



## Review

## Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review



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## ABSTRACT

**Objectives:** To explore current literature surrounding the knowledge, beliefs and attitudes of nurses and midwives of the healthcare needs of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) patients and their influence on equal and non-discriminatory care for LGBTQ individuals.

**Design:** Systematic integrative review.

**Data Sources:** CINAHL, MEDLINE, PubMed, InterNurse.

**Review Methods:** This integrative review used Wakefield's (2014) framework to establish the knowledge, beliefs and attitudes of nurses and midwives of the healthcare needs of LGBTQ patients. Qualitative, quantitative and mixed methods primary studies carried out between 2006 and 2015 from 7 countries were included. Four databases were searched and 98 studies were screened for eligibility by two researchers. Level of evidence was assessed by the Scottish Intercollegiate Guidelines Network (SIGN, 2010) criteria and quality was assessed by a screening tool adapted from Noyes and Popay (2007) for qualitative papers and Quality Assessment Tool for Quantitative Studies adapted from the Effective Public Health Practice Project (EPHPP, 2010). Following PRISMA guidelines, this integrative review analysed and synthesised evidence using thematic analysis to generate themes.

**Results:** 24 papers were included in the final synthesis which revealed four primary themes: Heteronormativity across Healthcare; Queerphobia; Rainbow of Attitudes; Learning Diversity.

**Conclusions:** Nurses and midwives possess a wide spectrum of attitudes, knowledge and beliefs which impact the care received by LGBTQ patients. Many issues of inadequate care appear to be due to a culture of heteronormativity and a lack of education on LGBTQ health. Further research is needed on interventions which could facilitate disclosure of sexual orientation and interrupt heteronormative assumptions by staff. It is recommended that LGBTQ issues be included within undergraduate nursing and midwifery education or as part of continued professional development.

### 1. Introduction

In 2015, Ireland became the first country in the world to legalise same-sex marriage by popular vote. This milestone in civil rights means that Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) families are now protected by the constitution and have the same rights and protections as different gender married couples (Table 1). Although this shift in state policy is indicative of broader social change, it does not mean that negative attitudes and beliefs towards LGBTQ people have disappeared. Thus, the health of LGBTQ people may still be at risk due to discrimination and barriers to appropriate healthcare.

Minority stress and engagement in risk-related health behaviours leads to significant health disparities amongst members of the LGBTQ community. The LGBTQ community experiences higher rates of smok-

ing, alcohol consumption, eating disorders, mental illness and suicidality (McNeil et al., 2012; Mayock et al., 2008; HSE, 2006). LGBTQ women experience higher rates of cardiovascular disease, polycystic ovary syndrome, breast, cervical and ovarian cancer (Brown and Tracy, 2008; HSE, 2006; Smolinski and Colón, 2006).

In spite of these issues, there are a number of barriers to LGBTQ individuals accessing healthcare, including fear of discrimination and stigma, difficulty disclosing sexual orientation or gender identity to staff and lack of staff knowledge of LGBTQ issues (Dearing and Hequemour, 2014; Jackson et al., 2008; Mayock et al., 2008; Peate, 2008a; 2008b; Brotman et al., 2007; Hutchinson et al., 2006). As person centred care should encompass the Rogerian values of empathy, congruence and unconditional positive regard (Rogers, 1957), it is essential that nurses and midwives be conscious of the

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**Table 1**

## Glossary of Terms

The following definitions are adapted from the [American Psychological Association \(2015a\)](#), [American Psychological Association \(2015b\)](#) and [McCabe et al. \(2013\)](#).

Biphobia	a term for prejudice against bisexual people
Bisexual	a person who is emotionally, romantically, and sexually attracted to both men and women
Cisgender	an adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth
Cisnormativity	a systemic bias based on the ideology that gender expression and gender identities are determined by sex assigned at birth rather than self-identified gender identity
Gay	a person whose emotional, romantic, and sexual attractions are for individuals of the same sex
GB men	gay and bisexual identifying men
Gender identity	refers to one's sense of oneself as male, female or an alternative gender
Heteronormativity	presumptions relating to sex and gender, which include beliefs in normality or naturalness of heterosexuality and the public recognition and celebration of heterosexuality through a variety of social discourses and institutions
Heterosexism	a belief system that assumes that all people are heterosexual and that heterosexuality is inherently normal and superior
Heterosexual	a person whose emotional, romantic, and sexual attractions are primarily for individuals of a different sex
Homophobia	a term for prejudice against LGBT people
Homosexual	a term used to refer to a person based on his or her same-sex sexual orientation, identity, or behaviour
LB women	lesbian and bisexual identifying women
Lesbian	a woman whose emotional, romantic, and sexual attractions are primarily for other women
LGB	lesbian, gay and bisexual
LGBT	lesbian, gay, bisexual and transgender
LGBTQ	lesbian, gay, bisexual, transgender and queer; umbrella term for minority sexual orientations and gender identities
LQ	lesbian and queer identifying women
Microaggressions	messages that communicate hostile, derogatory, or negative slights directed at marginalized groups in society
Misgendering	the use of incorrect pronouns or gender references when speaking to or about an individual i.e. referring to a trans woman as 'he' or male
Non-binary/genderqueer	refers to individuals who identify their gender as falling outside the binary constructs of male and female
Queer	a historically derogatory term for a gay man, lesbian, or gender non-conforming person. The term has been widely reclaimed, especially by younger LGBT people, as a positive social and political identity. It is sometimes used as an inclusive, or umbrella, term for all LGBT people. More recently, queer has become common as a term of self-identification for people who do not identify with the restrictive and binary terms that have traditionally described sexual orientation (for instance, gay, lesbian, or bisexual only). Some LGBT community members still find queer an offensive or problematic term
Queerphobia	a term for prejudice against LGBTQ people
Sexual orientation	refers to the sex of those to whom one is sexually and romantically attracted
Trans	short-hand for the terms transgender, transsexual, and/or gender nonconforming
Transgender	umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth
Transphobia	a term for prejudice against trans people

attitudes and beliefs that may influence their care of LGBTQ patients.

