Reframing Personal and Professional Values: A Substantive Theory of Facilitating Lesbian, Gay, Bisexual, Transgender and Intersex Youth-Inclusive Primary Health Care by Nurses

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ABSTRACT

LGBTI youth are prone to healthcare inequalities and experience poorer health outcomes than the general population. Nurses are not always equipped to effectively respond to LGBTI healthcare needs. The aim of the study was to develop substantive theory based on the social processes involved in facilitating LGBTI youth-inclusive primary healthcare. Using a constructivist grounded theory approach, a sample of seven nurses was interviewed. The codes and categories, that emerged during data analysis were conceptualised to develop the theory: 'reframing personal and professional values' which is outlined in three phases.

Phase 1 illuminates subtle and covert ways that nurses used to identify value-laden tension and conflict as barriers to LGBTI youth-inclusive care. Phase 2 and 3 reflect thoughtful and reflexive strategies that nurses used to facilitate nurse-patient interaction to resolve value-laden tension and conflict. The substantive theory provides a way of improving the healthcare and health seeking behaviour of LGBTI youth.

Key words: LGBTI youth; nurses, homosexuality; primary health care; sexual orientation; and youth-inclusive health care

Most lesbian, gay, bisexual, transgender and intersex **(**LGBTI) youth experience greater health inequalities than their heterosexual counterparts (Saewyc, 2011) despite laws against discrimination of the LGBTI population being passed in most countries (Ash & Mackereth, 2010; Meyer, 2016). LGBTI youth experience higher rates of poor physical and mental health (Müller, 2013; Mavhandu-Mudzusi & Sandy, 2015; Figueiredo & Abreu, 2015; Qureshi et al., 2017) such as low self-esteem, depression, anxiety, alcohol and substance abuse and suicidal ideation than the general population (Haas et al., 2011; McNair, Szalacha & Hughes, 2011; Qureshi et al., 2017). Despite experiencing these health challenges in most countries, LGBTI youth utilize health care services lesser than the general population (Cele, Sibiya, & Sokhela, 2015; Qureshi et al., 2017), because they perceive health care providers to be treating them differently from the general population (Eliason, Dibble, & Robertson, 2011; Shattell & Chinn 2014). As a result, they have limited access to LGBTI professional support networks that could help them to cope with their challenges and health care needs (Sabin, Riskind, & Nosek, 2015; Qureshi et al., 2017).

This study focused on the experiences of nurses regarding caring for LGBTI youth in primary health care (PHC) clinics in an urban area in South Africa (SA). In SA, discrimination on the basis of sexual orientation has been outlawed by the SA Bill of Rights. Section 27(1a) of the Constitution (Act 108 of 1996) which states that all citizens have the right of access to health care (OUT LGBT Wellbeing, 2007). SA has developed Adolescent and Youth Health Policy (2017) that is aimed at preventing and responding to health problems of the youth including those of LGBTI youth. Several LGBTI-friendly clinics have been established, namely; *OUT*

LGBT Wellbeing in Tshwane, Gauteng Province, *Durban Lesbian and Gay Community and Health Centre* in Durban, KwaZulu-Natal Province and *Triangle Project* in Cape Town, Western Cape Province (OUT LGBT Wellbeing 2007). These clinics were established to provide access to LGBTI-friendly PHC services that are aimed at reducing the effects of heterosexism and homophobia on the LGBTI population (OUT LGBT Wellbeing, 2007). PHC is regarded as the entry point into the health care system wherein competent health care providers can effectively respond to the needs of LGBTI youth (Reitman et al., 2013). However, the findings of the research conducted by OUT LGBT (2016), revealed that 11% of the LGBTI population that seek health care in the general public health services in a province in SA, experienced homophobic attitudes from the health care providers. They were being denied access to health care and received inappropriate or inferior care from the health care providers. In SA, research on LGBTIs' health, LGBTI patients' satisfaction with the health care services and theoretical concerns of health care providers has been largely neglected (OUT LGBT Wellbeing, 2007). Therefore, African countries, like SA, require an application of a human rights framework for understanding the challenges the LGBTI population face in societies that are heteronormative and discriminate on the basis of sexuality and gender (Victor, Nel, Lynch, & Mbatha, 2014).

Problem statement

Research findings reveal that the majority of LGBTI people experience poor patient-provider communication (Cele et al., 2015) and a lack of discussions about sexual health, including sexual orientation, sexual behaviour, and sexual transmitted infections (Riskind et al., 2014;

Mavhandu-Mudzusi, & Sandy, 2015). Health care providers do not respect their confidentiality, and often make inappropriate comments about their sexual orientation or gender identity (Snyder, Burack, & Petrova, 2016). Research aimed at examining the nurses' attitudes towards LGBTI patients and the role that nurses could play in promoting access to health care by LGBTI population and meeting their health care needs is limited (Levine, 2013; Coulter, Kenst, & Bowen, 2014; Dorsen, 2014). In order to address the complex challenges related to providing health care to the LGBTI community, it is important to assess the ways in which health care providers might best meet their needs. Therefore, studies that demonstrate the need for better interaction between LGBTI youth and health care providers should be conducted, including providing education and guidance about a variety of medical and psychosocial concerns unique to this population (Snyder et al., 2016). In SA, little formal research on how LGBTI youth-inclusive PHC should be like has been conducted (OUT Wellbeing 2016). This study therefore used a constructivist grounded theory method, a research approach commonly used in studies where little theoretical or factual knowledge is available about the phenomenon being investigated.

