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ORIGINAL RESEARCH: EMPIRICAL RESEARCH – MIXED METHODS

Do student nurses feel a lack of comfort in providing support for Lesbian, Gay, Bisexual or Questioning adolescents: what factors influence their comfort level?

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Abstract

Aim. The aim of this study was to find out if student nurses feel comfortable in caring by providing support for Lesbian, Gay, Bisexual or Questioning adolescents and what factors influence their level of comfort.

Background. Research indicates that nurses and nursing students experience varying levels of comfort when caring for adults who are Lesbian, Gay, Bisexual or Questioning: adult patients feel that nurse's attitudes change towards them once they disclose their sexuality. There has been minimal research to date on nursing attitudes to working with adolescents who are Lesbian, Gay, Bisexual or Questioning.

Design. Both quantitative and qualitative methods were used in this descriptive study. Questionnaires were completed by 152 nursing students and nine took part in semi-structured focus groups.

Method. A two-way ANOVA was used to analyse the questionnaires. Thematic analysis was used to identify the themes arising from the focus groups. Data were collected between August 2013 - July 2014.

Results/Findings. The results and findings of the study were that student nurse's felt discomfort in providing support; due to a lack of knowledge of Lesbian, Gay or Bisexual sexuality, personal and religious beliefs and the perceptions of others. However, all students indicated they had a positive attitude towards Lesbian, Gay, Bisexual and Questioning adolescents.

Conclusion. More needs to be done to raise self-awareness and improve the level of knowledge in relation to Lesbian, Gay and Bisexual issues amongst student nurses. Educational institutions and practice areas need to recognize this fact and reflect this in their educational programmes.

Keywords: adolescent, attitude, bisexual, comfort, gay, lesbian, nursing care, student nurses, support

Why is this research needed?

- Adolescents who are Lesbian, Gay, Bisexual or Questioning are at an increased risk of self-harm, depression, being bullied and misusing alcohol.
- Factors such as self-harm and depression can increase the likelihood for healthcare interventions and support.
- This research is needed to find out whether student nurses feel comfortable in caring by providing support for adolescents who are Lesbian, Gay, Bisexual or Questioning.

What are the key findings?

- The levels of comfort in student nurses when supporting Lesbian, Gay, Bisexual and Questioning adolescents were influenced by a lack of knowledge of Lesbian, Gay and Bisexual issues, personal and religious beliefs and the perceptions of others.
- Student nurses' practice was influenced by the perceived perceptions of the Lesbian, Gay, Bisexual and Questioning adolescent's family and nursing colleagues of their interactions.
- Whilst student nurses recognized that some attitudes of colleagues may be questionable they lacked the confidence to challenge these attitudes especially if they were expressed by qualified nurses.

How should the findings be used to influence practice and education?

- More needs to be done to increase self-awareness and challenge personal beliefs in relation to caring by providing support for Lesbian, Gay, Bisexual and Questioning adolescents through education.
- Lesbian, Gay, Bisexual or Questioning issues need to be addressed both in educational institutions and practice areas to increase student nurses' knowledge.
- Student nurses need to be helped to develop the skills necessary to challenge negative attitudes in practice.

Introduction

The process of identifying as Lesbian, Gay or Bisexual (LGB) occurs over a period, which can begin in early adolescence through to adulthood (Troiden 1989). Adolescents who are LGB or Questioning their sexuality are at risk of being bullied, stigmatized and isolated (Bakker & Cavender 2003, Davis *et al.* 2009). These experiences increase the chances that they will suffer from a variety of health problems such as depression, self-harm, increased alcohol and substance abuse and attempted suicide (Hatzenbuehler 2011, Guasp *et al.* 2012). At these points in their lives when they are at their most vulnerable it is essential they are treated with dignity and compassion. For this to happen all nurses including student nurses providing care for LGBQ adolescents need to feel 'comfortable' in providing support.

To provide comfort can be defined as treating a person with dignity, to console, to ease and alleviate distress (Stevenson 2015). Nurses who feel uncomfortable providing support for LGBQ adolescents may lack skills in providing competent nursing care, in that the above criteria of consoling and alleviating distress may be affected. The care provided to adult LGB patients has been recognized as problematic due to what could be described as a lack of 'comfort' on the part of the nurses caring for them (Röndahl 2009). Reasons given for this are due to a lack of knowledge of LGB issues and poor communication skills: such as the use of appropriate language and poor non-verbal communications and prejudice (Röndahl *et al.* 2006). It could be argued that for LGBQ adolescents the situation could be more problematic due to their age and the stage they are at in coming to terms with their sexuality; both of which require a particular level of support and sensitivity (Keighley 2002, Bakker & Cavender 2003, Glasper & Richardson 2006, Department of Health 2007, Richardson 2009, United Nations Educational Scientific and Cultural Organization 2012). In the United States of America (USA) this need has been recognized and a mission statement has been written by the Society for Adolescent Health and Medicine (2013) which highlights the need for health professionals working with LGBQ adolescents to have specific knowledge and skills, such as the ability to communicate effectively. It has been recognized that these issues need to be addressed in pre-registration nursing programmes (Irwin 1992, Fidelindo & Hsu 2016). Student nurses learn from their mentors, registered nurses and educators as to how to comfort and provide support for their patients (Christensen 2005, Felstead 2013).

Attitudes towards transgender adolescents were not included in this study, even though they are often grouped together with LGBQ adolescents, their needs and concerns are unique and different. The focus of the study is sexual identity and how attitudes towards sexual identity can influence feelings of comfort in providing support not gender identity.

