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ASSESSMENT OF CULTURAL COMPETENCY OF THE LGBT COMMUNITY IN THE

NURSING WORKFORCE

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Abstract

The lesbian, gay, bisexual, and transgender (LGBT) community comprises a significant, growing

patient population in the United States and faces a unique set of healthcare challenges which

must be addressed by the healthcare system and those employed by it. The LGBT community,

having experienced historic oppression and discrimination, has reflexively withdrawn from

healthcare workers, refrained from disclosing its LGBT identity and become reluctant to seek

healthcare, resulting in delayed treatments and poor patient outcomes. While recent years have

brought improved provisions, social acknowledgment, and public acceptance to the LGBT

population, health risks still prevail due to patients concealing their LGBT affiliation and

identities. One of the contributing factors toward improved LGBT patient disclosure is the

utilization of cultural competence by care providers in the delivery of healthcare. This systematic

review of the literature was conducted to explore the cultural competency of healthcare workers

and its influence on the disclosure of LGBT patients. The interventions outlined in this literature

review show practices which demonstrate cultural competency or a lack thereof in an effort

towards improved patient outcomes for the LGBT demographic.

Keywords: LGB*, homosexual, transexual/transgender, cultural competency, nurs*, healthcare

disparities, discrimination, disclosure, LGBT rights, America/United States, sexually transmitted

disease, HIV, sexual minorities, sexually transmitted infections, gay marriage, transgender

bathrooms, politics.

Assessment of Cultural Competency of the LGBT Community in the Nursing Workforce

Recent years have documented a dramatic shift in the cultural dynamics of the citizens of the United States, as a previously sequestered demographic has gradually emerged, becoming a prominent subculture. A 2011 study performed by the Williams Institute at the University of California, Los Angeles, found that 3.5% of the U.S. population identifies within the overarching "LGBT" (lesbian, gay, bisexual, and transgender) bracket, totaling at approximately 9 million Americans (Gates, 2013, p. 1; Ward, Dahlhamer, Galinsky, & Joestl, 2014, p. 1). The LGBT community consists of individuals that identify with nontraditional, or non-heterosexual, sexual orientations and gender identities; examples of nontraditional sexual orientations include lesbian, gay, bisexual, and others which differ from heterosexuality. Gender identity is separate from sexual orientation because gender identity refers to an individual's perception of his or her gender, which may vary from biological sex, as is the case with transgender individuals (Forcier & Haddad, 2013, p. 18). As a response to the increased vocalization of the LGBT community within the last decade, groundbreaking political and social reforms have occurred in the United States, culminating with the legalization of gay marriage in 2015 (Nava & Dawidoff, 2014, pp. x-xiii; Brewer, 2014, pp. 279-281). Despite recent progress, anti-LGBT violence is still a substantial threat to LGBT persons, as evidenced by events such as the 2016 mass-shooting at a gay bar in Orlando, Florida--the deadliest mass shooting in U.S history (Bloch, Hersher, Domonoske, Kennedy, & Dwyer, 2016, n.p.).

Through the growth of this minority demographic, the discrimination faced by LGBT individuals has become more apparent, as social media and major news stations cover incidents of maltreatment, hate crimes, and oppression. The Human Rights Campaign (HRC) surveyed 10,000 teens in a national study on perceived LGBT reception; it found that approximately 4 in 10 LGBT youth (42%) feel that their local community is unaccepting of self-identified LGBT members (Human Rights Campaign, 2016, n.p.). An LGBT healthcare advocacy group, Services and Advocacy for GLBT Elders (S.A.G.E.), assessed LGBT populations throughout the nation and found that 82 percent of older adults identifying within the all-encompassing LGBT bracket has been the target of verbal insults, harassment, physical violence or threats thereof (Hudson, 2011, p. 5).

In addition to being a target for marginalization within society, LGBT individuals have also been labeled an "at-risk" population by the American Psychological Association due to the repercussions caused by the aforementioned discrimination (American Psychological Association, 2017, n.p.). The American Medical Association (A.M.A.) has cited the lack of identity disclosure among LGBT patients to the accounts of prejudice they experience daily. Both personal experiences and social interactions have influenced this callous sentiment within the LGBT community; however, in concealing their sexual orientations, gender identities, and practices therein, LGBT individuals inhibit the ability of medical professionals to deliver necessary preventative care. S.A.G.E. estimates that as many as 21% of LGBT older adults have not disclosed their sexual orientation to their primary-care physician (Hudson, 2011, p. 5).

Since the LGBT community has only recently obtained a voice on a sociopolitical level, American culture remains, for the most part, heteronormative, where individuals who identify

with a heterosexual orientation are considered the social norm (Hayman et al., 2014, p. 120).

Additionally, this culture of heteronormativity may be more accommodating towards "cisgender

individuals," or those who resonate with the same gender as their biological sex (Forcier &

Haddad, 2013, p. 18). Society's predominantly heteronormative attitude places a stigma on

individuals who identify as LGBT, leading to numerous disparities in the healthcare that they

receive (Nava & Dawidoff, 2014, p. xiii; Forcier & Haddad, 2013, p. 17). As a result, this

demographic has been kept reticent, afraid to share its identity with providers, leading LGBT

individuals to fall at risk to diseases and health issues that would have otherwise been

preventable.

Background

While many countries have decriminalized same-sex sexual practices and outward

expression, several still uphold a stance against homosexuality and transgenderism. According to

a Russian law passed in June of 2013, it is illegal to distribute materials or convey any message

promoting "non-traditional relationships"--anything that differs from a cis-gender, heterosexual

relationship--to minors. The decriminalization of homosexuality in Russia took place in 1993,

the declassification of homosexuality as a mental illness took place an additional six years later.