Aim and objectives

The aim of this study was to develop substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in an urban area in SA. The research objectives were to:

- Explore and describe the experiences of nurses regarding caring for LGBTI youth in PHC clinics.
- Explore and describe the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

The study was guided by the following two main research questions:

- How do nurses experience their interaction with LGBTI youth in PHC in an urban area in SA?
- What are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in an urban area in SA?

Definition of terms

Bisexual person refers to a person whose fantasies and sexual attractions are to both men and women (Fish, 2010). In this study, the term referred to male and female youth who are self-identified as sexually attracted to both men and women.

Gay men refer to men whose fantasies and sexual attractions are toward other men (Cárdenas, Barrientos, Gómez, & Frias-Navarro, 2012). In this study, the term referred to male youth who are self-identified as sexually attracted to men.

Intersex refers to individuals who are born with ambiguous genital or reproductive anatomy (Fish, 2010). In this study, the term referred to those individuals who cannot identify themselves as either men or women.

Lesbian women refer to women whose fantasies and sexual attractions are to other women (Fish, 2010). In this study, the term referred to female youth who are self-identified to be sexually attracted to other females.

LGBTI is an inclusive abbreviation for lesbian, gay, bisexual, transgender and intersex persons or those whose gender identity or presentation does not conform to the norm or the biological characteristics of their sex (Human Rights Watch, 2011). In this article, LGBTI is used as an umbrella term to identify people with non-conforming sexual identity and sexual orientation.

Transgender is a term used to describe people who have gender identities, expressions or behaviours that are not associated with their biological sex (Johns, Zimmerman, & Bauermeister, 2008). In this study, the term referred to women who identify themselves as men and men who identify themselves as women.

Method

This study employed a qualitative methodology that is aimed at eliciting new knowledge by following a constructivist grounded theory approach. The grounded theory method enables the development of a substantive theory that describes the basic social processes involved in the phenomenon being studied, generated directly from the data collected (Charmaz, 2014). Constructivist grounded theory begins with the exploring of experiences and describing how participants construct them. Thus, the interpretation of the studied phenomenon is in itself recognized as a construction (Charmaz, 2014). Therefore, the aim of this study was formulated in such a way that it incorporates the participants' perspectives on the problems they encounter

and how they resolve those problems in clinical practice. Discovering more about the concerns of nurses and the basic social processes involved in facilitating LGBTI youth-inclusive PHC was critical to this study.

Study population and sample

The study population comprised of nurses working in public sector and university-based PHC clinics in an urban area of SA. In constructivist grounded theory, two sampling methods are applicable, namely initial sampling and theoretical sampling (Charmaz, 2006). The data presented in this study were sourced from interviews with an initial sample of five registered nurses followed by the theoretical sample of three registered nurses (whereby one participant was also part of the initial interview) working in PHC, with clinical nursing experience ranging between five and 25 years. Pseudonyms were used during the interviews and transcription of data so that no information could be linked to a participant. The participants' demographics and the sampling method that they were involved in, is outlined in Table 1.

Ethical considerations

The researcher gained approval to conduct the study from the Research Ethics Committee of the Provincial and District Departments of Health, the universities where the study took place; and from people in charge of the PHC services where the study was conducted. Informed consent was obtained from the participants after they were given written and verbal information about the study.

Table 1: Nurse Participant's demographics

Pseudonyms	Age	Gender	Nursing Rank	Years of experience in PHC	Sampling method
NP 1	54 years	Female	Registered Nurse	12 years	Initial sampling/Theoretical sampling
NP 2	47 years	Female	Registered Nurse	21 years	Initial sampling
NP 3	50 years	Female	Registered Nurse	11 years	Initial sampling
NP 4	45 years	Female	Registered Nurse	3 years	Initial sampling
NP 5	41 years	Female	Registered Nurse	13 years	Initial sampling
NP 6	49 years	Female	Registered Nurse	10 years	Theoretical sampling
NP 7	54 years	Female	Registered Nurse	24 years	Theoretical sampling

Rigour

In this study, the risk of biased interpretation was counteracted through reflexivity. Reflexivity addresses the influence of researcher-participant interactions on the research process (Hall & Callery, 2001). To ensure reflexivity, the researcher kept a research journal during data collection and data analysis and recorded information on the research process and verbal and non-verbal information gathered during the interviews. Charmaz (2006) suggests four key criteria for evaluating grounded theory studies: credibility, originality, resonance, and usefulness.

Credibility implies that the complexity and range of data collection is adequate enough to support the analytic claims (Charmaz, 2006). To enhance credibility, the researcher allowed the participants to guide the inquiry process; checked the generated theoretical construction against participants' meanings of the phenomenon; reflected on her personal views and insights regarding the phenomenon; and only **c**onsidered literature after the theory begun to emerge**.**

Originality implies that the research offers new insights, fresh conceptual understandings, and that the analysis is theoretically or socially significant (Watling & Lingard, 2012). The researcher ensured that the concepts developed in this study were original and grounded in the data, and offered new insights into the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

Resonance implies that the grounded theory makes sense to the participants and captures the essence and fullness of their experiences (Watling & Lingard, 2012). The researcher collected

data and continued with the constant comparison process until the categories were saturated. The theory will provide the nurses with a deeper insight into the processes involved in facilitating LGBTI youth-inclusive PHC.