Background

Sexuality is an essential part of a person's life and although sexual orientation can change throughout life it can be

argued that it is during the period of adolescence that is has the most impact on identity; 'adolescence, or the second decade of life, is a period where an individual undergoes major physical and psychological changes: alongside this, there are enormous changes in social interactions and relationships' (WHO 2012 p. 1). Therefore, this period of life can be especially challenging and confusing for LGBQ adolescents. It has been recognized that when LGB adults access healthcare, they experience problems in communication and feelings of isolation and vulnerability (Barbara *et al.* 2001, Röndahl 2009). When accessing health care services, for example after self-harming or feeling suicidal, LGBQ adolescents have expressed concerns about the interpersonal skills of health providers and their ability to provide support (Hoffman *et al.* 2009).

A literature review carried out by Fidelindo and Hsu (2016) concerning student nurses' attitudes towards LGBT people, found that less than 50% of the research reviewed suggested nursing student's attitudes were improving over the last decade. Studies of the experiences of adult LGB patients of the nursing care they have received have also highlighted concerns about nursing attitudes. One descriptive comparative study from Sweden that used self-administered questionnaires concerning the attitudes of Registered Nurses, assistant nurses, nursing students and assistant nursing students ($n = 165$) found that 36% ($n = 55$) would refrain from nursing homosexual patients if they had the choice, 22% ($n = 36$) of the participants had a non-Swedish background and they expressed more concerns about homosexuality then those from Swedish backgrounds (Röndahl *et al.* 2004a). However, a further study undertaken in Sweden by the same researchers and using the same method found that 58% ($n = 124$) of the participants had a positive attitude, if they thought that homosexuality was congenital (Röndahl *et al.* 2004b). Röndahl (2009) found in an explorative study using semi structured interviews that adult LGB patients' ($n = 27$) experiences of nursing care was less positive in that they felt insecure after disclosing their sexuality, with some staff being perceived as being more distant after disclosure. Several participants expressed their concerns about being nursed by; older nurses, nurses who were openly religious and being nursed by immigrant nurses which was due to their behaviour after disclosure; these feelings may have a basis in reality, as evidenced in the studies cited above (Röndahl *et al.* 2004a).

A study by Jones *et al.* (2002) in Australia explored the attitudes of health care students ($n = 1132$) from a variety of disciplines towards LG patients and the degree of comfort they felt when asking about sexual orientation. A questionnaire was used to collect information; the findings were that between 27% ($n = 306$) - 30% ($n = 340$) of the participants would feel uncomfortable if working with a lesbian or gay client. More than 50% of the participants stated they would feel uncomfortable asking about a client's sexual orientation. A further study in Australia used focus groups to gather data, both practitioners and LGBT clients ($n = 67$) took part; findings indicated that discrimination in the form of homophobia can go unchallenged and that staff often make negative and inappropriate remarks about LGB clients (Bowers *et al.* 2006).

The study

Aim

The aim of this study was to identify if student nurses studying in the child field of nursing feel a lack of comfort in caring by providing support for adolescents who are LGBQ and what factors influence their comfort level.

Design

This study used descriptive mixed methods of data collection. There were two parts to the study. Quantitative data were gathered in Part 1 through a questionnaire and qualitative data in Part 2 through focus groups.

Participants

A convenience sampling approach was taken to the recruitment of the participants, who were student nurses studying for a BSc (Hons) Nursing Degree (Child Field). Students from each year of training, including finalists were invited to participate in Part 1 of the study. However, only those continuing to study on the programme were invited to participate in Part 2. Initial contact for Part 1 was following lectures. Set representatives distributed the questionnaires and those that were completed were left in a box in the classroom. All participants were assured of anonymity. Contact for Part 2 was by university email, nine participants took part in the focus groups.

Data collection

Part 1: questionnaire

A Likert scale questionnaire (1 = strongly disagree; 5 = strongly agree) was designed to assess; what factors may influence [A] the students' level of comfort in caring by providing support to LGBQ adolescents, [B] their sense

of professional responsibility in relation to these groups and [C] their general attitudes towards LGB sexuality. The data in Part 1 were collected from August–December 2013.

Part 2: focus group interviews
Semi-structured questions were used, that evolved from the questionnaire in Part 1 of the study to guide and prompt the discussion (Joyce 2008). The data in Part 2 was collected during July 2014.

Ethical considerations

The research study was reviewed and approved by the University Health and Education Ethics Committee. Participants were provided with a participant information sheet (PIS), informed consent was obtained and all participants were reminded both verbally and with the written PIS, that they may withdraw consent at any time during the study. Students were told that confidentiality was assured.

Data analysis

Part 1: questionnaire
The quantitative data were analysed using SPSS (statistical package for social sciences version 23). Demographic data and questionnaire items (including indices) were analysed using descriptive statistics. Dimensional reduction and the identification of highly inter-related items were achieved by carrying out a factor analysis. Internal consistency for each index that comprised items was measured using Cronbach's alpha. Between-group comparisons were carried out with a two-way analysis of variance (ANOVA) (factor 1: ethnicity, White British or Ethnic Other; factor 2: religion, Religious or Non-Religious). A test for normality and checks for multicollinearity were carried out. To reduce the risk of Type I errors (*false positives*) due to multiple testing, each significant value was adjusted using Bonferroni's method. The significance level was set at $P \leq 0{\cdot}05$.

Part 2: focus group interviews
Two focus groups were held and each lasted between 60 and 90 minutes, semi-structured questions were only used to prompt students or to encourage them to explore an issue in more depth. The discussions were taped and transcribed. Thematic analysis was used to review the data and the researchers followed the principles proposed by (Braun & Clarke 2006, Clarke & Braun 2013). Each researcher reviewed the material independently and then together until the identification of two overarching themes: Personal Concerns and Professional Concerns were identified, five sub-themes were identified in the Professional Concerns theme; Age and Development, Sexual Confidence, Giving Advice, Level of Knowledge and the Mentor/Student role. Whilst the content of the focus groups has been presented under specific themes there was often a crossover between personal and professional concerns. Quotes from the focus groups will be used to illustrate the findings.

