be the same. Nurses should follow the same protocol like you would for other patients with other infectious disease. We should treat all the patients like everybody's infected, so you should protect yourself on all patient care.

Nurse Lulu gave her take on *dreading occupational exposure*:

I am anxious, nervous, and fearful of getting infected with the disease through occupational exposure, because at the time, we were saying yes, it could only be transmitted by blood and body fluids, by getting injected with sharps. But

working with that population and having a busy schedule, you were not sure, you know...your chances increased of getting stuck when you were doing blood work or giving medications. Administering medications . . . so yes, I was nervous, because I was afraid of getting infected.

Nurse Vanilla has her issue with *dreading occupational exposure* singled out from the narratives:

If you have 10 patients in your assignment and you did not know that any of them there is HIV/AIDS, you would treat them one way. But as soon as you realize that one of them is, you would treat that patient indifferently for the fear of occupational exposure. So occupational hazard is a risk in every single thing you do while working with these patients on the unit. And again, if you treat every single patient as though they are infected, then you would reduce that occupational hazard. You have to, because no one knows. What about let's say . . . I know we are talking about HIV/AIDS, what about hepatitis? No body treats a patient with hepatitis as badly as they treat somebody who has HIV/AIDS.

Nurse Sophie conveyed that *dreading occupational exposure* is paramount in the provision of nursing care to patients living with HIV/AIDS in whatsoever setting a nurse work, and this is her highlight on the issue:

Coming down with the disease process from getting stuck by a needle. That's my fear, you know, or removing an IV and having blood splash in my eyes or anywhere, you know in the mucous membrane. That is really scary. That is *swimming in deep waters* right there. As I said, a lot of nurses are becoming

infected by needle stick, because again, that's blood and body fluid. Um, and stuff like that. But, um, there are some patients I will take care of and for instance, you're doing a blood draw and they will tell you, "be careful. Please do not get stuck." While there are others and you're taking care of them with the disease process, they wanna be fidgeting and you're drawing blood and they're all over the place and they're moving their arms. Hello! I'm gonna leave you alone 'cause you're not gonna get me stuck. Occupational exposure is very scary in the patient care setting.

Nurse Petal contribution to dreading occupational exposure is simple to understand, this is how she summed it up:

You have to be cautious, yes, when you're dealing with shots that you have used on those patients. However, they are just like anybody else. They could be a family member, they could be a friend. So now I feel, personally that I could treat them as though they are human being and not just something that you should just stay away from and just do to be a necessity, because you have to.

Incapacitating

The theme *incapacitating* was identified through participants frequent mentioning of "struggling to provide safe care." *Incapacitating* is a transitive verb from the root word incapacitate, which is the ability to prevent someone or something from functioning in a normal way. In other words, to deprive of strength or ability, that which cripples or disables someone to perform at their best (Random House Dictionary, 2016).

Participant's sincere action to provide safe care for patients living with HIV/AIDS is

incapacitating or compromised as a result of many factors as indicated in various comments made. Nurse Lila commented:

I have spent sleepless nights and confusing days struggling with the notion of providing safe care to patients living with HIV/AIDS. I felt like I am in an incapacitating state of doldrums or stupor, I have to frequently pinch myself to stay afloat. But, uh, with time, training, and everything . . . I understand more about the disease, I said to myself, uh! Uh, I have to take care of them. I have . . . because they are human beings just like me.

Nurse Joan experience of *incapacitating* is presented in a subtle tone:

The first time I was assigned to care for a patient diagnosed with HIV/AIDS, I was kind of afraid, felt like I was paralyzed and experiencing a dead spirit. I did not know how I can be infected with the disease, so my entire world was caving in on me with the inability to move freely. However, with time and education I am very confident, having no problem caring for these patients, but still I'll have to be very careful when providing care. Education was the key for me to eradicate the crippling feeling in providing safe care.

Nurse Chloe take on the issue is simple as she conveyed her story:

You know in the beginning HIV/AIDS was a death sentence. There was a great concern among nurses on job in deciphering mode of transmission. This was not a very nice feeling especially when the possibility of a needle stick is contemplated. Most of the time I felt distressed, disabled, and have no motivation or spirit to provide decent care when I am supposed to do so. There was one time

I can recall that some incidents occurred with nurses and doctors, who would, uh . . . um, get a needle stick. To get a needle stick or any other sharps is a very, very bad thing for us nurses.

Mr. Banah emphasized emphatically that:

Nurses are not really angered by providing safe care to patients living with HIV/AIDS. They are rather angered by I mean the lack of recognition, and the lack of . . . I mean certain things that are needed to have the job done in a safe and competent manner. As nurses we are sometimes treated with disrespect and disdain. We are sometimes looked at as if, I mean, we are not like other professionals, or we are like feces cleaners. Nurses needed to be regarded and treated better which will alleviate the disability and crippling feeling when providing essential care to patient living with HIV/AIDS.

Nurse Bella placed a different spin on the matter but confirmed the same thing that everyone was saying:

It is a disabling and crippling feeling when you want to provide needed care to HIV/AIDS patients. However, caring for them is sometimes trying, you feel that you can only do so much and yet so little. You're limited in the sense . . . I think sometimes in caring, you feel like you want to provide something better, not say a cure, because you don't have it, but close to that. If it's providing more . . . assisting them in finding ways and means to find more financial means to help them, some of them, you know, how it goes on with the HIV/AIDS patients providing their medications, their living environment, and being more of a

support. That seems to be limited, as far as depending on the entity where you're working, and as far as what you can do. Sometimes you feel you want to do more, but you're limited in those areas, which creates a sense of the inability to provide effective and safe care.

Nurse Eula-Lee fought back tears when she conjured;

Because when people . . . years ago, when people tell you they have the disease HIV/AIDS, it's like uh . . . oh, you know. It's like the end. At times I felt lame wanting to do more as a nurse for these patients but my hands are tied. Years ago the verdict for HIV/AIDS was a death sentence in so many words and this characterize a feeling of disability and pain in providing care. But now they've come a long way. Medication is working. Patients are taking better care of themselves. I think they're more knowledgeable about their disease. That's the thing, because earlier, not many knew what HIV/AIDS, you know, they were not very knowledgeable. A lot of research and they've come with a lot of medications and patients are living much longer.

Nurse Lulu communicated with such anger when it comes to *incapacitating*:

On my first experience caring for a patient with HIV/AIDS I was not very happy at all, nervous, and trembling for the fear of infection. However, as I accepted the assignment I found myself getting very relaxed and paying more attention to the patient. I felt numb and incapable at times when I see how my colleagues render patient care. I was new on the unit at the time, and I didn't want to ruffle any feathers. I found myself in a trance with the inability to tell those nurses a piece

of mind. Sometimes your own colleagues will let you lose your religion fast and in a hurry, believe me, they are trying.

Dejecting

Obviously, the theme *dejecting* was uncovered from the frequent swells of participant's emotions, while sharing their naked experience concerning delivering care to patients living with HIV/AIDS. Dejecting is the transitive verb from the root word deject. It was first used in the Late Middle English around the 15th century, and is from the Latin word *dejectus*; its past participle is *dejicere* from the word *dejacere*, which means to cast down. Synonyms associated with *dejecting* are discouraging, disheartening, depressing, demoralizing, disparaging, and to make unhappy (Random House Dictionary, 2016). These are all the action words that came bolstering from the lips of some research participants in the documentation of their stories. It was quite emotional and polarizing to hear Mr. Banah state his case, and this is what he had to say uncut and uncensored:

As nurses, we are sometimes treated with disrespect and disdain. We are also sometime look down at as if, I mean, we are not like other professionals, or we are like shit cleaners. This is strictly so demoralizing, as nurses we need to be regarded and treated better than that. Right now we are seeing transformation, transformation in the form of . . . I mean nurses are getting higher education. At one stage I mean nurses were just trained in a hospital setting. Doctors would speak . . . they would speak down to them with utterly disrespect, and it was known for them to accept that kind of abuse as part of . . . I mean the normal work

day. This trend ought to be stopped. We are professionals, we went to school just like any other professionals, and we work hard to achieve our degrees with the intent to provide professional care to the community and to the people that we serve.

Nurse Bella chimed in under a different umbrella in articulating her point to the injustice of *dejecting*. This was her comment:

I feel disheartened, unhappy, and depressed that I cannot fulfill my job towards caring for patients living with HIV/AIDS. I think my real concern would be more, I wish I could help more, but it's always to a point. I am hoping that, you know, there will always be a time where I can say okay, thank God there's is a cure or you know, more advanced treatment. It is so disparaging you know, and at this point where I've seen certain people, where you can see when they can't afford, like, some celebrities do. When they can't afford certain treatments beyond what, you know, the status quo people get, and you can see they get to the point where they've been diagnosed as having just a trace of the diagnosis, which is very good. So, I think there is a possibility there, but it's limited. So, I think sometimes, too, socioeconomics play into that. I am so overwhelmed with the inability to barely perform my job effectively, its bone chilling.

Nurse Lila appeared to be a reformed advocate for patients living with HIV/AIDS in conveying her sentiments. She made it very clear that as a nurse we have to:

Know that it is within our scope to provide quality care to all patients, especially with this population in question. I am disheartened, discombobulated, weak, and

also troubled in my spirit if patients are not cared for the right and proper way. As nurses we have to know that to . . . the patients . . . uh, the patient is a human being just like anyone of us, okay. So when you go there to provide care, you don't want the patient to feel that you are, you know, putting them down, you know, and stuff like that. You've got to make sure that you show the patient some kindness. You don't want to show the patient that you don't want to take care of them of course not, that would not be very nursing.

Nurse Joan heartbreakingly mustered the courage to point out that it is important to treat all patients equally, as she commented:

I became very discouraged, disappointed, down trodden, and quite unhappy if patients are not taken care of properly. For me I think as nurses we should treat them equally, after all they are human beings too. Equal care to individual should be the focus, respect them, and um, encourage them to tell the truth of what they have. So that's why, you know, they don't have to spread it to other people before they do have sex or anything . . . the transfusion . . . anything. They have to always be straightforward and tell the truth. When secrets are kept and matter gets out of hand the inability exist to retard decent patient care. I am just saying what is laid on my heart.

Nurse Vanilla interestingly pointed out:

In the beginning HIV/AIDS was a fear thing, because you didn't want to get it. Right now, they are patients just like any other patients who just had surgery or something. I am very disappointed and lost for words sometimes how I see care is

given to this group of people. They need help and that's why they're here and that's why we're nurses. We are not here to judge them, we are here to care for them in the best way that we can. You have to care for them as a whole unit, definitely, you can't just put them in a basket and say okay, I'm just going to take care of the disease process only. Every aspect of their total man has to be addressed. Remember now they're psychological . . . they're psychological beings, and everything needs to be addressed. Emotional status need to be addressed too. Their family life need to be addressed, every single thing. Remember, they are not . . . you cannot fragment it. You have to treat them as a whole, not just physical, but physical, emotional, psychological, and spiritual as well.

Nurse Sophie made clear her concern with *dejecting*, this was her comment:

Quite frankly, at times I feel demoralized, disheartened, and depressed providing care for patient living with HIV/AIDS because of many factors involved. Why that is, sometimes cannot be explained. I believe as a nurse caring for patient with HIV/AIDS, that nurse should not take that patient, should not care for that patient, because you would not be giving the best care to that patient. And funny enough, patients can see when we're not giving the best care to them, and that too, can help with retarding their healing process. So if you feel, if you have examined yourself and say, okay, I won't be able to take care of this patient with HIV/AIDS, because of whatever situation you may have had some experience, personal experiences or such like that, you actually speak out. Do not take care of that

patient, because you would not be doing the best for the patient and yourself, which can become a serious problem.

Nurse Petal had her take on dejecting and this is her opinion:

Lack of knowledge is the biggest deficit that anyone who's HIV positive could think of. The shame that's attached to it and the thing about it is that they actually hold onto it knowing that they have been HIV positive and not telling anyone makes me disheartened, depressed, and discouraged. This will sadly cause a delay in care and treatment.

Feeling of Emptiness

The participants expressed a *feeling of emptiness* as patients are presented with different behaviors associated with HIV/AIDS. Patients are mostly, disoriented, reserved, non-compliant with treatment, and untruthful about their character. Some participants revealed that most of these patients were family members, neighbors, friends, or just people they know, and it instilled a *feeling of emptiness* or void in their souls. This leaves them with a lasting feeling of emptiness as articulated in their department hanging on the hinges of the interview promenade. The *feeling of emptiness* is manifested through inadequacies, lack of connection, avoiding responsibility, inability to provide guidance and attention, and to protect against pain. Nurse Fire made her comment by implying:

Well at times they get frustrated, angry and disoriented. You know, there was a lady who used to scratch us. She used to smear feces on the bed linen, floor, and walls of her room, but we try to give her emotional support and we . . . at first, you know, the nurses were kind of scared. Nurses used to wear gowns, masks,

and everything, but gradually we got off it, you know . . . there was a feeling of emptiness in me, because of my inadequacies in redirection, and the idea that this could be a family member or even me.

Nurse Lila shared her view on the *feeling of emptiness*:

Um, my experience with caring for HIV/AIDS patients . . . first of all you have to put yourself in that situation. Um, it could be you in that situation. Always remember they are human beings and as a nurse you are there to take care of sick patients. Um, I don't take them like they are strangers to me, um, the . . . I'm there to make them feel a little better, because sometimes they are crying and refusing to take their medications. I want to make sure that they don't feel that way, but a feeling of emptiness fill my soul, as I am unable to provide guidance and good housekeeping. I often felt I let the patient down, just me rolling over in my self-pity.

Nurse Chloe placed somewhat a different twist on the *feeling of emptiness* as it pertains to caring for patients living with HIV/AIDS. This is her reasoning in a nutshell:

I really don't see the HIV/AIDS patients different from any other patients. Um, because, um, it can happen to anyone. But, um, I know some nurses, if it's, um, in homosexual, um, then some nurses do resent . . . I . . . I don't feel that way at all. Uh, but I know some nurses they resent HIV/AIDS patients because they feel like it's a punishment. Like, uh, if a . . . if a gay person, um, contract the disease, they feel like, uh, well, they deserve it, because, uh, God didn't intend for them to be that way. So I hear people make that comment all the time, which left me with a

feeling of emptiness in my stomach because as nurses we should not discriminate, instead we should care.

Mr. Banah placed his response in overdrive on this issue and this is his contribution:

Many patients who have been . . . uh, who have gotten to the point of full blown AIDS, which is one of the encompassing things that is among them. The fear of helplessness; fear that they will be left in that bed with no one to help them, and the fear that if they should be sent home they would be disregarded by, I mean, their family members. Who probably may be thinking that, I mean, they will be infected if they go close to, um, that individual that is suffering from, I mean, HIV/AIDS. Again, it takes us right back to the point of education, and education cannot be stressed or cannot be uttered enough where HIV/AIDS patients are concerned. When you see and hear of these things it leave you with a knot in your throat, and a feeling of emptiness in your spirit. Thank God many of the nurses are, um...that I have worked with and have seen in today's world are no longer embracing the fear of HIV/AIDS patients. I think they are better educated now and they are better able to handle the situations surrounding a person that is infected with the disease.

On the contrary, Nurse Bella made similar comments in addressing the *feeling of emptiness* in providing care to patients living with HIV/AIDS:

For example, if providing . . . let's say they're on their medication and they need more nutrition, and they cannot afford it considering the environment, system, or the type of financial limitations that they have, then you can only do so much.

You can call certain governmental groups that maybe helping them, but even then that sometimes is limited to access to the client at times. So then that person, yes, they're taking their medication, but then they're not getting the adequate nutrition that they need to maintain and sustain them, so to help them with their disease process. You also, sometimes, you feel that you're limited in the process of seeing how the progression is working with the medication and working with the various doctors that are caring for them. Because you don't really have the full autonomy in that process it can become a drag and disheartening. So there are various things that does limit, you know. If they need finances, you can maybe call a social worker, but then, you know, how does it go beyond the point to actually going from getting them someone that can help them to actually getting closure to what they actually need, per se? This kind of impotency poignantly circumvents a feeling of emptiness in your humanness.

Nurse Lulu provided her story under the *feeling of emptiness* umbrella, and this is her experience:

Okay, I can't forget this. It was on the med/surg unit in a hospital in New York. A young man, 23 years old came to the unit with...what was the disease he has? Endocarditis. It was endocarditis and after he was tested . . . was . . . other symptoms of . . . with weight loss and other symptoms he was showing. And after blood test was done, was proven that this young man had HIV. It was very, very heart wrenching, lifeless for me, with a feeling of emptiness in my gut, absolutely no upliftment in my spirit. He was a young guy and he took it hard. He was very

emotional and of course . . . close to my age at that time. I felt a lot of sympathy for him, it was very, very hard on me to say the least. Providing care for him was no problem for me, I would spend a lot of time talking with him and listening to him and of course, he was isolated, because at that time, people going to the hospital, they were mostly alone in that unit. They were alone, not too many people come to visit, so it was a very, very tough situation for me at that time. But it didn't affect providing physical care, giving medication and of course taking care of him. He was very weak and I had to do bed bath at that time, too, because I was the nurse of the unit, was the primary care nurse. You take care of all your patient's needs; medication to physical care. For me it was emotionally, emotionally draining. It was emotional drain, because my heart went out to him. Yeah, yeah, I was very sympathetic . . . I was also very, very retarded, you know.

Nurse Vanilla speaks solemnly about the feeling of emptiness when she has to provide patient care and has the privilege of assessing the family unit for these patients as well.

These are her kind words:

Sometimes I feel a lump in my throat and at the point of tears with an emptiness inside, owing to the fact that when "the going gets tough, the tough gets going," alluding to an old proverb. You know it's not just support for the patients. You have to also support the family structure too, because now, if the patient was the sole breadwinner in the house, it's going to be a real sad thing for the entire family. Remember now, their financial support will be down, because if that person is sick and cannot work, they cannot support their family. Also I am not

aware of any governmental agency that will help to support the family just because that person has HIV/AIDS. For me you would have to have a heart of stone not to care, and not to have some kind of feelings about this terrible situation.

Nurse Sophie was on point when she indicated this:

I became empty inside when I happened to come across the ill will of stigmatization and discrimination meted out to patients living with HIV/AIDS. Personally, I do not stigmatize people with HIV/AIDS. I care for them like any other person with any other disease process. They do need someone to listen to them, they need someone to take care of them. Sometimes they even need a shoulder to lean on. I do give my heart all too them, because they don't know. Um, they were, some of them were, like, trustworthy, have partners whom they trusted and they contracted the disease process, and my heart goes out to them, you know. It is ashamed when you learn all this it makes you feel empty, down and out.

