Heteronormativity in a Nursing Context

Attitudes toward Homosexuality and Experiences of Lesbians and Gay Men

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Abstract

The general aim of the project was to describe the situation of lesbians and gay men in a nursing environment by studying the attitudes of nursing staff and students, and the experiences of gay nursing staff in their work environment and of gay patients and partners in their encounters with nursing. The study for papers I and II had a descriptive, comparative design. Nurses, assistant nurses, and nursing students completed the Attitudes Toward Homosexuality Scale (ATHS), the Causes of Homosexuality Questionnaire (CHQ), and the Affect Adjective Checklist (AAC), along with the Nursing Behaviour Questionnaire (NBQ).

In general, the participating nursing staff and students expressed positive attitudes, though some subjects reported very negative attitudes toward gay people. The participants also expressed a full spectrum of emotions from delight to anger. The studies for papers III and IV had a descriptive, explorative design. Here, the data collection was performed by semi-structured interviews. The informants were gay nursing staff, gay patients and partners of patients. The gay personnel reported fear and concern about heterosexuals’ reactions when these informants ‘come out’, and were constantly assessing the risk being open about their sexual orientation among their workmates. Nearly all patients and partners described several situations where heteronormative assumptions were communicated by the nursing staff. Almost all informants offered recommendations for nursing staff to facilitate communication.

According to the presented findings, probably only a small minority in Swedish nursing have negative attitudes toward lesbians and gay men. However, the informants told of heteronormative language and behaviour in nursing contexts that were perceived as insensitive, insulting and humiliating. Nursing staff need to learn how to communicate in a more natural way and to be aware of the norms they communicate through the language and behaviour they use.

Keywords: lesbians and gay men, homosexual, social norms, heteronormativity, intergroup relation, attitude, communication, nursing

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List of papers

The thesis is based on the following papers, referred to in the text by their Roman numbers:


III Röndahl G., Innala S., Carlsson M. To hide or not to hide, that is the question! Lesbians and gay men describe experiences from nursing work environment. *Journal of Homosexuality*, accepted.

Prologue

In many ways, lesbians and gay men have an outsider status since heterosexuality is the generally accepted, but rarely problematised, societal norm. Lesbians and gay men are therefore often a hidden and vulnerable minority. Often people believe that they do not know- or have never met lesbians or gay men, perpetuating the stereotype of homosexuals as strange people who wear ‘funny’ clothes at PRIDE festivals and parades.

Sweden has recently strengthened the legislation on the rights of gay people and society’s demands for tolerance towards lesbians and gay men. Accordingly, in the future, more people will probably show their homosexuality openly; you will meet lesbians and gay men in all kinds of nursing settings – employees, patients, and their significant others. The motivation for the present research project was therefore to contribute toward making lesbians and gay men visible in nursing.

The attitudes towards homosexuality in nursing are complex and encompass issues such as nursing culture and traditions, nursing knowledge, nursing ethics, interpersonal relationships and communication in nursing, mainstream Swedish culture, hidden prejudices and stereotypes, morality, gender perspectives, etc., etc. In the present thesis, I will attempt to provide definitions for the most common terms used to describe homosexuals and homosexuality in nursing settings. The research will illuminate different attitudes among nursing staff and students and present the work environment of gay nursing staff. It will also explore how gay patients and their partners experience nursing.

To write about female and male homosexuals is rather difficult since the available language is often offensive (please see APA publication manual 4th ed.). The same word can be perceived differently in different countries or in different social contexts, or be determined by the perceiver’s own sexual orientation. Some words are also ambiguous in that they have different connotations to different individuals. I therefore found it necessary to make choices about the words used in the studies, and these need to be defined. The problem with lexical choice is not only an existing problem for me, the language use is discussed in other parts of the world as well: ‘During the 1980s, the terms sexual orientation and sexual preference became common stand-ins for the word homosexual. Those words seemed somehow more polite, more benign, and by avoiding the loaded term homosexual, they served the gay rights movement well’ (Fausto-Sterling 2000:226). In Swe-
den, the term *homosexual* is often understood as less negative than *lesbian* and *gay* by heterosexuals, but seems to have a more negative ring among most homosexuals. Even so, the word *homosexual* is used here to encompass both women and men. Since *lesbians* and *gay men* are terms that are currently in wide use in, and by the gay community, these will also be used, as well as *gay* and *gay people* when referring to the group as a whole.

‘everyone…is both a victim and a supporter of the system’

(Jost & Kramer 2002)
Introduction

‘Until relatively recently, the stigma against homosexuality in Euro-American societies was so deeply rooted that it was not thought necessary to explain why being homosexual disqualified one from basic human and civil rights. Historically, there have been many attempts to justify the situation. Justifications have been based on religious concepts of sin, medical notions of sickness or political assertions that homosexuals represent a risk to national security, but justifications are not explanations’ (Wilton 2000:136).

Historical attitudes toward gay people

From time immemorial, man has tried to cure diseases and to prevent accidents. In all cultures, nursing has been influenced by religious faith. The first codes of ethics for modern Western nursing were strongly linked to Christian faith (Bentling 1995; Hamrin 1997). The Christian church has exerted considerable social control and has, as most other religious persuasions, considered homosexuality as sinful. In Sweden, homosexual acts were criminal until 1944, and thereafter classified as due to a mental disorder until 1979. In historical retrospect, the tradition has long regarded homosexuality as sinful, criminal or pathological (Månsson & Hilte 1990), and the connection between Christian beliefs and nursing has been strong (Bentling 1995; Hamrin 1997; Crow 2000).

In Sweden and other countries, the media initially presented HIV/AIDS as the ‘homosexual disease’ or the ‘gay plague’. Due to the particularly close association between HIV and homosexuality, the sexual relations of gay men have become more visible (Månsson & Hilte 1990). Two decades after the emergence of HIV/AIDS, homosexual HIV-infected men still risk encountering added stigma (Röndahl et al. 2003).

From 1992, the National Institute of Public Health has the task, as commissioned by the Swedish government, to follow up and improve the situation of gay people in society (Andreasson 1996).

The Ombudsman against Discrimination on grounds of Sexual Orientation (HomO) was appointed by the Government in 1999. It is commissioned as the authority responsible for combating homophobia and discrimination on the basis of sexual orientation in all areas of Swedish society (HomO 2004).
Officially issued proclamations and demands for tolerance of lesbians and gay men have increased over the past decade, and several laws have been imposed to strengthen the rights of gay people. However, further efforts are required to help change negative attitudes and to reinforce positive attitudes toward homosexuality, since a lot of negative attitudes originate in the existing culture (Wilton 2000; Howard-Hassman 2001; Landén & Innala 2002).

Social norms

Many beliefs are established at an early age, are often automatic, and can vary according to culture as well as over time in one and the same culture (Eagly & Chaiken 1998; Crandall & Eshleman 2003). Beliefs are often described as inflexible and as very hard to change (Fiske & Taylor 1991; Kruglanski & Higgins 2003). Norms are shared beliefs and must be observed from the perspective of both the individual’s psychological system and the socio-cultural system by which that individual is surrounded. Social norms represent a socially transmitted tendency to respond to particular interdependence situations in a specific manner (Thibaut & Kelley 1959). Instead of a specific approach to individual situations, cultural norms are often held as ‘the truth’ (Hinton 2003) that guides and/or restrains social behaviours (Cialdini & Trost 1998). In interactions with strangers, people often rely on understandable, calculated assumptions sometimes in an automatic and unconscious manner (Rusbult & Van Lange 2003). Cultures that are greatly bound by rules, norms, laws and social conventions may be mainly prone to perceiving ‘unknown others’ as threatening (Stephan & Renfro 2002). People who look different or act in ways outside the norm are often avoided as the objects of ridicule (Crandall & Eshleman 2003). When jokes provide a mean by which groups can be ridiculed, norms determine which jokes will offend and which will delight (Crandall et al. 2002). Increased knowledge of the stereotyped object and personal experience may change the cognitive content of the belief, but can also lead to a person violating prevailing norms or conventions and, in doing so, risking socially aversive consequences, such as rejection (Fiske & Taylor 1991; Kruglanski & Higgins 2003).

Religious belief may serve as a suppressor, as a justification ideology and, as a direct source of prejudice. Some religions teach tolerance but it can also teach that the limit of tolerance do not extend to some groups. Consequently, when social norms within the church favour prejudice, church members show very high individual levels of prejudice. Several studies report that lesbians and gay men may serve as scapegoats for moral decay and the failure of Christian evangelism (Crandall and Eshleman 2003).

Prejudiced attitudes are more complex and ambivalent than a simple positive-negative aspect. Positive and negative components of prejudice can represent an incorporated system of beliefs and emotions that increase preju-
dice (Fiske et al. 2002). Highly prejudiced people are more likely than those with low prejudice to perceive a social norm of tolerance of discrimination against members of a disparaged group (Ford & Ferguson 2004). Prejudice itself is usually not directly expressed since cultural norms are becoming increasingly negative toward open prejudice. Rather, prejudice is modified and suppressed to meet social and personal goals (Crandall & Eshleman 2003). Changing the norm about the expression of prejudice can have a strong effect on people’s tolerance for prejudice (Crandall et al. 2002). Crandall and Eshleman (2003) argue that ‘justification’ of a wide variety of cognitions, social norms, beliefs and values can serve to justify prejudice, an opportunity for the expression of prejudice, without internal or external punishment. Prejudice is so closely tied to important values that discrepancies between experienced and expressed prejudice can lead to guilt and shame. Values tell us how to behave and may be defined as a type of beliefs that is centrally located within one’s total belief system. Culture-bound values are especially relevant for intercultural communication and include concepts such as: power-distance, uncertainty avoidance, individualism-collectivism, self-disclosure, and emotional-behavioural expressiveness (Robinson 2004). When individuals who wish to believe they are unprejudiced are made conscious of intolerant behaviour, they intentionally avoid it, sometimes demonstrating reverse discrimination in the process (Brewer 2003).

Social desirability may be defined as an interpersonal conflict between two beliefs: a person’s personal beliefs and accepted ‘social correctness’ (Fiske & Taylor 1991), for example, a nurse’s personal prejudice against gay patients versus her/his ethical obligations and constitutions of nursing care standards. Crandall et al. (2002) suggest that the public’s unwillingness to express prejudice may be determined more by normative influence than by personal attitudes, i.e., external norms become- or cover internal attitudes. Crandall and Eshleman (2003) suggest that a range of social, political and religious values lead to suppression of prejudice. People who wish to appear non-prejudiced to others also wish to appear non-prejudiced to themselves. In a study by Röndahl et al. (2003), 27% of the nursing professionals and students (n=152) surveyed gave socially and legally correct answers to a question whether they would prefer to avoid nursing HIV-infected patients, if that was an option. A typical example of such answers was: ‘All patients have the right to the same care no matter what illness they have. My personal values do not affect my work.’

The heterosexual norm – Heteronormativity

The social life of heterosexual cultures is constructed on the assumption that all people are heterosexual, thereby making homosexuality socially invisible (Håkansson 1984). Some scholars use the term heterosexism and others heteronormativity to describe the complex socio-political process that assumes
the heterosexual nuclear family norm to be natural and universal (Wilton 2000; Herek 2004).

