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Lesbians' and gay men's narratives about attitudes in nursing

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Many nurses find it difficult to show compassion and sensitivity, and to give gay patients nursing of a quality equal to that given to heterosexual patients. The aim of the present study was to describe the experiences of gay patients and partners concerning attitudes in nursing. The method included qualitative semi-structured interviews with 17 women and 10 men, from different parts of Sweden. Nearly all informants described a sense of insecurity in 'coming out' to nursing staff. Most patients described being met by the nursing staff in a respectful manner, but sometimes they perceived a kind of distancing in the personnel's behaviour. Informants related that nursing staff judged homosexuality as something abnormal. Informants thought that, as partners, they always felt like outsiders, but these were emotions they believed all relatives experienced irrespective of sexual orientation. However, some partners associated negative attitudes of nursing staff with homosexuality. The informants believed that the insecure feelings affected their ability to interact. The majority of informants stated that they found most of the nursing staff kind and caring, but that there were differences and that the goal should be – for all patients and relatives – equality in nursing care.

Keywords: lesbians, gay men, experience, attitude, pathological approach.

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Introduction

Sexuality is an important aspect of human health (1) and, quality of life issue för both men and women (2). However, Magnan and Reynolds (1) reported severed barriers among nurses when addressing sexuality concerns with patients. The authers suggest educational programmes that promote comfort and confidence in addressing sexuality in nursing (1). Nursing is described as a 'helping discipline' with a focus on the interaction between the nurse and the patient, and relies on communication, participation and understanding of both oneself and others (3, 4). Working as a nurse builds on understanding the patient's needs as well as understanding that one's own values influence one's actions (3, 4). However, nursing staff often think they can care for people in a 'neutral' way, i.e. that personal attitudes do not affect the nursing care relationship (5–7).

When individuals disclose self-relevant information, they leave themselves vulnerable to possible rejection or mistreatment. In such situations, individuals are faced with negotiating a transaction between the profits to be gained by disclosure and the risk of mistreatment. Individuals extend their trust when they disclose their homosexuality, placing themselves in a dependent position. Because of the vulnerabilities inherent in intimate situations, this type of dependence is regulated by norms (8, 9).

Attitudes towards gay persons

In Sweden, violence against lesbians and gay men increased by 76% between the years 2000 and 2003 (10). Even if Sweden does have a 'gay-friendly' legislation (11), general attitudes may not differ from other countries with more limited anti-discrimination policy (12), as traditions and attitudes change slowly (13, 14).

Homophobia is the term used to describe specific attitudes towards gay people and is defined as a fear of, aversion to, or discrimination of homosexuality or homosexuals. The definition refers to a cognitive-, an affective- and a behavioural category (8, 9, 15). Intrapersonal attitudes may be negative in one category and positive in another. The consequences of this may be that a person experiences ambivalence. Holding ambivalent attitudes towards minorities can intensify the person's response to group members, either positively or

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negatively, depending on the situation. Studies have indicated that extreme attitudes are generally less ambivalent than moderate attitudes (16). Reactions to out groups can be generated when a person has both positive and negative attitudes towards those groups. The consequences of affective ambivalence lead individuals to prefer to avoid contact with out-group members, particularly contact that requires positive interactions such as helping someone (12).

Attitudes towards lesbians and gay men in nursing contexts

Earlier studies have indicated a relationship between homophobia and attitudes of nursing staff towards gay patients (17–20). Röndahl et al. (21) reported that, in general, respondents expressed positive attitudes towards lesbians and gay men. There was, however, a small number who expressed extremely negative attitudes towards homosexuality. Further, Röndahl et al. (22) reported that 36% of the nursing staff and 9% of nursing students questioned stated that they would choose to refrain from nursing homosexual patients if they were given the option.

In all probability, few individuals in Swedish nursing have negative attitudes towards lesbian and gay men, but there probably exists a blissful unawareness, which may heighten the fear of 'different' or unknown lifestyles and how this can affect attitudes and relationships in nursing (23).

Lesbian and gay patients' experiences of nursing. Several studies have shown that homosexual patients experience a fear of not feeling validated or receiving adequate nursing care if they disclose their sexual orientation (20, 24). Patients have expressed anxiety, feelings of discomfort, insecurity and fears of hostility and even bodily harm (25–27). They have also reported experiencing social isolation and neglect, which could lead to feelings of insecurity that may consequently force them into a decision to delay seeking care (20, 28). Studies suggest that many nurses find it difficult to show compassion and sensitivity, and to give lesbian and gay patients the quality of nursing equal to that given to heterosexual patients (29–35). The unacknowledged, invisible homosexual patient exists in silence, fearing the condemning attitudes of unknowing and, at times, homophobic nursing staff (13, 14, 31, 33, 36).