Therefore this review aims to explore the knowledge, beliefs and attitudes that nurses and midwives have of the healthcare needs of the LGBTQ population and to synthesise these findings in order to determine common themes across relevant studies and identify areas for future study.

## 2. Methods

### 2.1. Aims

This review aims to answer the following questions:

1. What can the current literature reveal about the knowledge, beliefs and attitudes of nurses and midwives of the healthcare needs of the LGBTQ population?
2. Do the knowledge, beliefs and attitudes of nurses and midwives affect access to equal and non-discriminatory healthcare provision for the LGBTQ population?

### 2.2. Design

Little literature exists regarding care episodes between healthcare staff and LGBTQ patients. The studies that do exist are largely qualitative with few examples of quantitative studies, meta-analyses or systematic reviews. Thus, the research method chosen to explore the research question was a systematic integrative review. The steps, outlined by [Wakefield's \(2014\)](#) framework, in doing an integrative review were adhered to in order to establish the knowledge, beliefs and attitudes of nurses and midwives of the healthcare needs of LGBTQ patients. Following PRISMA guidelines this integrative review analysed and synthesised evidence using thematic analysis to generate themes

and sub-themes.

### 2.3. Population

Broad and specific terms were used in identifying the staff caring for LGBTQ patients. This was later narrowed to papers which focused on nurses and midwives. The perspectives of both the LGBTQ population and nurses and midwives themselves are important in building a complete picture of the attitudes, knowledge and beliefs. Therefore, studies which inform both points of view were included.

### 2.4. Phenomena of Interest

The review explored the beliefs, knowledge and attitudes held by nurses and midwives of the healthcare needs of the LGBTQ community.

### 2.5. Context

The LGBTQ community is a diverse and heterogeneous population group. Research studies commonly conflate members of the population or focus in on one specific subset of the community (often lesbians or gay men). In order to attain a wide overview of the literature, both collective (e.g. LGBT, sexual orientation) and specific (e.g. gay, lesbian, bisexual, transgender) terms were used.

### 2.6. Search Strategy

A modified version of the PICO criteria was used to frame the review and develop key search terms ([Joanna Briggs Institute, 2011](#)). This version of PICO refers to Population, phenomenon of Interest and Context and was chosen because the research question is exploratory in nature, contains neither an intervention nor an outcome and focuses

**Table 2**  
Search Terms.

Boolean search terms	Phenomenon of Interest	Context
Population		
Healthcare workers OR healthcare professionals OR hospital staff OR health staff	Attitude* OR belie* OR knowledge	Sexuality OR sexual orientation OR LGBT* OR gay OR lesbian OR bisexual OR transgender

primarily on qualitative studies (Wakefield, 2014; Joanna Briggs Institute, 2011). A Boolean search of the electronic literature databases CINAHL, MEDLINE, PubMed and Internurse was carried out in June 2015 (Table 2). The reference lists of all identified studies were then searched for additional studies.

### 2.7. Inclusion and Exclusion Criteria for Screening Literature

Inclusion criteria included qualitative, quantitative or mixed methods primary studies carried out between 2006 and 2015 which addressed the beliefs, knowledge or attitudes of healthcare staff towards patients who identified as LGBTQ. Initially the search focused on healthcare staff. This time frame was chosen due to the cultural shift in attitudes towards the LGBTQ population in the last decade. Articles were excluded if the studies focused on LGBTQ parents or carers or if they took place outside the contexts outlined above. A second inclusion screening was later carried out to focus exclusively on nurses and midwives. Studies which included a number of healthcare professions were also included if nurses or midwives made up part of the study cohort.

The review focused on studies carried out in the United States, Canada, Australia, New Zealand, Scandinavia, the United Kingdom and Ireland. These locations were selected as they are the major English-speaking countries with similar equality and civil rights legislation as is present in Ireland. Clinical settings included primary care, acute hospitals, hospice care and nursing homes.

### 2.8. Quality Assessment

The initial search generated 1827 articles for review. Two researchers screened the titles and abstracts and 98 full-text articles were reviewed for eligibility and methodological quality appraisal. Level of evidence was assessed by SIGN criteria. 14 studies were at level 3 and 10 at level 2 (Scottish Intercollegiate Guidelines Network, 2010). The Quality Assessment Tool for Quantitative Studies (National Collaborating Centre for Methods and Tools, 2008) and Screening and Appraisal Tool for Qualitative Studies (adapted from Noyes and Popay, 2007) were used in quality assessment. 13 studies were deemed strong with 11 being moderate. Weak studies were excluded from the review. 24 studies included in final review and included 14 qualitative, 5 quantitative and 5 mixed methods studies (Fig. 1; Table 3).

### 2.9. Data Extraction and Analysis

Data were extracted from included papers using a standardised data extraction form (Table 3). The data extracted included specific details about the location of the study, characteristics of the sample, study design, key findings and the strength of the evidence as determined by the appraisal tools described above. Thematic analysis was carried out using the steps described by Braun and Clarke (2006). This involved becoming familiar with the data, reading and re-reading the studies, generating codes across the data set and collating these codes into possible themes. The themes were then reviewed, defined and named in order to refine each theme and produce a thematic 'map' of the data set.

## 3. Findings

All 24 papers were primary studies. 6 looked specifically at nurses and midwives and 18 focused on healthcare staff in general. The sample was made up of patients in 16 studies, staff in 5 studies and both patients and staff in 3 studies. A variety of methods were used across studies to collect data including in-depth interviews, focus groups and surveys. Methods of analysis included discourse analysis, thematic analysis and statistical analysis using SPSS. The themes were reflected across all studies. The findings from the quantitative and mixed methods studies concurred with the findings in the qualitative studies. Four major themes arose from the literature: "Heteronormativity across Healthcare", "Queerphobia", "Rainbow of Attitudes" and "Learning Diversity" (Fig. 2; Table 4).

The theme "Heteronormativity across Healthcare" arose in 15 studies (8 qualitative, 3 quantitative and 4 mixed methods studies).

The theme "Queerphobia" arose in 14 studies (8 qualitative, 2 quantitative and 4 mixed methods studies).