Usefulness implies interpretation that can be used in day-to-day situations by individuals who have interest in the phenomenon under study (Watling & Lingard, 2012). Detailed information about the sample and setting was provided so that people who want to adopt and use the basic social processes and theory that emerged from the study can decide whether it may be applicable to their context.

Data collection

An inductive method of data collection was adopted which enabled the researcher to progress simultaneously between data collection and analysis, a process referred to as constant comparative data analysis (Glaser, 2001). The researcher attempted to seek individual participant's account on how a particular phenomenon unfolded by conducting interviews with the initial sample of five registered nurses using an interview guide. A theoretical sample of three registered nurses, (whereby one participant was also part of the initial interview) was interviewed as informed by the emerging theory until theoretical saturation was achieved (Hallberg, 2006). Saturation implies that the categories and the relationships between the categories that were formed from the concepts of the theory have been finalised (Watling & Lingard, 2012). Field notes were written during and after the interviews.

Data analysis

Constant comparative data analysis was done manually and by using a software programme *Atlas ti* (version 7) (Archer, Janse van Vuuren, & Van der Walt, 2017). Four types of coding namely; initial coding, focused coding, axial coding and theoretical coding were employed (Charmaz, 2006). During initial coding, data was compared within one interview and between interviews. Every line of the interview transcript and field notes were studied to determine what exactly has been said and to find words and phrases with similar meaning to develop initial codes (Poteat, German, & Kerrigan, 2013). During focused coding, as codes recurred, they were compared for similarities and differences, examined and re-examined for overlap, and then collapsed into categories (Charmaz, 2006). During axial coding, related categories were organized and put back together by making connections between a category and its subcategories (Moghaddam, 2006) by looking for conditions, actions and consequences of the studied phenomenon (Strauss & Corbin, 1998). Finally, theoretical coding was undertaken using theoretical sampling by seeking new participants to collect data and analyse as categories emerged until the core category which formed the substantive theory emerged (Charmaz, 2006). Memos were also kept throughout to keep track of the data analysis process and to provide material for the theory construction. Once the substantive theory has emerged, the researcher considered how existing theories might relate or differ from the emergent theory (Watling & Lingard, 2012; McGhee, Marland & Atkinson, 2007).

Findings

The substantive theory that emerged during theoretical coding is: reframing personal and professional values to facilitate LGBTI youth-inclusive PHC by nurses. The substantive theory is presented as three sequential phases; each phase has its sub-processes as illustrated in Figure 1. The sub-processes are evidenced with direct quotations with the participant's number in brackets [Figure 1 near here]. The three phases are:

a) Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care;

b) Phase 2: Recognising the need to change values and attitudes; and

c) Phase 3: Applying strategies to promote interaction with LGBTI patients.

Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care

Phase 1 outlines how participants recognised barriers that hindered them from facilitating LGBTI youth-inclusive PHC. They recognised their personal subjectivity as they identified and reflected on their values, beliefs and attitudes and how that influenced their interaction with LGBTI patients. The participants described the barriers related to the personal 'self' that hindered them from facilitating LGBTI youth-inclusive PHC. Those barriers were described as personal, social, cultural and religious values, beliefs and attitudes which were found to be incongruent to those of LGBTI patients and the lack of knowledge about LGBTI health care. Participants developed some perceptions about LGBTI patients based on their personal, social, cultural and religious values as outlined in sub-process 1.1) recognising the influences of personal value; and sub-process 1.2) acknowledging having limited knowledge**.**