Heteronormativity is the term used to describe the powerful heterosexual structure and normative principle and is learned very early in life. The term refers to the assumption that heterosexuality is a general norm, i.e., that heterosexuality is the only sexuality of individuals and society. A consequence of heteronormativity is that homosexuals are addressed and treated like heterosexuals. People are assumed to be heterosexuals until they do or say something that disproves this assumption. This means that lesbians or gay men may choose to hide and remain invisible due to fear of negative attitudes and repercussions (Stevens & Morgan 1999; Stewart 1999; Platzer & James 2000; Wilton 2000; Yep 2003; Chur-Hansen 2004). Heteronormativity is everywhere, already present in individuals and collective psyches, social institutions, cultural practices and knowledge systems (Yep 2003). Lesbians and gay men may threaten one’s psychological sense of self in terms of sexuality and group identity since they do not live up to gender role- and nuclear family expectations (Bernstein 2004). Normalisation is a symbolically, discursively, psychologically and materially violent form of social regulation and control. According to Yep (2003), heteronormativity may be one of the most powerful forms of normalisation, the presumed heart of the society. Feminist scholars accurately maintain that heterosexuality is a key site of male power and dominance, a patriarchal institution that subordinates, degrades and oppresses women. Heteronormativity and heteropatriarchy are also harmful to men in perhaps less tangible ways, e.g., by forcing heterosexual men into a lifelong struggle of ‘proving’ their manhood. From a heteronormative perspective lesbians are not proper women and gay men are failed men (Yep 2003).

Cognitive, emotional and behavioural attitudes

The tripartite terms of attitudinal phenomena have often been described, by social psychologists, as consisting of a cognitive-, an affective- and a behavioural component. The cognitive component consists of beliefs, the affective component consists of emotions, and the behavioural component covers actions or the intention to act (Fiske & Taylor 1991; Eagly & Chaiken 1998; Kruglanski & Higgins 2003). The difference between cognitive beliefs and emotions may be that beliefs are something humans are prepared to build actions on, and that emotions turn thinking humans into acting individuals (Frijda et al. 2002). Some types of behaviours (e.g., social distance) are more responsive to emotional-based attitudes and some more belief-based attitudes (e.g., political issue) (Mackie & Smith 2002). The emotional component of attitudes has been documented as essential for understanding prejudice and intergroup conflicts (Devos et al. 2002; Blair et al. 2003).
Ambivalent attitudes

Intrapersonal attitudes may be negative in one category and positive in another. The consequences of this may be that a person experiences ambivalence. Depending on the situation, holding ambivalent attitudes toward minorities can intensify, either positively or negatively, a person’s response to group members. Studies have indicated that extreme attitudes are generally less ambivalent than moderate attitudes (Eagly & Chaiken 1998) and reactions to out-groups can be generated when one person has both positive and negative attitudes toward those groups (Brewer & Brown 1998). Individuals may hold a more negative attitude toward another person if she/he is viewed as blocking certain values, behaviours or traditions (Devos et al. 2002).

Crandall et al. (2002) propose that persons with high internal motivation to restrain their own prejudices are more ambivalent, more worried, anxious, fearful, motivated and subtle in the sense that they fit the social norms. On the basis of the ‘justification-suppression’ model, Crandall and Eshleman (2003) describe three psychological processes that may be characteristic of ambivalence due to prejudice – suppression-, affective- and equilibrium ambivalence. In suppression ambivalence, genuine prejudice is met by suppression processes that deny, suppress and restrain prejudice without presence of real positive affect. People feel they have prejudice which they should not have or express. Affective ambivalence is described as a conflict between genuine positive and negative emotions towards members of a group. People with equilibrium ambivalence know they have some prejudice and can balance it.

Intergroup relations and emotions

Each meeting between two human beings, carrying their own cultural conditionings, can be seen to have several dimensions of differences and assumptions as well as similarities (Seden 2004). Intergroup relations may be described as a group with several people who interact on a regular basis and have affective ties with one another. When people interact, the nature of their interpersonal relationship is noticeable in a variety of ways: by the distance they stand from each other, their posture, facial expressions, how much they look at each other, and so forth (Thibaut & Kelley 1959; Cialdini & Trost 1998). Positive emotions may be generated by the type of contact that is successful in improving relations. Negative emotions may be classified in attack emotions (e.g., frustration, anger), and exclusion emotions (e.g., disgust, contempt, fear/anxiety, insecurity) (Devos et al. 2002). Negative emotions of anxiety and insecurity can occur when people do not know how to behave around unknown members or are worried about appearing prejudiced (Smith & Mackie 2002). Prejudices may cause emotions such as fear and
worry, anxiety, pity, envy, dislike and pride, and may encourage specific behaviours (Fiske et al. 2002).

Situations involving intergroup relations are often complex, and most cognitive, affective and behavioural reactions to social structures and groups are ambivalent (Jost & Kramer 2002). Fiske et al. (2002) argue that ambivalent emotions can be a part of an attitude incorporated, in which positive and negative emotions are complementary rather than in competitive tension. When negative emotions (e.g., anger, fear, disrespect and disgust) occur, several different and conflicting emotions may be experienced by the same group at different times (or even at the same time) in different settings. Mackie & Smith (2002) assume that differentiated and emotional aspects of intergroup reactions are normal and are to be expected. However, the consequences of affective ambivalence may lead individuals to prefer to avoid contact with out-group members, particularly contact that requires positive interactions such as helping (Brewer & Brown 1998), e.g., when nursing staff neglect a patient’s sexual orientation and regard it as unimportant in the planning of the patient’s treatment, social support, etc.

Emotions and behaviours
When people experience emotions related to their group memberships, these emotions may play an important role in their reactions to out-groups. Emotions such as anger and irritation are expected to be linked to offensive action tendencies, the impulse to move toward the object. Emotions such as fear or anxiety, on the other hand, should immediately cause a desire to move away from the object (Devos et al. 2002; Fiske et al. 2002; Neuberg & Cottrell 2002). Emotions such as, pity, guilt and sympathy may lead to behaviour such as helping and other donations, whereas emotions like disrespect and anger lead to lack of assistance, since people often neglect persons they believe could have avoided their bad lot of life (Fiske et al. 2002). Attributions of responsibility may justify negative emotions, and can also create them (Crandall & Eshleman 2003).

Fear of the unknown
Fear arises from an appraisal of threat combined with an assessment of low power or control (Stephan & Renfro 2002; Brewer 2003). Fear is described as one of the most fundamental emotions, often beyond conscious and rational control, an engagement in or reaction to the belief of being in danger (Frijda et al. 2000; Gullone 2000). People are uncomfortable with the unknown (Blair et al. 2003). Fear of the unknown is one of the most commonly observed fears and is classified as a ‘normal fear’ (Gullone 2000). Normal fears often become an unwelcome and distressing burden in situations that are in fact not dangerous (Pissiota 2003). One way of handling fear, and the stress released by this emotion, is to avoid situations in which feelings of
helplessness and vulnerability occur. The degree of helplessness or control over the frightening situation experienced determines the level of fear (Riezler 1944; Dozier 2000; Frijda et al. 2000; Gullone 2000). Feelings of vulnerability and perceived threat may also increase emotions such as fear and anxiety (Kramer & Jost 2002; Crandall & Eshleman 2003). However, when people have practised interacting with ‘the unknown’ (e.g., members of an out-group), insecurity about how to behave and what to expect will be reduced, which may lead to a greater sense of predictability and control (Blair et al. 2003). Friendship or other types of positive personal contact have been shown to reduce negative emotions, such as anxiety (Mackie & Smith 2002).

Discomfort and anxiety
Fairly common reactions in interactions with members of an out-group are discomfort and anxiety (Dovidio et al. 2002; Brewer 2003). Anxiety may occur from a lack of experience with- or understanding of members of unknown groups (Dovidio et al. 2002). Intergroup anxiety may increase as a result of prejudicial attitudes that lead the perceiver to expect the worst from the out-group and to view any intergroup interaction as potentially threatening. A person who has little contact with a group or a more negative attitude toward the group is thus more likely to expect a more threatening type of interaction. This can lead to anxiety (Blair et al. 2003) and an immediate desire to move away from the out-group. The anxiety may also cause a desire to avoid interaction with out-group members in future (Devos et al. 2002), or subtle forms of discrimination (Dovidio et al. 2002).

Embarrassment
Feelings of embarrassment may consist of discomfort, awkwardness, disgust and sometimes fear, and may lead to anxiety, including loss of face or honour and undermining one’s self-identity or self-esteem (Stephan & Renfro 2002). Embarrassment is a powerful means of social control and occurs when rules are broken and loss of control can become a source of embarrassment. Embarrassment is indicated by reduced eye contact, increased body movement, smiling, etc. A rather common strategy to handle embarrassment is to use humour (Lawler 2004).

Social dilemmas
Social dilemmas are when individuals perceive a conflict between their own self-interest and the collective welfare (Brewer 2003). Distrust and suspicion between groups are common and frequent problems at all levels of social organisation. Distrust has generally been defined as a reflection of an individual’s negative beliefs and pessimistic expectations regarding the trustworthiness of other individuals or groups with whom she/he feels no belonging. Suspicion has been treated as one of the central cognitive components under-
lying such negative beliefs and expectations (Kramer & Jost 2002). Social
behaviours (e.g., the willingness to self-disclose and engage in informal con-
tacts) play an important role in the development of trust/mistrust. Mistrusting
may lead to paranoia, which may lead to a self-fulfilling pattern of suspi-
cious and mistrustful interaction. However, distrust and suspicion are not
always irrational (Kramer & Jost 2002). Close personal contact, conscious or
unconscious, may trigger prejudices and reactions due to hostile feelings
describe the nature of hierarchical intergroup trust dilemmas, which occur
when one group has low power or high dependence in relation to another
group with which it is dependent. Individuals of low power/high dependence
groups may experience feelings of emotional vulnerability, insecurity, fear
and anxiety when dealing with members of high power groups on whom
they depend. When an anxious or frightened member of one group overhears
members of another group laughing in a social setting, she/he may easily
believe they are laughing at her/him rather than at a joke that was told by the
group (Kramer & Jost 2002).

Attitudes towards lesbians and gay men

Homophobia is the most common term used to describe a specific attitude
towards gay people, although different definitions exist (Herek 2004). In
social psychology, homophobia is defined as a fear of, aversion to- or dis-
crimination of homosexuality or homosexuals. This definition refers to cog-
nitions, emotions, and behaviour toward homosexuality and gay persons.
Homophobia differs from phobias such as agoraphobia and claustrophobia in
that it is not viewed as an irrational, illogical, absurd or persistent fear,
which is usually the case in the diagnosis of clinical phobias. Homophobia is
more like xenophobia, i.e., a fear of strangers. Like xenophobia, homophobia
is something that most people exhibit to some degree and is accordingly not
defined as a psychiatric diagnosis (Innala 1995; Van de Ven 1994; 1995;
Van de Ven et al. 1996; Peterson 1997; Herek 2004). However, homophobia
is a criticised concept since no consistent definition exists in the literature
(Herek 2000; Bernat et al. 2001; Herek 2004). In one study, Logan (1996)
argues that ‘homoprejudice’ would be a more suitable concept than hetero-
phobia since anti-homosexual reactions deal rather with prejudice, and not
phobia. Herek (2000) argues for a clear distinction between the concepts of
homophobia and heterosexism, where homophobia is used to describe indi-
vidual anti-gay attitudes, and heterosexism refers to ideologies at the society
level and examples of institutionalised domination of non-heterosexual peo-
ple.
Internalised homophobia

Since all of a society’s individuals grow up in the same culture, adopting similar social norms, values and beliefs, lesbians and gay men also learn the myths and stereotypes about homosexuality (Innala 1995; Richmond & McKenna 1998; Taylor 1999). Interpersonal contacts and the messages mediated render homosexuality anxiety-ridden, guilt-producing, fear-inducing, shame-invoking, hate-deserving, psychologically blemishing, and physically threatening (Yep 2003). Lesbians’ and gay men’s own negative attitudes toward- and feelings about homosexuality are called *internalised homophobia*. Lesbians and gay men often experience an internalised homophobia in their identification of themselves as gay (the ‘coming out’ process) (Innala 1995; Taylor 1999; Herek 2004). Yep (2003) argues that emotions such as fear and shame due to one’s own gay orientation are caused by the heterosexual norm explained by the patriarchal institution of male power and dominance. These emotions are internal injuries that individuals inflict upon themselves from a very early age, and are defined as ‘soul murder’.