The theme "Rainbow of Attitudes" arose in all 24 studies (14 qualitative, 5 quantitative and 5 mixed methods studies). This theme can be broken down into three sub-themes: "Affirmation and Advocacy", "Treating Everybody the Same" and "Intrusion and Judgment".

The theme "Learning Diversity" arose in 16 studies (8 qualitative, 3 quantitative and 5 mixed methods studies). This theme can be broken down into two sub-themes: "Proactive and Appropriate Education and Skills" and "Insufficient Education and Skills".

## 4. Synthesis

This integrative review identified four themes relating to the attitudes and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population. These themes address heteronormative beliefs and actions, homophobia and the wide range of attitudes, skills and knowledge displayed by nurses and midwives (Fig. 2).

### 4.1. Heteronormativity Across Healthcare

Heteronormativity refers to the structures and discourses which recognise heterosexuality as normal and natural (McCabe et al., 2013). This was a common trait in service providers across studies. Horner et al. (2012) found that 86% of nursing home staff were unaware of any LGBTQ residents within their facilities. Care staff reported that they would be significantly more surprised by sexual contact between two men than any other gender pairing (Hinrichs and Vacha-Haase, 2010). Neville and Henrickson (2006) found that 83.2% of LB women and 65.8% of GB men were presumed to be heterosexual by healthcare staff. Hunt and Fish (2008) found that 40% of LB women were assumed heterosexual by healthcare providers whereas this rate dropped to 16% for GB men (Guasp, 2012).

Many LGBTQ patients described how the language used by nurses and midwives was a key indicator of heteronormativity, particularly during history taking and admissions (Daley, 2010; Bjorkman and Malterud, 2009; Gibbons et al., 2007; Røndahl et al., 2006). During sexual health screenings, staff appearing perplexed when LB women insisted that they did not need oral contraceptives or a pregnancy test (Fish and Bewley, 2010; Røndahl et al., 2006). LGBTQ patients also reported that staff would ask for the name of their partner using opposite gender pronouns and be confused when corrected (Røndahl et al., 2006). This often left patients with little opportunity for disclosure of sexual orientation or gender identity (Guasp, 2012; Daley, 2010; Hunt and Fish, 2008).

Cisnormativity is the systematic bias that recognises cisgender as normal and natural (American Psychological Association, 2015). This assumption was often related to assumptions of what trans individuals looked like and what their issues and needs were (Bauer et al., 2009).

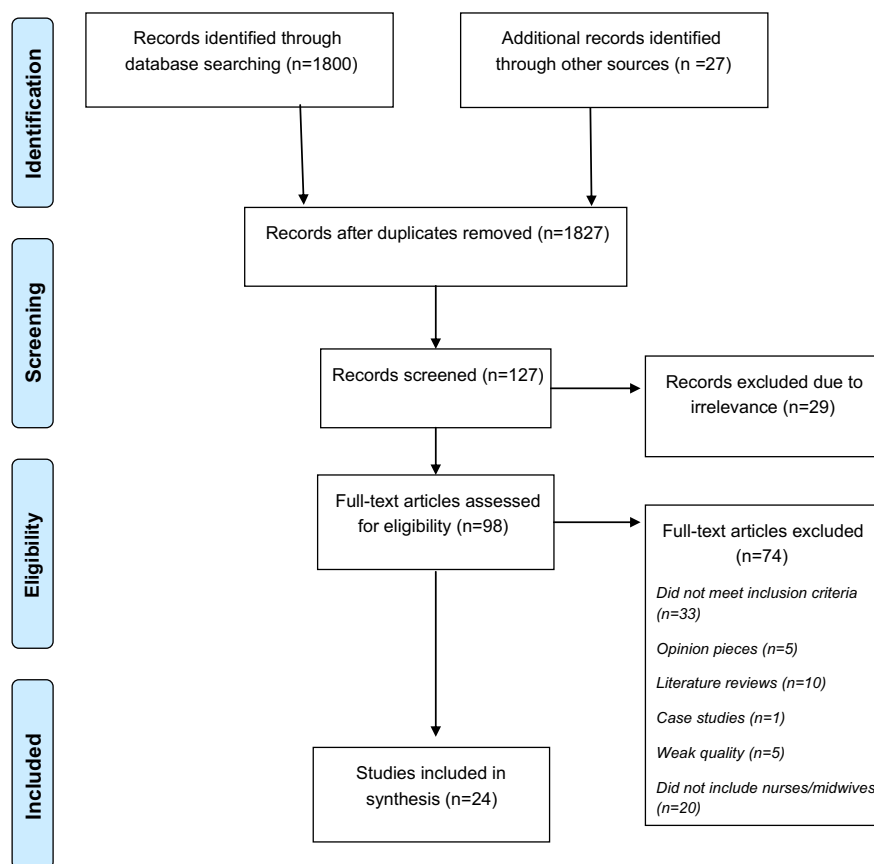


Fig. 1. Prisma Flow Diagram (Moher et al., 2009).

Those who conformed visually to their chosen gender and possessed corresponding identity documents had much higher rates of health service use than other transgender individuals (Grant et al., 2011). 20% of trans patients in the mental health sector and 16% of trans patients in the general health sector were told that they were not really trans (McNeil et al., 2012).

This theme is demonstrated in the assumptions about heterosexuality and assigned gender identity displayed by healthcare staff. Heteronormative attitudes can be seen to influence the language used by staff which often erased the possibility of disclosure.

#### 4.2. Queerphobia

Many studies pointed to homophobic, biphobic and transphobic attitudes and behaviour by nurses, which can collectively be described as queerphobia. Examples included use of hurtful language, incidents of ridicule, presumptions of HIV positive status amongst gay and bisexual men and depictions of bisexuality as an invalid identity (Guasp, 2012; Knight et al., 2012; McNeil et al., 2012; Eady et al., 2011; Gibbons et al., 2007).