Lacking Emotional and Physical Support

The sub-theme *lacking emotional and physical support* is at the forefront of participants experience in the provision of care to patients living with HIV/AIDS in Broward County, Florida. The ambition of all participants as identified during the discourse is to be properly supported both emotionally and physically in their day-to-day task of caring for patients stricken with HIV/AIDS, so that they can better care for them. On the other hand, as portrayed by their statements they would be privy to convey the

same consensus to patients in their hours of need, distress, and discouragement if offered to them. The idea of *lacking emotional and physical support* in the fight against HIV/AIDS is likened to a rattle snake in waiting for its prey. In understanding participants' arguments in this regard, just listen to what they have to say: Nurse Fire's input in this matter is as follows:

In my experience, as I said, you know, I see them as normal human beings. You know, they have needs. They have emotional and physical needs that have to be met, and they're just part of the population. I remember in the beginning we used to have those, uh, disposable trays for them. We stopped all that. I think it was an issue with the...when we had the surveyors coming in, and they went over with us that we're not to isolate them in any kind of way. So they eat with the same utensils, and you know, the plates and everything is just sterilized the same way we would do the rest of the residents here. The lacking of emotional and physical support in this situation for both the patient and the nurse would have proven futile for all parties involved. Emotional and physical support offered here has proven to be quite beneficial for all parties involved.

Nurse Lila expressed her views by proclaiming:

Whenever I have a patient with this kind of disease, I always look at the patient as a family member and as a . . . it could be me too in that situation too. Sometimes they don't even have anybody to come and visit them. This is where emotional and physical support is recommended to balance the scale between nurse and patient in the care of patient living with this disease. This is what I do if no one

else wants to do it. I make sure on my days off I would go and visit that patient too. If they go in the hospital, I go and visit them in the hospital too, and I make sure to, like... when it comes to Christmas time, I, uh, buy gifts for them. And, um, I make sure too . . . um, I embrace them . . . make them feel like they are human beings too. Okay, um . . . so lacking emotional and physical support in this way promote instability.

Mr. Banah has always contributed meaningfully and he is quite verbose in his explanation:

Yes, when you have the kind of respect and the kind of support, be it emotional, physical, and moral or otherwise, that is in a sense command a certain kind of a behavior. It gives you that kind of gleefulness that you want to do your job regardless of kisses or favors. The fact that, I mean, you are caring for someone that you know having buried in them a disease that can be transferred to you if you do not exercise care or safety in your practice is frightening. As you may have known Mr. Researcher, a hospital, your support system says a lot about any individual. So a good support system . . . good recovery promotes good health. So yes, we need a balanced support system to care for this individual or these individuals. In this emotional and physical support system we need the healthcare-trained individuals, and you also need the support from the community, more so the family members to balance that care.

Nurse Bella persuasively elucidate:

Well, I feel that as medical people in general, the care should be centered

strategically on emotional and physical support with the patient through everybody that's involved. Whether it's the physician, involving the physician, or as many specialists that are involved in the care, infectious disease and their primary doctors, and any other specialist that is involved in the care. The nurses, I really feel, too, I don't think at this point we do, but I think we should really have . . . since we're really the one on the day-to-day basis caring for patient.

Sometime each individual patient, their treatment are different, how they react to the treatments are different should play a more say in how we feel is best treatment for . . . in conjunction with the doctors. Also, I feel the family if any should play a big role in the support system of that particular person when they're going through it. And anybody else that we can involve . . . research centers, any kind of centers that can assist that person in either maintaining a quality of life or in progressing, you know, their health, when they get sick.

Nurse Eula-Lee emphasized that *lacking of emotional and physical support* is detrimental to the outcome of any condition, let alone HIV/AIDS. This is her proposition on the matter:

Well, I think the patient needs more support both emotionally, morally, and physically than . . . because you're taking care of the patient, you're supposed to be strong on supporting, you know, moral, physical, and emotional support. Moral support is . . . and trust. Moral support . . . you give as much support, according to the patient's needs. Not every patient . . . the same, so you look at the patient's behavior and you treat them accordingly.

Nurse Lulu believes that emotional and physical support on the part of the nurses is very important in the care of all diseases and with all patients, especially those infected with HIV/AIDS. Here is what she wanted to interject:

Faith-based organizations will make a difference in the care of patients with HIV/AIDS. I believe we should involve them more. Faith-based . . . yeah, well, compassion. Compassion is essential . . . faith-based people who are involved in faith-based ministries are more . . . I mean will show compassion to patients with HIV/AIDS. They will reach out to them, and of course help them to link with others in the community who are supportive and will help them spiritually, because they are spiritually beaten at the time, too. Help them spiritually, and help them emotionally, and physically. Link family members together. Those who were abandoned by family, to link . . . to get them back together to provide that support that they so desperately needed at that time, when they're going through all of that stuff. And of course, there are a lot of anger that comes from families, because sometimes there is a husband or a wife, somebody that...infect the other party. And it cause a lot of problems in the family. Faith-based institutions can help to reconnect the family, and provide the support that they need at that time.

Nurse Thelma thinks that *lacking emotional and physical support* in nursing is damaging to the profession and what it stands for, and this is her attitude to the issue:

Emotional and physical support is very important in our daily nursing duties. It is important to treat HIV/AIDS patients like any other patients, any patients, go and

talk to them, touch them. You can't really get anything from them by touching them, hugging them, you know, and sitting down with them offering *emotional and physical support* will show them that you cared about them. It is important to show your concern and listen to them, you know as a nurse. Let them talk, maybe they're depressed so that this way, you know, they know that you're listening to them and not just want to give them a pill and just to get out, that you're concerned about them, you know, human compassion. Human compassion is the key in treating these people, no matter how you feel in the beginning about the disease. Your job as a nurse is to go ahead and care and support the patient, care for the patient to the best of your ability. With physical and support, physical and, and emotional support, they were able to take their medications so that they can get stronger. So they can go back into their community and live a normal life and understand that they have to prevent the spread of the disease by, um, by not having, um, unprotected sex in the community and . . . sharing needles. And able to educate other people about the spread of HIV/AIDS, and this way they can live a more meaningful life.

Nurse Vanilla was very forthcoming in pragmatic commentary:

As for me, emotional and physical support in the planning of patients care in any condition is paramount, because number one, they are going through something that no one could experience, but themselves. The thought is that they will die. We all know we will die, but this is the stigma attached to HIV/AIDS, which is more than they could even think of. Then, they have to think of their loved ones

that they're going to be leaving behind, as well as if they had a partner, their sexual partner. Now this start the domino effect where that one person who was infected or is infected could be responsible for a whole lot of other people being infected, if he or she was indiscriminating their sexual activities. It is the nurse's role to educate them and let them know that it is not a death sentence like it was years gone by. They should be told with their medication and with proper education, and proper physical support, follow-up, testing of their blood frequently, they could live a long and . . . while I wouldn't say super healthy, but they could live a long life. Take for example, one of our super stars. He is a living proof that with proper medication and monitoring that you could live with HIV/AIDS.

Nurse Sophie instigated that *emotional and physical support* is an important aspect of the healing and recovery process in nursing care, and has this to say:

Support of any kind is an important and major variable in the nursing process. Patient do need support. They need emotional support, sometimes some of them may need financial support, 'cause when they are isolated and they don't feel love, and they are stressed. And you know stress when it takes over a whole system, it makes the disease process so much worst, you know. And when they know they have a support system, it's much easier for them to handle and take care of themselves. Just offer them some love. Give a listening ears, you know. And be there just to support, just to support them, because a lotta times, they don't want a lot from anyone. They just want someone to listen to them; just listen and

be empathic to their situation.

Nurturing

To conclude the thematic selection, *nurturing* was identified as the last anchor among the many themes and sub-themes to embellish participant's act of caring dictated through telling their stories as it pertains to patients living with HIV/AIDS in Broward County. *Nurturing* as it stands is the present participle of nurture, and its origin is from the Middle English norture/nurture which is from the Anglo-French nureture, and the Latin word nutritus founded in the 15th century (Random House Dictionary, 2016). It is no coincidence that nurturing is a synonym of fostering, which is the act of encouraging, nourishing, and caring for someone or something. In this sense it is the act of caring for patients living with HIV/AIDS in Broward County. *Nurturing* is enshrined as a huge part of being a nurse, which is to bring nursing or patient's every day care to the table. It is interesting to hear firsthand what participants have to say about *nurturing* in their own words. Nurse Fire impetuously commented:

Uh, it's like [laugh] nurturing plays a responsible role in the care of these patients with HIV/AIDS. When I say nurturing this is what I mean. You know, you make sure that everything is in order. I will speak about this facility here. We would make sure medications are given on time, lab works are done and followed through, and the dietician is on the case . . . you know, they come and review their diet and labs and make changes when necessary. The infection disease specialist visit every three months, reviews labs and make changes in medications as needed. We make sure they are weighed. All interventions that we have for the

whole population we use the same to conduct their care for effective outcomes.

Nurse Lila vehemently expressed *nurturing* in her own words:

Yes, for Christ sakes our professional code of ethics or conduct as nurses is to practice as the only advocate the patient has. As nurses we have to diligently provide holistic care without kisses or favors to all our patients in nurturing them back to health. I always tell the . . . my other nurses too. When you're taking care of them, which I mean the HIV/AIDS patients, you don't want the patient to feel, uh, that, uh, he or she is a bother or nothing. Um, you don't want to, uh, stigmatize the patients. That in my native tongue is like a cow giving a pail of milk and using her feet to kick it over. Um, always make sure that, uh . . . always . . . you show them that you're there at all times for them. They are people just like us, like, uh, any other people. So, um, um, you want to be there for them. You want to make them feel that they're at home, okay. So, um . . . in a fostering and nurturing environment.

Nurses Joan settled down comfortable at her dining table and placed her thoughts into perspective on the issue of *nurturing*, while blending her voice in expressing her experience:

I am a stickler for providing serious care for all my patients and HIV/AIDS patients are no difference. It is our responsibility as nurses to do our best in nurturing and restoring patients to viable life. I tried everything possible in coordinating their care from a nursing point of view. Um, you know, I, um, tell them to follow-up with their infectious doctor, and for lab work to be done as scheduled. Ensure that

weights are done, dietician involvement with nutritional counselling, and to adhere to medication management. This indeed show the nurturing part of nursing.

Nurse Chloe energizes the scene by sharing her thought on *nurturing*:

I think as nurses we should show more compassion for our patients living with HIV/AIDS as we do for the others. The only way we can accomplish this in a trying world as this one is to think of them as holistic beings, yes holistic beings. We have to help in every way possible carrying their burdens in nursing or nurturing them back to even basic health, if we cannot achieve optimum health. Let's be frank they are just, uh, they are the same as every other patient with a different disease. Providing tender loving care is a positive approach, and uh, when you hear the news, its, uh, its promising that, uh, you know, we can...they can live with the disease, uh, and not be killed by it.

In sharing a personal experience, Mr. Banah emotionally take *nurturing* to a positive level caring for a child infected with HIV/AIDS. This is Mr. Banah exclusive story:

This act of *nurturing* occurred while I was attending Long Island College Hospital School of Nursing. Believe it or not, this was like a two-year-old or three-year-old girl. When I first got the assignment, I was petrified. This was, like, about 1993, '94 . . . I mean petrified. Like for . . . as a male and based on, I mean my commitment to serve and care for patients, I researched and I decided I'm gonna give this the best shot ever. This little girl was such a sweetheart. Today I still have a little flower as a sticker that she gave me, and I have it on one of my

folders, and I will never part with it. This child got the infection from her mother who was infected with HIV/AIDS who has died, but the child had hope, because her viral count, her T-cells were within normal range. The viral count was at its lowest and her T-cells were at the highest, and every hope was there that, I mean, this child would reverse and become a normal negative HIV/AIDS person. I would have loved to tract her, but once I parted company with her, that would be it. But I'm just hoping that, I mean, she's still alive today and doing well. I felt like I was her dad. I wanted to protect her as my own using all means necessary by doing everything nursing and more. If you should ask me, she's one of my favorite patients ever. Just to reflect on her, I still feel a closeness to her.

Honestly, speaking, once I get to know the child who I cared for four weeks, while I was doing my rotation in HIV/AIDS, there was no fear availing itself to me. All I saw at that time was a child that needed me; a child that reached out to me; a child that outpoured love that I never had as a child; a child that looked up to me for supervision, guidance, and for care; a child that I will always remember as long as I live.

Nurse Bella did not hesitate to strut her feelings on the importance of *nurturing* in the care of patients stricken with HIV/AIDS. Here is what she has to share with her audience:

In the beginning of the disease, I felt very awkward caring for them, but as times went by I found I have no resentment towards them. Actually, I feel more empathetic in nurturing them. This is not a disease that someone asked for. It

happens and unfortunately, it happens to be one of the types of terminal illness where we have not yet found a cure. I think that is where...when you care enough that you're concerned about and you're limited in helping, and you want to do more, but you can only do so much. The little you have to work with you try to maintain them . . . assist them in maintaining the best quality of life for themselves and their activities of daily living (ADLs). Provide empathetic support as much as you can, and any type of other resources within your boundaries that you can provide for them. Sometimes in the *nurturing* game, as nurses you choke up with the feeling of helplessness; in the fact that when you're looking at them, and like I said, when your resources are limited you can only do so much.

Nurse Eula-Lee expressed her feelings in a very motherly tone, and explained that *nurturing* is a strategic characteristic of nursing, and this is her stance:

I believe nurturing should be a built in mechanism of every nurse. This should be an automatic impulse when caring for every patient and every disease, not just those diagnosed with HIV/AIDS. You don't know when . . . I mean, disease can hit home anytime you know. So put yourself in that person's position and how would I like to be treated. That's all, you know, I tell my patients. How would I like to be treated and you treat them the same way you would like to be treated, because it can . . . I can go and get a needle stick and wind up with HIV/AIDS. Like, how you treat them, like, in the family environment. You take care of them in the sense that you want them to get well, things like that. Patient centered . . .

you know, patient centered approach. The whole thing is centered on them. I don't want to be treated like an outcast, so you know, I project the same thing to my patients. I've really never had a problem taking care and *nurturing* them in a nurses manner.

Nurse Lulu has a story to tell that embellishes *nurturing*, and here is her one on one encounter:

Can I give you a story? Okay, when I lived in New York, there was a person living in my building who was a transvestite and she was very beautiful. Man to woman my description, very beautiful, was a hairdresser, and she leaves her home each morning looking like a beautiful woman. No problems. On the unit we worked in at the hospital we were working for in New York, someone . . . that patient . . . that lady was infected and got ill to the point where she could no longer take care of herself, her physical beauty. She ended up in the hospital, was placed in a unit with . . . AIDS unit and she was now placed in the same room with another man. Oh, my God this was a calamity. This patient has facial hair growing and was unable to shave herself, this person was a woman. She was left there with the beard hairs all-growing back. I am going to tell you no one visited and I could tell you, nurses including myself on that unit tap into our *nurturing* skills, jumped in and take care of that lady. I think that was a human thing to do. There was no stigma at that time. That person was sick and needed care, comfort, and emotional support.

Nurse Thelma has an experience to share when it comes to *nurturing*, listen to her story

as she expressed herself eloquently:

The first experience that I had is um, a 23-year-old, um, female patient with, um, tuberculosis, diagnosed with HIV/AIDS, um, she was very scared. She was, um, in isolation and, um, all the other nurses didn't want to take care of her. I was the new kid on the block, the new nurse in that hospital, so I ended up with that assignment, and this young girl was so scared. I felt so sorry for her that I would sit with her, and every time I get a chance just to talk to her, you know. And, um, she's, she's scared because, um, she said, um, she's gonna die and she don't want to die, you know. And she said this is her first sexual encounter and she end up with the disease. So, um, she was, um, she was there because, um, she said she couldn't breathe and it turned out that, um, she end up with tuberculosis and pneumonia and they were treating her. So with that when I look back on that, you know, I saw how lonesome she was, you know, and also scared that she was gonna die, you know. It's really, really, um, I . . . it hit home with me where I end up giving her extra care, spending more time with her, you know. And, um, after she was able to get all the isolation and mingle with the . . . with the, um, with the regular patient population, um, she didn't want her family to know, you know, except for her mom. She . . . her brothers and sisters, she want them not to know about it so that they wouldn't end up isolating her, and ostracizing her from the family.

The theme *nurturing* was supported immensely from participant's narratives in sharing their experiences; Nurse Vanilla's input was significant to her invocation expressed:

Hmm, I think, you know patients with HIV/AIDS need motherly, fatherly, and nursely *nurturing* than anything else. If you have someone who has a drug habit, there are nurturing programs for them. So these patients should also have some sort of *nurturing* foundation, so that there will be people with good stories to let them know that they have been living with HIV/AIDS for say 20 something years or so. And it is controllable and not just leave them up to the wiles of the . . . leave them up where they . . . they're just there by themselves, because they are so ostracized by society. Special assistance is needed quite frankly to champion their cause because ostracizing is wrong. It is definitely wrong. But it's society. It's not just nurses. It is still stigma that society has placed on that disease. It has lessened, yes, but it's still there.

Nurse Sophie believed that patients living with HIV/AIDS require specialized nursing care and her idea of *nurturing* is:

I'd like to say we live in an era where HIV/AIDS is here, right? Us knowing how to care for patients with HIV/AIDS makes a big difference. Just know that they're still human beings, they're someone who needs a friend and a confidant, and they're someone who needs a brother or a sister. They're someone who needs our compassion, and our kindness, you know. They're someone who needs to know that they have a shoulder they can lean or cry on. Be there to embrace them, to encourage them, to take care of them in every way you can, but most of all know how to take care of yourself, while you are taking care of them, that is my simple explanation of motherly or fatherly care.

Nurse Petal had this to say about *nurturing*:

The nurse's role in nurturing is to educate the patient more than anything else, teach them safe sexual habits, monitoring of their blood count, monitoring of their blood and to divulge to anyone early, early if they do get positive result, not just keep it a secret. They should let their partners know if they were tested and if they came . . . if it came back positive with them. We need to take . . . and you can only do this through education. It's only through education.

Since the dawn of HIV/AIDS on civilization many, many things have happened, many mountains have been climbed, and many mile stones have been reached.

Consequently, there are still impediments assimilated and embedded in its path in achieving the ultimate goal. The ultimate goal here is to eradicate and silence the disease for good, just trying to stay optimistic in this fight. However, it seemed that this proposition is far-fetched. In the meantime, for a peace of mind, this is going to take considerable time and patience on the path of all involved in the fight to bring some civility in caring, especially in patient-nurse relationship.