Validity, reliability and rigour

Part 1: questionnaire
This questionnaire was not validated in previous research; it was based on and questions were designed in relation to the Homosexual Attitude Scale (Kite & Deaux 1986), as this questionnaire was not appropriate for the purposes of this study. Validity was sought through asking two experts in research design to review the questions. Both gave feedback and revisions were made as directed. Students were asked to complete the questionnaire and their feedback was acted on to aid clarification.

Part 2: focus group interviews
The transcribed interviews were reviewed by focus group participants who agreed that the transcripts and excerpts used for publication were an accurate representation of the discussion. Themes were identified individually by each researcher and then collectively with the support of the supervisor until each theme was agreed on.

A mixed methods approach was adopted to increase rigour through triangulation.

Results

Part 1: questionnaire

All student nurses ($n = 160$) were invited to participate. The participation rate was 95% ($n = 152$). The average age of the participants was 25 years of age; 80% ($n = 122$) were 28 years of age or younger; 95% ($n = 145$) participants were women, 96% ($n = 146$) of the participants stated they were heterosexual. The demographic data showed that 61% ($n = 93$) of the participants had a non-White British ethnic origin i.e. Black British, Black Caribbean, Black African, Bangladeshi, Pakistani, Nepalese, Italian, Irish, German, Czech, Spanish, French and Brazilian referred to as 'Ethnic Other'. The data showed that 68% ($n = 103$) identified as being religious, the biggest groups being Christians ($n = 56$) and Muslims ($n = 22$) (Table 1).

Table 1 Demographics.

Stage in training programme	Sample (*n*)	Mean age	Gender (female)		Ethnicity (other)		Religion (religious)	
			%	*n*	%	*n*	%	*n*
1st year	47	23	96·0	45	47·4	22	65·2	31
2nd year	47	25	100·0	47	59·6	28	64·4	30
3rd year	30	27	87·0	26	70·0	21	80·0	24
3rd year finalists	28	25	90·0	25	60·7	17	74·1	21

Comfort [A]

Student nurses were asked to answer questions related to the degree of comfort or discomfort they may feel when working with adolescents questioning their sexuality and identifying as LGB. Data are mean and standard deviation (SD). In general the students felt comfortable discussing issues related to sexuality (mean = 4·17, SD 0·65) [A1]. However, they felt discussing issues related to LGB more difficult (mean = 3·62, SD 0·96) [A2]. But they would feel comfortable asking a young person about their sexuality if they felt it was helpful for the young person (mean = 3·58, SD 0·85) [A3]. The students felt comfortable using language related to sexuality when talking to adolescents in their personal life (mean = 3·85, SD 0·87) [A4] and they would not find discussing sexuality too difficult in their personal life (mean = 2·33, SD 0·98) [A5]. However, the students were not sure whether adolescents would discuss issues about sexuality with them in their personal life (mean = 3·25, SD 1·17) [A6].

Students felt comfortable using language related to sexuality when talking to adolescents in their role as a student nurse (mean = 3·82, SD 0·78) [A7], however, they are not sure whether they would feel comfortable discussing issues related to LGB issues difficult in their role as a student nurse (mean = 2·60, SD 1·00) [A8]. The students felt that adolescents would feel comfortable discussing issues related to sexuality with them in their role as a student nurse (mean = 3·67, SD 0·84) [A9] (Table 2).

A two-way ANOVA was conducted to examine the effects of ethnicity and religion on [A1–A9]. The two-way ANOVA for [A4] scores showed a significant effect for religion [$F(1144) = 3{\cdot}90$, $P = 0{\cdot}050$]: non-religious student nurses felt significantly more confident when using language related to sexuality when talking to adolescents in their personal lives than religious students. There were no statistically significant main effects for ethnicity or any interaction effects (Table 3).

Professional responsibility [B]

Student nurses disagreed with the question that it is not their role as a student nurse to discuss issues related to sexuality (incl. LGBQ) sexuality (mean = 1·91, SD 0·83) [B1]. The students would not want to avoid situations where such issues may arise (mean = 2·14, SD 0·87) [B2]. They disagreed with the question that they would prefer not to work with young LGBQ people if they had the choice (mean = 1·44, SD 0·71) [B3]. However, students were not sure whether they had enough knowledge about issues related to LGB sexuality to support adolescents who may be questioning their sexuality (mean = 3·17, SD 1·11) [B4]. They would want to care for adolescents who were questioning their sexuality (mean = 3·95, SD 0·76) [B5]. It was of no concern to the students whether the adolescent was LGBQ (mean = 4·48, SD 0·88) [B6]. Students were not sure

Table 2 Mean values (with standard deviation) for comfort.

General comfort	Mean	SD
[A1] In general I feel comfortable discussing issues related to sexuality	4·17	(0·65)
[A2] I feel discussing issues relating to gay, lesbian or bisexuality easy	3·62	(0·96)
[A3] I would feel comfortable asking adolescents about their sexuality if I felt it was helpful for them	3·58	(0·85)
Comfort in personal life		
[A4] I feel comfortable using language related to sexuality when talking to adolescents in my personal life	3·85	(0·87)
[A5] I would feel discussing issues relating to gay, lesbian or bisexuality with adolescents in my personal life difficult	2·33	(0·98)
[A6] In my personal life adolescents do discuss issues about sexuality with me	3·25	(1·17)
Comfort as a student nurse		
[A7] I feel comfortable using language related to sexuality when talking to adolescents in my role as a student nurse	3·82	(0·78)
[A8] I would feel discussing issues relating to gay, lesbian or bisexuality with adolescents as student nurse difficult	2·6	(1·00)
[A9] I feel that adolescents would feel comfortable in talking about their sexuality with me in my role as a student nurse	3·67	(0·84)

Table 3 Effects of ethnicity and religion on comfort (two-way ANOVA).