One in four frontline staff have witnessed colleagues make discriminatory comments about LGB patients (Somerville, 2015; Fish and Bewley, 2010). LGB patients have received inappropriate comments about their sexual orientation from staff (Eady et al., 2011; Saleh et al., 2011; Hunt and Fish, 2008). One in five staff have heard colleagues make offensive comments about trans patients (Somerville, 2015). Over half of trans patients experienced difficulties such as harassment, misgendering and ridicule (McNeil et al., 2012; Grant et al., 2011).

There were also cases of sexual orientation and gender identity being treated as pathology (Saleh et al., 2011; Røndahl 2009). 10% of staff had witnessed healthcare staff expressing the belief that it is possible to be cured of being LGBTQ (Somerville, 2015). Other patients

described being told their illness was due to their sexual orientation or gender identity, particularly in cases of mental illness (McNeil et al., 2012; Eady et al., 2011; Bjorkman and Malterud, 2009).

Several studies reported unequal or discriminatory care towards LGBTQ clients (Somerville, 2015; Eady et al., 2011; Grant et al., 2011). Half of LB women and one third of GB men have had negative experiences of healthcare in the last year due to their sexual orientation (Guasp, 2012; Hunt and Fish, 2008). Two thirds of trans individuals have had negative experiences within health services; this was consistent across mental healthcare, general healthcare and gender identity clinics (McNeil et al., 2012).

Trans individuals, in particular, reported inappropriate care or refusal of care altogether (Grant et al., 2011; Bauer et al., 2009). 1.3% of trans individuals had experienced a mental health professional inappropriately ask to see their genitals (McNeil et al., 2012). Trans patients also risk being placed on a single-sex ward as the gender they were assigned at birth (Bauer et al., 2009).

Queerphobia can be seen in the form of discriminatory and offensive comments and the pathologising of sexual orientation and gender identity. Many queer patients report negative experiences of healthcare and this is especially true of the trans community.

#### 4.3. A Rainbow of Attitudes

This theme can be broken down into three sub-themes: affirmation and advocacy; treating everybody the same; and intrusion and judgment.

#### 4.4. Affirmation and Advocacy

Nurses and midwives were described as open, accepting and attentive to their patients (Hardacker et al., 2014; Eady et al., 2011;

**Table 3**  
Data Extraction Findings.

Author(s) and year	Country	Sample	Design	Key findings	Strength of evidence (National Collaborating Centre for Methods and Tools, 2008; Noyes and Popay, 2007)	SIGN (2010) Level
Bauer et al. (2009)	Canada	85 transgender individuals	Qualitative: Semi-structured focus groups to describe how erasure functions to impact experiences of transgender individuals interacting with the health care system; analysis using NVivo 7 software	Informational erasure; Institutional erasure	Moderate	3
Beagan et al. (2012)	Canada	12 heterosexual nurses (11 female, 1 male); Bachelor's or Master's training; 10–20 years' experience; self-identified as working with LGBTQ patients	Qualitative: In-depth, semi-structured interviews to explore nurses' perceptions of working with LGBTQ patients; thematic analysis using ATLAS.ti software; analysis informed by critical feminist and queer studies	Denying difference by treating everyone as an individual; Acknowledging difference as discrimination; Focusing on sexuality/focusing on oppression and marginalisation	Strong	3
Bjorkman and Malterud (2009)	Norway	128 self-identified lesbian women	Qualitative: Open-ended online questionnaire to explore healthcare experiences of lesbian women; analysed with systematic text condensation; analysis informed by theories of heteronormativity	Awareness; Attitudes; Medical knowledge	Strong	3
Daley (2010)	Canada	22 self-identified lesbian/queer women, ages 20–58, with mental health diagnosis; 10 female mental health service providers, ages 31–60, self-identified as lesbian, queer, bisexual or heterosexual	Qualitative: Semi-structured interviews to explore the experiences of LQ women within organisations from service user and provider perspectives; thematic analysis through two-step coding	The negation and dismissal of lesbian/queer sexuality as an identity; Non-disclosing and compartmentalising of concerns; Lesbian/queer sexuality as a potential source of stress and/or support	Strong	3
Eady et al. (2011)	Canada	55 bisexual participants (38 with mental health problems), ages 16–69	Qualitative: 8 focus groups (3–9 participants each) and 9 individual semi-structured interviews to investigate experiences of bisexual individuals with mental health care; thematic analysis and phenomenological descriptive approach using QSR N6 text management software	Negative experiences – Contributing practices, Expressing judgment, Dismissing bisexuality, Pathologizing bisexuality, Asking intrusive or excessive questions; Positive experiences – Contributing practices, Seeking education, Asking open-ended questions, Maintaining positive or neutral reactions to disclosure	Strong	3
Fish and Bewley (2010)	UK	5909 LB women	Qualitative: online questionnaire; thematic analysis using NVivo software	Heteronormativity in healthcare; Improving attitudes amongst healthcare professionals; Equality in access; raising awareness and informed communities	Strong	3
Gibbons et al. (2007)	Ireland	43 LGB individuals (24 female, 19 male)	Qualitative: Semi-structured in-depth interviews to explore the experiences of lesbian, gay and bisexual (LGB) people with the health services in North-West Ireland; thematic analysis	Disclosure of LGB Sexual Identity to Health Care Providers; Experience of Disclosure of Sexual Identity to GP Services; Recognition of Partners and Parenthood; Mental Health; Sexual/Gynaecological Health; Suggestions for Improved Health Services for LGB Clients	Strong	3
Knight et al. (2012)	Canada	45 men (40 heterosexual, 4 homosexual, 1 bisexual), ages 15–25, and 25 clinicians, 14 nurses and 11 doctors (6 male, 19 female)	Qualitative: In-depth interviews to examine how heteronormative discourses affect sexually transmitted infection testing; thematic analysis using a modified grounded theory approach and QSR NVivo 8 software	(Re)producing the heterosexual status quo; Clinician's strategies to alleviate men's anxieties; (De)contextualizing men's health risks; Young men's experiences with STI risk assessments: 'the reality of risk'	Strong	3
Lee et al. (2011)	UK	8 lesbian women (7 birth mothers, 1 social mother)	Qualitative: Unstructured interviews to explore lesbian women's experiences of maternity care, specifically interpretations of negative experiences; thematic analysis using modified discourse analysis	Health professional attitudes; Organisational pressures; Sexual orientation and physical care	Moderate	3
Röndahl (2009)	Sweden	17 lesbian women and 10 gay men, ages 23–65	Qualitative: Semi-structured interviews to describe the experiences of gay patients and partners concerning attitudes in nursing; thematic analysis	Patients' and partners' experiences of attitudes in nursing; Pathological approach; Emigrated religion	Strong	3