Obviously, given the experience shared by participants; patients stricken with HIV/AIDS can live healthy and meaningful lives for longer if proper care and support is provided, even if it is only on the premise of the nurses. Furthermore, treatment, food, rest, and exercise given the appropriate care can strengthen patient's immune systems medically. In the nurse-patient relationship coping can be exclusive if both parties are happy with a feeling of productivity. Support given both emotionally and physically with a positive attitude will help in the nurse-patient relationship in avoiding all negativities.

Quite frankly, colossal engagements can also be carried out to avoid the devastating effects that HIV/AIDS illness and death have on children and families.

In the interim, this research study exploring the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida has uncovered emerging themes constituted in thick rich data, which secured the meanings participants had hidden in their life world. Incidentally, participant's expression of lack of knowledge, fear of the unknown, and finding themselves swimming in deep waters as a result of HIV/AIDS association proved disconcerting to them. However, with the availability of vast research studies coupled with the key factor "education" these participants were able to perform vivaciously even in between the cruxes of gloom and doom. Swinging the pendulum of emotional and physical support extended by these participants in their narratives, the researcher was able to find a robust pathway in understanding the uniqueness of their experiences, and to unravel the meaning hidden in disguise.

In practicality, the intention of this phenomenological inquiry was to explore and secure the meaning of the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. Resolution was intended to give nurses a platform through their voices to attest to their experiences through personal heart felt descriptions with a determination to disclose the true nature of their experiences. In an effort to extract the deeper understanding embedded in this phenomenon van Manen (1990) descriptive/interpretive phenomenological method of inquiry was the vehicle of choice. According to van Manen (1990), the unruly behavior of phenomenological

inquiry is not that too little is known about the phenomenon that the community wish to explore, but that too much is known. To accurately place into perspective, the researcher's common sense, pre-understanding, beliefs, norms, and the existing bodies of scientific knowledge, influence the research community to construe the nature of the phenomenon even before the researcher come to grasps with the importance of the phenomenological question.

Theory of Health as Expanding Consciousness

In conjunction with the study's findings *Margaret Newman's Theory of Health as Expanding Consciousness* will be applied to the lived experience of registered nurses caring for patient living with HIV/AIDS in Broward County, Florida. This theory is considered a grand nursing theory that described a process of becoming more of oneself, finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world. Theory enhances practice every day and vice versa, as both theory and practice are guided by principles and dogmas. The tenet of theory supports and reframe nurses thinking about the profession and directs the use of concepts and procedures. Theory aims to cement the breach between theory and research and predicts potentialities. A simple notion of the theory of health as expanding consciousness is that it guides nursing practice, produces knowledge, and aids in describing or explaining nursing, it also allows nurses to know the reason why they are doing what they are doing.

Chapter Summary

The cruxes of this chapter deliberated the fundamental findings of the phenomenological inquiry of the lived experience of registered nurses caring for patients

living with HIV/AIDS in Broward County, Florida. Collective discussion was carried out on demographic depiction, while physiognomies of each study's participant was completed using a descriptive presentation. The revelation of emerging themes *unknowing, incapacitating, dejecting, and nurturing*, and sub-themes *swimming in deep waters, exasperating, dreading occupational exposure, feeling of emptiness, and lacking emotional and physical support*, which mirrored participant's disposition in the theatrical caption of their true feelings, thoughts, and experiences during the narrative interview session on the phenomenon was presented in detail. Reflecting on the lived experiences of each participant, the researcher was able to establish and describe from the participant's perspective their experiences.

This also opened the door widely for the researcher to look clearly into the window of each participant's experience with the intention of capturing the evolving meanings, and imagery of the phenomenon. The summarization of the themes and sub-themes played an extraordinary role in the presentation of participant's life world, which also enabled the researcher to grasp the forestructure of understanding of each participant's experience. The aftermath of this phenomenological inquiry placed the researcher in a position to apprehend the quintessence of the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. By doing so, the researcher was able to unmask the working themes and sub-themes interconnected to participant's experience, which will showcase the meanings for discussion in Chapter Five.

Chapter Five

Discussion and Conclusion of the Inquiry

This chapter discussed and summarized the results from data analysis to draw meanings and conclusion on the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. The ultimate contention of this study was to achieve and secure an in-depth epistemology of the importance of what it meant providing care to this fragile population stricken with HIV/AIDS. Topics discussed were exploration of the meaning of the study, interpretive analysis of the findings, and significance of the study and to nursing. In addition, implications for nursing education, nursing, practice, research, and health and public policy. Strengths, limitations, and recommendations for future studies were also addressed followed by the study's connection to a nursing theoretical framework. This qualitative inquiry has explored registered nurses experiences regarding their position in the provision of care to patients living with HIV/AIDS in Broward County.

According to van Manen (1990), a qualitative inquiry using a phenomenological approach aims at establishing and transforming contact with unique experiences. A research project of this nature was to describe and disclose meanings as they are lived, illuminating the real quintessence of the phenomenon as it was experienced. The argument was that phenomenological depiction is always one elucidation, and no single clarification of human experience will ever deplete the probability of yet another harmonizing, or even theoretically richer or deeper explanation. The tenacity of this study was to investigate and comprehend this phenomenon; nurses caring for patients

living with HIV/AIDS in Broward County and to romanticize and promote optimistic results in the nurse-patient relationship.

In anchoring this study, van Manen's (1990) descriptive/interpretive phenomenology was the hydraulic tool employed to investigate the rich data extracted from participant's experience to reveal the contextual understanding and meanings of this puzzle. Descriptive phenomenology approach was to unravel the meaning of the lived experience between participants and the researcher through one-to-one interactions. In other words, context was of peripheral importance. Whereby interpretive phenomenology emphasized a central concern; meaning that participants cannot abstract themselves from various contexts that impact their choices and give meaning to lived experience (Wojnar & Swanson, 2007). Therefore, the life people live outside of being ill or well cannot be ignored when we consider what is it like to experience caring, healing, and wholeness. In fact, individual's very experience of health is in the context of family traditions, community values, and the broader sociopolitical context.

Hence, interpretive phenomenology is beyond the reach of knowledge of core concepts and essences (Wojnar & Swanson, 2007). Max van Manen (1990) explained that phenomenology attempts to describe and interpret the meanings of the lived experience to a certain degree of depth and richness. In hindsight, the emergence of the themes and sub-themes are indicative of the researcher's elucidation, and positioned for intellectual dialogue and further clarification. Furthermore, the themes and sub-themes identified from the study by van Manen's (1990) interpretive analysis were further explicated, which was enhanced through discussion.

Exploration of the Meaning of the Study

This research puzzle took on a qualitative phenomenological inquiry coupled with van Manen's descriptive/interpretive methodological approach, which was to describe and interpret the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. According to Wojnar and Swanson (2007), researchers who use phenomenological approaches to understand lived experiences of registered nurses in human healing, caring, and wholeness need to consider the differences that exist between descriptive and hermeneutic phenomenology. However, van Manen (1990) infinitely breakdowns the barriers between descriptive and interpretive phenomenology by concluding that when description is seriously arbitrated by expression then description is intoxicated overwhelmingly with a stronger aroma of interpretation. Moreover, it is argued among the research community that all description is ultimately considered interpretation, and the meaning of phenomenological description as a process is ingrained in interpretation.

Therefore, at the core of any phenomenological inquiry lay the challenges in describing and understanding any phenomenon, such as caring, healing, and wholeness as experienced by individuals in their lived world (Wojnar & Swanson, 2007). Moustakas (1994) also provided support for phenomenology by confirming that it aims to define what an experience means for the participants who have had the experience, and are able to provide an all-inclusive description of it. From participant's accounts, general or universal meanings are consequential, in other words, the cores or edifices of the experience. Support for this study was influenced by an enormous gap in the nursing

literature surrounding this phenomenon, hence, a critical investigation was warranted to describe and interpret the phenomenological question “What is the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida?”

Max van Manen (1990) argued that phenomenological question is called “meaning question,” which asked for the meaning and significance of certain phenomena. The consensus on the premise of meaning question is that it can be better or more readily and deeply comprehended, so that on the foundation of this understanding, the researcher may be able to act more considerately, and more discreetly in certain circumstances. Explicitly, in some sagacity, meaning question cannot be bolted down; they will forever remain the core of the conversational relations of any individual who is optimistic in benefitting from such intuition. On the fundamental principle of this meaning question “What is the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida,” the researcher involved many techniques to unravel the meaning of the phenomena alluded by each participant’s experience.

Figuratively, as the rich thick descriptive data were collected, the researcher strategized research activities, such as journaling, footnotes, and meanings articulated through literature reviewed, film, poem, music, and short stories in pursuit of the quintessence of this puzzle. The art of cultivating a non-threatening atmosphere for both researcher and participants alike, and listening attentively without distraction to their shared experience of the lived world gave clarity and understanding of the researcher’s imagination. On account of participants captivating narratives and penetrating depiction of their lived world experiences in providing care to patient living with HIV/AIDS, and

the many trials they are confronted with each day, invigorate a platform to explore the cruxes and meanings entrenched within their experience. It is the belief that the meaning of lived experiences can only be unraveled through one-to-one exchange between the researcher and the participants (Husserl, 1970).

Interpretive Analysis of the Findings

Unknowing

HIV/AIDS has been a severe problem since the turn of the 21st century. This disease is viewed as an unstable phenomenon ripping homes, families, and healthcare communities apart in an effort to make sense of its etiology, pathophysiology, risk factors, and treatment regimen. The intent was to prepare registered nurses with essential tools to dispel fears, discrimination, stigmatization, and biases when providing care to patient living with HIV/AIDS. However, the impediment of *unknowing* where the disease is concerned is creating a severe catastrophe for participants at the beginning of the disease and even more than 40 years later. The intimidation of *unknowing* personifies the insightful effect, weight, and burden attributed to nurses who come to grips of those patients living with the disease.

The craftiness of *unknowing* lies within not knowing, fear of the unknown, ignorance, unaware, and lack of knowledge thereof. Feeling scared, *swimming in deep waters*, *exasperating*, *dreading occupational exposure*, fear of infection, and fear of the unknown are all sentiments reverberated profoundly by all participants on the threshold of this unique theme. Fear of the unknown and lack of knowledge were singled out by participants as the most destructive forces in compromising their lives and livelihoods,

when caring for patients living with HIV/AIDS. The emergence of *unknowing* as a theme was significant as participants lay their claim on a disease that is so hated by many.

On account of this theme participants made known the criticality of the ferocious behavior that existed, and the turbulences in providing care to people living with HIV/AIDS. Participants being scared, anxious, having a fear of the unknown, and lack of knowledge are documented in many scientific studies concerning HIV/AIDS. The undermining of the disease HIV/AIDS by the action *unknowing* remains a pivotal factor for nurses providing care. In a study conducted by Mathole, Lindmark, and Ahlberg (2006), the researcher mentioned the action of *unknowing* in providing maternity care in the context of HIV/AIDS in rural Zimbabwe.

Although these nurses are involved in patients direct care a blanket of uncertainty and *unknowing* hangs around that predisposed them to the possibility of serious complexity. In solidifying the literature, Nurse Fire eloquently placed it into perspective;

In the early years of the disease lack of knowledge was a serious altercation, we were not 100 percent sure of what is going on, we were all scared of the unknown, especially about contracting the virus or what I will be taking home to my family. Even now at this stage of the disease *unknowing* is still a problem. To me the word *unknowing* is a very terrible word, which stimulate uneasiness anxiety, and fear of the unknown.” Mr. Banah also stated, “We sometimes are enslaved by our ignorance and I think with HIV/AIDS that was mainly the case.

Again participants were fearful as a result of *unknowing* as in what to do, and the lack of knowledge is what created the problem, creating a fear of the unknown.

Adepoju (2006) carried out a research study on the knowledge of HIV/AIDS among nurses in Southwestern Nigeria and reported findings that nurses has given way to several misconceptions about the disease, because of the lack of knowledge about the nature of HIV/AIDS. The study also found that the knowledge of HIV/AIDS is limited or remains unclear among these nurses, and they are equipped with insufficient education to appreciate the pandemic nature of HIV/AIDS infection, and the serious effect the issue may have on civilization. The literature also found that these participants had little or no knowledge about the phenomenon and that it is rather unfortunate. It is also stipulated that circular infusion should be incorporated in HIV/AIDS education and nursing care. This would allow participants to be better prepared and less homophobic in their attitude toward HIV/AIDS patients, and feel more positive in giving quality care to patients living with HIV/AIDS.

The reporting of the literature findings is in sync with Nurse Bella's commentary, well in the beginning we did not know exactly where the disease was coming from. There was a lot of misconceptions and speculations on where it was coming from, a certain culture, a certain type of racial background at the time we were told. Some nurses like me were really scared and thought you can get it by even touching the person, which, you know, now we have been educated enough to know that is not so, which is a good thing, because it's calmed down, you know certain fears. The anxiety for me was definitely the lack of knowledge, not knowing, and what we thought back then, as far as the person with HIV/AIDS and how it is contracted. And so to . . . so then to begin to approach a patient with the disease was kind of scary with fearing the unknown.

Lack of knowledge and fear of the unknown embellished *unknowing* when having a dialogue about patients living with HIV/AIDS. Mr. Banah explained his position on the matter, just like tuberculosis (TB), when TB came about:

Nurses were afraid to serve in that area. Even recently with that African illness that came abroad or came ashore here the Zika virus, nurses were very much afraid of caring for these individuals mainly because of the lack of knowledge or fear of the unknown. In one of our schools in Jamaica, we would sometimes say knowledge liberates and ignorance enslaves.

Consistent with Hassan and Wahsheh's (2011) study on the knowledge and attitudes of Jordanian nurses toward patients with HIV/AIDS: Findings from this nationwide survey had this to say. Nurse's weakness or lacking knowledge of HIV/AIDS care is considered critical, because correct knowledge along with an in-depth understanding of patient's needs can help improve much of the fear and anxiety associated with caring for patients with HIV/AIDS.

The researcher came across a similar conclusion in a study carried out by Chorwe-Sungani (2013), in Malawi. This was a quantitative descriptive design that used a convenient sample of a 109 participants from a central hospital in Malawi, which was to explore participant's level of knowledge and skill in providing mental health care to people living with HIV/AIDS. The study found that the lack of knowledge and skills among participants should be a cause for concern in caring for patients living with HIV/AIDS (PLWHA). Another study conducted by Suominen (2009), indicated that participants who lack knowledge because of *unknowing* and have a fear of the unknown

may possess negative attitudes toward PLWHA and may not be enthusiastic in providing care to this delicate population. Furthermore, according to Delobelle et al. (2009), nurses have an advanced occurrence of contact with PLWHA than any other healthcare providers on this planet. Therefore, it is imperative that nurses be equipped with adequate knowledge and skills to dispel fear of the unknown or “*unknowing*” for that matter, so that they may be knowledgeable and have an increased willingness to care for PLWHA.

The findings mentioned by these studies concluded that the theme “*unknowing*” has embedded in its nucleus the cells of fear of the unknown, and lack of knowledge, two unwanted perils to care. These two factors of hindrance placed participants in a serious predicament, which eroded the ability, and the preventative measures in providing care to PLWHA. The fundamental questions that shrouded participant’s ability in providing care to PLWHA are how well do I protect myself from infection, or how much do I know to safe guard myself against what I do not know. These are some of the burning questions and impotencies that still lingers, which incapacitate participant’s ability providing less than quality care to patients living with HIV/AIDS. Mullins (2009) confirmed that inadequate and inappropriate nursing care is a common problem in participant’s care giving experiences. Participants understanding of *unknowing* and its effects can be personalized and illustrated in the words of the poem inscribe below:

“*Fear of Unknowing*”

Fear of unknowing

Is what consumes us today?

Every little piece of knowledge we need

Is at our fingers tips

Just ask Siri

Google it

Look it up

But we fear the unknown and never do anything about it

When people were unacquainted with the rest of the world

They sailed to find it.

When people didn't know a word

They picked up a dictionary and found it

We fear that God exists or doesn't exist

In truth, we really don't know

We fear the unknown, so we pray to the unknown.

We are scared of the dark

Not seeing and knowing every dot of dust

Not knowing what may lurk

We don't know when the world will end

The idea that it could happen, but we don't know when scares us

It scares me, as I am no exception to this fear.

We don't know what will happen next

Maybe instead of fearing the unknown

We could find curiosity in it (Margaret, 2014).

In spite of the severity of HIV/AIDS on globalization over more than 40 years of its existence, participants found themselves under siege as a result of *unknowing*, which breeds and cultivates informal attributes, such as fear of the unknown, and lack of knowledge to cardinal nursing care. In ratification of these findings, the study completed by Harrowing (2011) on compassion practice by Ugandan nurses who provide HIV/AIDS care was quite consistent. Results demonstrate the many obstacles participants faced in providing more than proficient nursing care, and the emancipating effects of new knowledge and skills in HIV/AIDS care. In comparison to *unknowing* and its evil twin's fear of the unknown and lack of knowledge, participants continue to labor under duress in the provision of care to PLWHA.

Although participants continue to labor under duress, caring for patients living with HIV/AIDS as a result of the effect of *unknowing* and its evil twins, fear of the unknown and lack of knowledge the same holds true in the movie "And The Band Played On." The movie "And the Band Played On" was dramatized in the dawn of the 1990s to depict the presence of a strange disease's infiltration of civilization. This researcher had the autonomy to evaluate this movie and came away with the notion that no one had any understanding or knowledge of the precariousness of this misery. Subsequently, this relentless disease brought about a period of unrest, incivility, and unethical innuendoes

that supports the theme *unknowing*.

Therefore, this drama of *unknowing* led the directors and producers Karen J. McCabe, Sarah Pillsburg, Midge Sanford, and Roger Spottiswoode with an all-star cast, starring Matthew Modine and Alan Alda, in sending the message ingrained in its narratives spotlighting the apprehension of unknowing. This movie is a 1993 American film production from the bestselling 1987 non-fiction book “And the Band Played On: Politics, People, and the AIDS Epidemic” written by Randy Shilts. This movie depicts Matthew Modine as Dr. Don Francis an American Epidemiologist and Alan Alda as Dr. Robert Gallo an American Scientist. In particular, this film “And the Band Played On” is extremely penetrating with a detailed description of the start of the Acquired Immunodeficiency Syndrome (AIDS) in the United States in the dawn of the 1980s.

Subsequently, the film inaugurated with an intense setting showcasing Dr. Don Francis arriving in a small village on the bank of the Ebola River in Zaire, and realizes many of the villagers and doctors working with them have died from a cryptic disease. This illness was later recognized as Ebola hemorrhagic fever. The epic layout of this scene sets the overwhelming character on the profound reality of deadly diseases, and how society and the government respond to these kind of epidemics. This sentinel experience for Dr. Don Francis with the Ebola illness and the images of the dead that he cremated will plague him into his tenure with the Centers for Disease Control and Prevention (CDC) on his return to the United States. Central to the story line the film has a unique plot that depicts the premier case of Human Immunodeficiency Virus (HIV) of a Danish female around her mid-forties who succumbed to pneumocystis carinii.