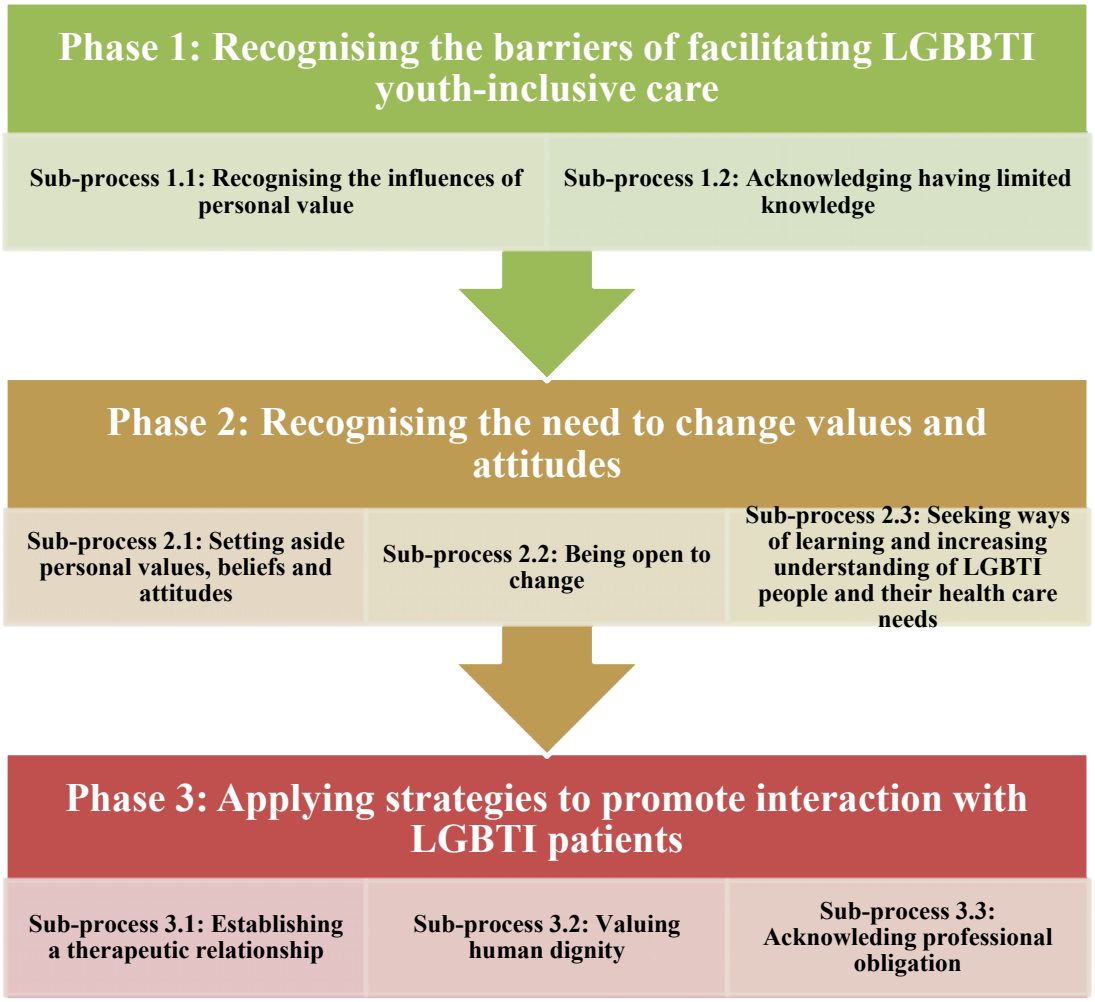

Figure 1: Phases of facilitating LGBTI youth-inclusive PHC by nurses

Sub-process 1.1: Recognising the influences of personal value

Sub-process 1.1 emerged as a foundation of self-reflection, self-awareness and self-interaction enabling the participants to gain insight into the personal 'self'. This insight enabled participants to identify their biases and the sources thereof, the misunderstandings, tension and conflict that they experienced when they interacted with LGBTI patients. Consequently, in a subjective way, they developed negative perceptions and attitudes about LGBTI people.

Most of the participants were being socialised in Christian hetero-normative societies. Based on their Christian hetero-normative values, beliefs and attitudes, they judged LGBTI people, and developed certain perceptions about them. They perceived LGBTI as 'a taboo object', 'unreal', 'immoral', 'exhibition of anti-Christian behaviour'. One participant said:

> Well, I believe God created Adam and Eve and … that's how it should be and … I'm not … comfortable talking about sex but asking a person straight out … "What is … what do you prefer, men or women?" I … haven't breached that yet… (NP3)

Participants were of the opinion that a man ought to be in a relationship with woman, and vice-versa. They were judgmental about LGBTI people and developed perceptions about how they live, their lifestyle, the sexual risk activities that they engage in, and their perceived health needs, which relied on stereotypes. At some stage, they perceived being LGBTI as a defence mechanism or a coping mechanism, a way of escaping from lives unpleasant experiences e.g. molestation during childhood. They were of the opinion that men become gay as a means of fending for themselves because they perceive male partners as providers of financial and material resources. Some participants attempted to seek deeper understanding by rationalising

and exploring factors that contribute to people 'becoming' LGBTI. Among other reasons, they perceived 'being' LGBTI as an 'inner self', over which people have no control, as 'genetically inherited', a trait with which a person is born, a 'lifestyle choice', 'actions and behaviour of insanity' and/or 'Satanism'.

> I don't think they can … pretend to be lesbians, maybe it's because of genetic or it is natural, it is … something that is inside … it's natural … there's something that they are born with, it is the feeling, it is not something that they do because they see other people doing (NP1).

Subsequent to having those perceptions about LGBTI people, the participants felt uncomfortable to discuss issues related to sexuality and sexual orientation, and in most cases, avoided discussing them. Some participants reacted in shock when they discovered the patient's sexual orientation unexpectedly, due to the fact that: 1) they have never been in contact with LGBTI person before, but have only learnt through media about their existence; 2) the patients did not exhibit external traits which might suggest a non-conforming sexual orientation; 3) culturally, being LGBTI is regarded as a taboo; and 4) in their view, being LGBTI contradicted their values and beliefs.

> …you know it was a shock to me because I'm from the rural area where … lesbians, gays … are still … I can say a 'no go' area … that's why I was shocked, okay they actually do exist … because it's something that you hear about from the … TV … then now it's like the person is sitting next to you … okay it does exist … (NP5).

On the other hand, the participants' professional experience made them identify LGBTI people based on external traits and gestures, as well as on clinical findings that the patients present with in clinical practice. Participants were able to discuss sexual orientation with LGBTI

patients in circumstances where male patients presented with anal sores, which suggested that they had contracted sexually transmitted infections anally. According to the participants, such ailments suggest that the patient could be homosexual, or engaging in a male-to-male sexual relationship.