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Table 3 (continued)

Author(s) and year	Country	Sample	Design	Key findings	Strength of evidence (National Collaborating Centre for Methods and Tools, 2008; Noyes and Popay, 2007)	SIGN (2010) Level
Röndahl et al. (2006)	Sweden	17 lesbian women and 10 gay men, ages 23–65	Qualitative: Semi-structured interviews to explore LG patients' experiences of nursing in hospital care; thematic analysis	Heteronormativity; Single and older; Knowledge	Strong	3
Saleh et al. (2011)	USA	21 African American HIV prevention service providers (8 females, 13 males); 21 African American men with a history of sexual activity with both men and women and not identifying as homosexual (MSMW)	Qualitative: Two focus group interviews with service providers and individual in-depth interviews with service users to explore beliefs and experiences from community-based service providers and from African American MSMW regarding the provision of HIV prevention services; thematic analysis	Critical attitudes towards MSMW; Consequences of the increased attention towards MSMW on service provision; Barriers to open discussion amongst MSMW clients; Need for innovative HIV prevention approaches for MSMW	Moderate	3
Spidsberg (2007)	Norway	6 lesbian couples, pregnant by donor insemination, reporting a total of eight children aged 6 weeks to 4 years	Qualitative: Joint and single unstructured interviews to describe the maternity care experiences of lesbian couples; thematic analysis using phenomenological hermeneutic method	Being open – Being open, Being closeted, Being open but not over-assertive; Being exposed – Being a theme, Being a mute theme or a non-theme; Being confirmed – Being in caring hands, Being in uncaring hands, Being in uncertain hands; Compromising	Strong	3
Spidsberg and Sorlie (2012)	Norway	11 midwives, ages 30–59, 4–32 years of experience	Qualitative: In-depth unstructured interviews to describe midwives' lived experiences of caring for lesbian women and their partners; thematic analysis using phenomenological hermeneutic method	Being open – Going public as a couple, Being anonymous, Being responsible for making space for communication; Being different – Being lovers and friends, Being the other mum; Creating a confidence – Overrunning the autopilot, Striking the note, Being a proper midwife, Being guided by instinct	Strong	3
Grant et al. (2011)	USA	6456 trans and gender non-conforming individuals	Quantitative: Online and paper 70 item questionnaire to explore discrimination against transgender and non-binary individuals; analysis by data tabulation	Health outcomes for all categories of respondents show much higher rates of HIV infection, smoking, drug and alcohol use and suicide attempts than the general population; 19% of reported being refused medical care due to their transgender or gender non-conforming status, with even higher numbers amongst people of colour; 50% of the sample reported having to teach their medical providers about transgender care; Participants reported postponing medical care due to discrimination (28%) or inability to afford it (48%)	Moderate	2 –
Hardacker et al. (2014)	USA	848 healthcare staff across multiple locations	Quantitative: To assess the effectiveness of HEALE curriculum, pre-test and post-test administered to participants. Participants also completed an evaluation to report change in personal attitude and individual response to the curriculum. Pre- and post-test scores for each module analysed using paired t-tests, including adjustment for clustering by location to account for correlation between responses from subjects in the same class; analysis using STATA version 10.1 software	There were statistically significant gains in knowledge in each of the six modules both in nursing home/home health-care settings and in hospital/educational settings, although participants in nursing home/home health care settings had lower pre-test scores and smaller knowledge gains in each of the six modules than those in hospital/educational settings. Mean increases ranged from 6.4 points (8.7% increase) in module 1–14.6 points (26.2% increase) in Module 6 ( $p < 0.01$ )	Moderate	2 –
Hinrichs and Vachha-Haase (2010)	USA	218 staff members in long term care facilities, ages 18–61	Quantitative: Questionnaire assessing knowledge about and attitudes towards elderly sexuality; Reactions to situation described in a vignette; statistical analysis by one-way ANOVA	Staff rated same sex pairings more negatively than heterosexual intimacy. Knowledge about older adult sexuality made little difference in staff ratings	Strong	2 –
Mahdi et al. (2014)	USA	183 school nurses, counsellors, social workers	Quantitative: 34 item survey to assess school health professionals' preparedness to address needs of LGBTQ students; analysed with SPSS, chi squared and logistic regression	Social workers and counsellors were more likely than school nurses to report moderate or high knowledge of LGBTQ youth health risks, including suicide and depression ( $p < 0.001$ ); Fewer school nurses (17.6%) reported that they had moderate or	Strong	2 –

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Table 3 (continued)