Secrecy about sexual orientation has been found to be feature of lesbians and gay men. Fear is one of the emotions that have been reported to have a close connection to secrecy, i.e., fear that relates to the secret being discovered. Consequently, secrecy may lead to emotions such as loneliness and feeling ‘different’ (Chur-Hansen 2004). The term *coming out* describes the process whereby a person acknowledges her/his homosexual orientation. To become conscious of- and accept one’s sexual orientation represents the internal aspect of the ‘coming-out’ process, the external aspect being when lesbians and gay men ‘come out’ to families, friends, and at the workplace, etc. In a society where heterosexuality is the prevailing norm, the ‘coming-out’ process is a lifelong process; lesbians and gay men ‘come out’ continuously, in different situations in which the degree of openness about their homosexuality may vary from situation to situation (Stevens & Morgan 1999; Taylor 1999; Wilton 2000; Forsberg *et al.* 2003). Bernstein (2004) advocates the importance of gay people ‘coming out’, particularly at work, as an effective way of reducing anti-gay attitudes.

From intolerance to violence

When individuals disclose sensitive and self-relevant information, they leave themselves vulnerable to possible rejection or mistreatment. In such situations, individuals are faced with a transaction between the profit of 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 to intimate situations, this type of dependence is regulated by values and norms (Cialdini & Trost 1998; Rusbult & Van Lange 2003; Robinson 2004).
Blair *et al.* (2003) write that the participants who reported having little contact with gays, higher levels of prejudice, or more conservative beliefs were especially likely to perceive greater anxiety when interacting with a gay person of the same sex as themselves. Disparagement humour (e.g., sexist- and gay jokes) acts as a form of social control, allowing members of the dominant group in society to maintain their privileged position. It increases tolerance of discriminatory events for people with high prejudice toward the out-groups (Ford & Ferguson 2004). Verbal assaults and abuse (Burn 2000; Wilton 2000; Thurlow 2001; Ljunggren *et al.* 2003; Yep 2003), or organised and spontaneous street violence towards homosexuals (Innala 1995; Peterson 1997; Van de Ven 1995; Van de Ven *et al.* 1996), are also examples of active discrimination. Another example of (passive) discrimination is the invisibility of the social lives of lesbians and gay men, as opposed to the public visibility of heterosexual lifestyles and behaviours. This invisibility functions as a mechanism of social exclusion, which leads to an out-group status (Wilton 2000; Yep 2003). Violence carried out by friends, family and workmates, for example, and also rejection by family members, is particularly harmful to the mental and emotional health of lesbians and gay men (Wilton 2000; Yep 2003; McAndrew & Warne 2004; Smith & Ingram 2004).

In many parts of the world, homosexuality remains illegal and/or is considered to be a disease. The situation is particularly grave for gays and lesbians in countries under Islamic law. Punishment such as being stoned to death or ‘curative’ treatments with electric shock, may be common in other parts of the world (Wilton 2000). In Sweden, a hidden discrimination of homosexuals is a reality (Andreasson 1996; Peterson 1997). This intolerance is masked by the fact that it is socially desirable to be outwardly non-prejudiced (Innala 1995). Even though Sweden has become a leading country for legislation against discrimination of lesbian and gay men, reported violence (i.e., reported to the police) against lesbians and gay men increased by 76% between the years 2000 and 2003 (HomO 2004).

**Communication**

Communication can be viewed as an interactive process involving the giving, receiving and conforming meaning (Seden 2004). Communication pervades social life, for the transmission of cultural knowledge and also access to the content of others’ minds. Language and the elements of social life that make up an intrinsic part of the way language is used are tools for verbal communication (Krauss & Chiu 1998; Maltén 1998; Kruglanski & Higgins 2003) and can mask the use of stereotypes (Crandall & Eshleman 2003). ‘Attempts to promote “better communication” will not succeed unless they are based on an understanding that all human communication is necessarily
embedded in social contexts and relationships. Since these are complex and variable, there is no single “right way” to communicate, no universally applicable “magic words”, and no quick fix for every problem’ (Cameron 2004:73).

Non-verbal communication can be enormously powerful. Heisel and Mongrain (2004) argue that the best non-verbal signs we get of the internal emotional state of others are facial expressions and body language. A mere touch or smirk can dramatically affect the balance of dominance, intimacy, trust and influence in a social encounter (Depaulo & Friedman 1998). If people are afraid that their expressed emotions may be interpreted incorrectly, they may choose to adopt a poker face (i.e., not to show any emotion). Such non-emotionality will supposedly prevent individuals from misunderstandings (Leyens et al. 2002). However, when ambivalent persons try to control their verbal expressivity, their faces may betray the negative emotions they are feeling (Heisel & Mongrain 2004) and prejudice may ‘leak’ out when such emotions can not be consciously suppressed (Crandall & Eshleman 2003). Lack of control may lead to insecurity, anxiety and stress, and may increase behaviours such as avoidance (Robinson 2004). A sign of avoidant non-verbal behaviour due to anxiety is less eye contact and speech errors (Brewer 2003).

The expression of emotions is directed toward other people, the decoders of emotions. Both the expression and decoding of emotions may play an essential role in the interactions of dominant and dominated group members (Mackie & Smith 2002). This role may stem from reciprocal misunderstandings at the level of expression and at the level of emotion.

Communicated misunderstandings may lead to interactions not being experienced as pleasant, and probably to an increase in the fear/anxiety usually present in any relation with strangers. Consequently, the members of the different groups will fear further interactions, and may avoid or refuse subsequent encounters (Leyens et al. 2002).

The nursing context

Nursing philosophy is based on humans and caring. Humans are unique and have a need to be understood. Nursing is described as a ‘helping discipline’, with a focus on interaction between the nurse and the patient, and relies on communication, participation and the nurse understanding both herself/himself and others (Bentling 1995; McCabe 2004). Working as a nurse builds on the nurse having a positive attitude to all patients and understanding the patient’s needs as well as understanding that her/his own values influence her/his actions and behaviour. An important instrument in nursing is dialogue, and nursing work may be described as a meeting between two people, one professional and one patient, a relationship. This relationship is a
requirement for understanding and participation and builds on good mutual communication (Bentling 1995; Henderson & Forbat 2004; McCabe 2004). However, many nurses and assistant nurses think they can care for people in a ‘neutral’ way, i.e., that personal attitudes do not affect the nursing care relationship (Richmond & McKenna 1998; Eliason & Raheim 2000; Röndahl et al. 2003).

Attree (2001) reported in one study that the central issues in good quality care for patients were, in particular, the interactional and interpersonal aspects of providing care. Nurses’ communication skills have been criticised, but Bowles et al. (2001) report a positive change after educational intervention. Skilbeck and Payne (2003) argue that communication is the medium for treatment and care in nurse-patient relationships. In a review, Johansson et al. (2002) report that clear communication and information, and also a good relationship between nurse and care-receiver, are prerequisites for a patient’s perception of satisfaction with nursing.

Many non-verbal cues communicate expectations and can affect the health care context. One of the most powerful of these cues is touch (Depaulo & Friedman 1998).

Lesbians and gay men in a nursing context

Very little consideration is given to questions of sexuality in nursing education and training, and most often no time at all is allocated to lesbian and gay issues. Until very recently, medical textbooks dealing with sexuality have explained homosexuality as a problem or deviation from the norm, ‘a disordered sexuality’ (Wilton 2000).

Many attitudes held by nursing staff are based on the unproblematised assumption that people are heterosexual. A lack of knowledge about different ways of life and how these affect health, can lead nursing staff to ask improper questions and to form incorrect judgements (Brogan 1997; Platzer & James 2000).

Heteronormativity in nursing

Some studies have reported that the heterosexual assumptions of nursing staff compete against potentially supportive interactions with lesbian patients. A common experience was that nursing staff stopped communicating with the patients after learning that they were lesbians. Nursing staff’s heterosexual assumptions can thus lead to widespread ignorance about the specific needs of lesbians (Stevens 1995; Brogan 1997; Stewart 1998; Platzer & James 2000; Spinks et al. 2000; Westerståhl 2003). Non-verbal responses along with particular verbal remarks, may also be stressful when lesbians disclose their sexual orientation to nursing staff (Platzer & James 2000).

The specific needs of lesbians and gay men related to the fear of being mistreated after disclosure. Other examples of heteronormative messages
communicated in nursing are the emotional distress of not disclosing one’s homosexuality, absolute confidentiality, family conflicts and rejections, social isolation, etc., as well as other consequences of invisibility (Kreiss & Patterson 1997; Stevens & Morgan 1999; Albarran & Salmon 2000; Yep 2003).

Since lesbians and gay men may be vulnerable to social exclusion, they may choose to ‘hide’ (Wilton 2000). Another more understated example of heteronormativity is the design of admission forms that assume heterosexuality, with the use of terms such as ‘marital status’ (Wilton 2000), along with the verbal language used in consultation settings (Westerståhl 2003).

**The work environment**

Many lesbians and gay men fear intolerance and the loss of social value if their sexual orientation were to become known at work. To avoid discrimination and other kinds of vulnerability, many gay people hide their homosexuality and are careful about whom they share this knowledge with (Håkansson 1984; Forsberg et al. 2003). One way to hide is to avoid answering questions about- or discussing their private lives (Håkansson 1984; Lindholm 2003). A lack of employment security, the stressful choice between hiding an important part of oneself or risking the harassment of colleagues and even dismissal, has far-reaching consequences for the health and wellbeing of lesbians and gay men employees (Wilton 2000; Smith & Ingram 2004). Openness, however, is an important component in the ability to establish close, friendly relationships (Lindholm 2003; Bernstein 2004).

Earlier studies have shown that openness about one’s homosexuality at the workplace quite often results in trust and a positive response (Håkansson 1984; Forsberg et al. 2003).

Overt discrimination and/or harassment are unusual at workplaces in children’s and geriatric care (Ljunggren et al. 2003). Forsberg et al. (2003) report, however, that nursing staff in geriatric care described problematic situations for both open and concealed lesbians and gay men employees in meetings with new staff members or others they were unfamiliar with. Both Ljunggren et al. (2003) and Forsberg et al. (2003) report that, irrespective of care-context, the most common type of discrimination was public condemning and ridiculing judgements of homosexuals and bisexuals, and that women, more than men, were exposed to harassment from workmates.

Earlier studies indicate that information and/or education reduce stereotypes, prejudice and discrimination of gay people in the workplace (Crow et al. 1998; Day & Schoenrade 2000; Saunders 2001) and in education situations (Burn 2000; Ritchey & Fishbein 2001; Saunders 2001; Thurlow 2001). In another study, Conley et al. (2001) uphold that education is one part of the solution, but that interaction between homosexuals and heterosexuals is also needed to reduce stereotypes and prejudices. Jacks and Devine (2002) also maintain that heterosexuals’ prejudices are reduced by interaction, but
that for integration to occur requires an easily accessible, unprejudiced model among the heterosexuals. In a Swedish study, Österman and Carpelan (2002) report that people who had contact with and knowledge about gay people demonstrated more positive attitudes than those who had spent no time with lesbians and gay men.

**Patients and their intimates**

Some studies report no instances of altered nursing behaviour related to the patient’s sexual orientation (Forrester & Murphy 1992; Cole & Slocumb 1994). However, others indicate a relation between homophobia and attitudes of nursing staff towards gay patients (Kemppainen et al. 1996; Richmond & McKenna 1998; Lohmann 2000; Wilton 2000; Röndahl et al. 2003).