	White british		Ethnic other		F (*P*-value)		
Variable	R*	NR**	R*	NR**	Ethnicity	Religion	E × R†
[A1]	4·13 (0·61)	4·26 (0·51)	4·10 (0·73)	4·40 (0·52)	0·183 (0·669)	2·400 (0·124)	0·359 (0·550)
[A2]	3·83 (0·83)	3·77 (0·88)	3·45 (0·99)	4·00 (0·94)	0·125 (0·724)	1·474 (0·227)	2·203 (0·140)
[A3]	3·50 (0·89)	3·51 (0·82)	3·58 (0·89)	3·90 (0·74)	1·614 (0·206)	0·812 (0·369)	0·678 (0·412)
[A4]	3·71 (0·96)	4·17 (0·57)	3·73 (0·96)	4·00 (0·67)	0·155 (0·694)	3·897 (0·050)	0·285 (0·594)
[A5]	2·42 (0·88)	2·11 (0·90)	2·45 (1·03)	2·20 (1·14)	0·086 (0·770)	1·741 (0·189)	0·013 (0·910)
[A6]	3·13 (1·12)	3·06 (1·21)	3·29 (1·20)	3·60 (0·84)	1·995 (0·160)	0·235 (0·629)	0·561 (0·455)
[A7]	3·83 (0·64)	4·00 (0·59)	3·70 (0·87)	4·00 (0·67)	0·176 (0·675)	2·074 (0·152)	0·176 (0·675)
[A8]	2·61 (0·84)	2·29 (0·71)	2·77 (1·12)	2·30 (1·06)	0·169 (0·681)	3·479 (0·064)	0·119 (0·731)
[A9]	3·67 (0·87)	3·69 (0·76)	3·65 (0·89)	3·70 (0·82)	0·001 (0·985)	0·040 (0·841)	0·009 (0·923)

*Religious.
**Non-Religious.
†E × R = Ethnicity × Religion interaction effect.
Note: Values are expressed as mean (SD).

Table 4 Mean values (with standard deviation) for professional responsibility.

	Mean	SD	Cronbach's alpha
[B1] I feel it is not part of my role as a student nurse to discuss issues related to sexuality in general (incl. LGBQ)	1·91	(0·83)	0·86
[B2] I would prefer to avoid situations or conversations where such issues may arise	2·14	(0·87)	-
[B3] I would prefer not to work with LGBQ adolescents if I had the choice	1·44	(0·71)	-
[B4] I do not feel that I know enough about issues related to LGB sexuality to support adolescents who may be questioning their sexuality	3·17	(1·11)	-
[B5] I would want to care for adolescents who were questioning if they were LGB	3·95	(0·76)	-
[B6] It would not concern me if the adolescent was LGBQ	4·48	(0·88)	-
[B7] I think it is the role of the qualified nurses to discuss issues related to sexuality in general (incl. LGBQ) with adolescents	3·15	(1·15)	0·93

whether it is the role of the qualified nurse to discuss sexuality with adolescents (mean = 3·15, SD 1·15) [B7] (Table 4).

A two-way ANOVA was conducted to examine the effects of ethnicity and religion on [B1–B7]. For [B4] scores there was a significant effect for ethnicity [F(1143) = 7·67, *P* = 0·006]: White-British student nurses felt that they had significantly more knowledge about LGB sexuality than the Ethnic Other group to support adolescents who may be questioning their sexuality. There were no statistically significant main effects for religion nor any interaction effects (Table 5).

Attitude [C]

Student nurses think that it is natural for adolescents to question (mean = 4·12, SD 0·85) [C1] and explore their sexuality (mean = 3·78, SD 0·85) [C2]. Moreover, they do not think that adolescents are not mature enough to know if they are LGB (mean = 2·07, SD 0·79) [C3]. The students think that being LGB is just another way of living (mean = 3·66, SD 1·05) [C4], therefore they should have the same rights as and be treated no differently to heterosexuals (mean = 4·43, SD 0·76) [C5]. They do not consider LGB as being a problem, it is society's attitude (mean = 4·31, SD 0·83) [C6]. The students do not think that LGB people are disgusting (mean = 1·38, SD 0·75) [C7]. Neither did the students think that being LGB is a sin (mean = 1·87, SD 1·35) [C8] nor that LGB sex is wrong (mean = 1·80, SD 1·23) [C9] (Table 6).

A two-way ANOVA was conducted to examine the effects of ethnicity and religion on attitudes [C1–C9]. For [C8] scores the two-way ANOVA showed a significant effect for both ethnicity [F(1142) = 4·644, *P* = 0·033], religion [F(1142) = 6·771, *P* = 0·010] and the interaction between ethnicity and religion [F(1142) = 6·431, *P* = 0·012]. Simple main effects analysis revealed that mean [C8] scores were not influenced by religion when the ethnic background was White-British (1·22 vs. 1·20, respectively,

Table 5 Effects of ethnicity and religion on professional responsibility (two-way ANOVA).