Studies of attitudes towards lesbians and gay men in nursing are necessary to provide nursing staff with an opportunity to understand that their personal and professional attitudes are linked and expressed to the patient, and also affect the relationship. The aims of the present study were to describe what lesbians and gay men had to say – (i) as patients and (ii) as partners – about their experiences from nursing in hospital care.

The study

Method

The present study was qualitative, explorative and descriptive, and was performed by way of semi-structured interviews.

Informants

The inclusion criteria for informants were that they should be self-identified lesbians or gay men, and have experience of hospital care in Sweden, as patients or partners of patients, within the past 5 years. A total of 57 persons expressed an interest in participating in the study, and 27 persons participated. Those who did not participate (n = 30) did not reply to the e-mail to book a time for the interview (n = 23) or had no prior experience from hospital care (n = 7). The participating informants were 17 women and 10 men ranging in age from 23 to 65 years, and came from different parts of Sweden. The informants told of 46 nursing experiences as patients, and 31 nursing experiences as partners from 12 different nursing settings. Some informants (n = 13) had experiences from several nursing settings and some also had experiences from different hospitals. Among the informants, eight had experiences only as patients and two only as partners. The participating informants' experiences from nursing is presented in Fig. 1.

Procedure and ethical considerations

Articles by James and Platzer (27) and Platzer and James (37) were used in designing the recruitment process, and

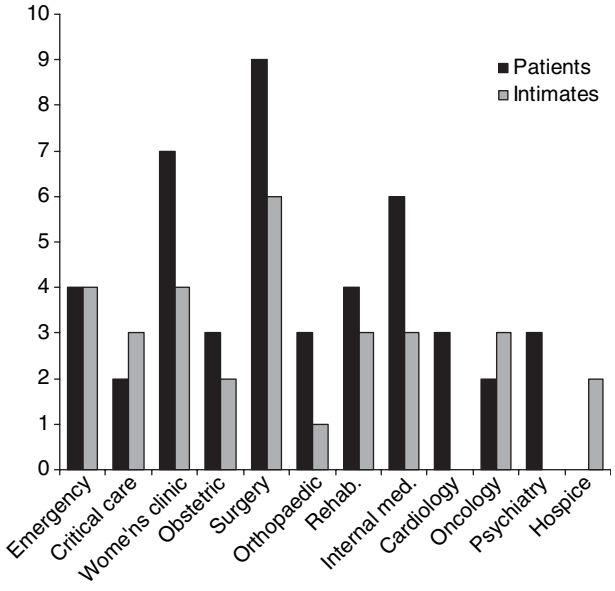

Figure 1 Patients' and intimate relatives' experiences from 12 different nursing settings.

the study was approved by the Medical Ethics Committee, Uppsala University (File no. Ups 02-249). The informants were recruited mainly by snowball sampling, but also by advertising on websites for gay people, starting with two key informants who were known by the first author. The key informants received written and oral information about the study and were also asked to recruit new informants by passing on the information letter. New informants were to contact the first author if they wanted to participate. The informants were also informed that, until they contacted the interviewer, only the person who had forwarded the letter knew who they were. In order to encourage informants to feel relaxed and comfortable with the interview procedure, they were given the opportunity to choose where the interview would take place. Careful consideration was given in preparing the questions to ensure that they were open-ended, sensitive, considering the potentially emotive nature of the subject matter, and would encourage a narrative flow.

Semi-structured interviews. The interviews were performed in the spring of 2004. An interview guide was designed based on a qualitative interview method (38). The taped interviews took place with each informant in the location of their choice and lasted 20–90 minutes. Demographic data, such as age and gender, and information on hospital experiences were also collected.

The interview started with a neutral question (i.e. nonemotionally charged question) regarding the words the informant preferred to use for women and men, who chose to live (have a sexual relationship) with another person of the same gender. These words were then used during the interview. Two questions were addressed: experiences from patients and/or partners in nursing contexts, and what the informants regarded as important to communicate concerning gay patients in nursing. The natural conversational flow was expanded by asking more specific questions and/or for reflections on statements relevant for the study. The interviews were later transcribed verbatim by the author.