> … a patient who came to me, so that I can know … that person is a gay, is because of the condition that he came to my room for consultation, I asked that patient … what is the problem with you, and then the patient … said "I've got … the sores … on the rectum (anus) … he said …., "Sister I've got … a partner that I'm sleeping with, and he is … a gay, I'm a gay … (NP1).

Some participants would perceive the patients as being LGBTI, based on the physical appearance or mannerisms, which are often interpreted according to generalisations or stereotypes on "how" gay, lesbian or straight people should look or behave. In cases where a male patient presents with feminine looks, or speaks in a feminine voice, that patient will be presumed to be gay.

> … I've already seen that this is a gay, … because of the way he dressed … the way he was talking … the voice according to experience, it will tell you that … this one is not a woman it is a male but … it was highly pitched … the way he was stretching the hair … you can see the feature of a male but it was a very beautiful boy, so that's … when I started to see … this is a gay … (NP1).

It was under those circumstances that the participants would realise the significance of discussing issues related to homosexuality with the patients. For the participants, developing some perceptions about LGBTI patients seemed to provide a definition of what being LGBTI meant, therefore determining how they should respond towards them during clinical interaction.

Sub-process 1.2: Acknowledging having limited knowledge

Sub-process 1.2 of phase 1 revealed that participants acknowledged having limited knowledge about LGBTI people and their health care needs. This was identified as another barrier to facilitating LGBTI youth-inclusive care. The lack of knowledge about LGBTI people and their health care needs emanated from the lack of basic nursing training on LGBTI health care. The participants discussed their limited knowledge on LGBTI people and their health care issues as follows: 1) being uncertain about what being LGBTI meant; 2) feeling helpless, uncomfortable and uncertain in providing care and support to LGBTI patients; 3) being ignorant about LGBTI issues; 4) assuming a heterosexist stance when interacting with LGBTI patients; 5) lacking knowledge about the behaviours and the lifestyle of LGBTI people; and 6) lacking knowledge about the health care needs of LGBTI people and how those health care needs should be addressed.

Participants acknowledged their inadequate skills for addressing LGBTI health issues. They were of the opinion that if the lack of skills could be addressed, the LGBTI patients and nurse interaction would improve. One nurse participant alluded:

> … I really don't know how to ask … "what is your sexual orientation"? I think there's a gap, … I … still think today it's not really addressed … in that sense, I don't know if there are places that addressing it directly … I think … there's room for improvement and there's room to sharpen the skill … (NP3).

The participants were concerned about their lack of knowledge about LGBTI health issues and their health care needs, which suggested that they were not providing adequate health care to LGBTI patients.

Phase 2: Recognising the need to change values and attitudes

While phase 1 illuminates the subtle and covert ways that nurses used to make assumptions and judgments about LGBTI patients, Phase 2 and 3, reflect thoughtful and reflexive strategies used by the nurses to facilitate the care of LGBTI patients in the context of PHC. Phase 2 reflects affective, cognitive and behavioural processes participants used to redefine the way they perceived and behaved towards the LGBTI patients. During this phase, participants became aware of how personal traits like values, beliefs, attitudes; and having limited knowledge about LGBTI health care issues, restricted them from facilitating LGBTI youth-inclusive care. Therefore, recognising the need to change values, beliefs and attitudes meant: 1) setting aside their personal values, beliefs and attitudes; 2) being open to change; and 3) seeking alternative ways of learning and increasing understanding of LGBTI people and their health care needs.

Participants were willing to overcome the effects of their personal values, beliefs and attitudes on nurse-patient interaction. This phase became a reflexive response of re-establishing the personal and professional 'self' from the tension that they experienced due to value conflict and cultural shock. They sought various ways of resolving the value-laden conflict and tension and pursuing personal and professional transformation. Participants expressed their willingness to change their attitudes towards LGBTI patients. Consequently, they were able to establish

conducive nurse-patient relationship whereby they accommodated LGBTI patients on their own terms. Participants were able to alter the meaning of their situation, which enabled them to gain some level of control and confidence in caring for LGBTI patients. The sub-processes related to Phase 2 are, 2.1) setting aside personal values, beliefs and attitudes, 2.2) being open to change, and 2.3) seeking ways of learning and increasing understanding of LGBTI people and their health care needs.

Sub-process 2.1: Setting aside personal values, beliefs and attitudes

When they realised their own limitations in caring for LGBTI patients, participants used cognitive and affective processes to set aside personal values, beliefs and attitudes. Cognitively, participants suppressed and bracketed their own values, beliefs and attitudes and were open to change in order to meet their professional obligations towards LGBTI patients. One participant said:

> … what I have learnt is that … if you're a human being … and then you told yourself that you are a Christian, being Christianity doesn't mean that you need to … judge the people or you have to discriminate … the people or what, yours is just to, you must learn that a human being is a human being … (NP1).

Bracketing was followed by reassuring the patients that they will not allow personal feelings to affect their roles and moral obligations of caring for all patients in a humane manner.