Many lesbians and gay men do not feel safe enough to come out to doctors and other health care professionals and so delay seeking treatment (Wilton 2000). Other studies (Platzer & James 2000; Spinks et al. 2000; Westerståhl 2003) have reported that women in particular feel vulnerable when they disclose their sexual orientation. Several studies have shown that gay patients fear intolerance and loss of social value if they disclose their sexual orientation, for example, by introducing their same-sex partner (Platzer & James 2000; Wilton 2000). Patients have expressed anxiety, feelings of discomfort, insecurity, and fears of hostility and even bodily harm (Brogan 1997; James & Platzer 1999; Salmon & Hall 1999; Al barran & Salmon 2000; Platzer & James 2000). Moreover, many patients and partners have reported a lack of psychosocial support from medical services. The authors suggest that many nurses find it difficult to show compassion and sensitivity and to give gay patients nursing of equal quality as they do to heterosexual patients (Lehmann et al. 1998; Wojciechowski 1998; Carr et al. 1999; Salmon & Hall 1999; Stevens & Morgan 1999; Taylor 1999; Wilson 1999; Spinks et al. 2000). Thus, the unacknowledged, invisible gay patient often exists in silence, fearing the condemning attitudes of unknowing nursing staff (Kreiss & Patterson 1997; Carr et al. 1999; Roberts & Sorensen 1999; Wilson 1999; Allison et al. 2000; Landén & Innala 2002).

**General aim**

The general aim of the project was to describe the situation of lesbians and gay men in a nursing environment by studying the attitudes of nursing staff and students, and the experiences of gay nursing staff in their work environment and of gay patients and partners in their encounters with nursing.
Specific aims

Papers I and II investigated attitudes (cognitive and emotional components) with quantitative methods. Papers III and IV investigated lesbians and gay men’s experiences in the nursing context with qualitative methods. The thesis is therefore presented in two parts, i.e., a compilation of papers I & II and of papers III & IV, and the specific aims for each paper address a more abstract level.

**Paper I & II:** The aims were to investigate the attitudes of nursing staff and nursing students towards gay persons.

**Paper III & IV:** The aims were to describe gay nursing staff, gay patients and partners’ experiences from different nursing settings and from different parts of Sweden.
Method

An overview of the sample, data collection and data analysis used in the papers is presented in Table 1.

Table 1. Sample, data collection and data analysis in the papers.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Data collection</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper I 48 nurses, 37 assistant nurses, 113 nursing students, 165 assistant nursing students</td>
<td>Attitudes Toward Homosexuality Scale (ATHS), Causes of Homosexuality Questionnaire (CHQ)</td>
<td>Descriptive statistics for demographic data, independent t-test or ANOVA for intergroup comparisons</td>
</tr>
<tr>
<td>Paper II 48 nurses, 37 assistant nurses, 113 nursing students, 165 assistant nursing students, as in Paper I</td>
<td>Affect Adjective Checklist (AAC), Nursing Behaviour Questionnaire (NBQ)</td>
<td>Descriptive statistics for demographic data, independent t-test or ANOVA for intergroup comparisons, factor analysis for AAC, content analysis for NBQ</td>
</tr>
<tr>
<td>Paper III 14 lesbian and gay nurses, 3 assistants nurses, 1 psychiatric assistant nurses, 3 nurse aides'</td>
<td>Semi-structured interview</td>
<td>Qualitative analysis performed in five steps applied to areas, categories, subcategories.</td>
</tr>
<tr>
<td>Paper IV 27 lesbian and gay patients and partners</td>
<td>Semi-structured interview</td>
<td>Qualitative analysis performed in five steps applied to areas, categories, subcategories and themes.</td>
</tr>
</tbody>
</table>

Participants

Paper I & II

All nurses (n=48) and assistant nurses (n=37) at one infectious disease clinic in central Sweden were asked to participate. The inclusion criterion was that they should work directly with patients. The response rate was 67% (n=57). Demographic data such as gender, age and occupation was collected. The majority of the participants were women (90%), and 62% (n=35) were older
than 36 years of age. Additional participant groups were all nursing students registered in semesters two and six of the nursing program of a university in central Sweden (n=155), and all students in semesters four and six of the upper secondary assistant nursing program of a school in central Sweden (n=113). These semesters were selected in order to include students at early and later stages of their training. The total response rate for the nurses and assistant nurses in training was 62% (n=165). Demographic data such as gender, age, educational level and national origin were also collected. Of these participants, 86% were women and 14% were men. The mean age of the nursing students was 27 years, and 18 years of age for the assistant nursing students. The demographic data showed that among the 165 respondents, 31 (4 nursing students and 27 assistant nursing students) were of non-Swedish origin, with origins in Asia (13), Africa (10), other European countries (6) and South America (2) represented.

Paper III & IV

The inclusion criterion for informants was that they should be self-identified lesbians or gay men. Informants who identified themselves as bisexual were excluded. This is since it was supposed that the bisexual’s situation in nursing contexts is not directly comparable to that of homosexuals. Rather, the bisexual situation could well be even more complex and thus demand a separate study.

Paper III

The participating informants were nurses (n=14) and other nursing staff (n=7), made up of 11 lesbians and 10 gay men ranging in age from 19 to 58 years. The informants came from various educational backgrounds, had different work experience, and worked in different nursing settings (i.e., ambulatory care, emergency care, anaesthesia, surgical care, internal medicine care, geriatric care, elderly care and psychiatric care) in different parts of Sweden, representing rural communities (n=6), towns (n=11) and metropolitan areas (n=4).

Paper IV

The participating informants (n=27) were 17 women and 10 men ranging in age from 23 to 65 years. The informants had different educational backgrounds, including grammar school (n=8) and university (n=19). They came from different parts of Sweden, and three were of non-Swedish origin. The informants told of 46 nursing experiences as patients and, 31 nursing experiences as partners. Some informants (n=13) had experiences from several nursing settings and some also had experiences from different hospitals. Among the informants, 8 had experiences only as patients and 2 only as partners.
Design and Procedure

Paper I & II
This study had a descriptive and comparative design. To achieve a high response rate, an anonymous collection of data was employed. The data was collected from nursing staff in 1999. The second phase of data collection (nursing students) was performed in 2000. The participants consisted of nurses, nursing students, assistant nurses and assistant nursing students. In the case of the nursing staff, the respondents received the questionnaires at work and were asked to fill them out (at work or at home) and place the completed surveys in a locked box at their department. A reminder was sent after two weeks. The questionnaires were anonymous and coded by profession (e.g., nurse) or by education and semester for the students (e.g., nursing student/4). In the case of the students, the first author was present during the data collection, and able to answer questions from the four teachers who handed out and collected the completed questionnaires. The completed questionnaires were returned to the author immediately after they were collected.

Paper III & IV
This study had a descriptive and explorative design and the qualitative semi-structured interviews were performed in 2003 and 2004. Recruitment of the informants was done by snowball sampling, for Paper IV also by advertising on websites for gay people. The study started with two key informants known to the first author. The key informants received written and verbal information about the study and were asked to recruit new informants by passing on or sending the information letter. New informants were asked to contact the interviewer if they wanted to participate. The informants were also assured that, until they contacted the interviewer, only the person who had forwarded the letter to them knew who they were.

Data collection and data analysis

Paper I & II
The data collection took the form of four questionnaires which took about 20 minutes to fill out. The questionnaires were delivered in the following order: the Affect Adjective Checklist (Ernulf & Innala 1987), the Attitudes Toward Homosexuality Scale (Herek 1984), the Causes of Homosexuality Questionnaire (Ernulf et al. 1989), and the Nursing Behaviour Questionnaire (Rönndahl et al. 2003). The survey data included the demographic data collected.
Affect Adjective Checklist (AAC)
The AAC was developed to measure emotional aspects of homophobia. The checklist starts with a short anecdote describing how a young man (Gunnar) tells his parents that he has fallen in love with his friend (Martin) and that they have decided to live together. Directly after the anecdote, respondents are asked how they feel about this (‘How did you feel right after you read the anecdote?’). The participants respond by filling in a checklist consisting of 15 adjectives, including embarrassed, compassionate, contended, guilty, satisfied, encouraged, enlightened, angry, disdainful, happy, ashamed, proud, disgusted, frightened and awkward. A score is given for each adjective using a 4-point scale, ranging from ‘very much’ to ‘not at all’, based on the degree to which that adjective represents their emotions. Innala and Ernulf (1992) have earlier reported a factor analysis of the checklist. The analysis of the adjectives yielded three emotional factors: homophobic anger, homophobic guilt, and delight.

A principal component factor analysis with Varimax rotation was performed. Only loadings >.40 were regarded as significant, see Table 2. The factor analysis yielded three factors, accounting for a logical explanation of 64.4% of the total variance.

Table 2. Factor analysis of the affect adjective checklist (AAC).

<table>
<thead>
<tr>
<th>Adjective</th>
<th>Factor loading</th>
<th>Adjective</th>
<th>Factor loading</th>
<th>Adjective</th>
<th>Factor loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embarrassed</td>
<td>.64</td>
<td>Guilty</td>
<td>.75</td>
<td>Contented</td>
<td>.84</td>
</tr>
<tr>
<td>Angry</td>
<td>.78</td>
<td>Compassionate</td>
<td>.50</td>
<td>Satisfied</td>
<td>.88</td>
</tr>
<tr>
<td>Disdainful</td>
<td>.93</td>
<td>Frightened</td>
<td>.57</td>
<td>Encouraged</td>
<td>.84</td>
</tr>
<tr>
<td>Ashamed</td>
<td>.59</td>
<td>Enlightened</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disgusted</td>
<td>.81</td>
<td>Happy</td>
<td>.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awkward</td>
<td>.52</td>
<td>Proud</td>
<td>.83</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 15 items had significant loading for three interpretable factors: homophobic anger, homophobic guilt and delight. The reliability coefficients (Cronbach’s alpha internal consistency) for the Homophobic Guilt, Homophobic Anger and Delight subscales were 0.80, 0.79 and 0.90, respectively.

Attitudes Toward Homosexuality Scale (ATHS)
The ATHS was developed to measure attitudes towards homosexuals (Herek 1984). A shorter, 10-item Swedish version was used (Innala 1995). Half of the items referred to attitudes toward lesbians and the other half to gay men. The 10 item statements were:
1. Lesbians don’t fit into our society.
2. I would like to have lesbian friends.
3. Female homosexuality is a sin.
4. Homosexual behaviour between two men is just plain wrong.
5. Male homosexuality is merely a different kind of lifestyle that should not be condemned.
6. Female homosexuality in itself is no problem, but what society makes of it can be a problem.
7. Lesbians are sick.
8. I think male homosexuals are disgusting.
9. Male homosexuality is a perversion.
10. Just as in other species, male homosexuality is a natural expression of sexuality in human men.

Participants noted their response by marking a number on a scale of 1 (strongly agree) to 9 (strongly disagree). Four items (2, 5, 6 and 10) were positively worded and were therefore reversed-scored, so that a low score indicated a negative attitude towards homosexuals. Consequently, the total scores could range between 10-36 (negative attitudes), 37-63 (neutral/tolerant attitudes) to 64-90 (positive attitudes). In the presented study, the measure of reliability (Cronbach’s alpha internal consistency) of the sample’s entire scale was 0.73.

Causes of Homosexuality Questionnaire (CHQ)
The CHQ estimates a person’s beliefs regarding the causes of homosexuality. The respondents were asked about the causes of homosexuality and were given four statements to choose from:
1. They are born that way (homosexual)
2. They choose to be that way (homosexual)
3. They learn to be that way (homosexual)
4. Other. For the reply ‘Other’, there was room to add comments.