Data analysis

Inspired by Creswell (38), Hyrkäs and Paunonen-Ilmonen (39) and Nordgren and Fridlund (40), the analysis was performed in five steps:

1. All interviews were repeatedly read until a feeling of *what* the informants had said, a feeling of entirety, was attained.

2. The second step contained an examination of *how* the informants described their experiences as patients and as partners. During this step, a spectrum of different perspectives emerged. Similar responses were sorted into positively, negatively or neutrally expressed information.

3. The positive, negative and neutral responses were classified into *areas* such as attitudes.

4. The areas were divided into *categories*. One example of a category is 'reactions', under the question area of 'attitudes'.

5. The different categories were analysed separately and specific words identified, leading to *subcategories*. One example of a subcategory is 'avoiding' under the category of 'reactions'.

The data were analysed by the author and by a senior scientist at the department separately, after which a collective analysis of the individual analyses was carried out until accordance was achieved. Necessary revisions of the classifications/categories/subcategories were made throughout the five steps of the analysis process. The findings for *Patients' and partners' experiences of attitudes in nursing*, especially the categories for *pathological approach* and *emigrante religion*, are described and illustrated below in this study.

The findings are presented as a descriptive summary of the informants' narratives and organized in a way that best contains the interview data and, with representative quotes taken from the interviews. This is a method of choice when pure description of the phenomena is desired. Summaries are valuable primarily as end products, and secondarily as entry points for further study (41).

Findings

Several informants told about their sense of insecurity in 'coming out' to nursing staff due to their not knowing how the personnel would react. Several informants regarded both heterosexuals and homosexuals as able to perceive this insecurity. Some informants felt that the insecurity upset the relationship between patients, partners and nurses, and thereby easily led to misunderstandings:

> ... I think that when you conceal it and hide, you end up with a very strange situation where the other person can tell that you're hiding something and she maybe becomes unsure of herself, which I interpret as unfriendliness toward me - but it doesn't necessarily mean that's what it is. It may just be a misunderstanding – an awkward situation that becomes tense and turns out all wrong – and that both of us react to. (man, 53 years)

Patients' experiences of attitudes in nursing

The patients described most of the nursing staff as just as respectful, tolerant or neutral as they expected. Some patients said that they sometimes experienced a kind of remoteness in the personnel's behaviour, but that this could be due to the medical conditions and not entirely to homosexuality. Other patients described feelings of

uncertainty regarding this distanced attitude and could not exclude that the nursing staff may be avoiding them:

> … what was going through my mind was that I was very much alone – I remember that – the staff came only if they had to do something and maybe that's how it is, but I wondered sometimes if they were avoiding me because I'm a lesbian. (woman, 31 years)

Some patients believed the distanced/avoiding attitudes to be signs of the nursing staff's own insecurity of dealing with the unknown.

Pathological approach. Some informants said that they had experienced that some nursing staff considered homosexuality as abnormal and pathological. One woman who sought care after being raped described the pathological approach she experienced in this way:

> ... there was an unfortunate focus on my sexuality because I'm lesbian. Because otherwise I don't think that, as a patient, one is ever sexual, but because I'm a lesbian there was a focus on that aspect – I think that it was important for them from a psychological standpoint because, in their eyes, it also somehow set me apart mentally – like as if I'd said I suffered from panic attacks or something. (woman, 28 years)

Several informants felt that whether or not lesbians and gay men experienced pathological attitudes depended on the generation of the nursing staff they met. They found they met with a higher degree of understanding among younger nursing staff, even if this staff could also display insecurity. The informants felt that younger staff were more open-minded, at least when it came to female personnel:

> ....it's the intense old matronly type that's worst, the ones in their 60 s. They know nothing about it and don't want to learn anything new either – the bulk of them still see it as a disease – they are staunch conservatives when it comes homosexuality and how families 'should' be made up. Many of the old matrons working in care no doubt still think of us being developmentally disabled or mentally ill – diseased in any case – even if no-one says it, at times you can sense something that makes you wonder anyway – like there's something wrong with us, we're abnormal. (woman, 65 years)

Immigranted religions. Several informants talked about the anxiety of being nursed by religious nursing staff and by personnel with culture backgrounds other than Swedish:

> .... there was also this nurse once who got down on her knees to pray for me, so that I would be rid of my sinful ways. And she asked if she could take it up with her prayer group. (woman, 45 years)

All informants who talked about their concerns of being nursed by immigrants described this from a religious aspect:

> ... I think that immigrants from some cultures have more difficulty accepting me. They get quiet and sort of dissociate themselves – not hostility but a little in that direction – especially people from Muslim countries – it makes me afraid that I'm not getting as good care – it doesn't happen with everyone, but with a lot of them – I've never felt anything like that from other immigrants, only the Muslim ones – because they follow their way of life no matter where they live – they don't want to think along any other lines – they assign me a different value than they have, and I don't like that. (man, 53 years)

Partners' experiences of attitudes in nursing

Some of the informants who had experience as both patients and partners perceived that being in the position of close relative always entailed having outsider status, where they struggled with feelings of powerlessness, abandonment and lack of information. As one informant expressed it:

> … mostly I felt like I was in the way, but those were my feelings – nothing that the staff communicate. (man, 51 years)

Some informants felt these feelings of loneliness were not unique to them, as gay persons, but found that they shared this experience with other relatives they spoke with on the ward. However, some informants linked negative attitudes from nursing staff with homosexuality:

> .....I wasn't seen as an 'accepted' relative. Everyone wrinkled their nose and wondered what I was doing there. (woman, 42 years)

and:

> ....I was pointed to a chair outside the door where I was to sit – it was unbelievably condescending when they said that I should understand that it was absolutely forbidden for relatives to go in there, in part because of the spread of infection, but also because women who have just undergone surgery are super sensitive and shouldn't be bothered in any way. But as it turned out new mothers were allowed to have their husbands there. (woman, 30 years)

Other informants felt that it was not possible to automatically connect homosexuality with negative attitudes towards gay patients or their relatives, but that there may be other causes.

Discussion

Nearly all informants described a sense of insecurity in 'coming out' to nursing staff. This insecurity affected the interaction with nursing staff and easily caused misjudgments. Most patients found nursing staff to be polite and open-minded, although they sometimes experienced a kind of remoteness in the personnel's behaviour,

which was not necessarily due to their homosexuality. Patients assumed the nursing staff's distanced attitude as a behaviour that stemmed from an uncertainty regarding desirable behaviour. Informants felt that nursing staff judged homosexuality as something morbid, although some described this as being dependent on the generation and gender of the nursing staff. Several informants described a fear of being treated by religious nursing staff. Informants thought that, as partners, they usually felt like outsiders, but that these were emotions they believed most partners experienced irrespective of sexual orientation. Further, the partner's well-being always came second to that of the patient and, naturally also, that of the personnel. The informants believed that feelings of insecurity affected their ability to interact.

The informants spoke about insecurity related to being open about their sexual orientation. This finding could be an example of the ambivalent emotions that may arise when an individual weighs the advantages to be gained by disclosure against the risk of mistreatment, as Eagly and Chaiken (16) and also Brewer and Brown (42) have cited. This ambivalence led to insecure emotions and could easily lead to misjudgements and misunderstandings. The finding could be a sign of a culture clash that may appear when two cultures have both fears and prejudices against each other. Nevertheless, the findings serve as an indicator of the need for a better understanding of gay issues and education in communication strategies for interacting with minorities, such as gay people, in nursing.

A positive finding was that the informants considered most of the nursing staff friendly and caring. This corresponds well to the nursing profession, which presupposes compassion and participation (3, 4). The informants assumed that the distanced attitudes of some nursing staff were a sign of insecurity. The informants' experiences indicate that personnel may believe they are nursing in a 'neutral' manner (5, 17, 43). Good knowledge about how social norms are communicated and how they affect the professional relationship (7) is important for interactional professions such as nursing (4).

The pathological approach and other negative experiences described by some patients were closely connected to the gender and generation of the nursing staff. It is possible that nursing staff from older generations misapply outdated traditions and knowledge, which earlier classified homosexuality as a mental disease. Wilton (20) has written about the lack of education in nursing concerning sexology and different cohabiting forms. The tradition in nursing to consider homosexuality as morbid is very long (20), but younger generations of nursing staff may be open to new views. Attitude changes advance slowly (11, 14) and even though Sweden has become a leading country in legislation against discrimination of lesbian and gay men, the findings of the present study show results similar to that of other studies regarding the experiences of homosexual patients and relatives. However, a more natural way of meeting 'different' lifestyles would be for more lesbians and gay men to become visible, e.g. through lesbian and gay personnel talking about their everyday life, so that heterosexuals can learn that gay life is fairly common and not as 'different' as one may think.