Pneumocystis carinii is an illness that is associated primarily with immune-compromised patients. This case was first noted in Zaire, and the whereabouts of this illness was unknown. In other words, no one knew how this illness was contracted and transmitted.

On account of the Zaire's case, the movie has plots and scenes showcasing the same condition destroying lives here in the United States. Dr. Francis became aware of the increasing amount of deaths from a mysterious cause among gay men in Los Angeles, New York City, and San Francisco and is impelled to begin a thorough exploration of this conceivable source. The potential problem facing Dr. Francis is that he has no financial solvency to work from, space is limited, and the equipment were severely antiquated. Another plight to Dr. Francis's relentless desire is the bureaucratic red tape seen through politicians, and members of the medical and gay communities. Moreover, many of these people resented Dr. Francis's involvement as a result of their personal aggrandizement, chief among these notables are Dr. Robert Gallo.

However, this condition continues to baffle many in the medical community exhibiting disarray, state of unrest, panic mode, and bewilderment trying to make sense of what is causing the susceptibility of *Pneumocystis carinii*. Individuals who have already succumbed to this illness and other unscrupulous diseases have severe compromised immune status, which was revealed through many investigations carried out. A startling discovery found that many of these individuals have a T-cell count of zero. Therefore, the expediency of this issue found CDC epidemiological inquiries taking a very proletarian method by going out and about in the by-ways and edges to find the chief source of this surprising plague.

As the “Band Played On” settings, scenes, and plots depicts true experiences of everyday lives. The film delineates causes and effects that an individual will pursue to claim fame, fortune and aggrandizement as in the case of Dr. Robert Gallo. Dr. Gallo’s squabble about who should attain credit for discovering the virus is extremely important for his “persona,” while the recipients of the infection perish, and the death toll keeps marching forward. On the other hand, there are many like Dr. Don Francis who would exemplify human decency by climbing tall mountains and swimming in deep waters to find the solution for a resolution for the common good of humankind.

The spirit of the movie culminates with a candlelight vigil and a march on San Francisco with images of individuals with HIV or the involvement with HIV education, screening, and research. This movie ended with a bang on the erosion of ethical principles, guidelines, implications, challenges, considerations, and an attack on character to say the least as a result of theme *unknowing*. One of the finest accomplishments noteworthy in the discovery of the virus and what is called the AIDS epidemic led to the collective practice of screening all donated blood samples for hepatitis, HIV, and other transmittable illnesses that compromise medicine today. The rendition of “*The Last Song*” by Sir Elton John adds zest to the cause, fight, discovery, prevention, and caring of a killer disease.

Consequently, the Lyrics of “*The Last Song*” by Sir Elton John was written shortly after Freddy Mercury died of AIDS. A time in history, when HIV/AIDS was becoming a pandemic, little was known about the disease, how to treat and care for it. At the beginning of the disease sufferers were shunned, scorned, feared, stigmatized,

discriminated against, and still remain prudent even 40 years later. This song was used as the closing montage of the 1993 Home Box Office (HBO) docudrama “And the Band Played On,” which narrates the story of an estranged father coming to terms with his son’s disease and homosexuality, while the son is coming to terms with dying. This is Sir Elton John lyrics at a dark time in human history and it is as follow:

The Last Song

[Verse one]

Yesterday you came to lift me up
As light as straw and brittle as a bird
Today I weigh less than a shadow on the wall
Just one more whisper of a voice unheard
Tomorrow leave the windows open
As fear grows please hold me in your arms
Won't you help me if you can to shake this anger
I need your gentle hands to keep me calm

[Chorus]

Because I never thought I'd lose
I only thought I'd win
I never dreamed I'd feel
This fire beneath my skin
I can't believe you love me
I never thought you'd come

I guess I misjudged love

Between a father and his son

[Verse Two]

Things we never said come together

The hidden truth no longer haunting me

Tonight we touched on the things that were never spoken

That kind of understanding sets me free

[Chorus]

The emerging sub-theme *swimming in deep waters* was identified as a metaphor affixed to *unknowing*, which consistently spouted from the lips of several participants, reflecting the dilemma participants found themselves in caring for patients living with HIV/AIDS in Broward County. Participant's tales of *swimming in deep waters* represents the extreme difficulties that lay ahead where participants are concerned in the fight against HIV/AIDS. This piece of linguistic communication demonstrated its interpretation in the same way it is read, and conveyed a spirit of disaster in its tentacles. Welton (2005) found that the metaphor *swimming in deep waters* is used regularly to explicate, describe and express a variety of communications throughout daily discussion.

Consequently, the interpretation uncovered through this sub-theme was recognized that participants are not convinced if they are going to survive the venomous implications of HIV/AIDS when care is to be carried out to patients living with this disease noted from the bearing of their experiences. In aquatic narration, participants are not sure they are going to swim, sink, drown, eaten by sharks or stung by stingrays as it

pertains to the danger of this deadly pandemic. To explain the aquatic narration, participants expressed their experiences at the initial stage of their profession when they first come in contact with patients with the disease framing it as a death sentence, feeling scared, feeling afraid, and a fear of being infected. Goatly (1997) inferred that *swimming in deep waters* is rudimentary to language and thinking as it is used to convey a host of sentiments, events or conditions. This is true in the words of Nurse Fire, we nurses are going to find ourselves *swimming in deep waters* if a cure is not found soon, life will never be the same with HIV/AIDS in our lives. We are really at a crossroad of deep trouble and destruction.

Participants also conveyed how disturbed and perplexed they were to even look at patients living with HIV/AIDS, the struggle that abound to even touch them, and the moral aptitude to provide essential nursing care. Nurse Lila categorically state her mind, as participants we are *swimming in deep waters*, and in over our heads with this disease on our hands. Oh! My God, nurses like me are afraid, scared, and in despair with fear of drowning, as in the sense of being infected. In a study conducted by Welch (2000) *Morality, Metaphors, and Myths The Correctional Response to Prisoners with HIV/AIDS* reported that inspections further contextualizes HIV/AIDS ideologically by attending to hostile societal responses dependent on metaphors in generating distinctive cultural meanings.

In essence, a conspicuous ideological theme in common illustrations of the disease HIV/AIDS is a metaphorical use of the disease, insinuating that those who are infected are being punished by a greater authority for indulging in illegitimate drug use,

homosexuality, or promiscuity. This indeed stirs emotions and passions in the experiences shared by the participants in making their distinct claim. Nurse Joan was carried away by emotions when she shared that HIV/AIDS has no boundaries, it is not really considered a gay man disease any more, and it felt like we are paddling in deep waters with no destination in sight. McAllister (2002) conducted a study doing practice differently: solution-focused nursing and refuted that participants are ill-prepared to be practical and defensive, while frequently searching for problems, we craft for ourselves and the patients with whom we work, difficulties which need to be overcome.

In defense of Nurse Joan; Mr. Banah voiced discontent by saying, I would very much equate fear of the unknown with the disease HIV/AIDS with *swimming in deep waters*. Oh! Most definitely, that is a very good example. If I am taught how to swim, there is no depth or treacherous water that I will not be able to swim in. But if I'm just struggling there to swim, I probably drown by it, because of a lack of knowledge not knowing how to swim. So, yes, taking a participant that has no knowledge of HIV/AIDS, was never taught, never trained, and place that participant to work in an HIV/AIDS clinic or setting is like throwing that person in the deep waters for sure to either sink or swim.

Nurse Bella made similar comments, okay, like I remember when I first learned about HIV/AIDS, the first thing that came to mind is that we are up a creek without a paddle, over our heads in deep waters, and in for a rude awakening. Speculation came in that the disease came from certain country or continent. Okay, but that was in America and if you went to other countries they had different ideas of where it came from. So then, you were privilege with information that it wasn't true and you got the first one or

two cases in the United States. You had to figure out where the disease came from or asked yourself the question did they go to that certain country to get the disease and that was not the case either.

So now, you begin to . . . whether it's a certain socioeconomic that really gets it to the point where we are now. We are finding out now that HIV/IDS is a disease that anybody can catch. What a royal mess this is? *Swimming in deep waters* is an understatement in my opinion. Heller (2015) carried out a study titled, Rumors and realities: making sense of HIV/AIDS conspiracy narratives and contemporary legends found that there is no magic bullet that can dispel rumors pertaining to Nurse Bella's discourse. However, recognizing the social facts about their backgrounds and effects, and tracking changes in rumor, are necessary steps to contend with them as part of the real social landscape in which public health education, and other procedures take place; rumors are neither stagnant nor epiphenomenal.

In the same token van Manen (1990) indicated that language that realistically speaks the world rather than conceptually speaking of it is a linguistic that resonates the world, as Merleau-Ponty says, a dialectal that chants the world. It is imperative that we must participate in an original invocation or poetizing, which hearkens back to the silence from which the words originate. What we must do is to ascertain what lies at the ontological core of our being. So that in the words, or perhaps better, in spite of the words, we find recollections that paradoxically we never thought of or felt before.

Interestingly, in the words of van Manen (1990) in relationship to *swimming in deep waters*, there lay the lack of knowledge coupled with experience and education as

potential barriers to patient care. These barriers can very well thwart the way patients living with HIV/AIDS are cared for in society today, denoted by participant's narratives. Participants also highlighted that on a global consortium without education, experience, and knowledge participants may have difficulties providing less than quality nursing care to patients living with HIV/AIDS. In understanding the meaning of *swimming in deep waters*, as it is used metaphorically by participants to discuss the severity of HIV/AIDS on the care of patients living with the disease Nurse Lulu has this to contribute:

I believe education is the key in finding a common ground bridging the gap in nurse-patient relationship. Education should begin from nursing school on this issue. And when these participants get into the workforce, they should be given orientation. They should be given education on prevention and information on how the disease spread and how to protect themselves. If they're given good educational information they should not fear nor should it affect the way they provided care to these patients. Lack of knowledge, education, and experience should be reversed with strategic training and good education.

Delobelle et al. (2009) spearheaded a cross-sectional study on HIV/AIDS knowledge, attitudes, practices and perceptions of rural nurses in South Africa and found similar arguments voiced by participants. Participants expressed trepidations about their lack of knowledge, education, and experience regarding care and treatment of patient living with HIV/AIDS, and promoted training for all nursing staff, regardless of their specialized ranks to allay the deleterious impact on caring for patient with HIV/AIDS. Multifarious studies also found that the lack of HIV/AIDS knowledge and fear of

infection among participants in emerging countries, coupled with indecisive feelings toward caring for patients living with HIV/AIDS. Therefore, given the tremendous impact of the pandemic and the increasing numbers of patients requiring therapy, it seems imperative to hasten HIV/AIDS education and training for all participants, regardless of their position or place of employment to castigate the metaphor “*swimming in deep waters*.” Evidently, metaphor allows participants the figurative expression needed to amalgamate challenge and compassion; as both participants and patients faced the fragility of the physical body under stress, and the loss of basic control.

The second sub-theme conjured in the caring for patients living with HIV/AIDS in Broward County, Florida, that was founded on the principle of *unknowing* and assimilated into *swimming in deep waters is exasperating*. This was insightful as a result of participant’s claim of becoming irritated, frustrated, annoyed, and angered in providing care to patient living with HIV/AIDS in their line of business every day. This sub-theme was vehemently recognized by participants as an outlet to decry patient’s behavior through their experiences caring for them on a daily basis. Participants blended their voices in unison to both criticize the disease and patient’s behavior where the disease is concerned.

These are some of the sentiments tossed around by participants as they aired their feelings, “we are so damned frustrated and angered by these people actions and behavior that only God can tell, they are uncooperative, noncompliant, and nasty, with absolutely no hearing.” Nurse Fire had this to say:

In the early years, because we were not 100 percent sure of what’s was going on,

we were all scared. I for sure was very angry, perturbed, and frustrated at the beginning of this HIV/AIDS crisis. That's a normal human reaction, but as, uh, we get more educated, we know about how to protect ourselves. Then we realize that after all they are human beings, just like us, and would not want to be infected with the disease.

To place confirmation on Nurse Fire's emotions, Young (2000) implied, nurse caring role in the healthcare corridor places nurses in crucial loci to excite discussion in areas like this one. Some participants in this study constantly put their conscience out in the open where *exasperating* is an avenue that stimulate impropriety, but felt they are sometimes unable to control their buccal expression. Consequently, they leveled the playing field by honestly admitting that *exasperating* is a precursor of poor judgment, bad attitude, imbalance, inexperience, stigmatization, and discrimination when providing care to patients living with HIV/AIDS. A similar study conducted by Rahmati-Najarkolaei (2010) found that nurse's fear of becoming infected with HIV/AIDS, together with religion and value-based postulation about patients living with HIV/AIDS, led to high levels of stigmatization, discrimination, and bad attitude. The study further shore up support that perceived negativities, including attitudes of participants demonstrated and written extensively by previous studies in different parts of the world.

One of the participants in this study Mr. Banah expressed the *exasperating* sub-theme a little by looking at it from a different angle. This is what he told the researcher:

I was extremely angry and infuriated by the lack of knowledge where HIV/AIDS is concerned. I was more angered, infuriated, and annoyed because as I said

before people were being looked down on with a lot of disdain as a result of...the HIV/AIDS. Many times I mean they would be regarded as homosexuals, especially the men. People were afraid to get closer to them because of the fact that they think that, I mean HIV/AIDS will be spread via direct contact. Initially, when the disease came about, no one understands it or no one understood how it would be spread. As a result of that there came the stigmatization, discrimination, and stereotyping which is what made me so enraged.

Mills et al. (2011) in their study confirmed that some of the nurses were asked about the challenges to caring for patients living with HIV/AIDS and more than half of the participants mentioned stigma as a significant deterrent to disclosure, and subsequently to nursing care.

It is said that nursing is an art in the truest senses. What is important about nursing practice is it embraces the whole human experience and participant's spirit must be nurtured and poetized by more than the uniqueness of science. It is said that poetry fills the cracks and illuminates the darkness. Join the frontline workers in exploring the ways poetry links spirit and body to renew ourselves, and to be fully present for others. It is important to hear from the experience of other established nurse's poets in connecting participants' own hands and hearts with words. According to van Manen (1990), poetizing is thinking on an original experience and is speaking more in primordial intellect. Participants should always try a primal telling in an incantative, and evocative speaking, wherein they should aim at involving the voice in an innovative singing of the world. Here lies in this poetizing collaboration the voices of the participants in this study.

Exasperated Dust

True confessions of the day, which never seem to end

Often bring deep shadows into light

When exasperating tales of how we crush each other's spirit

We bring home to our loved ones and recite

To forget about the day and come home with just a smile

So often, we quickly forget that this we need to do

Instead, we bring the awful grief that has been left at our feet

Into our homes to rest upon the ones we love so true

Now I will be the first to admit that we all need shoulder to cry upon

Someone to tell about the gist of our unpleasant day

Yet I think most would agree with me, if given a choice outright

That our homes should be a refuge, come what may

When you travel through the door of your most blessed home

Shake the exasperated dust of the day from your feet

Greet your loved ones with a smile and rest there for a while

Leave the worst of your day there on the street (Flores, 2010).

The third sub-theme identified in this study and pioneered by the major theme

unknowing is dreading occupational exposure. The inferiority of marginalization, stigmatization, discrimination, stereotyping, and stigmatization application to HIV/AIDS is devastating to participants who parade themselves in the clutches of the disease. Therefore, participant's fears of infection in providing care to patients living with HIV/AIDS is astounding in the declaration of their experiences, and declare *dreading occupational exposure.* The primary fight and flight that surrounds this sub-theme is fear of occupational exposure from needle sticks and blood splashes in mucous membranes.

Nurse Chloe mentioned:

The dreading of occupational exposure is stifling; especially when it comes to needle sticks. I am very apprehensive, and fearful about this captivating fear in providing nursing care. Although, there are policies and procedures in place to handle needle sticks, participants displayed contrition about the severity of oppression on their life world.

Similar findings of this nature are reinforced by a cross-sectional study completed by Kumakech et al. (2011) in Uganda, which demonstrated that participants experienced occupational exposures to HIV/AIDS through mucous membrane contamination and percutaneous injuries was found to be prevalent among participants. Other findings called into question that occupational exposure to HIV/AIDS through percutaneous injuries and muco-cutaneous contamination compared with other healthcare worker are not unique, and found that nurses and midwives were at higher risk of sustaining occupational injuries.

On the other hand, Mr. Banah chastised that education is the key in providing safe

care where occupational exposure is concerned in the fight against HIV/AIDS. Primarily as research states, body fluid exchange is the culprit in transmission of the disease. Studies mastered by Gaidhane et al. (2009) and Chan et al. (2008) revealed that while occupational exposure is high on the mind of nurse, most of them believe that fear of HIV/AIDS contamination has not influenced their career choices. However, participants made it clear that occupational exposure has contributed to a decrease in less than quality nursing care due to the fear of HIV/AIDS infection. The studies completed by Aghamolaei et al. (2009) in Bandar Abbas south of Iran, and by the International Council of Nurses (ICN) (2003) revealed that participant's main concern with occupational exposure was the everlasting fear of getting infected, while providing patient's care. Another highlight to this finding is that more than half of the study's participants claimed that preparing to take care of patients living with HIV/AIDS placed them in a precarious and disabling situation (ICN, 2003). Evidently, under disabling situation such as this, the nurse's prayer is inevitable:

A Nurse's Prayer

Long before you entered nursing
The Lord had played His part,
Planting seeds of love and kindness
In the portals of your heart.

For it's clear that you're been gifted
With a sympathetic ear,

And blessed from the beginning

With a willingness to cheer.

And the people who you care for,

When they're touched by your compassion,

By the person that you are.

For in times of woe and worry

When they're frightened or they're blue,

No one could be more consoling than the friend they'll find in you (Vera, 2013).

Incapacitating

The second major theme identified from the interpretation of participant's experience in the care of patients living with HIV/AIDS is *incapacitating*. This theme *incapacitating* placed a value on participants that they felt they want to do more for their patients living with HIV/AIDS in Broward County, but found themselves limited in many ways than one with the emphasis position on the fear of infection. The "wanting to do more feeling" is also hampered by public, private, and family support, and even the basic responsibility of compliance from patients themselves. Participants expressed the demeaning struggle and the inability in providing patients with safe and appropriate care as patients are presented with different behaviors and conditions to complicate the present situation.