Nursing Behaviour Questionnaire (NBQ)
The NBQ was designed to study nursing staff and students’ experience of nursing- and willingness to nurse HIV-infected patients and homosexual patients, see Appendix 1. The NBQ consisted of four statements. The first two dealt with the respondent’s experience with HIV-infected patients and of caring for homosexual patients. These were ‘Yes’ or ‘No’ questions. The third statement was: ‘If I was given the possibility to choose, I would give up nursing HIV-infected patients.’ The fourth statement was: ‘If I was given the possibility to choose, I would give up nursing homosexual patients.’ These two statements were to be answered on a 4-point scale ranging from 1 (strongly agree) to 4 (strongly disagree). Consequently, the total scores could range from 1-2 (to some degree would like to avoid nursing homosexual
patients) to 3-4 (had no wish to avoid nursing homosexual patients). For the third and fourth statements, there was also space for separate comments.

Paper III & IV

Interviews

An interview guide was designed based on a qualitative interview methodology (Creswell 1998), see appendices 2 and 3. The taped interviews took place with each informant in the location of their choice and lasted for 20-90 minutes. Demographic data were also collected.

The interview started with a neutral question (i.e., a non-emotionally charged question) regarding the words the informant preferred to use for women and men in general, and for women and men who choose to live (have a sexual relationship) with another person of the same sex. These words were then used during the interview. Two questions were addressed for Paper III: the experiences of gay nursing staff in the work environment, and what informants thought was important to emphasise regarding homosexuality and the nursing work environment. Two questions were addressed for Paper IV: the experiences of patients and/or partners in hospital care, and what the informants regarded as important to communicate concerning gay patients in nursing. The natural conversation was expanded with more specific questions and/or reflections on statements relevant to the aim of the study. The interviews were later transcribed verbatim by the first author.

Data analysis

Inspired by Creswell (1998), Hyrkäs & Paunonen-Ilmonen (2001) and Nordgren & Fridlund (2001), 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 and what they considered important to communicate concerning homosexuality and nursing. Similar responses were sorted into positively, negatively and neutrally expressed information. (3) The positive, negative and neutral responses were classified into areas. (4) The areas were divided into categories. (5) The different categories were analysed separately and words identified. These words led to subcategories. Necessary revisions of the classifications/categories/subcategories were made throughout the five steps of the analysis process and, finally, the levels of abstraction were raised to themes before a summary of the content was made.
Critical discussions of methods

Paper I & II

One limitation of the study is that the sample was rather small and not randomly selected, making wider generalisation difficult. The participants completed the questionnaires in the following order: (1) information sheet and demographic data, (2) Affect Adjective Checklist (AAC), (3) Attitudes Towards Homosexuality Scale (ATHS), (4) Aids Attitude Scale (AAS), and (5) Nursing Behavioural Questionnaire (NBC). Earlier studies (Innala 1995; Van de Ven et al. 1996) show that the structure of individuals’ affective reactions to gay social situations is independent of what gender the anecdote in AAC is presented. The male version was therefore used in the present study. The order in which the questionnaires were given may have influenced the participant’s answers, especially with respect to AAS’ influence on answers in NBC. The question about the wish to refrain from nursing HIV-infected patients may, in addition, have influenced the findings for the question about the wish to refrain from nursing homosexual patients. None of the students had any work-related experience of gay patients so the possibility exists that they may have confused homosexual male patients with HIV-infected patients, and responded accordingly. The participation was anonymous, so no follow-up could be done concerning the reasons why some participants wanted to refrain from caring for homosexual patients.

Paper III & IV

It was difficult to reach and recruit nursing assistants, psychiatric nursing assistants, and nurse’s aides. This could be due to the fear of disclosure being bigger in these groups than the participating informants, since these groups are at the bottom of the nursing hierarchy, i.e., they depend more heavily on social value and thus have more to lose. It was also difficult to reach and recruit older lesbians and gay men. Some of the oldest participating informants suggested a number of contacts, but these did not lead to these other people contacting the interviewer (i.e., the author). This could be due to the fear of disclosure being greater for older lesbians and gay men than for the informants that participated, since they have a long tradition of secret life and of living double lives due to society’s past legislation and stigma. The elderly have unique experiences and are often in need of recurring nursing and their information had therefore been of great value. More time should have been spent on recruiting more persons from these groups as they may have specific information to contribute concerning the nursing context.

Most informants related similar experiences despite their having been recruited from nearly all parts of Sweden. Platzer & James (1997) state that the
weakness of the snowball sampling method is that you receive similar data. The method was chosen, however, since snowball sampling has proven most effective in other comparable studies (Platzer & James 1997). The informants who participated may not be representative of all gay nursing staff or patients and partners, but are able to illustrate experiences of nursing for lesbians and gay men within a concrete historical, institutional and organisational context. The narratives are important for future studies concerning the conditions of gay staff, patients and partners in nursing.

Credibility is an issue of importance with open interviews and refers to confidence in the truth of the data (Graneheim & Lundman 2004). The interviewer’s personal interests may influence the data gathered from the informant such 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 (Polit & Hungler 1999). To minimise 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 may have been possible to reduce the threat to credibility but at the risk of losing important information.

The data were analysed by the author and the second supervisor, separately, after which a collective analysis of the author’s individual analyses was carried out until accordance was achieved. The analysers have different educational backgrounds, different gender and different sexual orientation, which may be a strength for the performed analysis and lead to a higher degree of trustworthiness (Graneheim & Lundman 2004). After analysis of the data, the informants were given the opportunity to read the final results (in Swedish) and to correct possible misunderstandings (respondent validation) (Polit & Hungler 1999), but no one did. The findings have also been discussed in seminars at HomO (the Ombudsman against Discrimination on grounds of Sexual Orientation), an organisation that has the competence to validate the relevance and meaning, i.e., conformability (Burnard 1991), of the information and how it is interpreted. Finally, the findings are presented as a descriptive summary of the informants’ narratives and organised in a way that best contains the interview data, which 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 (Sandelowski 2000).
Ethical considerations

Paper I & II

Before data collection began, approval was obtained from the department heads and those responsible for the nursing- and assistant nursing programs. The participants were informed of the study orally and in writing during a workplace meeting or at a lesson. Those who did not wish to participate were asked to write down the reason for this, but no one did. All participants received verbal and written information before the study started, stating that their participation was voluntary and that their responses were confidential. Completing and returning the questionnaires indicated a participant’s tacit consent.

Paper III & IV

The study was approved by the Medical Ethics Committee, Uppsala University (File no. Ups 02-209 and File no. Ups 02-249).

Before the conversational interview started, all informants received verbal and written information stating that their participation was voluntary, that the information they provided would be confidential, and that informants would remain anonymous in any interview material published. Only the interviewer knew the identity of the informants, in most cases learning this when an informant took contact for the interview. 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.
Summary of findings and discussions

**Paper I & II**

**The cognitive components**

A comparison of the attitudes of the nursing staff (nurses, assistant nurses) and the students (nursing students, assistant nursing students) was performed. A high score (maximum 90) indicates appropriate knowledge and a positive attitude toward lesbians and gay men. The sample as a whole (n=224) reported appropriate knowledge and positive attitudes (M=68.90, SD=16.70). The variation in attitudes toward homosexuality in the entire sample (n=224) ranged from: negative attitudes – expressed by 17 participants (8%), neutral/tolerant attitudes – expressed by 67 participants (30%), and positive attitudes – expressed by 140 participants (62%).

The attitude scores of subjects who believed that homosexual people were ‘born that way’ (congenital) were compared to those who believed that they ‘choose/learn to be that way’, the latter belief thus endorsing the view that homosexuality is acquired. A total of 212 subjects responded to the question concerning the causes of homosexuality. A majority of the subjects (58%, n=124) believed homosexuality to be congenital, 35% believed it to be acquired, and 7% chose the response ‘Other’. Typical examples of written comments from students who responded ‘Other’ included: *Today, homosexuality has become a whim of fashion; A result of humanity having turned its back on God.*

The two groups (congenital or acquired) reported significant differences in attitudes according to their belief about the cause of homosexuality (t=3.46; DF=182; p=0.0007). The group that believed homosexuality to be congenital expressed a higher score for positive attitudes than the group that believed homosexuality was acquired.

**The emotional components**

A comparison of the emotional components of the attitudes held by the nursing staff (nurses, assistant nurses) and the students (nursing students, assistant nursing students) was performed. The four respondent groups demonstrated significant differences concerning both *homophobic anger* (F=6.058; DF=3/217; p=0.006) and *homophobic guilt* (F=3.986; DF=3/219;
The assistant nursing students expressed more homophobic anger and homophobic guilt than the other groups. There were also significant differences between the groups concerning delight ($F=6.012; DF=3/217; p=0.0006$). The nursing students and the assistant nursing students expressed more delight than the nurses and assistant nurses.

Since a considerable percentage (22%) of the students had a non-Swedish cultural background, the relationship between emotions and cultural background was investigated. The results showed significant differences between the groups regarding both homophobic anger ($t=3.24; DF=157; p<0.001$), and homophobic guilt ($t=4.35; DF=157; p<0.001$). Those with a cultural background other than Swedish showed higher scores for homophobic anger and homophobic guilt than those with a native Swedish background. No significant differences were seen between the groups regarding delight ($t=0.96; DF=157; p=0.334$).

**Discussion of Paper I & II**

In general, the participating nursing staff and students expressed positive attitudes, though some subjects reported very negative attitudes towards gay people. The positive result may therefore show a change in cognitive attitudes (Fiske & Taylor 1991; Eagly & Chaiken 1998; Crandall & Eshleman 2003; Kruglanski & Higgins 2003) toward gay people and increased knowledge about homosexuality in nursing than reported in earlier studies (Brogan 1997; Platzer & James 2000). Nursing contact requires positive interaction (Bentling 1995; Brewer & Brown 1998; Henderson & Forbat 2004; McCabe 2004). Although nursing staff often think they can care for patients in a ‘neutral’ way (Richmond & McKenna 1998; Eliason & Raheim 2000; Röndahl et al. 2003), studies have shown that patients’ perception of good quality care depends on the interpersonal aspects of the care provided (Attree 2001; Johansson et al. 2002). In the present study, nearly one third of the participants expressed neutral/tolerant attitudes toward gay persons, which is a positive result if this can be attributed to tolerance, even though nursing requires positivism, engagement and empathetic attitudes towards all patients (Attree 2001; Johansson et al. 2002), probably to a greater extent than many other professions where neutral/tolerant attitudes are enough. The finding may be an expression of ambivalent attitudes (Brewer & Brown 1998; Eagly & Chaiken 1998; Jost & Kramer 2002) due to lack of control (Riezler 1944; Dozier 2000; Frijda et al. 2000; Gullone 2000), experience (Blair et al. 2003), and knowledge of how to behave (Smith & Mackie 2002; Robinson 2004), or to suppressive-, affective- or equilibrium ambivalence (Crandall & Eshleman 2003). It may also be an indication of respondents giving ‘socially desirable’ answers (Fiske & Taylor 1991), demonstrating a conflict between personal attitudes and ethical obligations (Crandall et al. 2002; Brewer 2003; Crandall & Eshleman 2003). However, ambivalent attitudes are normal and
to be expected (Fiske et al. 2002; Mackie & Smith 2002), even if they may cause negative emotions such as insecurity, anxiety and embarrassment, and undermine one’s professional self-esteem (Stephan & Renfro 2002; Blair et al. 2003). Neutral/tolerant nursing staff and students should be encouraged to develop a more positive attitude toward nursing contact with homosexuals (Brewer & Brown 1998), and it is important to increase knowledge and positive personal contacts to reduce negative emotions (Fiske & Taylor 1991; Cialdini & Trost 1998; Conley et al. 2001; Jacks & Devine 2002; Mackie & Smith 2002; Kruglanski & Higgins 2003; Bernstein 2004). The negative emotions maybe otherwise lead to prejudices (Bernat et al. 2001; Fiske et al. 2002), distrust and suspicion (Kramer & Jost 2002), and social distancing (Mackie & Smith 2002). The small group of very negative participants may not be overlooked, since they may be persons with high prejudice (Ford & Ferguson 2004) and greater anxiety (Fiske et al. 2002) when duty demands interaction with a gay person of the same sex as themselves (Dovidio et al. 2002; Blair et al. 2003). Consequently, emotions such as anxiety may cause the urge to move away from the person (Devos et al. 2002; Fiske et al. 2002; Neuberg & Cottrell 2002), or even lead to a more intense dislike of gay persons than before the interaction (Devos et al. 2002; Blair et al. 2003) and a greater tolerance of discrimination toward the person who caused the anxiety (via one’s own prejudices) in the first place (Ford & Ferguson 2004). Although infrequent, it is probable that gay patients encounter nursing staff who would like to refrain from giving them nursing care. Gay patients may also hesitate to seek the care they need because of an earlier encounter with negative reactions or neglect.