In many parts of the world, homosexuality remains illegal or is considered to be a sickness. The situation is particularly serious for gays and lesbians in countries under Islamic law. Other examples include countries where punishment such as being stoned to death or 'curative' treatments with electric shock exist, which may be common in some parts of the world (20). In the present study, the informants described their anxiety regarding a number of specific cultural religious minorities. In view of the attitudes towards lesbians and gay men in the cultures noted by the informants, this fear cannot be dismissed as irrational, but may indeed be rational. Further studies concerning different religious cultures' attitudes in nursing towards homosexuality are needed.

The partners' feelings of being assigned 'outsider' status, as well as the feeling that their well-being was regarded as unimportant, represented the most common topic of the narratives. The findings confirm earlier studies (28, 32, 36) which have described similar concerns among relatives. Nursing focuses mostly on the patient's needs, but relatives represent an important support for the patient as well as possible future patients. It is therefore important to give some time and care to them too, as negative experiences from nursing may affect them as patients in future (24, 25, 44) as well as affect their immediate well-being.

Insecurity, on the part of either personnel or relatives, could bring further interaction to a halt. Most nursing staff probably do not harbour negative attitudes towards gay persons and are unaware that their attitudes convey a sense of dislike. In all likelihood, nursing staff experience a great sense of insecurity concerning how they should behave in interactions with gay families. The findings in the present study are probably largely attributable to a clash of cultures and insecure 'meetings' similar to the culture clashes that appear in nursing with respect to immigrant groups (43). More information about lesbians and gay men in nursing, written and oral, may be needed, as it is for different religions and foreign cultures.

Some recommendations for nursing staff can be derived from the present study with regard to attitudes towards homosexual patients and partners: Reflect on personal attitudes and prejudices concerning homosexuality. Reflect on personal behaviour when dealing with different minorities in nursing. Keep an open mind for 'different'

lifestyles! Respect the individual patient's family life. If you are unsure of how to behave, obtain the necessary knowledge but not from the patient or her/his relatives. Handle personal reactions professionally and explain to the patient and relative, if you 'lose face'.

Limitations

It was difficult to reach and recruit older (>65 year) lesbians and gay men for the study. Some contacts were suggested through some of the older participating informants, but these did not lead to direct contact with the interviewer. This could be due to the fear of disclosure being greater for older gay people than for those who participated in the study, as they have a long tradition of keeping their homosexual lives secret and living a 'double life' because of society's stigma and earlier legislation. Elderly people have a unique set of experiences and are often in need of recurring nursing care. Their input would therefore have been of great value.

Information saturation was achieved after 21 interviews. Most informants related similar experiences despite their having been recruited from nearly all parts of Sweden. Platzer & James (37) state that the weakness of the snowball sampling method is that you receive similar data. The method was chosen, however, as snowball sampling has proved most effective in comparable studies. The 27 informants who participated may not be representative of all homosexual patients and partners in institutional care, but are able to illustrate homosexual patients and their partners' experiences from nursing within a heteronormative communicational and attitudinal context. The narratives are important for future studies concerning homosexual patient and partners' conditions in nursing.

Credibility is an issue of importance with open interviews. The interviewer's personal interests may influence the data gathered from the informant so that the interviewer hears what she/he wants to hear. Similarly, the feelings, prejudices, attitudes and values of the interviewer may result in a misrepresentation of information by the informant or no information at all. To minimize this risk and ensure a safe conversation place, the interviews were performed close to the informant's neighbourhood at a location chosen by the informant. By selecting a more structured question guide, it might have been possible to reduce the threat to credibility but at the risk of losing important information.

Concluding remarks

Nursing staff have a responsibility to uphold professional performance as well as personal behaviour. Distanced behaviours stemming from insecurity and/or ambivalent attitudes are understandable but not acceptable. It is the obligation of nursing staff to generate a safe atmosphere that makes the patient feel protected and respected. This sets demands on personnel to reflect on their own behaviour, to be aware of their prejudices about minorities, and to discuss these with colleagues at work. It also sets demands on knowledge about same-gender relationships in nursing, as well as on employers and unions to create forums where the specific needs of different patient minorities may be openly discussed and communicated. Furthermore, even if it is more easily said then done, homosexual patients and their relatives have to be open about their needs so that nursing staff are able to recognize them and give them the care they have a legal right to. No patients or partners should feel that personnel are avoiding them, experience a fear of religious personnel, or be exposed to pathological attitudes due to their sexual orientation. The majority of the informants felt that most nursing staff were kind and caring, but that there were differences and that the goal should be – for all patients and relatives – equality in nursing care.

Future studies should investigate the attitudes of different religious cultures among nursing staff towards lesbians and gay men.

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