Incapacitating is nothing further from the inability to preventing someone from functioning in an autonomous or normal way. It is the epitome of draining strength,

placing a crippling sensation on the human body, and depriving someone of the basic fundamental rights in providing appropriate nursing care. The effects of *incapacitating* as expressed by participants was that it inhibited and stagnated care to patients living with HIV/AIDS in Broward County, and brought on a feeling of helplessness through the aggressor the fear of being infected. According to Nurse Lila:

I spent sleepless nights and confusing days struggling with the notion of providing safe and competent care to patients living with HIV/AIDS. I felt like I am in an *incapacitating* state of doldrums or stupor for the fear of contamination. I have to be frequently pinching myself to stay afloat.

This was well supported by Nurse Joan in her commentary, “the first time I was assigned to care for a patient diagnosed with HIV/AIDS, I was kind of afraid, felt like I was paralyzed and experiencing a dead spirit. I did not know how I can be infected with the disease, so my entire world was caving in on me with the inability to move freely.”

Nurse Chloe confirmation was on point when she said:

You know in the beginning HIV/AIDS was a death sentence. There was a great concern among participants on the job in deciphering mode of transmission. This was not a very nice feeling, especially when the possibility of a needle stick is contemplated. Most of the time I felt distressed, disabled and have no motivation or spirit to provide decent care when I am supposed to do so.

A study by Tshweneyagae (2007) sided with the participants by arguing that the advent of HIV/AIDS has changed the nursing landscape and has made nursing care extremely complex.

One of the main reasons for this statement is because HIV/AIDS recipients require more centralized nursing care and longer treatment hours that can be burdensome, overwhelming, and cumbersome for the nurses. This is due in part to the multifarious assortment of problems faced by nurses, such as the number one culprit fear of infection. A similar study by Rujumba et al. (2010) found that nurses are more comfortable and settled in caring for adults with various comorbidities, but not HIV/AIDS. Mavhandu-Mudzusi et al. (2007) sanctioned that phases of frustration, emotional stress, and exhaustion coupled with severe hindrances are associated with nursing care of sick patients and provided a feeling of helplessness. Orner (2006) found that inability, emotional exhaustion, and fatigue are common among nurses who often practice under duress with a stigmatizing disease, encountering death and despair on a daily basis, and to add to insult, the lack of adequate compensation, encouragement, and recognition.

These informal attributes divulged by Orner (2006) confirmed by participants that they have created an unhealthy environment in rendering less than quality nursing care to patients living with HIV/AIDS. Mr. Banah emphasized emphatically that nurses are not really angered by the inability to provide safe nursing care to patients living with HIV/AIDS. They are rather angered by the lack of recognition and the lack of support to get the job done in a safe and competent manner. As participants we are sometimes treated with disrespect, disdain, and like feces cleaners. Participants needed to be respected, regarded, and treated better, which will alleviate the disability and crippling feelings when providing essential care to patients living with HIV/AIDS.

Nurse Bella has her spin on things and this was her contribution:

It is a disabling and crippling feeling when you want to provide need care to HIV/AIDS patients. However, caring for them is sometimes trying, you feel that you can only do so much and yet so little. You're limited in the sense . . . I think sometimes in caring, you feel like you want to provide something better, not say a cure, because you don't have it, but close to that. If it's providing more . . . assisting them in finding ways and means to find more financial means to help them, some of them, you know, how it goes on with the HIV/AIDS patients providing their medications, their living environment, and being more of a support. That seems to be limited, as far as depending on the entity where you're working, and as far as what you can do. Sometimes you feel you want to do more, but you're limited in those areas, which create a sense of the inability to provide effective and safe care.

For patients suffering with various illnesses and patients infected with HIV/AIDS for that matter in acquiring quality and competent nursing care, participants deserve some components of sustenance from stakeholders. Furthermore, Richter et al. (2009) stand in solidarity that nurses do require some form of appreciation from both patients and family members on the resilience in providing their loved ones with competent and safe care. On the contrary, this is not so, the bad mouthing, disrespect, and easy to point out the incompetencies of nurses actions created tunnel for distress and disaster for both the study nurses and the patients alike. Recognition is also deemed necessary from facility's management as participants provided unconditional care to patients suffering from HIV/AIDS (Pongruengphant & Tyson, 2004).

Interesting to note, providing appropriate nursing care to patients living with HIV/AIDS place considerable demand on the shore line of nurses in this ring of fire (Orner, 2006). It is plausible that participants are often thrown in the deep waters without adequate education, training, and supervision providing care to patients living with HIV/AIDS. Moore and Henry (2005) in their study remarked that all participants in providing care in many ways felt inadequacy. They also expressed frustration and anger indicating that as much as they were willing or eager to provide care, they felt awkward in meeting the care of people living with HIV/AIDS. In the interim, some participants may be masters of disguising their feelings and emotions, and try their best to cope in a very stressful environment at all cost, while some cannot; evidenced by participants' contentions. Greeff and Cur (2007) in their study implied that something must be wrong with the nurses themselves who work with PLWHA, or else they would not be prepared to work with this group of people.

Participants invoked that nursing executives are too busy and may not be able to recognize the feeling of grief, frustration, and the naked inabilities experienced by participants who frequently faced limitations, deaths of their patients, and avenues of reprisals on the continuum of care. Participants also divulged that they are tired of the nursing rhetoric and the lack of essential collaboration from stakeholders relative to the care they provided to patient's living with HIV/AIDS. They are convinced that meaningful collaboration and staying away from nursing rhetoric may be just the opportunity to derail the *incapacitating locomotion*. In addition, another detrimental factor in the care of patients living with HIV/AIDS is patient's inconsistencies and non-

compliance with care as expressed by those who cared.

Nawafleh et al. (2005) conducted a study in Jordan on the influence of HIV/AIDS on the practice of primary care nurses in Jordan: Rhetoric and reality, and found that rhetoric presented by nursing management and ratification in policy is not insightful of the veracity of nursing care. The study claimed that poor and insufficient resources, educational preparedness, limited nursing skill mix, and entry to proficient growth, poor nursing leadership and role models, cultural beliefs, geographical isolation, and patient's inconsistencies are all factors that decrease the capability of the primary care nurses. These factors instigate the inability of the primary care nurses to raise awareness, and therefore, markedly influence the care, prevention and control conveyed to people living with HIV/AIDS. The findings are consistent with the findings of this current study that nurses' inabilities, frustrations, limitations, exhaustion, and fear can be alleviated to some degree if stakeholders and patients alike throw some petals of love, respect, truth, and recognition at nurse's feet.

Dejecting

Dejecting is the third major theme uncovered in the meaning of this research puzzle on account of participant's testimonies in the delivery of nursing care to patients living with HIV/AIDS. Participants in this study castigated their emotions as being disheartened, discouraged, depressed, demoralized, despaired, and unhappy; all opinions shared through their experiences. These action words placed *dejecting* on an accelerated pathway for interpreting participants' experience in the provision of care to patients living with HIV/AIDS in Broward County. Mr. Banah reflect on his experience and his words

were not very kind, but simple honest and forthcoming. As nurses he said:

We are sometimes treated with disrespect and disdain. We are also sometimes look down at as if, I mean, we are not like other professionals, or we are like shit cleaners. This is strictly so demoralizing, as nurses we need to be regarded and treated better than that.

Moore and Henry (2005) articulated plainly in their study that nurses felt demoralized, despaired, frustrated, and separated because HIV/AIDS has changed the healthcare continuum and social outlooks indefinitely, whether society likes it or not.

The reactions to *dejecting* was not related to any negative feelings toward the patients, but to the disrespect meted out to nurses by other healthcare personnel, while providing care to people living with HIV/AIDS. Many studies have shown that it is possible to enhance participants' empathetic abilities (Brunero et al., 2010). Nurse Bella made her comment by saying, "I feel disheartened, unhappy and depressed that I cannot fulfil my job toward caring for patient living with HIV/AIDS. I think my real concern would be more, I wish I could help more, but it's always to a point." According to Williams et al. (2006), nurses need to have the knowledge base and self-assurance in protecting themselves, while performing their job effectively and must be well educated about the clinical course of HIV/AIDS, and about actual approaches for its treatment and prevention.

Another twist to *dejecting* was that nurses found themselves in a quandary because relatives would take their loved ones to the hospital to be cared for, and in the same token these same relatives return to place blame on the nurses for their loved one's

poor health or poor prognosis. This kind of labelling made these study participants extremely furious, demoralized, and bewildered for family's lack of compassion, and placing guilt where it does not belong. Smit (2004) and Harrowing and Mills (2009) converged on the matter and found that participant's experiences were that the family thought that the nurses did not do a good job with the patient in providing competent care meanwhile abusing them. Hence, participants are accused for everything that goes wrong in any healthcare setting on the poor quality of care delivered under conditions that are beyond their control.

Nurse Joan pointed out in her discourse with the researcher:

I became very discouraged, disappointed, down trodden and quite unhappy if patients are not taken care of properly. For me I think as nurses we should treat them equally, after all they are human beings too. Equal care to individual should be the focus, respect them, and encourage them to tell the truth of what they have. When secrets are kept and matter get out of hand the inability exist to retard decent patient care.

Nurse Vanilla side with Nurse Joan by confirming:

I am very disappointed and lost for words sometimes how I see care is given to this group of people. They need help and that's why they're here and that's why we're nurses. We are not here to judge them, we are here to care for them in the best way that we can.

The study was completed on neuroscience nurses' intentions to care for persons with HIV/AIDS conducted by Dilorio (2003) found that other studies disclose that

participants often harbor an array of feelings and trepidations about providing decent nursing care to patients living with HIV/AIDS. These feelings and trepidations are the grounds for participant's unwillingness to care for patients living with HIV/AIDS. In addition, the intricacy of care for patients living with HIV/AIDS presents a test to participants' competency to proficient and particular principles and to moral persuasion. To be consistent with this study's findings, Smith (2005) concluded appropriately that nurses are expected to provide quality care to patients irrespective of diagnoses; it is anticipated that nurses are morally bound to act indiscriminately toward all patients, including those living with HIV/AIDS.

Nurse Lila had similar comments on *dejecting* as Nurse Bella and Nurse Vanilla, when she communicated.

I am disheartened, discombobulated, weak and also troubled in my spirit if patients are not cared for the right and proper way. As nurses we have to know that the patient is a human being, just like anyone of us. It is imperative that participant's code of ethics should be enforced at all times in the sub-conscious steering participants to do the right thing when duty called.

A study carried out by Valimaki et al. (2008) on the willingness to care for patients with HIV/AIDS found that nurses in common may share the same value base and goals in their daily practice, ethical responsibilities, cultural values, and nursing education, however, nursing care may vary considerable. Furthermore, studies are calling for educational interventions for the developing world where the willingness to provide comprehensive care to patients living with HIV/AIDS will be delivered with competency

and compassion (Williams et al., 2006). Participants experience is poetized in the words of this poem.

Dejected

There's a feeling you know

A feeling deep inside

One that cannot be rightly expressed

You may show it with anger, love or pain

Some may hide it with a smile

But the strongest remain completely silent

It's a feeling of being neglected

It's when you feel dejected (Luthra, 2015).

The sub-theme *feeling of emptiness* was identified in association with *dejecting* seen in the provision of care to patient living with HIV/AIDS. Participants spoke candidly about the *feeling of emptiness* as they told their stories. Through this sub-theme patients were observed with different behaviors in association with HIV/AIDS, which was manifested in disorientation, reservation, non-compliance, and untruthfulness. Participants claimed that they do have some *feeling of emptiness* through inadequacies, lack of connection, avoiding responsibility, inability to provide guidance and attention, and to protect against pain. Nurse Fire gave a synopsis on how she felt having a *feeling of emptiness*, while providing care to an infected patient:

Well at times they get frustrated, angry and disoriented. You know, there was a lady who would scratch us. She used to smear feces on the bed linen, floor, and

walls of her room, but we try to give her emotional support. There was a *feeling of emptiness* in me, because of my inadequacies in redirection, and the idea that this could be a family member or even me.

On the other hand, Holly (2007) directed a study and found that the use of combined resilience and resources between nurses and clients that the *feeling of emptiness* can be arrested. Most likely they can extend hope to all people in need of care, strength, and love no matter what they are going through each day.

A similar study carried out by Kylma et al. (2000) addressing hope, despair, and hopelessness in living with HIV/AIDS: A grounded theory is consistent with this study's findings by declaring that hope, despair, hopelessness, and the *feeling of emptiness* are viewed in relation to each other. Mr. Banah commented on the issue by saying:

Many people who have been . . . uh, who have gotten to the point of full blown AIDS, which is one of the encompassing things that is among them. The fear of helplessness; fear that they will be left in that bed with no one to help them, and the fear that if they should be sent home they would be disregarded by, I mean, their family members. When you see and hear of these things it leave you with a knot in your throat, and a feeling of emptiness in your spirit.

The study by Klonsky (2008) what is *emptiness*? Clarifying the 7th criterion for borderline personality disorder reports that the outcome from the present analyses suggest that the theme of isolation, loneliness, and hopelessness also may be useful in evaluating the *feeling of emptiness*. Furthermore, other studies indicated that the *feeling of emptiness* is closely associated to the feelings of hopelessness, loneliness, and isolation.

The study also claimed that participants and patients can find it extremely difficult to make oral explanations of the *feeling of emptiness*. Participants expressed a *feeling of emptiness* characterized by helplessness, isolation, hopelessness, and loneliness as patients are presented with diverse conditions and behaviors. They are mainly manifested in disorientation, depression, anxiety, and non-compliance.

These sentiments were uttered as follows by Nurse Lulu:

Okay, I can't forget this. It was on a med/surg unit in a hospital in New York. A young man, 23 years old came to the unit with...what was the disease he has? Endocarditis. It was endocarditis and after he was tested . . . was . . . other symptoms of . . . with weight loss and other symptoms he was showing. After blood test was done, was proven that this young man had HIV. It was very, very heart wrenching, lifeless for me, with a *feeling of emptiness* in my gut, absolutely no upliftment in my spirit. He was a young guy and he took it very hard. He was very emotional of course . . . close to my age at that time. I felt a lot of sympathy for him; it was very, very hard on me to say the least.

To confirm this experience, studies carried out by WHO (2008) revealed that HIV/AIDS inflicts a major psychological liability on patients living with HIV/AIDS and nurses as well. Therefore, people living with HIV/AIDS suffer from anxiety and depression as they amend to the effects of the diagnosis of sustaining the infection and encountered the complications of living with a long-lasting life-threatening disease. Nurses are also caught between the disease and the patient in a dilemma dealing with patients' furious behaviors and providing care which also placed psychological contraption on their inner

person if there is a heart.

Another study by Stojanovski et al. (2007) cemented the findings of this current study, and collaborated with other similar studies. They found that there are epochs of psychosomatic misperception that come in instance of catastrophe, like learning about the diagnosis, introduction of therapy, HIV/AIDS related hospitalization and other traumatic conversions. Participants confer that some of these patients living with HIV/AIDS are neighbors, families, or friends and it seriously disturbs them to the core, but they have no choice but to continue providing care regardless of the current condition. In addition, participants declared that these patients living with HIV/AIDS are frequently in refutation of their status and believe they are entrusted with a death sentence. However, participants concluded that it does not matter what one's motives are, nursing care has to be carried out as indicated.

Nurse Lila speaks about *the feeling of emptiness* with much poise and certainty when she has to provide and coordinate care to patients living with HIV/AIDS:

Um, my experience with caring for HIV/AIDS patients...first of all you have to put yourself in that situation. Um it could be you in that situation. Always remember they are human beings and as a nurse you are there to take care of sick patients.

The poem written by Janieta Lister (2006) showcase participant's experiences in a brilliant fashion:

The Feeling of Emptiness

I look into a broken mirror,

I seek to see why I am still living.
When I look around all I can see,
Is darkness and pain . . .

My chest is tight, I can hardly breathe.
I feel empty and broken,
I feel like a monster is trying to escape.
I don't know which way to go . . .

I am crying but only dry tears,
Dust on my face and sores on my mind,
I do not speak nor do I try,
I have a million times.
When I speak, silence over take,
I can scream and still no one will hear.
I am invisible, no one can see,
I have pain inside, please let me free.

Before I save myself,
And death is my way,
Not long from today
I am seeking my way . . .

The last sub-theme identified in this puzzle underlining the umbrella of the major theme *dejecting* was captioned *emotional and physical support* in the care of patients living with HIV/AIDS in Broward County. HIV/AIDS trajectory even over 40 years is still unknown because a cure is not inevitable to say the least. This disease is a disaster to civilization and has placed enormous burden and demand on *emotional and physical support* for the participants, while care is being provided to infected patients. For quality care to be given to infected patients, participants are required to have some kind of *emotional and physical support* from all those who are involved in the patient's care. Participants indicated in their statements that they would be more than privy to convey *emotional and physical support* to patients infected with HIV/AIDS likewise in their darkest hours of needs, distress, and discouragement.

Nurse Fire one of the first to offer herself has this to say:

In my experience, as I said, you know, I see them as normal human beings. You know, they have needs. They have emotional and physical needs that have to be met, and they're just part of the population. I remember in the beginning we used to have those, uh, disposable trays for them. We stopped all that. I think it was an issue with the . . . when we had the surveyors coming in and they went over with us that we're not to isolate them in any kind of way. So they eat with the same utensils, and you know, the plates and everything is just sterilized the same way we would do the rest of the residents here. The lack of *physical and emotional support* in this situation for both the patient and the participant would have proven futile for all parties involved. *Emotional and physical support* offered here has

proven to be quite beneficial for all parties involved.

Nurse Lila also shared the same covenant with Nurse Fire and this was her comment:

Whenever I have a patient with this kind of disease, I always look at the patient as a family member and as a . . . it could be me too in that situation too. Sometimes they don't even have anybody to come and visit them. This is where *emotional and physical support* is recommended to balance the scale between nurse and patient in the care of patients living with this disease. This is what I do if no one else wants to do it. I make sure on my days off I would go and visit that patient too. If they go in the hospital, I go and visit them in the hospital too, and I make sure to, like . . . when it comes to Christmas time, I, uh, buy gifts for them. And, um, I make sure too . . . um, I embrace them . . . make them feel like they are human beings too. Okay, um . . . so lacking *emotional and physical support* in this way promote instability.

Speaking of *emotional and physical support* on the contention of participant's expression in the care of patients living with HIV/AIDS. Vasconcelos et al. (2014) made it clear in their study findings that nurses play a pivotal role in the field of *emotional and physical support* when intermingling holistically. This is strictly done to promote participants practice channeled by inclusiveness of activities, such as providing patients with *emotional and physical support* that will help the patient to understand their current condition. Sowell and Phillips (2010) found that traditionally, nurses have been on the forefront of HIV/AIDS care and prevention, and it should be comprehended that every

nurse is actually an AIDS nurse. Most participants articulated logic of both physical and rational fatigue.