In a cross-national study, Ernulf et al. (1989) investigated the relationship between homophobia and an individual’s beliefs (n=610) about whether homosexuality is congenital or acquired. A majority of the subjects (72%) believed that homosexuality was acquired. The group that believed that homosexuality was congenital represented a minority (28%) in the study. In the present study, the participants expressed the reverse, which might be a sign that the social desirability of believing in one or the other cause of homosexuality has shifted, as argued by Ernulf et al. (1989). The present study also showed that people who believed that homosexuality was congenital expressed less negative attitudes than those who believed that it was somehow acquired, confirming earlier studies (Ernulf et al. 1989). In the present study, some participants believed in an explanation of homosexuality ‘other’ than congenital or acquired, with some of the written comments indicating religious beliefs such as a failure of Christian ideology as described by Crandall and Eshleman (2003).

The sample also expressed a full spectrum of emotions, from delight to anger. However, the most commonly expressed emotions loaded in homophobic guilt or delight, which may be classified as exclusion emotions (Devos et al. 2002) and positive emotions (Mackie & Smith 2002), respectively,
and defined as the simplest kind of emotional component of homophobia (Innala 1995; Van de Ven 1994; 1995; Van de Ven et al. 1996). Guilt and fear may be caused by suppressed prejudice (Crandall & Eshleman 2003) resulting from inflexible socio-cultural norms (Thibaut & Kelley 1959; Hinton 2003) in which unknown others are perceived as threats (Stephan & Renfro 2002; Robinson 2004), automatic and unconscious (Rusbult & Van Lange 2003), and cause ambivalent emotions such as insecurity (Smith & Mackie 2002) and fear of the unknown (Gullone 2000; Stephan & Renfro 2002; Blair et al. 2003; Brewer 2003; Röndahl et al. 2003), which are normal reactions (Fiske et al. 2002; Pissiota 2003) and are to be expected (Mackie & Smith 2002) in situations involving intergroup relations (Jost & Kramer 2002). Emotions such as guilt and compassion may lead to behaviours like helping (Fiske et al. 2002), which is a necessary component in empathic quality care (Attree 2001; Johansson et al. 2002). Emotions loaded in homophobic anger, such as anger, disdain and disgust, may be classified as attack emotions (Devos et al. 2002) and may lead to lack of assistance (Fiske et al. 2002; Blair et al. 2003). When these reactions are activated, it may lead to different kinds of discrimination (Devos et al. 2002; Dovidio et al. 2002).

In earlier studies (Innala 1995), the emotion of embarrassment has loaded in the factor homophobic guilt, but in the present study embarrassment loaded in homophobic anger. Earlier studies describe embarrassment as consisting of several negative emotions and a powerful means of social control (Stephan & Renfro 2002; Lawler 2004). Nursing staff have no opportunity to choose patients and are expected to treat every patient equally regardless of the emotions they experience or beliefs they have. The finding may be due to the fact that the study was performed in nursing, where discomfort and awkward situations may lead to frustration and the anxiety of losing face or honour, which is so embarrassing that it in turn creates anger, as Stephen and Renfro (2002) and Lawler (2004) argue. Specific studies are needed to investigate this.

The fact that assistant nursing students were the group with most homophobic anger, guilt and delight might be explained by the group’s heterogeneity with respect to gender, life experiences and cultural backgrounds. This finding may also reflect that teenagers nowadays can have a great variety of different opinions, influenced by television, the media, etc. Further, the group that expressed the highest level of homophobic anger and guilt were assistant nursing students with non-Swedish cultural backgrounds. With a growing number of the nation’s population coming from non-Swedish cultures, the need for nursing staff with experience from different cultures is increasing. There is an evident need for providing staff who are prejudiced with the education and tools necessary (Crow et al. 1998; Burn 2000; Day & Schoenrade 2000; Ritchey & Fishbein 2001; Saunders 2001; Thurlow 2001) to provide equal care to patients, independent of their sexual orientation. In
order to do so, courses to increase the care provider understanding of and respect for lesbians and gay men should be made mandatory.

All nursing staff have a moral obligation to acknowledge and accept the diversity of humans’ life experiences and relationships. Interaction between heterosexuals and lesbians and gay men can help to break down false and narrow stereotypes when these stereotypes are unconfirmed (Jacks & Devine 2002; Österman & Carpelan 2002). However, to do so requires an openness about one’s own prejudices and ambivalent emotions in order to reduce feelings of insecurity and anxiety related to gay issues in nursing. Even so, negative emotions may leak out (Crandall & Eshleman 2003) and communicate reciprocal misunderstandings (Leyens et al. 2002), and increase behaviours such as avoidance due to insecurity (Robinson 2004). Studies have shown that people with the most negative attitudes sometimes become less negative after interaction with lesbians and gay men, and that people with neutral/tolerant attitudes can become more positive towards gay people (Herek & Glunt 1993; Innala & Ernulf 1993; Landén & Innala 2002). However, since gay patients have often been a hidden group in nursing care, open interpersonal contact is nearly impossible and/or infrequent. In order to make gay patients visible and change negative attitudes towards homosexuality, education is a necessary beginning, as well as an important aspect of practical nursing ethics (Richmond & McKenna 1998; Taylor 1999; Allison et al. 2000; Röndahl et al. 2003).

Paper III & IV

The purpose of the analysis of the interview data was to identify qualitative similarities and differences between informants’ experiences as nursing staff, patients and/or partners in nursing contexts. Several categories and themes were found, including heteronormativity, fear, insecurity and communication. Since pure description of the informants’ information was desired, these are presented below using descriptive and typical quotations taken from the interviews.

Nursing staffs experiences from the work environment

Initially, the informants were asked to describe their psychosocial work environment. Several answered that the nursing environment reflects the views of society. As one informant stated:

It isn’t really much different than being homosexual in a heterosexual society where the heteronorm prevails ... a daily struggle against what is taken for granted in the world around you.
Most informants spoke positively about their psychosocial work environment. They felt they were accepted and respected by their workmates. Many of the informants never thought of themselves as ‘different’ or experienced themselves as outsiders. Instead, they saw themselves as a part of workplace fellowship. Further, they experienced positive feelings when workmates learned ‘the truth’ and telling all the white lies was no longer necessary. Many also spoke positively about- and described a great relief when the reaction from heterosexual workmates was positive, instead of negative as anticipated. Several informants pointed out the dilemma that many heterosexuals appeared to confront when meeting a lesbian or gay man for the first time: One informant explains:

I think that most people are decent but can sometimes act stupidly – not out of maliciousness but because they just don’t know any better… I firmly believe that the reason things can go so wrong sometimes is heteronormativity. It causes problems… People mean well but it turns out soooo wrong!

Regardless of whether informants were open or concealed about their sexual orientation at work, they talked about the constant fear they carried. Fears of social exclusion and/or special treatment were most strongly worded:

It’s not that I think someone is going to stand up and say “you’re ugly and stupid and shouldn’t be allowed to exist”. It’s more the risk of being excluded that you always have to take into account. I don’t think … that I would be excluded … but I’m afraid of being treated differently somehow… I’m always afraid that it will be... negative somehow.

Some informants thought that fear could be great among both homosexuals and heterosexuals, which made the fear even more complex. Many attributed insensitive jokes about lesbians and gay men told by heterosexuals as an expression of a fear of people who are ‘different’ or not ‘normal’. Further, the fear of not being accepted was described as common among lesbians and gay men, and the most common protection strategy was to hide their sexual orientation.

Patients and partners experiences from hospital care

Nearly all informants described several situations where heteronormative assumptions were communicated by the nursing staff. The informants felt that nursing, as an institution, took a conservative approach, which was followed by the nursing staff without reflection:

...They take for granted that I’m heterosexual until I say that I’m not, and then everything comes to a halt. It’s typical of the health care system.....it’s a very old-fashioned way to look at it, I think.
Heteronormativity is often communicated immediately in waiting rooms and other public areas, through brochures and other information materials, but also through different kinds of forms where personal information is filled in, such as civil status (i.e., married, divorced or single). The informants felt that the norm possibly had a restraining effect on both heterosexuals and homosexuals and that the nursing institution was probably unaware of this.

If informants stated ‘cohabiting’, the nurse would ask for his name (in the case of female patients) and her name (for male patients) and then show surprise and/or a perplexed reaction. Some informants reported that when the patient gave the (same gender) name of her/his partner, the nurse repeated the question, as this patient explains:

...Since I’ve been living with a man for 24 years, it was his name I gave and said that he was the partner I lived with. Then the nurse said: “Okay…but don’t you have a relative or someone?” ...It was kind of strange how she was so surprised because as a care worker you’d think she must have met a lot of homosexual men ...

The informants told of negative experiences related to a lack of open and direct communication and heteronormative assumptions. The informants assumed that many misunderstandings were based on language use since they believed heterosexual people were afraid of humiliating someone by choosing the ‘wrong’ words when communicating with gay people. The informants felt that their own choice of words was often based on consideration of heterosexuals’ sensitivity for gay issues, and thereby led to apprehensive communication on the part of both personnel and patient:

...They shouldn’t be so afraid of maybe, possibly stepping on someone’s toes...You can use more neutral words like ‘homosexual’ and upset one person, or ‘dyke’ and upset someone else...But as long as it’s positive, it doesn’t really matter...you can call me whatever you want...(laugh)

Many informants said that they often met personnel who seemed to be afraid to meet gay patients the ‘wrong way’, but that this fear easily led to insecurity for both the patient and personnel, which thereby disrupted communication. These informants described the patient situation as oppressive, and being open about their homosexuality under those circumstances was frightening, since they supposed the personnel would react negatively. Other informants considered it important to emphasise openness about homosexuality since it may affect the communication positively and reduce misunderstandings:

If you’re secretive about the way you live and all, it can easily lead to you being treated funny. I think my own personality and self-assuredness have a greater effect on how I’m treated than my homosexuality.
Several informants compared their experiences as patients and as partners, and described the experience as this woman did:

…In my experience as both a patient and a close relative, it’s been worse to be the relative …As a patient, they pretty much have to take care of me, but as a relative they can ignore me…like my being there makes the patient homosexual – if I weren’t there, she would just be another patient in the lot. But since she had me with her – she suddenly became something else …and it’s probably easier to just close your eyes and pretend I’m not there …but I can really only interpret it as if they didn’t accept that we had a homosexual relationship…. They would much rather talk to our parents, even though we are adults...

Implications for nursing

The informants were encouraged to express what they thought was important to emphasise concerning lesbians and gay men as personnel, patient or partner in the nursing context. Almost all informants contributed by noting some issues, recommendations and/or advice. The points noted by personnel, patients and partners on the topic of what they thought was important to emphasise and their recommendations were compiled and are presented, in brief, below.