The affective process involved empathising with LGBTI patients. The participants realised that LGBTI people were ostracised in their families and society, including the health care system. Thus, empathising allowed them to reflect on how one would act, react and think if faced with

similar challenges as LGBTI patients. Empathising enabled the participants to critique their actions and reactions and engage in a new meaningful way that acknowledge the challenges and health care needs of LGBTI patients.

> … I think mostly, you feel for me as a person, I feel sorry for them, because … of what they have to go through … it's … still being frowned upon and they are still being ostracized especially by their family, because … he just told us "Look my mum doesn't know, she's not aware of the status and she should know though … about this (NP4).

Through adjusting their behaviour, actions and emotions participants became more sensitive and tried to understand LGBTI people's thoughts and feelings and their health care needs. Awareness and understanding of LGBTI peoples' challenges were enhanced through participants' professional and personal relationships with a LGBTI patient, acquaintance or relative, who shared experiences of being judged and discriminated against.

Sub-process 2.2: Being open to change

'Being open to change' constituted: 1) understanding of others' challenges; and 2) changing old values and establishing new ones. As the participants became open to change, they became considerate of the diversity of LGBTI patients, less judgmental and began to perceive the patients' differences as distinctive personal traits. 'Being considerate' was described by participants as an affective process that involved giving up part of the personal 'self' in order to preserve the relationship with others. It meant being sensitive to the needs and feelings of LGBTI patients and attending to those needs despite experiencing internal conflict.

> I was trying to reach out the reality that he need to face as a patient … how do you call it, the clustered group that he falls in, it's not by his choice, nobody forced him to be there, just to accept it as it is, and this will also help other people to know how to tackle the problem, because once you start smiling and like, looking like you are amazed and let this person to be, like start to be a little comforting him (NP4).

The participants shared how they had learned to deal with conflicting values by developing new attitudes and skills. To meet the needs of the patients, they had to give up their personal values, beliefs and attitudes. As the participants made this conceptual transition of reframing personal and professional values, they felt more accountable for their own actions and perceived caring for LGBTI patients in a humane manner. This increased sense of accountability and integrity helped the participants to put aside their values and avoid judging and stigmatising the patients. This process also helped them to overcome their helplessness and the lack of confidence they initially had in caring for LGBTI patients.

Sub-process 2.3: Seeking ways of learning and increasing understanding of LGBTI people and their health care needs

This sub-process demonstrates participants' eagerness to learn and increase their knowledge and understanding of LGBTI people and their health care needs. Participants admitted that the lack of knowledge which emanated from the lack of formal education and training on LGBTI health care was a limitation towards efficiently caring for LGBTI patients. The participants suggested various learning mechanisms that would enable them to acquire more knowledge about LGBTI issues. For example, learning from the LGBTI community about the 'factors that led them to be 'LGBTI', their lifestyle, sexual preferences, and sexual activities.

Participants viewed learning from each other as a mutual and interactive process that takes places between people and results in connecting existing and new knowledge in order to obtain a better understanding of the phenomenon being addressed. The participants suggested the following ways of learning from each other: 1) learning from other health care workers who have experience in working with LGBTI people; 2) a one-on-one interactive and collaborative process of learning from others; 3) e-learning methods where information could be shared through available electronic media like emails; 4) a database on LGBTI health issues; 5) periodic counselling sessions; 6) giving and receiving feedback; 7) benchmarking with other institutions; and 8) engaging in support groups. One participant indicated:

> Well … an update is always good … a face to face interaction … with other … professional nurses … working in primary health care and it also face what I'm facing and nowadays with technology, good database where you can maybe e-mail someone and say "Look, I'm sitting with this … even phone and say "… how do I handle the situation because I really don't have any idea what to do about this… (NP3).

Participants were of the opinion that collaborating with others who are knowledgeable about LGBTI issues will assist those nurses working with LGBTI patients to bridge their knowledge gap. They anticipated that these proposed innovative strategies will empower them with the necessary knowledge to facilitate LGBTI youth-inclusive care.

Phase 3: Applying strategies to promote interaction with LGBTI patients

Reflecting on the professional values that guide the nursing profession and their moral obligation towards LGBTI people assisted participants in developing strategies to facilitate LGBTI care. Professional values provided participants with the ways in which they should

behave and respond towards LGBTI patients. Participants have learnt that they might not have interacted with an individual patient *per se,* but allowed the perceptions that they held about the patient to influence the way they interacted with him or her. Phase 3 shed light on how the participants consciously developed approaches to manage tensions that existed when working with LGBTI patients. Phase 3 comprises of three sub-processes namely, sub-process 3.1) establishing a therapeutic relationship, sub-process 3.2) valuing human dignity and sub-process 3.3) acknowledging professional obligation.

Sub-process 3.1: Establishing a therapeutic relationship

Participants adopted strategies of establishing a therapeutic relationship with LGBTI patients which they described as: 1) establishing rapport; 2) increasing the patients' comfort level; 3) being available; 4) gaining patients' trust; 5) engaging in open communication; 6) reaching out to the patients; 7) having good communication skills; and 8) treating people with respect. What was paramount for participants was increasing LGBTI patients' comfort level and engaging in open communication, which became a gateway to gaining trust. Participants were of the opinion that such an enabling environment optimised discussions about sensitive issues related to sexuality, sexual orientation and LGBT health care. One nurse participant said:

> … he must be free for whatever he want to tell me, I'm here to come and help him, he must never be afraid that I'm going to say this and that, no … I said I talk to him very friendly and then he start to open, that is why I think he just judged me and said "no, this one is a woman, a mother, I'm going to tell him, I'm not going to lie, I'm going to tell her the problem that I'm having, I want help … (NP2).