These authors inferred that patient living with HIV/AIDS in particular is extremely burdensome which they attributed to their experience in the provision of care in general. Participants implied that the feelings of physical weariness is a factor to care, however, they are more disturbed about their experiences of emotional exhaustion and stress. For participants, dealing with the way in which their patients reacted to their own anguish and the manner of dying as a result of HIV/AIDS was particularly emotionally draining. Mr. Banah a male nurse aged 59 years and practicing in Vitas hospice care, expressed his feelings in the following way:

Yes, when you have the kind of respect and the kind of support, be it emotional, physical, and moral or otherwise, that is in a sense command a certain kind of a behavior. It gives you that kind of gleefulness that you want to do your job regardless of kisses or favors. The fact that, I mean, you are caring for someone that you know having buried in them a disease that can be transferred to you if you do not exercise care or safety in your practice is frightening. As you may have known Mr. Researcher, a hospital, your support system says a lot about any individual. So a good support system . . . good recovery promotes good health. So yes, we need a balanced support system to care for this individual or these individuals. In this *emotional and physical support* system we need the healthcare-trained individuals, and you also need the support from the community, more so the family members to balance that care.

On account of the findings of this present study, Smit (2004) conducted a study HIV/AIDS and the workplace: perceptions of participants in a public hospital in South Africa, a qualitative inquiry with a sample of 35 participants. The study found that apart from biomedical education, distinct importance should be placed on the emotional, physical, and psychological needs of patients living with HIV/AIDS in order to contribute to the enhancement of their holistic quality of life. Furthermore, it is quite essential to distinguish the significance of more practical influential ingenuities to support participants in coping with challenges and addressing their physical and emotional apprehensions. The study also found that in order for participants to provide excellent nursing care; healthcare establishments must make available a practicing and enticing environment where adequate physical amenities are on hand for utilization.

Another study using a quantitative method of inquiry to address online support group for patients living with HIV/AIDS was completed by Mo and Coulson (2014). This study found that emotional support given by nurses was extremely important in the encouragement of patients to be more vigilant, determined, and specific in managing the illness of HIV/AIDS. The conclusion in the findings of these studies exhibited the effects *emotional and physical support* has on both nurses and patients in the care of HIV/AIDS. These findings were trustworthy to the descriptions given by participants in this study who explore patients living with HIV/AIDS on a daily basis. The spirit that was strongly emphasized by participants indicate how influential *emotional and physical support* is when providing care to patient living with HIV/AIDS

Nurturing

Nurturing is a fundamental principle of nursing and it is strongly influential when providing care to those who are in need, especially those who are suffering from illnesses of any kind. The principles of *nurturing* are being taught, preached, practiced, and nursed throughout Christendom. It is mentioned frequently in the bible in many ways more than one. Having the opportunity to research the meaning of *nurturing* in the bible, this researcher read many definitions and meanings, and found a meaningful entry that is quite fitting for this study. Ephesians five and verse 21 clearly states, “Submitting to one another out of reverence for Christ.” This is very important when considering indulging *nurturing* in the plan of care of any illnesses.

Nurturing was the fourth and final theme that emerged from participant’s expression in the care of patients living with HIV/AIDS in Broward County, Florida. In explaining the meaning of *nurturing*, Duffy (2005) implied that participants need to be grossly involved in patient’s care to ensure public policy and local involvements are intended at improving compassionate environments and decreasing HIV/AIDS misery. Harrowing (2011) mentioned that nurturing in HIV/AIDS care is important in easing misery or terminating the disease for good. Describing *nurturing*, Peters (2013) inferred that this theme is important in finding meaning in participants providing care to patients living with HIV/AIDS, which have been found to be an effective characteristic of healthy coping and healing. The study also found that participants need to have specific knowledge and skills to increase the efficacy of *nurturing* when providing care to patients living with HIV/AIDS.

Further results of *nurturing* were found in a study conducted by Richer et al. (2009) among participants in South Africa who provided care for patients living with HIV/AIDS. The researcher found that the personal effects of HIV/AIDS on participants' lives, the encumbrance in the public health sector on medical care for people living with HIV/AIDS has rested solely on nursing staff *nurturing* ambition. This condition aggravates the anguish inherent in the hospital as participants try to nurture patients, caregivers, and children. Yet, in the same token, the preparation, backing, and skills with which participants are provided rarely equals the burdens of the *nurturing* that they are required to offer.

Zhao et al. (2014) also found the significance of *nurturing* very crucial as extracurricular awareness, and is making such undertakings accessible to stimulate resilience in children affected by HIV/AIDS in resource-limited locations. Interestingly, the theme "*nursing care*" drafted in this study alluded that in an effort to manage with these growing problems and inadequate means, care systems tend to become more inflexible and nurses draw on their power of *nurturing* in care provision.

In consistency with this conclusion Nurse Chloe shared her thought on *nurturing*:

I think as nurses we should show more compassion for our patients living with HIV/AIDS as we do for the others. The only way we can accomplish this in a trying world as this one is to think of them as holistic beings, yes holistic beings. We have to help in every way possible carrying their burdens in nursing or *nurturing* them back to even basic health, if we cannot achieve optimum health. Let's be frank they are just, uh, they are the same as every other patient with a

different disease. Providing tender loving care is a positive approach, and uh, when you hear the news, its, uh, its promising that, uh, you know, we can . . . they can live with the disease, uh, and not be killed by it.

The nature of fostering as in *nurturing* was not only provided to those who are infected and living with HIV/AIDS, but was configured to those children and families who are also suffering from the impact of this pandemic.

Rhodes, Malow, and Jolly (2010) intervened by empowering nurses to be activist in their *nurturing* role in advocating for the enclosure of those living with HIV/AIDS, and those affected in resolution making, significant setting, research design, and assessment. Smit (2005) in his evaluation of participant's awareness in a public hospital in South Africa, found that nurses are equipped with the *nurturing* touch in caring for children and families seriously affected by HIV/AIDS. The participants in the study contented that *nurturing* and *fostering* should be included in the plan of care for children and families, because they are profoundly in anguish from the effects of the disease likewise. Participants sharing their experience in this study expressed that *nurturing* should not only be for those living with HIV/AIDS, but for those who are not diagnosed as well. Nurse Eula-Lee endorsed this by sharing her kind words of wisdom:

I believe *nurturing* should be a built in mechanism of every nurse. This should be an automatic impulse when caring for every patient and every disease, not just those diagnosed with HIV/AIDS. You don't know when . . . I mean, disease can hit home anytime you know. So put yourself in that person's position and how would I like to be treated.

Nurse Eula-Lee in her comment made a very strong invocation that she believe *nurturing* should be a built in mechanism of every nurse, which the researcher solemnly agreed wholeheartedly. To confer with Nurse Eula-Lee's statement this researcher came across an independent piece of writing from a nurse who works in an intensive care unit (ICU) of a certain hospital somewhere in the north of this country. This nurse has nothing to do with this current study, but the researcher was more than obliged to adopt this comment made by Bernie Badong as true testament to nurturing, and this is what he had to say:

After caring for a female patient in the intensive care unit (ICU), one of her daughters tapped me on my back and utter these words, sir thank you for taking care of my mom . . . that comment made me even prouder to be nurse! Be proud to be a nurse, let's give our best cares to all our patients.

With that said, here is the epitome of nurse's convocation in a poem by Pauline Hamblin (1999):

The Heart of a Nurse

Nurses are compassionate and caring,

With love in their hearts for all.

Forever extending a heart of mercy,

Always there when there is a call.

Endless hours they stand on their feet,

Wondering, "Did I do my best?"

To help this patient get through this illness,

Ease their pain so they can rest.

In their hearts you hear God's whisper

Through a nurse he sends his love.

Ever sensitive, kind and caring,

Souls as pure as a snow-white dove.

Angels, yes, she tends to be,

For her presence comforts me.

Concern for the sick shows on her face,

Her gentle touch, my fears erase.

In this 21st century, presently HIV/AIDS still remains a mystery, its path is unknown, incurable, and continue to derive negative innuendoes in the healthcare environments. Bam and Naidoo (2014) conducted a qualitative research study in KwaZulu-Natal, South Africa using Husserl's descriptive phenomenological approach with Giorgi's steps of analysis used to make meaning of the data. The study was to explore and describe the lived experiences of nurses caring for patients with terminal HIV-related illness in selected wards of a level one-district hospital in KwaZulu-Natal. A sample size of 10 participants was selected in 200- bed hospital who have experience caring for patients living with HIV/AIDS.

The study found that participants *nurturing* skills were at their best because they

experienced affirmative outlooks, such as joyfulness, in improving patient's lives as they assisted them in caring and managing their disease. In this current study, the findings are in-sync with the findings in Bam and Naidoo's (2014) study, as participants expressed that nursing care has to be provided in a *nurturing* manner at all cost, because after all they are human beings too. Nurse Sophie was very quick without hesitation to verbalize her contention:

I'd like to say we live in an era where HIV/AIDS is here, right? Knowing how to care for patients with HIV/AIDS makes a big difference. Just know that they're still human beings, they're someone who needs a friend and a confidant, and they're someone who needs a brother or a sister. They're someone who needs our compassion, and our kindness, you know. They're someone who needs to know that they have a shoulder they can lean or cry on. Be there to embrace them, to encourage them, to take care of them in every way you can, but most of all know how to take care of yourself, while you are taking care of them, that is my simple explanation of motherly or fatherly care.

Participants indicated that it is their ambition to provide *nurturing* for every patient, including those infected and living with HIV/AIDS whether we like it or not. Almost every participant cordially remarked that patients living with HIV/AIDS are considered human beings too, and require extended love and support. Participants affirmed that sometimes there are challenges, hurdles to jump, bridges to cross, and mountains to climb but the responsibility to provide appropriate nursing care is the number one priority that rest with them. The words of the poem written by Donna Phillips-Grande (2015) will be used to culminate the theme *nurturing*:

(Nurse's Week 2015)

I walk through those doors with pride,

Whose life will I save tonight?

Someone is waiting for me,

Someone is alive today because of my duty.

Sometimes we cry because we can't save them all,

God sometimes won't let us interfere when he calls.

A baby's first breath when he looks at me,

The joy of my first delivery.

The tear I wipe away with my own hands,

The life ending of an old gentle man.

The night seems so dark and the morning so bright,

Being a nurse you see life in a different light.

Who will I save tonight?

Who will hold my hand during their last breath with no fright?

Who will enter this world on my shift?

How many mothers will greet their babies with a kiss?

I don't know who these special people are,

But I will meet them with every call.
I will hold them tight and help the pain,
I will hold them up when they feel faint.
I will be strong when I am needed,
That is my job,
I am a Nurse.
That is my duty!

Theory of Health Expanding Consciousness

Each day life world experiences are met with challenges of various degrees that require unravelling, no matter if they are great or small. These challenges can be sorted out either by one's own intuitions or using a theoretical ensemble to discover the greater meaning in life to these challenges. This challenge or phenomenon called the lived experience of registered nurses caring for patients living with HIV/AIDS is using a phenomenological effort to unravel its meanings. Max van Manen (1990) said this of human science using a phenomenological approach, "it is indeed an investigation into the life world of human structure, the everyday situation and relations as experienced in life world." He further posited that one's lived experience and the themes generated from these lived experiences can be defined and construed in establishing the colossal intricacy of the life world.

To discover the greater meaning in life to these structures of meanings Margaret Newman's (2008) *Theory of Health as Expanding Consciousness* (HEC) was employed to garner an in-depth understanding in answering these concerns caring for patient living

with HIV/AIDS in Broward County, Florida. This theory is a grand nursing theory, which emphasized that every situation and every person, no matter how chaotic and desperate it may seem, is an occupier of the universal process of expanding consciousness. This theory describes “life as a process of expanding consciousness.” It highlighted a practice of becoming more of oneself, the discovery of greater meaning to life, and of attaining new milestones of connectedness with humans and the universe. The *Theory of Health as Expanding Consciousness* was established to articulate the quintessence of nursing practice. This theory deliberated illness as a prospect for consciousness and development, and changes the emphasis of healthcare from fighting the adversary of the illness by gaining knowledge about oneself through the illness experience (Macharia, Jelagat, & Juma, 2014).

The Assumptions of Theory

The *Theory of Health as Expanding Consciousness* as defined by Margaret Newman is the informational capability of the system (human being); that is the capacity of humans to intermingle with the environment. Perception embraces not only the mental and effective alertness that is generally related with consciousness, but also interconnectedness of the entire human being that comprises physiochemical maintenance, and the developmental processes as well as the immune system. The *Theory of Health as Expanding Consciousness* is founded on five assumptions (a) health encompasses conditions before defined as illness or in medical terminology pathology, (b) pathological conditions can be a total pattern of the individual, (c) pathology manifestation of the individual is primary and exists prior to structural or functional changes, (d) pathology

removal does not change the pattern of an individual, and if (e) illness is the only way an individual pattern can manifest itself, then that is health for that person (Newman, 2010). Hence, the pressure that defines illness can permit configurations of expanding consciousness to appear.

Description of the Theory

The description of the *Theory of Health as Expanding Consciousness* was inspired out of trepidations for those individuals who consider health as the absence of disease or disability and believe it is not possible. Participants often relate to such person as facing ambiguity, debilitation, loss and subsequent death related to patients living with HIV/AIDS. This theory proceeded to embrace the health of all people irrespective of the presence or absence of disease. Therefore, humans are exposed to the entire power system of the cosmos and continually interrelating thereby with the power, and with this manner of interface, humans are developing their individual configuration of the whole (Newman, 2010). It is obvious that within the lived world experience there is always a need to decipher meanings, and contemplate its purposes.

In conferring with Newman, comprehending the design is vital, and the increasing awareness is the design's acknowledgement. The exhibition of HIV/AIDS depends on the design of the person so the pathology of the ailment occurs before the indicators appear, so elimination of HIV/AIDS symptomatology does not alter the individual configuration. Newman has the ambition to change nursing in this sense, and explain that nursing is the practice of distinguishing the individual in relation to the environment, and having the ability to comprehend consciousness. Subsequently, the participants help to

understand the individual by using the energy within to cultivate a greater level of consciousness (Newman, 2010). Interestingly, on this premise the individual has the autonomy to chart their course of action when challenges and misery arose in any given illnesses.

Furthermore, *Theory of Health as Expanding Consciousness* is kind in assisting the participants to understand HIV/AIDS progression, treatment, recovery, and prevention. Newman also elucidated the importance and interrelatedness of movement, time, and space into the weaving of consciousness. According to Newman (2010), time and space are few of the life world existential with sequential form that depicts the person, which both have admiring affiliation. Consequently, humans are persistently shifting through time and space, and it certainly displays distinctive pattern of authenticity (Newman, 2010). In finding a greater meaning in life to HIV/AIDS manifestation in the provision of care to those living with the disease, participants and patients alike can find some comfort in satisfaction, healing, appreciation, and thereby exemplify each other purpose to life

The Nursing Metaparadigm of the Theory

The *Theory of Health as Expanding Consciousness* is situated on four nursing metaparadigms, namely: (a) health, (b) nursing, (c) human, and (d) environment. In interpretation, health and illness are amalgamated as health, and the meld on one state of being as in HIV/AIDS (disease) with its reverse (non-disease) resulting in what can be considered as health. Nursing is the provision of care in the experience of person's health, which is understood as a corporation between the participants and the patient with

both cultivating in the sagacity of advanced levels of consciousness. On the other hand, human being is an individual that cannot be alienated into fragments and is attached to the environment in many ways.

Therefore, humans as persons and individuals as species are recognized by their forms of consciousness. Likewise human beings do not possess consciousness, but the individual is consciousness. Human beings are centers of consciousness within a general form of expanding consciousness. Subsequently, the world is defined as a cosmos of exposed structures that housed the environment that will allow the human-to-human interaction through consciousness.

The shelter of Margaret Newman's *Theory of Health as Expanding Consciousness* is a mantle to the findings of this current study. Its uniqueness affirmed this researcher to make a non-hesitant connection to the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. The relevant themes of *Unknowing*, *Incapacitating*, *Dejecting*, and *Nurturing* were all influential and ran concurrently with the essential concepts of this theory. The sub-themes *swimming in deep waters*, *Exasperating*, *Dreading occupational exposure*, *Feeling of emptiness*, and *Lacking emotional and physical support* were all in tuned with these concepts of the *Theory of Health as Expanding Consciousness*. The importance of this theory is that it was beneficial because it can be applied in any setting and generates caring interventions.

Concepts of the Theory

The essential concepts of Newman's (2010) *Theory of Health as Expanding Consciousness* suggested that every human being in every situation, no matter how

discombobulated or miserable it may seem, is part of the universal process of expanding consciousness. These four concepts identified are (a) *a process of becoming more of oneself and consciousness*, (b) *of finding greater meaning in life*, (c) *of reaching new dimensions of connectedness with other people and the world*, and (d) *pattern*. The formation of this theory was motivated by apprehension for those for whom well-being as the nonexistence of illness or debility is not possible. The interpretation of this according to Newman (2010), well-being is not a lack of disease, or a practice to become healthy from being sick, but instead the extension of consciousness as a consequence of individual's selections made within the milieu of forms of conduct. In this sense, participants often relate to these individuals as patients facing the ambiguity, incapacitation, defeat, and ultimate death connected with prolonged disease, such as HIV/AIDS.

Furthermore, Newman (2003) gave an explanation to nursing that the perception of well-being is seen as a wholistic pattern, and illness is considered a manifestation that is originated from the relations between the patient and the environment. Subsequently, the usual focus on treatment of symptoms shifts to a focus on pattern recognition, when nurses view illness as a relationship between the client and the environment. On account of this observation, illness is regarded as influential portion of the establishing progression of expanding consciousness. Therefore, nurse's role in this matter is to assist patients to recognize and positively identify and address their own pattern of behaviors.

Newman's approach and focus for nurses is to (George, 2002):

1. Place attention on the "we" in a nurse-patient interaction, rather than seeing the

other individual as an entity external of themselves.

2. Place special emphasis on the significance of the complete individual rather than the “fixing” of a section or the addition of the section.

3. Attend to the experience of the human-to-human collaboration in a relationship with the patient.

4. Foster empathetic communal consciousness rather than influencing or controlling, of another individual’s pattern of conduct.

5. Consciously attend to the here and now (the moment) rather than try to recognize previous reasons or conceivable impending things.

In understanding the meaning of participant’s experiences through the emerging themes and sub-themes, this researcher skillfully weaved the concepts and focuses of Newman’s HEC to bring out the quintessence of providing care to patients living with HIV/AIDS in Broward County, Florida.