Make gay people and gay culture visible by:

- If you are gay, talk to your workmates about your everyday life to spread knowledge about gay culture.
- Create forums and discussions on a general basis about gay issues in nursing contexts.
- Use gay employees as a resource in nursing since they possess a great competence of their own culture and also have experience as a minority.
- Be aware of that lesbians are less open and therefore less visible than gay men, but that there are probably just as many of them.

Almost all informants offered some advice for nursing staff to facilitate communication. The following statements represent some of the things informants would like nursing staff to think about:

- All patients are not heterosexual, there do exist other kinds of families.
- Use gender-neutral terms in family matters such as: Do you live alone or with someone? Who do you live with?
- If the patient is open about her/his gay life, ask specific questions for gay patients at registration as: How open are you? Could you be placed in a room for two patients even if your partner visits you? Do you get support from friends and family, your partner’s relatives? Does your partner communicate with your parents and siblings?
• Ask the patient directly what she/he wants the personnel to call her/his partner and how it shall be documented.
• Talk directly to the patient about her/his partner in a neutral way.
• Chat with the patient and their partners about neutral things on an everyday basis.
• Many single lesbians and gay men have a poor social network and therefore depend on support from nursing staff.
• Elderly gay persons are most often secretive about their homosexual lifestyle and often live a double life socially.
• Elderly gay persons often have few close friends who they can turn to when they need help and support.
• Elderly gay persons are particularly sensitive to the verbal and non-verbal language used, and many use a code language that is often only known by a few other people.
• Put gay literature and other information, e.g., local gay associations, in waiting rooms and other public spaces.

All informants advocated emphasising gay people as rather plain, ordinary people, just like everybody else in society. They also cite a great need for spreading knowledge about gay issues since they felt there was a lack of this in nursing, enabling unconscious prejudices and stereotypes. The informants recommended in particular knowledge in the following subject fields:
• Personal relationships and different family constellations.
• Same-sex relationships.
• Sexuality-based prejudice.

Discussion for Paper III & IV
The heterosexual norm is learned from early childhood (Wilton 2000) and exists everywhere and in all social situations (Yep 2003) based on the cultural ‘truth’ (Hinton 2003) that assumes the heterosexual nuclear family norm as the natural form of living arrangement (Håkansson 1984; Wilton 2000; Bernstein 2004; Herek 2004). In the present study, all informants illustrated their nursing experiences as similar to other life experiences for gay people. Similarly to other settings in society, their meetings with heterosexuals in nursing were based on heterosexual norms communicated both verbally and non-verbally, which confirms earlier studies (Brogan 1997; Platzer & James 2000). All relationships involve verbal and non-verbal communication (Seden 2004) and a transmission of cultural knowledge (Krauss & Chiu 1998; Maltén 1998; Kruglanski & Higgins 2003), and the informants were likely automatically assumed to be heterosexuals until they communicated otherwise (Håkansson 1984; Stevens & Morgan 1999; Stewart 1999; Platzer & James 2000; Wilton 2000; Yep 2003; Chur-Hansen 2004). This finding is
not strange since the heterosexual norm probably is as powerful as Yep (2003) argues.

In the present study, the gay personnel reported fear and concern about heterosexuals’ reactions to their ‘coming out’. The finding may be a sign of the fear of negative attitudes and negative consequences, as earlier studies argue are due to heteronormativity (Stevens & Morgan 1999; Stewart 1999; Platzer & James 2000; Wilton 2000; Yep 2003; Chur-Hansen 2004). The finding may also be a sign of the anxiety and insecurity suggested by Smith and Mackie (2002), related to an ambiguity about how to behave and ambivalent emotions, which lead individuals to prefer to avoid contact (Brewer & Brown 1998; Mackie & Smith 2002) due to low power and control (Stephan & Renfro 2002; Brewer 2003) and emotional expectations of the worst (Blair et al. 2003) scenario.

The patients and partners told about the insecurity of ‘coming out’, as several earlier studies have noted (Brogan 1997; Salmon & Hall 1999; James & Platzer 1999; Albarran & Salmon 2000; Platzer & James 2000; Wilton 2000), and supposed that heterosexual nursing staff were also insecure about appropriate lexical choices and behaviour towards gay patients and partners. These emotions may cause behaviours that send ‘double messages’ (Depaulo & Friedman 1998; Leyens et al. 2002; Mackie & Smith 2002; Crandall & Eshleman 2003; Cameron 2004), especially if the persons try to control and suppress their communication (Brewer 2003; Crandall & Eshleman 2003; Heisel & Mongrain 2004). This can lead to interactions being experienced as negative (Stevens 1995; Brogan 1997; Stewart 1998; Platzer & James 2000; Spinks et al. 2000; Westerståhl 2003), and cause lesbians and gay men to delay seeking care in future (Wilton 2000; Devos et al. 2002) due to feelings of vulnerability and the perceived threat of negativity (Kramer & Jost 2002; Blair et al. 2003; Crandall & Eshleman 2003). If nursing staff feel torn between an underlying impulse to be tolerant towards gay persons and a visceral discomfort with gay culture, this may cause suppression or affective ambivalence (Crandall & Eshleman 2003). Communication may also be influenced by ambivalent emotions, which are normal and expected (Fiske et al. 2002; Mackie & Smith 2002), but may cause great risks for misunderstanding (Depaulo & Friedman 1998; Leyens et al. 2002; Brewer 2003; Heisel & Mongrain 2004; Robinson 2004). Such misconceptions may very well be caused by the ambiguous heterosexual norms communicated by nursing staff (Robinson 2004; Stevens 1995; Brogan 1997; Stewart 1998; Platzer & James, Spinks et al. 2000; Westerståhl 2003), prejudiced behaviours expected by gay persons (Brewer 2003; Kramer & Jost 2002), and a lack of control over the feared situation (Riezler 1944; Dozier 2000; Frijda et al. 2000; Gullone 2000; Dovidio et al. 2002; Blair et al. 2003). Furthermore, if ‘invisible’ gay patients and partners do not ‘come out’, and hide important information about their living conditions, they risk not receiving adequate...
The informants regarded openness as important since heterosexuals need to ‘get used to’ gay relationships, families, culture, language, etc. Earlier studies (Mackie and Smith 2002; Lindholm 2003; Bernstein 2004) argue for the importance of friendship since it may reduce negative emotions. In the present study, fear and insecurity influenced the openness about one’s sexual orientation and all informants, to some degree, always calculated the necessity of openness. Gay nursing staff that had ‘come out’ to workmates felt a sense of relief and had only positive experiences of workmates’ reactions, as also Håkansson (1984) and Forsberg et al. (2003) reported, yet were once again afraid in new situations. Taking into account the risks of ‘coming out’ was a continual process. The cited consequences of being secretive were social isolation and having to tell white lies about one’s private life. This finding is not hard to understand since the informants leave themselves vulnerable to possible rejection or unfair treatment when they disclose themselves (Cialdini & Trost 1998; Rusbult & Van Lange 2003; Robinson 2004), and their distrust is not always irrational (Kramer & Jost 2002). Brewer (2003) writes that social dilemmas are common in all social groups, and Kramer and Jost (2002) describe distrust and suspicion as frequent in dilemmas between groups where one group has low power or high dependence. The informants’ ambivalent emotions may explain the vulnerability and insecurity that a distrust of others can cause (Kramer & Jost 2002) or be a sign of internalised homophobia (Innala 1995; Richmond & McKenna 1998; Taylor 1999) that may lead to emotions of shame over one’s own gay orientation as Yep (2003) argue, or may simply be a sign of the constant ‘coming out’ process (Stevens & Morgan 1999; Taylor 1999; Wilton 2000; Forsberg et al. 2003). Nevertheless, it is important for lesbians and gay men to ‘come out’ among workmates to reduce negative emotions, prejudices, stereotypes, etc., among both heterosexuals and homosexuals, as Bernstein (2004) argues. However, lesbians and gay men remain invisible (Stevens & Morgan 1999; Stewart 1999; Platzer & James 2000; Wilton 2000; Yep 2003; Chur-Hansen 2004) and live with the stress, the fear, the insecurity, and assessing the risks of disclosure, that easily result in personal consequences, which can lead to both depression and distress (Wilton 2000; McAndrew & Warne 2004; Smith & Ingram 2004), which in turn may end in ‘soul murder’ (Yep 2003).

Without knowledge about same gender families and relations, nursing staff can not possibly have an understanding of a gay person’s life (Wilton 2000). Nevertheless, nursing staff must learn how to communicate in a natural way with gay people and to be aware of the norms communicated through their use of language and behaviour (Brogan 1997; Platzer & James 2000). Ridiculing humour (Forsberg et al. 2003; Ljunggren et al. 2003; Ford & Ferguson 2004) and embarrassed laughs (Lawler 2004) in sensitive situa-
tions must be seen as serious discrimination of lesbians and gay men, and as a form of social control that can increase tolerance of discrimination as argued by Ford and Ferguson (2004). The informants’ testimonies of heteronormative communication and behaviour are probably a better explanation for negative experiences than an explanation based on homophobia (Logan 1996; Bernat et al. 2001; Herek 2000; Herek 2004), since most nursing staff are friendly, caring and empathic in their concerns of patients and significant others. For the most part, nursing staff are also polite and kind to their workmates since they are educated in a ‘helping discipline’ (Bentling 1995; McCabe 2004), which builds on understanding other humans’ ways of life (Bentling 1995; Henderson & Forbat 2004; McCabe 2004), and they depend on each other’s help at work. Nursing staff do, however, need to be aware that their personal attitudes, ambivalent or not, do affect their relationships to patients, partners and workmates (Richmond & McKenna 1998; Eliason & Raheim 2000; Röndahl et al. 2003). Heteronormativity in the nursing environment needs to be addressed (Kreiss & Patterson 1997; Stevens & Morgan 1999; Albarran & Salmon 2000; Wilton 2000; Westerståhl 2003; Yep 2003) to ensure a more equal climate, which would be beneficial for all individuals, independent of whether they are women or men, heterosexuals or homosexuals, immigrants or Swedish, etc.

The informants regarded it important to spread knowledge about gay issues in nursing through casual conversation and small talk, and through different kinds of discussion forums. If there exists a ‘fear of the unknown’ in nursing, the informants’ recommendation may help both heterosexuals and homosexuals to communicate in a more natural way, which may facilitate positive interaction and reduce the insecurity caused by the ‘normal’ fear Pissiota describes (2003). According to Seden (2004), small talk may function as an interactive process, in which cultural knowledge is reciprocally communicated (Krauss & Chiu 1998; Maltén 1998; Kruglanski & Higgins 2003). To undermine the powerful heteronormativity, which places many lesbian and gay men in a vulnerable situation, the informants suggested several pieces of advice to assist the communication and interaction between heterosexuals and homosexuals. Cameron (2004) argues that there is no ‘right way’ to communicate, no ‘magic words’ to use in all situations, and nursing staff can not adopt a ‘poker face’ (Leyens et al. 2002) in unfamiliar situations. The recommendations given by the informants in the present study need to be tested and investigated in nursing.