A therapeutic environment enable LGBTI patients to disclose their sexual orientation without fear of being judged or discriminated against, and to return to the health care facility for further health care assistance when a need arose. Building therapeutic relationships with LGBTI patients also involved: 1) spending more time with them, 2) attempting to ascertain the patients' comfort levels, 3) having good communication and listening skills, 4) assuring patients of confidentiality and 5) demonstrating empathetic understanding.

Sub-process 3.2: Valuing human dignity

Sub-process 3.2 revealed a conscious and intentional process undertaken by participants to respect human dignity in order to prevent doing harm to LGBTI patients. For the participants, valuing human dignity involved treating patients in a humane manner by 1) showing love, 2) having a positive attitude, 3) addressing patients with their titles rather than their names, 4) treating patients comprehensively and 5) effectively responding to their health care needs which will result in patients' satisfaction. Participants demonstrated confidence in caring for LGBTI patients in their use of concepts like: 1) respect for others, 2) respectful communication, 3) treating everyone the same, 4) being sensitive to patients' unique circumstances and health needs and 5) being non-judgmental, which demonstrated how much they valued human dignity of LGBTI patients. For the participants, "treating everyone the same" meant: 1) putting everyone in the same queue as any other patients in the clinic; 2) not discriminating against anyone; 3) welcoming all patients; 4) making patients feel comfortable; and 5) not viewing patient's sexual orientation as significant when rendering care. Applying the principles of human rights and equality irrespective of the patients' social background and circumstances,

resulted in professional conduct and an increase in the patients' sense of self-worth. Reflecting on professional values raised awareness on the significance of these values in guiding decision-making and reducing prejudice, judgement, and discrimination in clinical interaction.

> I think we need to give them benefits of … a doubt, to see themselves as human being amongst us, and to be treated with respect, and not to be judged (NP4).

Professional values and moral obligations play an influential role in how participants facilitate LGBTI care. Discussing the significance of the role that professional values such as valuing human dignity and respect for personal and professional 'self' play, enhanced the participants' ability to tolerate differences, and to interact with LGBTI patients in a respectful manner.

Sub-process 3.3: Acknowledging professional obligation

Participants made reference to the core values and ethical principles of the nursing profession, which guided the technical and social aspects of their nursing practice. Acknowledging their professional obligations helped participants to reframe their personal and professional values. One participant mentioned:

> I choose to become a nurse, to help people… accordingly … not to be judgemental, because … you need … to put up your listening skills and then you give the patient [time] to vent [ventilate], the main reason sometimes… you reach out to the patient who's there for a certain reason (NP4).

The participants' moral aspects were aided by referring to their professional accountability to put the needs of patients first. This concludes the discussion of Phase 3 and all of the three

phases of the substantive theory: reframing personal and professional values to facilitate LGBTI youth-inclusive PHC.

Discussion

The aim of this study was to develop a substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in an urban area in SA. The substantive theory of reframing personal and professional values explain the way nurses respond to LGBTI patients. When looking through the lens of their personal, social, cultural and professional values that they had been socialized to, they may treat LGBTI patients in a stereotypical and judgemental way. Personal values refer to the beliefs that people have about what is right and wrong, and that control their perceptions, actions and behavior (Locke, 1976). In this study, personal values are seen as cultural, social and religious values which guide nurses' perceptions, judgements and actions towards LGBTI patients. In this study, 'reframing' emerged as a concept that explains the process i.e. series of actions of viewing and reflecting on values, experiences, ideas and emotions and ultimately finding more positive alternatives to mediate the care provided to LGBTI youth in PHC.

In the substantive theory, personal and professional values are viewed as binary opposites. Being influenced by personal values acts as a barrier towards facilitating LGBTI youth-inclusive health care, while being influenced by professional values and moral obligations contributes towards facilitating LGBTI youth-inclusive health care. Blumer (1969) asserts that people consciously form meaning about objects, thus, are open-minded to change the meaning

and perceptions about the object when they are presented with new facts and evidence. Similarly, in this study, participants needed to change their self-concept by altering the personal 'self', by compromising their own values, beliefs and attitudes, consequently altering their perceptions about others.

The International Council of Nurses (ICN) Code of Ethics (2006) is clear in its mandate that nurses should respect human rights and not discriminate against any patient, stating that "inherent in nursing, is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect". Similarly, the nurses' pledge of service and the Code of Ethics for Nursing Practitioners in SA (2013) mandate the nurses to respect human rights without consideration of age, colour, race, creed, disability, illness, nationality, gender, sexual orientation or social standing. Nevertheless, some nurses still experience internal struggles between their personal attitudes and beliefs and their professional responsibilities with regards to providing care to LGBTI patients. As a result, LGBTI patients still experience many covert and overt forms of stigma and discrimination which includes physical, verbal and emotional abuse and are sometimes denied health care by health care providers (Rounds, McGrath, & Walsh, 2013).