Author(s) and year	Country	Sample	Design	Key findings	Strength of evidence (National Collaborating Centre for Methods and Tools, 2008; Noyes and Popay, 2007)	SIGN (2010) Level
Neville and Henriksson (2006)	New Zealand	2269 LGB individuals (1026 females, 1243 males)	Quantitative: 133 item survey to explore people's perceptions of disclosure of sexual orientation to primary healthcare providers; statistical analysis using SPSS using ANOVA and chi squared Mixed methods: In-depth online survey to explore the healthcare experiences of gay and bisexual men; analysis by Sigma Research	high experience intervening to stop LGBTQ student harassment, compared with 66.7% of school counsellors ( $p < 0.0001$ ) Significant number of HCWs usually or always presumed heterosexuality; Attitudes towards identity was important when choosing a primary healthcare provider A third of GB men who have accessed health services in the last year have had a negative experience related to their sexual orientation; A third of GB men are not out to healthcare professionals; One in six GB men said that in the last year healthcare professionals had assumed that they were straight; One in six GB men said that during the last year there was no opportunity to discuss their sexual orientation with a healthcare professional; GB men were less likely than patients in general to feel they were treated with respect and dignity all of the time across health services Older non-heterosexual people are often obscured within ageing population discourses, and conceal their identity for fear of discrimination	Moderate	2 –
Guasp (2012)	UK	6861 GB men, ages 16 to 85			Moderate	2 –
Horner et al. (2012)	Australia	83 facility managers, 36 CEOs (quantitative) 3 facility managers, 3 GLBTI community members (focus groups)	Mixed methods: Executive surveys, facility surveys, and focus groups to explore attitudes, knowledge and current practices of retirement and residential aged care providers in Western Australia towards accommodating LGBTI individuals; qualitative data analysed using NVivo v. 8; quantitative data analysed using SPSS, chi squared		Moderate	2 –
Hunt and Fish (2008)	UK	6178 LB women, ages 14–84	Mixed methods: In-depth online survey to explore the healthcare experiences of lesbian and bisexual women; analysed by Sigma Research	Half of LB women have had negative experiences in the health sector in the last year; Half of LB women are not out to their GP; One in ten say that a healthcare worker ignored them when they did come out; Three in ten LB women say that healthcare workers did not make inappropriate comments when they came out; One in ten felt that their partner was welcome during a consultation 62% of people that had used Gender Identity Clinic services experienced one or more negative interactions, 63% in general mental health services, and 65% in general health services; For nearly 30% of respondents, a healthcare professional had refused to discuss a trans-related health concern; Within mental health services, 29% of the respondents felt that their gender identity was not validated as genuine, instead being perceived as a symptom of mental ill health; 17% were told that their mental health issues were because they were trans, when they disagreed and saw them as separate; 38% experienced difficulties within the inpatient unit due to being trans including harassment, misgendering and uncertainty about placement within single sex facilities. LGBT patients continue to experience	Moderate	2 –
McNeil et al. (2012)	UK	889 transgender and non-binary individuals	Mixed methods: Online survey to explore trans people's mental health needs and experiences, explored in the context of daily life, social/support mechanisms and when accessing healthcare and mental health services; analysis through data tabulation		Moderate	2 –
Somerville (2015)	UK	3001 health and social care staff in patient	Mixed methods: In-depth online survey, with		Moderate	2 –

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Table 3 (continued)

Author(s) and year	Country	Sample	Design	Key findings	Strength of evidence (National Collaborating Centre for Methods and Tools, 2008; Noyes and Popay, 2007)	SIGN (2010) Level
		facing roles, with a subsection of 1861 most relevant practitioners with direct responsibilities for patient care	further questions for subsection of practitioners to explore the treatment of LGBT people within health and social care services; analysed by YouGov plc	discrimination, abuse and bullying; There is a lack of confidence amongst health staff in their ability to understand and meet the needs of LGBT patients; Many health staff say they don't feel able to challenge discriminatory language and behaviour from their colleagues or patients; 25% of staff have never received any equality and diversity training, and those who have often report that the training did not include important issues in caring for LGBT patients		

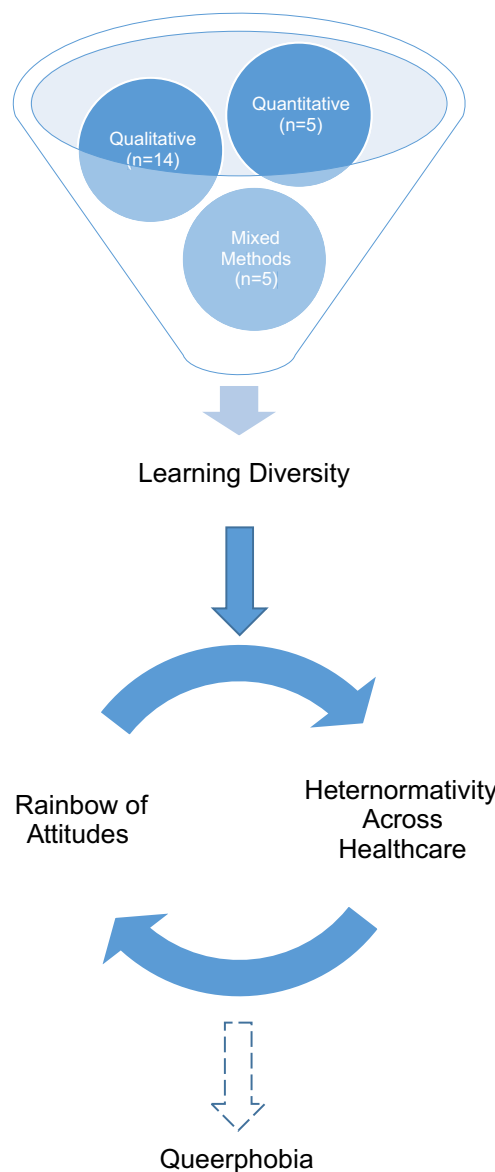


Fig. 2. Framework of Themes.

Saleh et al., 2011; Fish and Bewley, 2010; Bjorkman and Malterud, 2009; Gibbons et al., 2007; Spidsberg, 2007). Nurses were also reported as being affirming, respectful and supportive (Beagan et al., 2012; Guasp, 2012; Eady et al., 2011; Røndahl 2009; Hunt and Fish, 2008).

Health practitioners acknowledged the significance of disclosure, the potential stress surrounding sexuality and the social and psychological consequences of coming out (Daley, 2010). Midwives described how they aimed to develop their communication skills, foster a trusting therapeutic relationship and accommodate the couple regarding language and documentation (Spidsberg and Sørli, 2012). Healthcare professionals facilitated disclosure for 9% of GB men (Guasp, 2012) and 7% of LB women (Hunt and Fish, 2008). Nursing staff facilitated disclosure through the use of broad questioning and reacting in neutral or positive manner to disclosure (Beagan et al., 2012; Eady et al., 2011).

Several studies revealed examples of nurses and midwives advocating on behalf of their LGBTQ patients. Nurses and midwives challenged their colleagues in order to improve patient care and mitigate stigma and advocated for the inclusion of same-sex partners in care (Beagan et al., 2012; Spidsberg and Sørli, 2012; Bjorkman and Malterud, 2009; Gibbons et al., 2007).