	White british		Ethnic other		F (*P*-value)		
Variable	R*	NR**	R*	NR**	Ethnicity	Religion	E × R†
[B1]	1·69 (0·72)	1·86 (0·87)	2·04 (0·87)	1·70 (0·68)	0·294 (0·589)	0·233 (0·638)	2·025 (0·157)
[B2]	2·13 (0·90)	2·06 (0·59)	2·18 (0·94)	2·20 (1·03)	0·273 (0·602)	0·015 (0·904)	0·059 (0·808)
[B3]	1·29 (0·46)	1·40 (0·55)	1·54 (0·84)	1·20 (0·42)	0·030 (0·863)	0·604 (0·438)	2·223 (0·138)
[B4]	2·71 (1·04)	2·94 (1·03)	3·35 (1·15)	3·60 (0·97)	7·665 (0·006)	1·090 (0·298)	0·002 (0·967)
[B5]	4·04 (0·55)	3·86 (0·55)	3·95 (0·90)	4·10 (0·57)	0·213 (0·645)	0·011 (0·917)	1·054 (0·306)
[B6]	4·67 (0·57)	4·49 (0·82)	4·36 (1·02)	4·70 (0·48)	0·061 (0·806)	0·179 (0·673)	1·898 (0·170)
[B7]	3·25 (1·03)	2·97 (1·14)	3·22 (1·15)	3·15 (1·38)	0·094 (0·760)	0·510 (0·476)	0·178 (0·674)

Note: values are expressed as mean (SD).
*Religious.
**Non-religious.
†E × R = Ethnicity × Religion interaction effect.

Table 6 Mean values (with standard deviation) for attitudes.

	Mean	SD	Cronbach's alpha
[C1] I think it is natural for adolescents to question their sexuality	4·12	(0·85)	-
[C2] It is natural for adolescents to explore their sexuality	3·78	(0·85)	0·95
[C3] Adolescents are not mature enough to know if they are LGB	2·07	(0·79)	0·98
[C4] Being LGB is just another way of living	3·66	(1·05)	0·99
[C5] LGB people should have the same rights as and be treated no differently to heterosexual people	4·43	(0·76)	0·97
[C6] Being LGB is not a problem, it is society's attitude	4·23	(0·95)	0·98
[C7] I think that LGB people are disgusting	1·38	(0·75)	0·96
[C8] Being LGB is a sin	1·87	(1·35)	1·00
[C9] LGB sex is wrong	1·80	(1·23)	1·00

Religious and Non-Religious). However, mean scores were influenced by religion when students identified as Ethnic Other (2·45 vs. 1·10, respectively, Religious and Non-Religious; [F(1142) = 10·814, $P = 0·001$]: student nurses that identified themselves as being religious and having an ethnic background other than White-British had significantly higher scores for [C8] indicating that they were Not Sure whether they thought if being LGB is a sin whereas all the other groupings Strongly Disagreed.

The two-way ANOVA for [C9] showed significant effects for both ethnicity [F(1142) = 5·800, $P = 0·017$], religion [F(1142) = 8·467, $P = 0·004$] and the interaction between ethnicity and religion [F(1142) = 6·097, $P = 0·015$]. As with [C8], analysis of simple effects revealed that mean [C9] scores were not influenced by religion when the student nurses were White-British (1·22 vs 1·11, respectively, Religious and Non-Religious). Again, mean scores were influenced by religion when students identified as Ethnic Other (2·36 vs. 1·10, respectively, Religious and Non-Religious; [F(1142) = 11·853, $P = 0·001$]: student nurses that identified themselves as being religious and having an ethnic background other than White-British had significantly higher scores for [C9] indicating that they were Not Sure if they thought that LGB sex is wrong. In contrast, all the other groupings Strongly Disagreed with this. (Table 7).

Part 2: focus group interviews

An invitation was sent by e-mail to all the students who had completed the questionnaire and were still studying on the programme ($n = 134$); 13% ($n = 18$) responded, with 16% ($n = 3$) declining the invitation due to prior commitments. 84% ($n = 15$) students accepted the invitation and of this number, 50% ($n = 9$) of the students attended. The nine participants were divided to form focus groups 1 and 2, each focus group consisted of a mixture of 1st, 2nd and 3rd year student nurses. The small size of the groups aimed to increase the opportunity for all participants to contribute to the overall discussion (Joyce 2008).

Two overarching themes and five sub-themes were identified in the second overarching theme:

- Personal.
- Professional–Age and Development, Sexual Confidence, Giving Advice, Conflict, Student/Mentor role.

Personal

Those students that discussed LGB issues in their personal lives had mixed views on how comfortable they felt.

Table 7 Effects of ethnicity and religion on attitudes (two-way ANOVA).

	White british		Ethnic other		F (*P*-value)		
Variable	R*	NR**	R*	NR**	Ethnicity	Religion	E × R†
[C1]	4·58 (0·58)	4·14 (0·65)	3·97 (0·99)	4·30 (0·68)	0·457 (0·500)	0·067 (0·796)	2·400 (0·124)
[C2]	4·00 (0·66)	3·91 (0·51)	3·63 (0·98)	3·95 (0·90)	0·855 (0·357)	0·415 (0·521)	1·266 (0·262)
[C3]	1·94 (0·79)	1·81 (0·57)	2·25 (0·88)	1·87 (0·32)	1·189 (0·277)	2·432 (0·121)	0·556 (0·457)
[C4]	3·83 (1·19)	3·82 (0·87)	3·56 (1·08)	3·43 (1·13)	2·080 (0·151)	0·082 (0·774)	0·076 (0·783)
[C5]	4·67 (0·57)	4·66 (0·54)	4·22 (0·85)	4·70 (0·48)	1·683 (0·197)	2·288 (0·133)	2·477 (0·118)
[C6]	4·46 (0·72)	4·60 (0·55)	3·97 (1·11)	4·47 (0·57)	2·504 (0·116)	2·640 (0·106)	0·816 (0·368)
[C7]	1·11 (0·27)	1·17 (0·39)	1·58 (0·94)	1·20 (0·42)	2·559 (0·112)	1·062 (0·304)	2·008 (0·159)
[C8]	1·22 (0·67)	1·20 (0·72)	2·45 (1·54)	1·10 (0·32)	4·644 (0·033)	6·771 (0·010)	6·413 (0·012)
[C9]	1·22 (0·67)	1·11 (0·32)	2·36 (1·41)	1·10 (0·32)	5·800 (0·017)	8·647 (0·004)	6·097 (0·015)

Note: values are expressed as mean (SD).
*Religious.
**Non-religious.
†E × R = Ethnicity × Religion interaction effect.