In practicality, Newman unequivocally articulates credence in the unitary nature of human beings, yet she also deliberates the individual as a system made up of physiological edifices and functions, such as the genetic code and the immune system, reflecting on normal science coordination. For Newman the unison of the human system is projected on the idea that mind and matter are made up of the same basic substance. It is extremely appropriate within Newman’s theoretical stance that the physiological, psychological and emotional processes of the human system are integral to the absolute consciousness. Therefore, the emerging themes and sub-themes from this study filtered appropriately through the concepts and focuses of Margaret Newman’s Theory of Health

as Expanding Consciousness.

The *Theory of Health as Expanding Consciousness* was adopted to provide care to patients living with HIV/AIDS, and to answer many apprehensions participants have, and to increase their independence in carrying out effective nursing care. It is also intended to provide helping hands to individuals who are experiencing inevitable suffering find ways and means in which to cope as they search for meaning in their lives. The emphasis of the theory is centered on “*becoming more of oneself*.” This means that the individual will be able to discover meanings when faced with life tribulations or experiences. However, before anything can be done about it, the individual is required to acknowledge the issue first and foremost. In accepting and acknowledging the illness will eventually lead to a new found wonderful consciousness (expanding consciousness) where help can enter the individual’s life. Consciousness is an expression of a progressing pattern of patient-universe collaboration and that consciousness is an ongoing development (Macharia, Jelagat, & Juma, 2014).

A Process of Becoming More of Oneself and Consciousness

One of the essential concept of the *Theory of Health as Expanding Consciousness* is a *process of becoming more of oneself*, which speaks to all the major themes and sub-themes identified in this study: major themes, such as *Unknowing*, *Incapacitating*, *Dejecting*, and *Nurturing*; and sub-themes, such as *Swimming in deep waters*, *Exasperating*, *Dreading occupational exposures*, *Feeling of emptiness*, and *Lacking emotional and physical support*. It was paramount that in order to address the emergence of these themes and sub-themes, a process of becoming oneself is fundamental as the

person is a united whole and was in continuous collaboration with the environment. It can be interpreted as the “we” in a human-to-human exchange, rather than viewing the person as an object outside of ourselves, which should be the real focus for interaction.

For example, in the case of HIV/AIDS, a patient can experience health and completeness in the midst of having this lasting and advanced illness. Therefore, even before and after CD4 plus T-cells levels projecting symptoms indicate the requisite to initiate antiretroviral therapies (ARTs), and opportunistic infections medications; participants’ unified self is summoned to provide care. This concept more than all is undeniably synonymous to the theme *nurturing* and sub-theme *Lacking emotional and physical support* where the “we” would be attended to in a nurse to patient relationship or interaction. Participant’s responsibility is called in to question to provide *nurturing, emotional and physical support* to patients living with HIV/AIDS even in dire challenges to attain health, stability, and wellness within their capabilities. Participant’s responsibility should be centered on fostering a human to human contact or a relationship of good faith caring for the patient as a human being rather than an object nor castigating that individual as an outcast. Furthermore, for participants it is obvious that patients living with HIV/AIDS can experience a state of well-being even when they are tangibly or emotionally ill when appropriate care is provided in a non-threatening environment.

Participants should find means in *nurturing* the person resourcefully, and provide holistic care through *emotional and physical support* that should include the complete individual, not just a body part, system or object, but should be seen as a divine creation. However, participants should be encouraged to emphasize this *nurturing* and offering of

emotional and physical support at every occasion during individual follow-up appointments; whether in the hospital or in any other healthcare environment. It is understood that well-being is not the contrary to ailment, but rather well-being and ailment are both indicators of a superior whole, a whole that is visible and recognized through participants/client interaction. An individual can be very well in the midst of incurable illnesses, such as HIV/AIDS, as long as they sustain good *nurturing*, have a forceful social network, *emotional and physical support* system, evade re-infection, and is compliant with prescribed treatments amid other things. According to Weingourt (1998), participants must avoid restoring the individual to his or her peculiar characterization of well-being; otherwise they should interact with the individual realistically, and support them in identifying the energy that is within them to make concerted decisions about oneself. This can only be achieved through human-to-human interaction guarding against inappropriate characterization.

The concept a process of becoming more of oneself strive to convey gratification to an individual who is trying to claim his or her habitation in the environment whether it is the participant or the client. According to Jones (2006), in a caring relationship with the participants, the individual can identify occasions for action and direction. Explicitly, this concept allows for new choices to be made, and open doors and windows for increased freedom and connectedness, as well as for relationships, which is conceivable through a new consciousness of the human possibility. It is obvious that when activities are introduced to foster change, there is movement and development, improved consciousness for the participant and the individual, and innovation and personal

conversion through a mediated environment of good human-to-human interaction.

Speaking of consciousness, it is tailor made with all the fittings and trimmings to address the major themes of *unknowing, incapacitating, dejecting, and nurturing*. In addition, the sub-themes of *swimming in deep waters, exasperating, dreading occupational exposure, feeling of emptiness, and Lacking emotional and physical support* emerging from this study. Sheldon (2014) maintained that a principal purpose of consciousness is to assist as a partially independent boundary between one's internal cognitive/emotional machinery on one hand, and the external environment on the other. Temporary consciousness may have developed so that an individual can adjust malleably and productively to the conditions at hand. Conveniently, it is to process the experience of the interaction in partnership with the patient.

Therefore, "becoming more of oneself" is stimulated by the capability of consciousness to select goals that offer an opening for optimistic temperaments and evolving inclination within one's own inherent disposition. In this case, an individual who is living with HIV/AIDS is challenged by changes in his endurance and strength, reproductive capacity, sexuality and self-image, as well as their own mortality. However, that individual has to seek means and set goals that will provide an outlet for a positive disposition (Sheldon, 2014). On the path of the client this can only be accomplished by processing the experience of the interaction in partnership with the participants or the nurses.

Subsequently, participants providing care for patients living with HIV/AIDS in Broward County appeared to be complicated in the beginning of the disease, but at this

point in time care is being met with a sense of responsibility. In this research puzzle participants sought to derive meaning from a process of becoming more of oneself through consciousness in many ways, irrespective of the difficulties they are faced with each day. The negative connotations and propaganda that maligned HIV/AIDS in the caring cycle have allowed participants to discover their full potential under a process of becoming more of oneself through consciousness, and attending to the “we” in a human to human interaction. Participants operating at their full potential through a process of becoming more of oneself in this new consciousness; are expected to include the patient in the plan of care at every occasion possible; rather than seeing them as an entity outside of themselves.

Through this consciousness participants should be prepared to explain their goals, tell whether they are old, new or they remain the same goals, and how they are going to achieve it on the caring continuum (Macharia, Jelagat, & Juma, 2014). The opportunity delineated by this concept using acquired knowledge and experience allowed the participants to make educated decision in promoting unique care for patients living with HIV/AIDS. Participants confided that with gainful knowledge and experience their entire persona and attitude changed toward patients living with HIV/AIDS, because they are capable of providing evidence-based care for them under the domain of a process of becoming more of oneself using consciousness as the structure.

In acknowledging a process of becoming more of oneself aligned with consciousness, Nurse Thelma had this highlight:

Human compassion is the key in treating these people, no matter how you feel in

the beginning about the disease. Your job as a nurse is to go ahead and care and support the patient, care for the patient to the best of your ability. With physical and emotional support, they were able to take their medications so that they can get stronger. So they can go back into their community and live a normal life and understand that they have to prevent the spread of the disease by, um, by not having, um, unprotected sex in the community and . . . sharing needles. And able to educate other people about the spread of HIV/AIDS, and this way they can live a more meaningful life.

Nurse Thelma and Nurse Lulu believe their understanding of a process of becoming more of oneself referring to consciousness is to treat patients living with HIV/AIDS like any other patient. Prudent advice that was given is for participants to give of themselves what they had by extending love, kindness, compassion, hugging and sitting down with patients in conversation when possible, and showing some concerns by listening to them. It is significant to encourage them to talk, by doing so they may be depressed and want someone to hear their stories. Quite frankly, here the participants becomes more conscious about their real self, as they strive to find greater meaning in their lives, and also into the lives of patients living with HIV/AIDS. Most importantly self-awareness for participants may ultimately lead to recognition of one's self, and one's situations and restriction (Macharia, Jelagat, & Juma, 2014). Participants in this study who initiated planting the seed of *a process of becoming more of oneself* through *consciousness* have the ability to change lives in just a simple format, and finding meaning in their life world experiences by indulging in meaningful interaction.

Finding a Greater Meaning in Life

Another concept of the *Theory of Health as Expanding Consciousness* was of finding a greater meaning in life, which assimilates well into this current study on the premise of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. The concept of finding a greater meaning in life is synonymous with participants geared toward caring for patients living with HIV/AIDS, and paired well with the theme *unknowing*. Frankly speaking, it can also be connected to the sub-themes of *swimming in deep waters*, *exasperating*, and *dreading occupational exposure* aforementioned in this study. *Unknowing* for participants is the ambition of navigating through an illness that is treacherous with no knowledge of what lays ahead or behind, and to question what is there to be found and its true meaning to life. On the other hand, of finding a greater meaning in life has inspired participants to search for better ways and means on how information are to be extracted in the provision of appropriate nursing care to patients living with HIV/AIDS. Therefore, what better ways are there for information extraction but through the “we” method of human-to-human interaction. Here it is significant for participants to view clients as unitary beings, rather than lifeless materials to secure trust and confidentiality in return for needed information extraction.

Moreover, it is extremely important for participants to place special emphasis on the significance of the complete individual rather than fixing of a section or in other words the addition of a section. This is achievable, while utilizing the process of becoming more than oneself in addressing *nurturing*, and the *lacking of emotional and physical support* for HIV/AIDS patients. This means that participant’s responsibility

when providing care to patients living with HIV/AIDS should sincerely recognize the client as a total person on the healthcare continuum. Therefore, when care is being carried out participants should conduct a complete head to toe assessment of the individual, instead of just fixing a complaint or a few complaints mentioned by the client. Participants should view the client, as the epicenter of consciousness, which is continuously expanding and requiring needed attention addressing their behavior. Nurse Lulu expressively endorse this focus by reporting:

Patients living with HIV/AIDS are human beings too. They are here or they come to the office for care and as nurses, we should not treat them differently because of their disease. In fact, we should reach out more to these people, because they need us more than yeah . . .

Reaching new dimensions of connectedness with other people and the world is another concept illustrated by the *Theory of Health as Expanding Consciousness* which is fundamental in the provision of care to all individuals more so patients living with HIV/AIDS. This concept speaks to the themes dejecting as participants became discouraged, disheartened, and despaired by the disrespect and discriminatory immaturity shown to patient living with HIV/AIDS by other healthcare personnel. The theme incapacitating hinges on this concept as participants found themselves limited, disabled, and unable to provide the needed care patient require for viability, and a healthier life style. The focus in tuned with themes dejecting and incapacitating is for participants to consciously attend to the here and now this present moment, rather than try to recognize previous reasons or conceivable impending things that will definitely cause impairment

in care.

Therefore, in order for participants to provide strategic and evidence-based nursing care to patients living with HIV/AIDS, they have to first look beyond themselves working on the present situation instead of deciphering on the patient's behavior or motive for the contraction of this illness. Participants should attend to the experience of encouraging the human-to-human collaboration to foster a relationship with the patient so that an avenue of trust, confidentiality, and a fostering environment can be established. Cody (2013) indicated that the restriction of an individual movement forces one into an enclosed position beyond space and time, which is not conducive on the care tracker dealing with patient living with HIV/AIDS. It is encouraged that participants should throw of self-concerns, and recognized one's own boundlessness and timelessness and gain the freedom of returning to an absolute consciousness (Cody, 2013).

Pattern

The themes *incapacitating*, *dejecting*, and the sub-theme of *exasperating* were patterns of behavior displayed by participants providing care to patients living with HIV/AIDS at the beginning of the disease, and even in some hot spots today. Pattern was the last identifiable concept in *Theory of Health as Expanding consciousness* by this researcher. This concept was also one of the many that mirrored the major themes and sub-themes documented in this current study. According to Newman (2010), well-being is not an absence of disease, or a progression to become well from being sick, but in instead the extension of consciousness as a consequence of selections made within the context of patterns of conduct. Margaret Newman's pattern appreciation is responsible

for the foundation of participants-patients interaction in this study on the principle of this theory. Suggestion was made that the duty in involvement is a pattern acknowledgment accomplished by participants in becoming conscious of the pattern of other individual who is in touch with their own pattern of recognition.

It is not recommended that these patterns of behaviors should exist contingent on nurse's code of ethics. However, the epicenter of consciousness is always expanding at all times for both nurses and clients alike. Through this consciousness the attainment of knowledge saw life as a component of a huge whole referring to the universe. Therefore, the focus of Newman's approach for participants is to foster empathetic communal consciousness rather than influencing or controlling, of another individuals pattern of conduct noticeable in the themes *incapacitating*, *dejecting*, and the sub-theme *exasperating*, while attending to client in the caring environment. It is indicative that a pattern of consciousness is embedded in every individual surrounded by family, community, world, nursing, and other boundless patterns, all making sense of an infinite whole (Newman, 2010).

Another remarkable focus of Newman's *Theory of Health as Expanding Consciousness* that coordinates well with the sub-theme *feeling of emptiness* was processing the experience of interaction in partnership with the client through the pattern concept. Most participants experienced the feeling of emptiness when they observed the challenges and miseries patients living with HIV/AIDS face on a daily basis. Participants would express their sentiments as having a knot in their throat, feeling of inadequacies, lack of connection, avoiding responsibility, inability to provide guidance, attention, and

redirection, and protect against pain; prominent behavioral patterns. The feeling of emptiness came about when participants intervene and attempt to provide care expecting to form a partnership with the client, then found themselves entangled in a web as a result of clients immediate condition that require immediate intervention. Consequently, for participants processing this experience of interaction sometimes create an inadequate environment not conducive for partnership.

Haugan (2013) conducted a study which found that participant-patient knowledge, collaboration, and interaction significantly connects to the purpose in life and meaning midst cognitively intact HIV/AIDS patients, and might just be an essential resource in relation to the patient's universal well-being and mental health. The study further concluded that participants delivering high quality patient interface and care on the health stratosphere might just aim to intensify patients meaning to life, escalate psycho-spiritual functioning, well-being, and increase psychological and physical health in this vulnerable population. Participant's act of unselfishness aligned with their convocation in acquiring meaning is fundamental in the delivery of evidence-based nursing care to patients living with HIV/AIDS in Broward County, Florida. Creating meaning and comprehending participants idiosyncratic experiences is a central fragment of life (Myersburg & McNally, 2011).

Synthesis of Theory Application

It is quite interesting that human beings cannot be separated in portions, but remains intricately as whole beings. Therefore, well-being for both the participants who provide care and the patients living with HIV/AIDS are significant to the theory and was

seen as a process of developing consciousness to life, the self, the universe, and pattern recognition. The four major themes of this study *Unknowing, Incapacitating, Dejecting,* and *Nurturing* are intricately intertwined and woven into the fabric of the concepts of the *Theory of Health as Expanding Consciousness*. This was rather important in delivering a stunning recognition to participant's steadfastness in providing human-to-human interaction through care to patients living with HIV/AIDS in Broward County, Florida. Moreover, the derivative of the sub-themes *Swimming in deep waters, Exasperating, Dreading occupational exposure, Feeling of emptiness, and Lacking emotional and physical support* through the scope of the *Theory of Health as Expanding Consciousness* gave clear and concise meaning on how nursing care should be carried out. Therefore, participant's exclusive ways of delivering nursing care to patients living with HIV/AIDS would be definitely enhanced by the concept and focuses of Newman's *Theory of Health as Expanding Consciousness*. Thus, the Serenity Prayer written by the American theologian Reinhold Niebuhr (1892-1971) coined distinctly participant's wishes:

The Serenity Prayer

God grant me the

Serenity

To accept the things I cannot change:

Courage

To change the things I can:

And Wisdom

To know the difference.

Significance of the Study

This study brings to the table important information to the science of nursing, nursing education, nursing practice, nursing research, and the aim for healthy working policies tied to HIV/AIDS in healthcare. Information contributed from participants providing care to patients living with HIV/AIDS as a career specialization helped to identify special needs for participants, and consequently ways in which appropriate support, encouragement, and stability is provided. Relative information extraction was forthcoming that will be influential in designing undergraduate and graduate nursing curriculum or program for future participants, and educators alike who are involved in HIV/AIDS care. The ability to study this area of the HIV/AIDS experience is paramount to participants and even the science of nursing here in Broward County, Florida, and around the globe on the preponderance of social support, strength, and care to this delicate population. Another pivotal undertaking is to lobby policy makers to formulate policies geared at HIV/AIDS care through the study findings. The study's findings will eventually lead to fundamental changes in nursing, education, practice, health/policy, and provide advance knowledge in the care of patients living with HIV/AIDS.

Significance to Nursing

This study's intention for the science of nursing have significant implications in the hierarchy of practice, research, education, policy building, curriculum development, and healthcare. Research endeavors are fundamental to the science of nursing in comprehending this phenomenon of interest, and its contribution to the healthcare delivery system on the premise of HIV/AIDS. Intricately the ability to study this area of

the HIV/AIDS experience was paramount to participants and the science of nursing here in Broward County, Florida, and around the globe on the preponderance of social support, strength, and care to this delicate community. Hence, comprehending the effects in providing care to patients living with HIV/AIDS has attributable significance for the discipline of nursing encountering this fragile population.

Implications for Nursing Education

Nursing education is the backbone of the discipline of nursing anywhere in this globalized world. The ability to endow education appropriately in the discipline of nursing whether here in Broward County, or elsewhere around the universe is paramount in the care of any disease; thus, this study will guide practice to evidence-based knowing, significant to this vulnerable population. The influence of participant's reactions in telling their stories caring for patients living with HIV/AIDS through this study set the stage or platform for changes in educational curriculum development, and practicum arenas. The art of nursing education is to disseminate the rich knowledge available in provoking the understanding of theories, frameworks, models, and concepts applicable to the discipline of nursing through this study's findings.

This study's findings will definitely enhance continuation of leadership development where participants cultivate in depth experience, education, and maturity (Fagin & Lynaugh, 1972). The inclination of comprehending HIV/AIDS pathophysiology could have direct implications on nursing education in Broward County. In comprehension of this educational orchestration, faculty, and nursing schools will have a stage to dance on in advancing knowledge to young minds in the care of patients living

with HIV/AIDS in Broward County, Florida. The influence of participant's reactions through this study will bring about changes in curriculum development, practicum areas, and how nursing day-to-day businesses are conducted and operated.