**Table 4**  
Themes identified across studies.

Author(s) and year	Design	Heteronormativity across healthcare	Queerphobia	Rainbow of attitudes	Learning diversity
Bauer et al. (2009)	Qualitative	✓	✓	✓	✓
Beagan et al. (2012)	Qualitative	✓		✓	✓
Bjorkman and Malterud (2009)	Qualitative	✓	✓	✓	✓
Daley (2010)	Qualitative	✓		✓	
Eady et al. (2011)	Qualitative		✓	✓	✓
Fish and Bewley (2010)	Qualitative	✓	✓	✓	✓
Gibbons et al. (2007)	Qualitative	✓	✓	✓	
Knight et al. (2012)	Qualitative		✓	✓	
Lee et al. (2011)	Qualitative			✓	
Röndahl (2009)	Qualitative		✓	✓	
Röndahl et al. (2006)	Qualitative	✓		✓	✓
Saleh et al. (2011)	Qualitative		✓	✓	
Spidsberg (2007)	Qualitative	✓		✓	✓
Spidsberg and Sørli (2012)	Qualitative			✓	✓
Grant et al. (2011)	Quantitative	✓	✓	✓	✓
Hardacker et al. (2014)	Quantitative			✓	✓
Hinrichs and Vacha-Haase (2010)	Quantitative	✓	✓	✓	
Mahdi et al. (2014)	Quantitative			✓	✓
Neville and Henrickson (2006)	Quantitative	✓		✓	
Guasp (2012)	Mixed methods	✓	✓	✓	✓
Horner et al. (2012)	Mixed methods	✓		✓	✓
Hunt and Fish (2008)	Mixed methods	✓	✓	✓	✓
McNeil et al. (2012)	Mixed methods	✓	✓	✓	✓
Somerville (2015)	Mixed methods		✓	✓	✓

#### 4.5. Treating Everybody the Same

A prominent view amongst nurses and midwives was that LGBTQ patients should be treated the same as everybody else (Somerville, 2015; Hardacker et al., 2014; Beagan et al., 2012; Horner et al., 2012; Spidsberg and Sørli, 2012). However, this often manifested as deeming sexual orientation and gender identity as irrelevant to care (Somerville, 2015; Beagan et al., 2012; Horner et al., 2012). In other cases, sexual orientation was only seen as relevant in relation to sexual health (Beagan et al., 2012).

In some cases, nurses and midwives ignored sexual orientation or gender identity. Lesbian couples described their orientation being ignored which created feelings of invisibility, uncertainty and awkwardness towards staff (Spidsberg, 2007). This also led to the need to disclose or repeat essential information several times to staff (Lee et al., 2011; Fish and Bewley, 2010; Spidsberg, 2007). LGBTQ patients described distance and remoteness from staff which led to self-reliance and 'feeling forgotten about by nurses' (Röndahl 2009; Spidsberg, 2007). Although patients described staff as neutral and tolerant (Röndahl 2009), sexual orientation was not enquired about or was ignored when mentioned by patients (Fish and Bewley, 2010). Additionally, one in six staff would not challenge homophobic remarks made about or towards LGBTQ patients (Somerville, 2015).

Staff showed signs of discomfort around sexual orientation and gender identity. 16% of frontline staff are uncomfortable asking patients about sexual orientation and 18% are uncomfortable asking patients about gender identity (Somerville, 2015). Some nurses stated they did not care about sexual orientation as long as there were no evident displays of affection (Beagan et al., 2012; Gibbons et al., 2007). There was fear around saying the wrong thing and offending patients, which created overly cautious communication and feelings of uncertainty and unease in nurses and midwives (Beagan et al., 2012; Spidsberg and Sørli, 2012; Röndahl et al., 2006).

#### 4.6. Intrusion and Judgment

10% of lesbian women report that health professionals continued to treat them as heterosexual after disclosure (Hunt and Fish, 2008). Nurses and midwives have been described as disregarding same-sex partners, asking for an alternative next of kin, not speaking to the

partner and questioning the partner's presence in the care setting (Röndahl 2009; Hunt and Fish, 2008; Röndahl et al., 2006). In a study of school health professionals, nurses were found to have significantly greater negative attitudes towards gay men and lesbians compared to counsellors and social workers (Mahdi et al., 2014). Hinrichs and Vacha-Haase (2010) found that staff rated same-sex pairings in sexual contact as significantly less acceptable than heterosexual pairings.

Inappropriate and intrusive questioning was a common complaint amongst LGBTQ patients (McNeil et al., 2012; Eady et al., 2011; Hunt and Fish, 2008; Spidsberg, 2007). Questions were seen as an invasion of privacy, irrelevant to the patient's health concern and overly focused on sexual practices.

A small but noteworthy subset of health professionals condemned LGBTQ identities on moral or religious grounds. When running a cultural competency training program in which attendance was mandatory, Hardacker et al. (2014) noted that some groups were willing to risk their jobs rather than attend. The authors noted that nursing home staff had the most religion-based objections and questions. Patients also reported nurses sharing their religious objections to their sexual orientation with them (Röndahl 2009).

The attitudes of staff are widely varied, ranging from supportive and understanding to hostile. Nurses and midwives specifically displayed positive attitudes in 12 studies, neutral attitudes in 8 studies and negative attitudes in 4 studies. The prevalence of positive attitudes is encouraging but there is still evidence that negative attitudes persist amongst this staff grouping.

#### 4.7. Learning Diversity

This theme encompassed two sub-themes: Proactive and appropriate education and Insufficient education and skills.

#### 4.8. Proactive and Appropriate Education and Skills

26% of GB men and 10% of LB women have received relevant, knowledgeable health education from staff (Guasp, 2012; Bjorkman and Malterud, 2009; Hunt and Fish, 2008). Nurses were knowledgeable about sexual practices, transgender issues, barriers to healthcare and the importance of disclosure (Beagan et al., 2012; Knight et al., 2012). In a study of school healthcare professionals, 55.8% of nurses reported

moderate or high knowledge of suicide and depression risk for LGBTQ youth and 65.3% of nurses reported confidence in discussing health risks with LGBTQ youth (Mahdi et al., 2014). Hardacker et al. (2014) recorded staff knowledge on a number of issues relevant to LGBTQ elders, before and after undertaking a six module training program. Post-test scores revealed significant knowledge gains, supporting recommendations for training and education on LGBTQ issues.