Students who stated that discussing such issues in their personal lives was difficult recognized that it was influenced by their beliefs and culture:

> Well, in my personal life I have no difficulty in talking about that sort of thing with friends and family or other people because I have lots of gay friends. My younger relatives and cousins and stuff sometimes ask me questions like that and I have no problem talking about it with them. (S2–WB/NR)

> Oh, it's just because I moved to this country, my parents are very strict and very conservative and we don't talk about certain things. Back home you just don't talk about things. It was a bit of a shock when I came here. People just really talk and we don't do that back home (S9 EO/R)

Professional

The majority of the student's discussions related to their professional lives: what would and would not cause discomfort for them when they worked with LGBQ adolescents, their experiences in the work place and their anxieties about their role as a student nurse in providing support. It was clear at times that the students felt conflicted, between their personal beliefs and professional responsibilities which led to some statements being made where the students seemed to contradict themselves.

Age and development

It was clear that 'age' was a major concern, working with younger LGBQ adolescents causing the most discomfort. There were two reasons identified for this, firstly the student's concerns about what type of language should be used when answering questions. Secondly, if the young person was underage, that is younger than 16 (the age of consent for sexual activity in the UK) they were concerned they may be viewed as condoning or encouraging them to be sexually active by the family of the adolescent or others:

> Because you would have to change your language, you know a twelve-year old might say something and your language would be different than with a sixteen-year old, so that would have a big impact on me. (S8–EO/R)

> I think I would be looking at age, you know to see if there were any guidelines. If you were talking to a thirteen-year old about their sexuality or sexual experiences, you know, you could be seen as condoning underage sex. (S2–WB/NR)

Sexual confidence

Sexual confidence on the part of the adolescent caused a high level of discomfort for the students. When discussing providing support for adolescents who were confident about being LGB the students said they would feel uncomfortable. However, it was clear that if the adolescent was questioning and seeking support that students would be more comfortable in working with them:

> I think I would feel less comfortable with that than I would be talking about their confusion and their seeking answers, rather than somebody who is just advertising their rainbow pyjamas and I can't explain it more than that, but yes, I'd have more difficulty with that, with a 15 year old who just wants to tell the world and what effect would that have on the other people on the ward. (S4–WB/R)

> I think I would be happier or more comfortable talking to someone who feels upset, confused, questioning and wanting reassurance or who was having a problem with their sexuality. (S4–WB/R)

Giving advice

When students discussed LGBQ adolescents talking about their concerns regarding their sexuality in the clinical areas there was a noticeable level of discomfort. This was related to how the students felt that professional boundaries may be crossed and their role in giving advice, such as when and where to have conversations:

I have not really come across anything like this on any of my placements but if I was to come across it to be honest I wouldn't know how to approach that person, advice wise and I think that is due to me being a practising Christian. (S5–EO/R)

I think it's just that being in a ward situation or clinical situation is more difficult because you're in a professional role and you are responsible and accountable for what you say and the advice that you give because whoever you give that advice to would be more likely to listen to you and take that advice into account. So as I was saying, if something happened because of what you'd said then it could come back to you and people could have an issue with what you'd said and so it is completely different in your own life than in your professional life. It's very different. (S5–EO/R)

Conflict

Students that had experienced situations where staff expressed negative views about LGBQ people commented on how difficult that was and that they lacked the confidence to challenge staff about their views:

I think it is an ongoing issue, people in their own life have their own personal beliefs and that can sometimes impact on how they are in clinical practice. Because obviously, professionally you have to respect everyone's rights and individuality but if their life choices conflicts with that person's own beliefs it can sometimes put up barriers, if that makes sense and make it more difficult for them to sort of be professional, does that make sense? (S1–EO/R)

When I have raised something before somebody said to me sometimes it is better not to say anything as a student. (S2–WB/NR)

Mentor/Student role

When discussing their role in supporting adolescents in clinical settings who are LGBQ there was a consensus amongst the students that they would refer the issues to their mentors, although there were students who felt that their mentors would not necessarily know what to say or do. It was clear that none of the students would ignore the issue and that it was important to give help:

But I would try and see if I could help even though I am a student, I could be of some help. I think maybe a member of staff would feel as uncomfortable as I would feel. (S1–E0/NR)

Oh, well, in that situation that would make a difference, if you are saying that the reason for the self-harm was their confusion, then that immediately is an issue because if they are causing harm to themselves we would have to take steps to give them the proper support that they need. (S3–EO/R)

Discussion

This study was designed to assess how comfortable student nurses felt in caring by providing support for adolescents who are LGBQ and what factors may influence their level of comfort. The results in both parts of the study indicate that participants considered themselves to be accepting of LGBQ adolescents. However, their levels of comfort in providing support were influenced by factors such as; a lack of knowledge of LGB issues including the use of language, personal and religious beliefs and the perceptions of others. A lack of knowledge about LGB issues has also been reported as a concern by nursing students in other research studies, as a consequence the participants stated that they felt uncomfortable or unprepared to provide care (Eliason & Raheim 2000, Carabez *et al.* 2015).