Quality nursing care is dependent on the decisions made by nurses during clinical encounters with patients, therefore it is important to understand how nurses respond when their personal values are in conflict with those of their patients. Regardless of these conflicting values, nurses to fulfil their professional and moral obligations towards patients. The substantive theory that emerged from this study makes explicit the process that will help the nurses to facilitate LGBTI

youth-inclusive PHC, thereby promoting health care utilization. Participants suggested that all patients should be treated with respect and that LGBTI patients be treated the same as other patients. The theory provides insight into the relationship between nurses' cognitive and affective processes and social action and interaction. When reflecting on their professional values, nurses become aware of the significance of these values in guiding decision making and reducing the prejudice, judgemental actions, and discrimination during clinical interaction. Sub-processes such as 'establishing therapeutic relationships', 'valuing human dignity'; and 'acknowledging professional obligations' play an influential role in how nurses facilitate LGBTI care. Valuing human dignity enhances a therapeutic nurse-patient relationship, intensifies respect for the 'self', the profession and others and enhances nurses' ability to tolerate differences, and to interact with others in a respectful manner (Jormsri, Kunaviktikul, Ketefian, & Chaowalit, 2005).

In this study, participants experienced the lack of formal and informal training as a barrier to providing effective nursing care to LGBTI patients. Therefore, seeking more insight about LGBTI people and their health care needs was a conscious response of nurses to overcome their lack of knowledge that had a negative effect on nurse-patient interaction. The findings of the study suggested various mechanisms that will enable health care providers to acquire more knowledge about LGBTI issues in order to render more effective healthcare. Education strategies that focus on an evidence-based approach to LGBTI health care should be considered (Carabez et al., 2015, Fish & Evans, 2016); therefore theories that explain the basic social processes involved in facilitating LGBTI youth-inclusive PHC can guide educators to develop

educational programmes that could translate the theory into care. Despite the fact that this research did not set out to explore solutions, participants suggested strategies and recommendations to facilitating LGBTI youth-inclusive PHC. The theory that emerged from the study may creatively inform nursing practice, research and education.

Like any other qualitative study, this study had certain limitations that should be taken into consideration. The results of this grounded theory study were based on the interviews with a small, convenience sample and therefore cannot be generalised. The questions asked, the way they were asked by the researcher and the way they were interpreted by the participants, may have yielded different results. The main limitations related to all grounded theory studies conducted under the interpretive and constructivist paradigm is that the theory is not created but interpreted, constructed and co-constructed by the participants and the researcher (Charmaz, 2014). Therefore, the subjective nature of both data and theory building should be acknowledged. Limiting the study to one specific area, which formed a part of a province comprising of major urban and rural areas with different demographic overview, could have impacted on the findings of this study. As a result of the regional limitation, the findings of the study could not be generalized to all other PHC settings in other provinces. The usefulness of the substantive theory of this study will depend on the health care providers' ability to interpret its applicability in similar settings i.e. LGBTI youth primary health care.

Recommendations

Recommendations stemming from the findings of this study relate to nursing practice, education and research.

The substantive theory that emerged from this study could assist in improving the health care and health seeking behaviour of LGBTI youth. Extending the context of this theory beyond LGBTI patients to include the nursing care of all the vulnerable populations who experience the same dynamics as LGBTI patients will offer significant contribution to expand this theory. This study has encouraged the nurses to enhance their self-awareness during interaction with minority and vulnerable populations by reflecting on factors that may hinder them from effectively addressing the needs of those patients. Having reflected and identified such factors will enable the nurses to adopt strategies to overcome those hindrances.

This study has provided a theoretical foundation from which further research can expand, test, and/or refine the substantive theory. The substantive theory describes the basic social processes involved in the facilitating of LGBTI youth-inclusive PHC that can be operationalized and tested in future research using a different methodology which comprise of a non-probability sampling method. The categories that emerged from this study offer opportunities for further research and comparison with similar research, concepts and higher level nursing models and theory. The findings highlight the cognitive, affective and behavioural processes involved in facilitating LGBTI youth-inclusive PHC which leave room for further exploration in this area. The theory could also be extended by exploring the behaviour and perspective transformation

in nurses caring for LGBTI patients and structures and processes involved in facilitating LGBTI youth-inclusive health care by health care providers.

Conclusion

This study attempted to develop the basic social process involved in facilitating LGBTI youth-inclusive PHC in order to enhance the care provided by LGBTI patients and promote their health care utilization. The substantive theory that emerged from this study set out conditions, context, actions, interactions and consequences of facilitating LGBTI youth-inclusive PHC and how the theory can be applied to enhance the nursing care of LGBTI patients. Furthermore, the theory can be applied in nursing practice; education and future research. In SA, research on LGBTI people's health and theoretical concerns of health care providers has been largely neglected. This study addressed the complex challenges related to providing health care to the LGBTI community and the ways in which health care providers might best meet their needs. It is anticipated that the substantive theory that emerged from this study could assist in improving the health care and health-seeking behaviour of LGBTI youth.

Acknowledgements

The authors would like to thank the Department of Higher Education and the South Association of Campus Health Services for their financial contribution, the universities and the health services concerned for permission to conduct this research. Special appreciation is extended to the participants in the study, SANTRUST and the funders who made this study possible.

Disclosure statement

No potential conflict of interest is held by the authors.

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