Implications for Nursing Practice

Nursing practice is the runway of patient care significant to the science, and discipline of nursing. Participants are considered the chief frontline fighters in practice; providing care and support for this high risk group of people and most vulnerable to the phenomenon. According to Munhall (2012), there are no values in nursing research unless it is influential in the clinical practice arena. The unique aspect of nursing practice is for participants to make their contribution in a meaningful and positive manner in coordinating and enhancing care for the common good of mankind instigated by their code of conduct. This research study findings will bring to light significant data relevant to nursing practice on the way members of the discipline of nursing cope with phenomenon of this magnitude. On the other hand, through evidence-based practice participants will exhibit unique clinical skills and experiences geared at improving better patient's relationship and liberation of HIV/AIDS. Participant's responsibility through practice is to provide assistance without impunity for the benefits and well-being of every patient that require significant nursing care.

Implications for Nursing Research

Nursing research has a profound influence on current and future professional nursing practice, thus, rendering it an essential component of the educational process. On the other hand, it is necessary for continuing advancements which will promote

optimal nursing care through knowledge attainment for the practice environment. This study's contribution to nursing research will add another dimension to evidence-based nursing care (Tingen, Burnett, Murchison, & Zhu, 2009). Durham and Lashley (2010) emphasized the importance of using best practices by reviewing selected evidence-based interventions that have been recommended by the CDC, and the WHO as models for specific population, such as HIV/AIDS care. Therefore, the advancement of research in this arena will influence changes in caring for patients living with HIV/AIDS. Research endeavors are fundamental to the science of nursing in comprehending any phenomenon significant to nursing, and its contribution to the healthcare delivery system on the premise of HIV/AIDS care. Subsequently, through exposure, experience, and diligence participants will understand the concept, and the importance of nursing research in the care of patients living with HIV/AIDS.

Implications for Health/Public Policy

Health and public policy refers to resolutions, procedures, and arrangements that are undertaken to achieve specific healthcare goals within a society. According to Penny, Campbell-Heider, Miller, Carter, and Bidwell-Cerone (1996), public policies are a course of action developed by officials or governmental bodies for handling matters of public concern. Healthcare policy is one type of social policy, which refers to policy statements related to the health and healthcare of people and communities stricken with the disease HIV/AIDS. The appropriate and timely implementation and development of health policies, programs, and activities related to HIV/AIDS, and other infectious diseases of public concerns are significant in the treatment and outcome of the disease. Therefore, an

explicit health and public policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short, medium, and long term. It also outlines priorities and the expected roles of different groups; and it builds consensus and informs people.

Nursing has the strategic ability to direct health policy issues through public policies; enacted by governmental bodies for the benefits of patients entrusted in participant's care. The experience achieved through this study findings will agitate nursing leaders to engage in credible health policy activities through accepted innovations. This study findings will influence these two major issues galvanizing effective health and policy making articulated by participants in the direct care of patients living with HIV/AIDS. Health and public policy statements are enacted daily to put into place significant guidelines to regulate the provisions for human survival. Another aim is for policy makers to formulate policies geared at HIV/AIDS care through this study's findings. Hence, comprehending the perception of caring from the viewpoint of participants in this study will create strategic benchmark for public policies to set aside resources to meet the needs of this delicate aggregate.

Strengths and Limitations of the Study

The centrality of this study was to uncover data relevant to this research exploring the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida. This involved participants in the direct practice arena caring for patients living with HIV/AIDS. The vehicle of choice in the investigation of this phenomenon was a phenomenological descriptive interpretive approach set aside by Max

van Manen's (1990) methodology. This approach was used purposefully and voluntarily to elicit rich responses that would not have been permissible by any other means of investigation. The study permitted participants with the autonomy to express their insights, fears, and challenges associated with caring for patients living with HIV/AIDS in Broward County, Florida.

Furthermore, it provided an avenue for the researcher to redirect his thoughts and experiences, and capture deeper meaning and understanding of the lived experience of registered nurses caring for patients living with HIV/AIDS. According to Wojnar and Swanson (2007), phenomenological investigations in nursing are descriptive and interpretive in nature. These two approaches are concerned with understanding phenomena foundational to nursing. The directions of these paradigms provide interpretation of the structures of experience, and with how things are understood by participants who live through these experiences and by those who study them. A remarkable strength of this research study is that it was not attempted before in Broward County, Florida or the United States for that matter. It also provided an awareness into the experiences of nurses caring for this delicate population, and generated exceptional knowledge and understanding in addressing concerns already implied that could be useful in future studies.

Limitations in this study were related primarily to design, setting, transferability, data collection, and inexperience on the researcher's premise. Another key component to limitation in this process was influenced by the researcher's nursing background, which was made known to participants. Interviews for this study were carried out in Broward

County, Florida; however, participant's non-commitment played a pivotal role in data collection. On account of unforeseen limitations, such as participant's non-commitment, guidance from experts in this field of research study was sought for direction.

Recommendations for Future Study

For participants and others who provide care to patients living with HIV/AIDS here in Broward County, Florida and throughout globalization there is definitely a gap for more qualitative studies to be completed to fully grasp and gain a deep understanding of the lived experience. The gap that exists here in Broward County for qualitative studies addressing the experience of registered nurses caring for patients living with HIV/AIDS is colossal and the exploration of this study is well supported. This study can be retained within the developing body of knowledge on how nurses providing care to patients living with HIV/AIDS is challenging and full of complexity. The following areas for future research study could address personality traits of nurses, coping mechanisms, social, emotional, and physical support bases in HIV/AIDS care. Exploring influences that contribute to the insufficient enactment of support programs for nurses caring for patients living with HIV/AIDS, and the development of wellness monitoring tools.

Conclusions

Finally, providing care for patients living with HIV/AIDS in Broward County, Florida, continues to be a complex situation for nurses as the pandemic shake recipients of all ages, cultures, diversities, and nationalities. This phenomenological inquiry with a blending of Max van Manen's (1990) methodology was to explore the lived experience of registered nurses caring for patients living with HIV/AIDS in Broward County, Florida.

Its purpose was to gain an in-depth understanding of the lived experience of registered nurses providing care to this vulnerable population. This chapter deliberated the findings of the study and the meaning of the experience as defined by the participants in their own words.

The experiences described in this study by the participants caring for patients living with HIV/AIDS in Broward, County Florida, highlights the numerous effects of the disease on healthcare and nurses alike. There is a necessity for a comprehensive approach to make it possible to provide appropriate nursing care that can also address the new threat of HIV infection in Broward County, which has developed greater than any other. Participant's enthusiasm in sharing their life world experience on caring for patients living with HIV/ADS once involved in the study culminate the general purpose of this phenomenological exercise. From the rich thick data received through participant's descriptions of their experiences four major themes of *Unknowing*, *Incapacitating*, *Dejecting*, and *Nurturing* was identified.

The sub-theme of *Swimming in deep waters*, *Exasperating*, *Dreading occupational exposure*, *Feeling of emptiness*, and *Lacking emotional and physical support* were also generated on the evidence of the experiences shared by participants. These four major themes and five sub-themes brought about the quintessence and meanings in life of the participant's experiences. Margaret Newman's *Theory of Health as Expanding Consciousness* was central to this study to solidify deeper understanding of the themes and sub-themes identified. The concepts of the theory were well aligned with themes and sub-themes of this study. After all The *Theory of Health as Expanding*

Consciousness is a universal tool that can be adopted and indulged in any qualitative undertaking.

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Barry University

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Research with Human Subjects Protocol Review

Date: February 9, 2016

Protocol Number: 160125

Title: The Lived Experience of Registered Nurses Caring for Patients Living with HIV/AIDS. A Phenomenological Inquiry

Meeting Date: January 20, 2016

Researcher Name: Mr. Archimore Wright
Address: 14121 SW 54th Street
Miramar, FL 33027

Faculty Sponsor: Dr. Claudette Chin

Dear Mr. Wright:

On behalf of the Barry University Institutional Review Board (IRB), I have verified that the specific changes requested by the convened IRB on January 20, 2016, have been made.

It is the IRB's judgment that the rights and welfare of the individuals who may be asked to participate in this study will be respected; that the proposed research, including the process of obtaining informed consent, will be conducted in a manner consistent with requirements and that the potential benefits to participants and to others warrant the risks participants may choose to incur. You may therefore proceed with data collection.

As principal investigator of this protocol, it is your responsibility to make sure that this study is conducted as approved by the IRB. Any modifications to the protocol or consent form, initiated by you or by the sponsor, will require prior approval, which you may request by completing a protocol modification form.

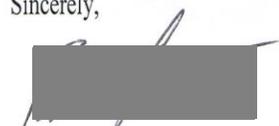
It is a condition of this approval that you report promptly to the IRB any serious, unanticipated adverse events experienced by participants in the course of this research, whether or not they are directly related to the study protocol. These adverse events include, but may not be limited to, any experience that is fatal or immediately life-

threatening, is permanently disabling, requires (or prolongs) inpatient hospitalization, or is a congenital anomaly cancer or overdose.

The approval granted expires on February 10, 2017. Should you wish to maintain this protocol in an active status beyond that date, you will need to provide the IRB with an IRB Application for Continuing Review (Progress Report) summarizing study results to date. The IRB will request a progress report from you approximately three months before the anniversary date of your current approval.

If you have questions about these procedures, or need any additional assistance from the IRB, please call the IRB point of contact, Mrs. Barbara Cook at (305)899-3020 or send an e-mail to dfeldman@barry.edu. Finally, please review your professional liability insurance to make sure your coverage includes the activities in this study.

Sincerely,

A black rectangular redaction box covers the signature of David M. Feldman. A pen nib is visible above the box, suggesting the signature was handwritten.

David M. Feldman, PhD
Chair, Institutional Review Board
Barry University
Department of Psychology
11300 NE 2nd Avenue
Miami Shores, FL 33161

Cc: Dr. Claudette Chin

Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

Appendix B

Barry University

INFORMED CONSENT FORM

Your participation in a research project is requested. The title of the study is, “The Lived Experience of Registered Nurses Caring for Patients Living with HIV/AIDS in Broward County, Florida: A Phenomenological Inquiry.” The research is being conducted by Archimore A. Wright, a doctoral student in the College of Nursing and Health Sciences at Barry University, and is seeking information that will be useful in the field of nursing. The aims of the research are to gain an in-depth epistemology of registered nurses lived experiences in caring for people living with HIV/AIDS in Broward County, Florida. In accordance with these aims, the following procedures will be used: participants will be asked to choose their own pseudonyms, complete a demographic questionnaire (15 minutes), and begin the first interview via a face-to-face method using open-ended questions related to the lived experience of nurses caring for patient living with HIV/AIDS, which will last no more than 45 to 60 minutes and will be audiotaped. The second interview utilized for member checking will be done using a face-to-face method, which will last no more than 45 minutes. The purpose of the second interview is for clarification and verification of information collected during the first interview. A total of 105 minutes will be required to complete the research procedures. We anticipate the number of participants to be a maximum of 25.

If you decide to participate in this research, you must meet the following criteria:

1. Be a registered nurse with more than one year working-experience residing in Broward County.
2. Be English-speaking registered nurses willing to participate in the proposed study.
3. Must possess current experience working with people living with HIV/AIDS (PLWHA) on the health care continuum for one year.
4. Must be willing to speak openly about their experience.
5. Have access to a telephone or the internet.

If you decide to participate in this research, you will be asked to do the following: (a) review and sign an informed consent form, (b) choose a pseudonym (c) complete a demographic questionnaire no more than (15 minutes), (d) participate in the first scheduled interview for not more than 45 to 60 minutes at a mutually agreed time and place, and (e) participate in a second interview within three weeks after the first interview for no more than 45 minutes to review the written transcription for accuracy. You will receive a \$25 Visa gift card as a token of appreciation for participating in the study whether you complete the interviews or not.

Your consent to be a research participant is strictly voluntary and should you decline

to participate, choose not to answer any question (s) or should you choose to drop out at any time during the study, there will be no adverse effects on you. Information supplied will not be used in the study if you decided not to participate. A transcriptionist will be employed who will be asked to sign a third party agreement for confidentiality in transcribing data collected from the digital audiotapes recordings.

There are no known risks associated with this study.

There are no known direct benefits to the study.

As a research participant, information you provide will be held in confidence to the extent permitted by law. Any published results of the research will refer to group averages only and pseudonyms will be used in the study. Data will be kept in a locked file in the researcher's home office indefinitely. Destruction of audio-tapes is planned once accuracy of data transcription is confirmed by the researcher.

Your signed consent form will be kept separate from all other data. All data pertaining to the study will be kept indefinitely in a secured location.

If you have any questions or concerns regarding this study or your participation in the study you may contact me, Archimore A. Wright, at [REDACTED] or [REDACTED], or faculty sponsor, Dr. Claudette Chin at [REDACTED] or [REDACTED], or the institutional Review Board point of contact, Barbara Cook, at [REDACTED] or [REDACTED]. If you are satisfied with the information provided and are willing to participate in this research study, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and the purposes of this study by Archimore A. Wright, and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in this research endeavor.

Signature of Participant

Date

Researcher

Date

Witness

Date

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

Appendix C



Barry University Recruitment Flyer

Calling Registered Nurses Caring for HIV/AIDS Clients

You are invited to participate in a research study: Exploring the Lived Experience of Registered Nurses Caring for Patients Living with HIV/AIDS in Broward County, Florida:

A Phenomenological Inquiry.

Qualified participants are eligible for Visa gift card of US \$25.00



Researcher:
Archimore A. Wright, MSN/ED, RN,
Call: [REDACTED]
Email: [REDACTED]

Research Sponsor:
Claudette Chin PhD, ARNP
Call: [REDACTED]
Email: [REDACTED]

IRB Representative:
Barbara Cook
Call: [REDACTED]
Email: [REDACTED]

Inclusion Criteria:
Registered nurses with more than one year working experience residing in Broward County.
English-speaking registered nurses.
Nurses with current experience caring for people living with HIV/AIDS (PLWHA).

Study participants will complete 2 interviews

A total time commitment of 105 minutes will be required for each participant.

Appendix D
Barry University
Demographic Questionnaire

Please answer the following items by circling and filling in the appropriate response.

Thank you for your participation.

1. Pseudo Name Chosen_____
2. What is your gender?
 - a. Male
 - b. Female
3. What is your age?
 - a. 18-29
 - b. 30-39
 - c. 40-49
 - d. 50-59
 - e. 60-69
 - f. 70 and over
4. What is your marital status?
 - a. Single
 - b. Married
 - c. Divorced
 - d. Widowed
5. What is the highest level of education you have completed?
 - a. Diploma
 - b. Associate degree

- c. Bachelor's degree
 - d. Master's degree
 - e. Doctoral degree
6. What is your ethnicity?
- a. Native American
 - b. Asian or Asian American
 - c. Hawaiian or other Pacific American
 - d. Black or African American
 - e. Hispanic or Latino
 - f. Non-Hispanic White
7. Length of employment at facility_____
8. Length of time working with HIV/AIDS patients_____

Appendix E

Barry University

Interview Questions and Prompts

Primary Question

1. “Tell me about your experience as a nurse caring for patients infected with HIV/AIDS.”

Additional Questions

1. Can you tell me what you understood about the disease HIV/AIDS
2. What would you say is the etiology of HIV/AIDS?
3. How can one become infected with the HIV/AIDS?
4. Tell me about your first experience caring for a patient infected with HIV/AIDS.
5. How do you feel about caring for patient diagnosed with HIV/AIDS?
6. What would you say is considered a patient-centered approach to HIV/AIDS care?
7. How would you describe HIV/AIDS prevention, care, support, and treatment continuum in your agency?
8. Is there anything else you would like to share related to HIV/AIDS?

Approved by Barry University IRB :

Date : 2/12/16

Signature :

[Redacted Signature]

Institutional Review Board
Protocol Form
February, 00 12

Appendix F

Barry University

Permission Letter

February 1st, 2016
Chief Nursing Officer
Memorial Healthcare System
3501 Johnson Street
Hollywood, Florida 33021

My name is Archimore A. Wright, MSN/ED, RN. I am a doctoral student at Barry University in Miami, Florida in the preparation stage of my study. My proposed research study is titled "*The Lived Experiences of Registered Nurses Caring for Patients with Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) in Broward County.*" The results generated from this research endeavor may be significant in the discipline of nursing by allowing registered nurses in Broward County to share their experiences through audiotaped semi-structured interviews.

I am requesting your permission to post recruitment flyers in your health care facility for nurses to participate in this study. I am asking for flyers to be mounted in the hospital lobby, conference rooms, foyers, nurses' station and lounges. Your cooperation and collaboration on this matter would be sincerely appreciated. Any question about this request, I can be reached at [Redacted], or [Redacted], or my faculty sponsor Dr. Claudette R. Chin at [Redacted] or [Redacted], or the Institutional Review Board point of contact Barbara Cook at [Redacted] or [Redacted]. Thanks in advance for your kind consideration and chief cooperation.

Archimore A. Wright
Barry University
Doctoral Student

Appendix G

Barry University

Confidentiality Agreement

Title of Research Study: The Lived Experience of Registered Nurses Caring for Patient Living with HIV/AIDS in Broward County, Florida: A Phenomenological Inquiry

As the transcriber of this research study, I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in this study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any information unless specifically authorized to do so by approved protocol or by the principal investigator (PI) acting in response to applicable law or court order, or otherwise, as required by law.
- I understand that all data submitted for transcribing will be returned to the principal investigator after completion.
- I understand that a breach of confidentiality may be grounds for termination of your service.
- I agree to notify the principal investigator immediately should I become aware of an actual breach of confidentiality or situation, which could potentially result in a breach, whether this be on my part or on the part of another person.

Signature: _____

Date: _____

Appendix H
Barry University
Curriculum Vitae

**Education**

University of Phoenix
 Miramar, FL
 Masters of Science in Nursing/Education **2009 - 2011**

University of Phoenix
 Plantation, FL
 Bachelor of Science in Nursing **2006 – 2008**

Miami-Dade College
 Miami, FL
 Associate Degree in Nursing **1997- 1999**

Employment Experience 2015 – Present Memorial Manor Rehabilitation & Nursing

777 Douglas Road

Pembroke Pines, Florida 33025

2008 – 2015 Memorial Home Health Registered Nurse

7369 Sheridan Street

Hollywood, Florida 33024

2004 – 2008 Southeast Home Care Registered Nurse

7719 N. W. 48th Street, Suite 330

Doral, Florida 33166

2003 – 2008 Pro-Health Nursing Registered Nurse

9700 Sterling Road

Hollywood, Florida 33024

1998 – 2007 Miami Jewish Home Registered Nurse

5200 N. E. 2nd Avenue

Miami, Florida 33137