A study in Sweden identified that nursing students from backgrounds other than Swedish expressed higher levels of discomfort in working with LGB patients. The high levels of discomfort were related to feelings of hostility (Röndahl *et al.* 2004a), whereas in this study hostility was not identified as a factor. The influence of religious beliefs was not assessed in the Swedish study and so it is not possible to know what impact that may have had on the findings but it is clear personal issues did but not the reason for them. There were contradictions in the results of this study in relation to personal beliefs, for example in Part 1, participants who identified as White British (Religious and Non-Religious) 'Strongly disagreed' that LGB sex was wrong or a sin, whereas those who identified as Religious (Ethnic Other) indicated they were 'Not sure'. However, in Part 2, those who identified as being religious, White British or Ethnic Other expressed a lack of comfort in working with LGBQ adolescents, particularly if they were too confident about their sexuality. The students recognized the ambiguity in their responses but they could not explain why and it is interesting to note that the students did not always seem aware of the contradictions in their attitude. However, some students were aware that their religious beliefs had an impact on their level of comfort in providing support.

The factor of how others may perceive their interactions with LGBQ adolescents was unique to this study. The students did not explain why this made them feel uncomfortable in providing support, but it could be interpreted as a lack of awareness of their prejudice towards LGB sexuality.

The factors identified above resulted in students stating that they would refer LGBQ adolescents to their mentors or other Registered Nurses for support. Frankowski does propose this as a means of dealing with concerns raised by LGBQ adolescents, as she recognizes that 'many individuals have strong negative attitudes about homosexuality or may simply feel uncomfortable with the subject, 'Even discomfort expressed through body language can send a very damaging message to non-heterosexual youth' (2004:1830). It is arguable if this in fact is an appropriate approach as it condones prejudice and excuses nurses from their responsibilities. The student nurses in the study reported that they had heard Registered Nurses making derogatory remarks about LGB people but had not challenged them, although that would be there responsibility to challenge poor practice. Perhaps the reluctance to challenge other nurses is as much about their own concerns about LGB people as their anxiety about the power balance. It is important that when educating student nurses that the needs of all cultural groups are addressed and to develop confidence and professionalism.

Discussing issues relating to LGBQ sexuality can be difficult in health care services, particularly in countries where LGB issues are legislated against and attitudes are negative and so it is concerning that the guidelines from the World Health Organisation (World Health Organisation, Department of Maternal, Newborn, Child and Adolescent Health 2012) 'Making health services adolescent friendly' fail to specifically include sexuality in their statements regarding treating all adolescents with 'equal care and respect, regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason,' (World Health Organisation, Department of Maternal, Newborn, Child and Adolescent Health 2012:32).

Limitations

The unique design of the questionnaire would make it difficult in drawing direct comparisons with other studies assessing student nurses' attitudes towards LGBQ adolescents. The mix of participants in relation to ethnicity and religious beliefs would not be representative of more rural locations and difficult to replicate. The use of broad groupings make it difficult to explore issues in depth. For example is religion A more accepting of LGBQ adolescents than religion B? The small number of participants who took part in Part 2 of the study cannot truly represent the questionnaire sample and can only provide some insight into levels of comfort, sense of professional responsibility and attitude in relation to working with LGBQ adolescents. Both researchers were well-known to the students and this may have influenced them in that they may have modified their responses to seek approval. Anecdotally students said they had not volunteered to take part in the focus groups because they did not know enough about the issues.

Conclusion

The increase in ethnic and cultural diversity throughout the world will have an impact on the recruitment of student nurses who may come from cultures unlike their adopted country, It would seem from this study that for those students moving to cultures that are accepting of LGB people this may be difficult when caring for them due to factors identified above. When LGBQ adolescents disclose their sexuality it is essential they receive the right support. (Saunamaki *et al.* 2010, Saunamaki & Engström 2013) have identified that whilst Registered Nurses recognize the need to discuss sexuality with patients they do not always do so, due to a lack of confidence. Therefore, it cannot be assumed by educational institutions that students will develop the necessary skills in practice, particularly in relation to discussing LGB sexuality with adolescents from their mentors.

The question is what can be done to support student nurses in increasing their levels of comfort. Firstly, it is important for educational institutions to raise self-awareness and increase confidence in nursing students by ensuring LGB issues are taught in nursing curricula. Secondly, it is important to provide a safe environment to explore concerns and to challenge negative assumptions and stereotypes both in educational establishments but also in practice. Today's students are the nurses and mentors of tomorrow, increasing their cultural competence may have a positive impact in the future. One important issue that needs further exploration is what LGBQ adolescents want from the nurses caring for them.

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References

Bakker L.J. & Cavender A. (2003) Promoting culturally competent care for gay youth. *The Journal of School Nursing* **19**(2), 65–72.

Barbara A.M., Quandt S.A. & Anderson R.T. (2001) Experiences of lesbians in the healthcare environment. *Women and Health* **34** (1), 45–62.

Bowers R., Plummer D., Mc Cann P., McConaghy C. & Irwin L. (2006) *How We Manage Sexual and Gender Diversity in the Public Health System*. Department of Health and Human Sciences, Tasmania.

Braun V. & Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**(2), 77–101.

Carabez R., Pellegrini M., Markovitz A., Eliason M.J. & Dariots W.M. (2015) Nursing student's perceptions of their knowledge of lesbian, gay, bisexual and transgender issues. Effectiveness of a multi-purpose assignment in a public health nursing class. *Journal of Nursing Education* **54**(1), 50–53.