Some of the important issues that the informants expressed may indicate that the nursing system is unaware of gay peoples’ existence in nursing. Earlier studies have also described nursing staff’s heterosexual assumptions (Stevens 1995; Brogan 1997; Stewart 1998; Platzer & James 2000; Spinks et al. 2000; Westerståhl 2003), for example, heteronormative communications and the consequences of invisibility in nursing (Kreiss & Patterson 1997; Stevens & Morgan 1999; Albarran & Salmon 2000; Wilton 2000; Wester-
Perhaps nursing needs knowledge about the pressure of social norms (Cialdini & Trost 1998; Brewer & Brown 1998; Crandall et al. 2002) and the relevance of culture-bound values for intercultural communication (Robinson 2004), and how they affect and cause of reciprocal ambivalent emotions (Smith & Mackie 2002) in intergroup relations (Jost & Kramer 2002), which are normal and are to be expected (Mackie & Smith 2002). In the present study, the informants also argued that the situation of single and elderly lesbians and gay men was especially sensitive and that lesbians were more invisible than gay men. Earlier studies have reported that lesbians are particularly vulnerable (Platzer & James 2000; Spinks et al. 2000; Westerståhl 2003) and that many nurses find it difficult to show compassion and sensitivity towards lesbians and gay men (Lehman et al. 1998; Wojciechowski 1998; Carr et al. 1999; Salmon & Hall 1999; Stevens & Morgan 1999; Taylor 1999; Wilson 1999; Spinks et al. 2000). However, keeping the informants’ recommendations in mind may make communication easier and reduce the insecurity of how to behave in unknown situations. In the present study, the informants told about many lesbians and gay men’s poor social network and, as earlier studies have suggested, this may be one issue that is unknown in nursing (Stevens 1995; Brogan 1997; Stewart 1998; Wojciechowski 1998; Platzer & James 2000; Spinks et al. 2000; Wilton 2000; Westerståhl 2003). The informants also recommended a number of other things that are needed to achieve a better understanding of gay culture. Earlier studies report that increased knowledge indicates reduced prejudice and intolerant behaviour (Crow et al. 1998; Day & Schoenrade 2000; Saunders 2001), as well as increased interaction between heterosexuals and homosexuals (Conley et al. 2001), and suggest a necessity for unprejudiced heterosexual models (Jack & Devine 2002). Making gay literature and other materials available in public places would appear to be an easy way to demonstrate a willingness to create a tolerant atmosphere in nursing, and to show a willingness to treat all patients with the same compassion and see them as the individuals they really are.

Concluding remarks
The present thesis has described several concepts since the attitudes towards homosexuality in nursing are multifaceted and difficult to explain in a straightforward manner. The findings from the studies were discussed and explained by some- but not all of the concepts as I did not want to decide in advance which concepts were the ‘right’ ones to explain the complex attitudes and communication in nursing conditions. The findings may thus be understood in several ways depending on the particular discipline of focus. I chose to highlight the social norms communicated and the emotional and behavioural components of attitudes, and the ambivalence that may occur in
nursing. However, historical attitudes, gender perspectives, religious beliefs and nursing traditions are probably of greater importance than can be seen here.

The lesbians and gay men in the studies described the nursing system as conservative and heteronormative. New knowledge and old prejudices and traditions sometimes lead people to experience ambivalent feelings and attitudes, irrespective of sexual orientation. People are often torn between a basic impulse to be tolerant and a more ‘visceral’ discomfort with an unfamiliar culture. One and the same person may react at times with positive attitudes towards the unknown, and at times with negative emotions such as embarrassment or guilt. These individuals may experience shame and self-blame caused by their negative thoughts about the unfamiliar, or they may experience embarrassment when their positive emotions towards these individuals do not agree with the more ambivalent emotions they normally have towards unfamiliar people. The gay community has long lived with the stigma that regards homosexuality as a problem or deviation from the norm, ‘a disordered sexuality’. This may explain the homosexual’s fears of social isolation and sense of insecurity in ‘coming out’, and prejudices towards heterosexuals. Nevertheless, even if the legislation strengthens the rights of lesbians and gay men, attitudes based on social norms are hard to change. In Sweden, violence against gay people has increased, which may be a sign of more openness among gay people but the attitudes of society not having kept up as required. Or perhaps the violence is sign of ambivalent attitudes among people without personal contacts with the gay community.

The gay informants stated that when they ‘came out’ they had met the awkward reactions of personnel, which sometimes delayed further communication, at least for a while. The most common negative emotions experienced by the lesbians and gay men were insecurity and/or fear of social exclusion and neglect. Many believed and felt that heterosexuals also experienced some kind of insecurity and/or fear. The informants believed that heterosexuals felt a sense of insecurity in appropriate lexical choice and about how to behave ‘correctly’ socially and professionally, i.e., that they wanted to act socially correct but experienced prejudiced feelings and fear of the unknown and therefore assumed avoidance behaviours or somehow ‘just didn’t get it right’. Emotions such as insecurity and fear may lead to verbal and non-verbal communication that sends a ‘double message’, which may likely lead to misunderstanding. These misconceptions are likely the result of unconsciously communicated heterosexual norms by nursing staff, and an expectation of prejudiced behaviour by gay persons.

Nursing staff must be given the opportunity to receive knowledge about same gender families and relations, which will hopefully lead to a knowledge and understanding of gay patients’ lives and about the code language that is common among older lesbians and gay men. Nursing staff also need opportunities to meet and chat with gay people to learn to communicate in a
natural way and to be aware of the norms they communicate through the language they use and their behaviours. Homophobia is the concept most commonly cited with regard to attitudes towards gay people, but it has been criticised. For nursing staff who do not have adequate knowledge about the concept or about gay people, the concept of homophobia may easily be associated to clinical phobias. Consequently, the concept may further stigmatise and increase prejudices and stereotypes of homosexuality in nursing since old psycho-medical traditions looked (and - as informants narrated - sometimes still do look) upon it as a disorder. Furthermore, to inform and educate nursing staff and make them realise that they maybe do not communicate and interact with gay patients and treat them equally compared to heterosexuals may therefore be difficult. More than just being intolerant, nursing staff that communicate or act ‘strangely’ in front of gay patients are more likely experiencing ambivalent emotions due to insecurity. They are likely also unaware of the power of heteronormative communication and how it affects lesbians and gay men. Most likely, it is this heteronormativity that causes the assumed ambivalent emotion.

According to the findings in papers I and II, probably only a small minority in Swedish nursing have negative attitudes toward lesbian and gay men. However, there probably exists a blissful unawareness that may heighten the fear of unknown or ‘different’ ways of living and how, in turn, this fear can affect attitudes and relationships in nursing. The informants in papers III and IV, however, told of heteronormative language and behaviour in nursing contexts, which were experienced as insensitive, insulting and humiliating (‘Even though they are not nasty people they do nasty things and they do discriminate’ [Patient]). Nevertheless, even if it is easier said than done, gay patients and partners need to be open about their needs so that nursing staff can recognise them and give them the care they have a legal right to. Individuals must weight the pros and cons of disclosing their sexual orientation and no one can place this responsibility on another person. Secrecy does however have its consequences. If gay patients and their partners remain invisible in the nursing context, no change will occur. To create a safe atmosphere for gay patients and partners and break the invisibility, however, must be the responsibility of the nursing community. Furthermore, if gay nursing staff dare to ‘come out’ to their workmates and chat about their everyday lives, nursing staff must learn how to communicate in a more natural way and be made aware of the norms they communicate through the language they use and their behaviour.
Epilogue, personal reflections

Through the entire research process, from C level studies to the present thesis, my project has sparked attention and received a central place in discussions. When asked about what I was doing, I always had to weigh my answers carefully since I learned early on that they would lead to further questions and discussions. I constantly had to monitor the mood I was in and, depending on the atmosphere, had to decide if I would tell the ‘whole’ truth or some ‘modified’ version of it. I learned that people would always react in some way or another. I have met many different kinds of negative reactions, mostly non-verbal but also verbal, including suspiciousness, ridiculing comments and even openly displayed disdain and written threats. In every situation, there was always some element of unpleasantness, and I often felt I had to be prepared to explain and defend myself and my research. Furthermore, when I told people I was heterosexual, some became even more suspicious and distanced; I assume they thought I was lying. I therefore believe that I share some sense of the insecurity felt by lesbians and gay men when they ‘come out’ to strangers. But I have great difficulty understanding why lesbians and gay men hide their homosexuality from workmates and friends they know well. I would feel insulted if I knew that a gay workmate did not take part in discussions in the coffee room, I would feel hurt if a friend had to tell ‘white lies’ about her/his daily life in front of me. It would also upset me if I knew that gay people I met chose to hide if I said something ‘wrong’ or behaved awkwardly, and thereby caused them to feel insecure or fear. Because something I have learned is that it does not matter what I say, what words I use, as long as I say something and have an open mind. At work, I have noticed that nursing staff, as other people, often avoid situations they do not know how to handle. It is human to be unsure when faced with the unknown. And it may be an explanation, but it must never, ever be acceptable for nursing staff to avoid gay patients and their partners who depend on their support and compassion. Under such circumstances, it is better to ‘lose face’ for a while and tell the person the reason for your strange behaviour, i.e., that you do not know what to say or how to behave. I am truly grateful to all the gay persons who participated in this study (and other support from the gay community) who helped to educate me by telling me about their way of life and culture. I sincerely hope that I may transfer this knowledge to other unknowing people, because we all have something to win and nothing
to lose. No matter what the source of our fears and insecurity – it can only be a relief to rid ourselves of them.

‘We are what we are because they are not what we are.’
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Sammanfattning (Summary in Swedish)

Det övergripande syftet med avhandlingen var att beskriva lesbiska och bögar:s situation i vården genom att studera vårdpersonal och sjuksköterskestudenters och studerandes på gymnasiets omvårdnadsprogram attityder, homosexuell vårdpersonals upplevelser i arbetsmiljön och homosexuella patienters samt närståendes upplevelser i vården.

Studien, för artikel I och II, hade en deskriptiv och komparativ design. Sjuksköterskor, undersköterskor, sjuksköterskestudenter och studerande på gymnasiets omvårdnadsprogram besvarade Attitudes Toward Homosexuality Scale (ATHS), Causes of Homosexuality Questionnaire (CHQ), Affect Adjective Checklist (AAC) tillsammans med Nursing Behaviour Questionnaire (NBQ). Generellt uttryckte vårdpersonal och studenter positiva attityder men några deltagare rapporterade mycket negativa attityder till homosexuella. Deltagarna uttryckte också hela spektrat av emotioner allt från tolerans till ilska.


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Appendix 1

Please answer statements 1 and 2 by circling the answer you think most appropriate. For statements 3 and 4, please indicate the extent to which you agree or disagree with each statement using the scale of 1 to 4 shown. Space has been given below statements 3 and 4 where you can comment on your answers to each statement.

1. I have experience of nursing HIV patients.  YES NO

2. I have experience of nursing homosexual patients.  YES NO

Please indicate (using the scale of 1 to 4 shown below) how strongly you agree or disagree with the following statements. Please explain your choice.

1  2  3  4
 strongly agree strongly disagree

___ 3. If I were given the option I would not nurse HIV-infected patients.

Comments to statement 3:
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

___ 4. If I were given the option I would not nurse homosexual patients.

Comments to statement 4:
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
Appendix 2

Interview Guide for personnel

Time for interview: Date: Place:

Questions:

Opening question: What words do you use for women, men and the group who wants to live (sexual relationship) with a person of same gender?

What experiences do you as a homosexual have of the nursing work environment?

Are you open about your homosexuality at your work?

Do you feel you have the same opportunity as everybody else to participate in the chatting with workmates at coffee breaks?

Can you tell me any story you heard about some other nursing staffs’ work environment?

What do you think is important to highlight regarding homosexuality and nursing?

Do you think homophobia exist in nursing?
Appendix 3

Interview Guide for patient and/or intimate

Time for interview: Date: Place:

Questions:

**Opening question:** What words do you use for women, men and the group who wants to live (sexual relationship) with a person of same gender?

**What experiences can you tell from your hospital care?**

Are you open about your homosexuality in nursing?

Treatment and caring?

Can you tell me any story you heard about some other gay patients or partners?

**What do you think is important to highlight regarding homosexuality and nursing?**

Do you think homophobia exist in nursing?
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