#### 4.9. Insufficient Education and Skills

6% of nurses stated that they were not confident responding to the care needs of LGBTQ patients and 21% of nurses reported that they were not confident in meeting the specific healthcare needs of trans patients (Somerville, 2015). In several studies, nurses and midwives lacked the knowledge and education to address the concerns of LGBTQ patients (Horner et al., 2012; Spidsberg and Sørli, 2012; Bauer et al., 2009; Røndahl et al., 2006). Many patients reported being given incorrect information regarding their health concerns or were refused screenings such as cervical smear tests (McNeil et al., 2012; Fish and Bewley, 2010; Bjorkman and Malterud, 2009; Hunt and Fish, 2008).

Lack of appropriate training and opportunities for continuous professional development (CPD) was a common occurrence. Information specific to the LGBTQ population is rarely integrated into undergraduate curricula or healthcare policy (Bauer et al., 2009). Only 11% of staff responsible for patient care had received education on the health needs of LGBTQ patients, and over half of those trained were only educated on sexual health needs (Somerville, 2015). A lack of LGBTQ awareness training amongst mental health professionals was frequently reported by service users (McNeil et al., 2012; Eady et al., 2011; Fish and Bewley, 2010). None of the 83 elderly care facilities sampled by Horner et al. (2012) reported provision of LGBTQ-specific training or CPD opportunities.

Service users with lesser known identities often referenced the need for patients to educate their care providers. Bisexual participants described the frustration with being expected to provide an education to health care staff rather than receiving the services on which they were spending time and/or money (Eady et al., 2011). Trans patients also reported having to teach staff about transgender care (Grant et al., 2011; McNeil et al., 2012; Bauer et al., 2009). Even when attending Gender Identity Clinics, 10% of respondents reported the need to educate healthcare providers (McNeil et al., 2012).

Whilst 7 studies demonstrated evidence of appropriate knowledge and training amongst nurses, the majority of studies under this theme showed that nurses and midwives were not offered sufficient training opportunities and therefore lacked the confidence and knowledge to adequately address the health needs of their LGBTQ patients.

## 5. Discussion

Heteronormativity influences the attitudes of the staff working within the heteronormative environment. Similarly, the attitudes of nurses and midwives reinforce the culture of heteronormativity across healthcare settings. Both themes are informed by the skills and education of healthcare providers and the opportunities they have to learn about diversity and how it affects health. Queerphobia and associated hostile behaviour can be seen as a potential output of the interaction between heteronormativity, attitudes and knowledge. Therefore it is possible that by offering opportunities to 'learn diversity', the cycle of heteronormativity and negative attitudes can potentially be changed and the output of queerphobia reduced.

## 6. Limitations

There are a limited number of studies on this topic which are specific to nurses and midwives. Although all studies reviewed included nurses and midwives in their sample, many of the larger studies

included a number of professions, including doctors, allied health professionals, care assistants and administrative staff. This creates difficulty in drawing conclusions specific to nurses and midwives as separate entities to other health professions. Therefore, analysis and the conclusions drawn about the attitudes, knowledge and beliefs of nurses and midwives may be skewed by the attitudes, knowledge and beliefs of other healthcare providers as this appraisal does not account for the training, roles and specific interactions that inform nursing and midwifery care and practice.

## 7. Conclusion

The first aim of this review was to explore what the current literature would reveal about the knowledge, beliefs and attitudes of nurses and midwives of the healthcare needs of the LGBTQ population. The theme 'Rainbow of Attitudes' reveals that nurses and midwives possess a wide spectrum of attitudes, knowledge and beliefs towards LGBTQ patients in their care. While there are nurses and midwives who strive to deliver fair and equal care, there are also those whose care is coloured by bias and prejudice as demonstrated in the theme 'Queerphobia'. However, the majority of inadequate care appears to be based not on malice or prejudice, but rather on heteronormative beliefs and a lack of education and knowledge on LGBTQ issues and health concerns.

The second aim of this study was to determine if the knowledge, beliefs and attitudes of nurses and midwives affect access to equal and non-discriminatory healthcare provision for the LGBTQ population. Heteronormativity and neutral or negative attitudes appear to be the greatest barrier to access. Whilst negative attitudes and homophobia play a part, it appears that nurses and midwives simply don't think to ask about sexual orientation or gender identity, and may be ill-equipped to confidently deal with disclosure. Nurses and midwives may also avoid asking about sexual orientation or gender identity because they deem it unimportant to the care they provide. Such attitudes, actions and omissions may create barriers to adequate healthcare provision for the LGBTQ population. If nurses and midwives wish to practice with empathy, congruency and unconditional positive regard, it is essential for them to acknowledge their biases and work to ensure that such biases do not affect the quality of care they provide to LGBTQ patients.

This review highlights the need for research into the knowledge, beliefs and attitudes of nurses and midwives of the healthcare needs of LGBTQ patients. Although a gap in knowledge and skills is evident, further research is required to design and test the effectiveness of educational modules for nurses and midwives. The review also highlights the pervasiveness of heteronormativity and the need for interventions to break this culture.

### Recommendations:

1. Further research and policy making should aim to break down the culture of heteronormativity present in healthcare systems so as affect the attitudes of nurses and midwives and reduce the potential for bias and discrimination.
2. LGBTQ issues should be incorporated into undergraduate education and continued professional development in order to promote positive attitudes, knowledge and beliefs of nurses and midwives towards the LGBTQ population and equip nurses and midwives with adequate skills to care for LGBTQ patients.
3. Because lack of opportunity for disclosure was described as a problem in several studies and is related to a culture of heteronormativity, further research and education should aim to facilitate disclosure of sexual orientation and gender identity in order to provide holistic, person-centred care.

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## Conflicts of interest

None.

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