Christensen M. (2005) Homophobia in nursing: a concept analysis. *Nursing Forum* **48**(2), 60–71.

Clarke V. & Braun V. (2013) *Successful Qualitative Research: A Practical Guide for Beginners*. Sage, London.

Crawford T., Geraghty W., Street K. & Simonoff E. (2003) Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescents* **26**, 619–629.

Davis T.S., Saltzburg S. & Locke C.R. (2009) Supporting the emotional and psychological well being of sexual minority youth: youth ideas for action. *Children and Youth Services Review* **31**, 1030–1041.

Department of Health (2007) *Briefing 3: Young Lesbian, Gay and Bisexual (LGB) People*. London, DoH Publications, Briefings for health and social care staff.

Eliason M.J. & Raheim S. (2000) Experiences and comfort with culturally diverse groups in undergraduate pre-nursing students. *Journal of Nursing Education* **39**(4), 161–165.

Felstead I. (2013) Role modelling and student's professional development. *British Journal of Nursing* **12**(4), 223–227.

Fidelindo A.L. & Hsu R. (2016) Nursing students attitudes toward lesbian, gay, bisexual and transgender persons: an integrative review. *Nursing Education Perspectives* **37**(3), 144–152.

Frankowski B.L. (2004) Sexual orientation and adolescents. *Pediatrics* **113**(6), 1827–1832.

Glasper A. & Richardson J. (2006) *A Textbook of Children's and Young People's Nursing*. Churchill Livingstone, London.

Guasp A., Statham H., Jadva V. & Daly I. (2012) *The School Report: The experiences of gay young people in Britain's Schools in 2012*. Stonewall, Centre for Family Research, Cambridge.

Hatzenbuehler M.L. (2011) The social environment and suicide attempts in lesbian, gay and bisexual youth. *Pediatrics* **127**(5), 896–903.

Hoffman N.D., Freeman K. & Swan S. (2009) Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *Journal of Adolescent Health* **45**, 222–229.

Irwin L. (1992) Critical re-evaluation can overcome discrimination; providing equal standards of care for homosexual patients. *Professional Nurse* **7**(7), 435–438.

Irwin L. (2007) Homophobia and heterosexism: implications for nursing and nursing practice. *Australian Journal of Advanced Nursing* **25**(1), 70–76.

Jones M.K. Pynor R.A., Sullivan G. & Weerakoon P. (2002) A study of attitudes towards sexuality issues among health care students in Australia. *Journal of Lesbian Studies* **6**(3-4), 3–86.

Joyce P. (2008) Chapter 28: focus groups. In *Nursing Research Design and Methods* (Watson R., McKenna H., Cowman S. & Keady J., eds), Churchill Livingstone/Elsevier, London.

Keighley A. (2002) Chapter 6. Sexuality in childhood and adolescence. In *The Challenge of Sexuality in Health Care*. Blackwell Science, London.

Kite M.E. & Deaux K. (1986) Attitudes toward homosexuality: assessment and behavioural consequences. *Basic and Applied Social Psychology* **7**, 137–162.

Richardson B.P. (2009) Same-sex attraction: a model to aid nurses' understanding. *Paediatric Nursing* **21**(10), 18–21.

Röndahl G. (2009) Lesbians' and gay men's narratives about attitudes in nursing. *Scandinavian Journal of Caring Sciences* **23** (1), 146–152.

Röndahl G., Innala S. & Carlsson M. (2004a) Nursing staff and nursing student's attitudes towards HIV-infected and homosexual HIV-infected patients in Sweden and their wish to refrain from nursing. *Journal of Advanced Nursing* **41**(5), 454–461.

Röndahl G., Innala S. & Carlsson M. (2004b) Nurses' attitudes towards lesbians and gay men. *Journal of Advanced Nursing* **47** (4), 386–392.

Röndahl G., Innala S. & Carlsson M. (2006) Verbal and non-verbal heterosexual assumptions in nursing. *Journal of Advanced Nursing* **56**(4), 373–381.

Royal College of Nursing (2008) *Adolescence: Boundaries, Connections and Dilemmas*. RCN Publishing, London.

Royal College of Nursing and Unison (2007) *Not 'Just' a Friend; Best Practice Guidance on Health Care for Lesbian, Gay and Bisexual Service Users and their Families*. RCN Publishing, London.

Saunamaki N. & Engström M. (2013) Registered nurses' reflections on discussing sexuality with patients: responsibilities, doubts and fears. *Journal of Clinical Nursing* **23**, 531–540.

Saunamaki N., Anderson M. & Engström M. (2010) Discussing sexuality with patients: nurses' attitudes and beliefs. *Journal of Advanced Nursing* **66**(6), 1308–1316.

Society for Adolescent Health and Medicine (2013) Position paper: recommendations for promoting the health and well-being of lesbian, gay, bisexual and transgender adolescents: a position paper of the society for adolescent medicine. *Journal of Adolescent Health* **52**, 506–510.

Stevenson A. (ed.) (2015) *Oxford Dictionary of English*, Online Version. Oxford University Press, Oxford.

Troiden R.R. (1989) The formation of homosexual identities. *Journal of Homosexuality* **17**(1–2), 43–73.

United Nations Educational Scientific and Cultural Organization (2012) *Booklet 8: Education Sector Responses to Homophobic Bullying. Good Policy and Practice in HIV and Health Education* UNESCO, France.

World Health Organisation, Department of Maternal, Newborn, Child and Adolescent Health (2012) *Making Health Services Adolescent Friendly: Developing National Quality Standards for Adolescent Friendly Services*. WHO publications, Geneva; Switzerland.