Despite these apparent improvements, gay and lesbian individuals are still not allocated the same

provisions by the government that "traditional" couples are, and, as a result, there are no laws

protecting members of the LGBT community from blatant discrimination (Clark, 2014, p.

500-501). Due to social pressures and the threat of legal repercussions, the majority of the LGBT

community in Russia refrains from protesting. According to Denis Godlevskiy, an advocacy

officer for the Moscow AIDS Healthcare Foundation, these laws perpetuate the spread of

HIV/AIDS, since they prevent healthcare officials from discussing preventative measures with LGBT individuals due to the threat of persecution and social consternation for both client and healthcare professionals who participate in discussion (Clark, 2014, p. 500).

Russia is not the only country facing these civil rights issues; homosexuality is still illegal in 78 countries, and the punishment for practicing same-sex sexual acts varies from imprisonment to death. In countries from Senegal to Malawi, the HIV infection rate among gay men ranges from anywhere between 20% to 50%, depending on the nation and its respective legislation (Clark, 2014, p. 502). According to Fiona Clark, an outspoken author covering health issues including those that affect the LGBT community, facing discrimination delays the desire for LGBT individuals to seek medical attention (Clark, 2014, p. 501-502). In France, for example, where the prevailing attitude towards homosexuality is unfavorable and antagonistic, 53% of those infected with HIV seek treatment later in the disease process, reflecting a hesitancy to come forward for medical care when the disease is still treatable. As a result, not only do individuals risk spreading HIV/AIDS to their sexual partners, but they also have higher mortality rates due to their time spent untreated, where disease pathologies are left to exacerbate (Clark, 2014, p. 502).

In contrast with countries such as France and Russia, the United States has passed legislation within the last decade demonstrating an increased level of acceptance towards the LGBT community. Despite the ground-breaking legalization of gay marriage in 2015 and subsequent anti-discrimination laws thereafter, disparities still exist in the delivery of healthcare to LGBT individuals (Brewer, 2014, pp. 279-280). The Center for Disease Control (CDC) gauged in its 2014 HIV Surveillance Report that 70% of the HIV cases that year were attributable to male-to-male sexual practices (Center for Disease Control and Prevention [CDC],

2016, p. 9). The prevalence of HIV among gay men alludes to a lack of disclosure between LGBT patients and healthcare providers. The United States embodies a more tolerant culture than many developing countries by making notable strides in pro- LGBT legislation. Despite this, a lack of improvement in healthcare provider-LGBT patient relations will continue to place the LGBT population at a heightened risk for certain illnesses.

In the United States, a history of discrimination and maltreatment has bred a lack of trust between the LGBT patients and healthcare personnel. Unfortunately, this has made patients less comfortable opening up with healthcare workers, thereby reducing the desire of patients to seek medical attention. S.A.G.E. has performed national surveys over LGBT individuals, finding that increased accounts of victimization have reduced the willingness of LGBT patients to disclose their sexual and gender identities to healthcare providers (Hudson, 2011, p.g. 5). Even in the United States, where the acceptance of the LGBT population exceeds that of many countries, discrimination continues to keep a large percentage of the community uncommunicative about its sexual orientation and practices (Whitehead, Shaver, & Stephenson, 2016, p. 3). Through educated, culturally competent healthcare personnel perceived intolerance by LGBT patients might be challenged, subsequently prompting earlier medical interventions.

Cultural competence is being conscious of one's own beliefs, values, experiences, and situations to avoid imposing these personal ideas on the cultures of others. It also includes having a sound foundation in cultural insight and understanding, which leads to the respect and acceptance of diversity (Flowers, 2004, p. 48). In the context of nursing, cultural competency is crucial to best interact with, communicate to, and care for patients. To better facilitate the interactions nurses have with patients of the LGBT community--a community subject to a history

of discrimination with the general public and taciturn with healthcare workers as a

result--cultural competence requires some level of adaptation related to the nurse's delivery of

care. In a country that contains so much diversity, cultural competency enables the provision of

fair, adequate care to all those in need of medical attention (Lim & Bernstein, 2012, p. 170). The

United States has made great strides in the realm of nursing concerning of cultural competency,

but, as new demographics emerge, will those demographics be included in the movement

towards acceptance?

Significance

Living in a country that allows the practice of many religions and lifestyles, nurses must

be able to cater to the needs and practices of each person, while being wary not to cast judgment

or impose the personal opinions of his or her worldview. Doing so can be difficult for some,

especially when their own beliefs or practices conflict with the cultures of their patients. With the

influx of patients encountered on a daily basis, nurses will inevitably face a patient whose beliefs

contradict his or her own. It is at this point that nurses must practice cultural competency to

avoid the barriers of personal opinions on their collection of medical histories and conduction of

health assessments. Failure to provide care concerning the patient's culture can result in distrust,

tension, and poor communication between nurses and patients that may precipitate legal

repercussions (Flowers, 2004, n.p.).

In the rapidly-changing modern world, new cultures and lifestyles which were previously

unacknowledged have begun to rise to the forefront of popular culture. These changes have

created new patient populations for which the healthcare system must accommodate to provide

the best treatment to its patients. One such population to notably surface in social influence in the

last decade is the LGBT community. While homosexuality, in essence, has existed since early

human history without social acknowledgment, popular culture and landmark events have

dramatically altered the public's perception of the LGBT community.

In the mid-1980s, there was an HIV/AIDS epidemic in the U.S., with young adults as the

primary victims (Rosenberg & Biggar, 1998, p. 1897). The CDC issued a statement citing

participation in gay and lesbian sexual acts as a risk factor for the virus, which led many to

correlate homosexuality and participating in these actions with the development of HIV/AIDS.

With this association came the idea that HIV/AIDS was a disease exclusively affecting gay or

bisexual individuals. Upon later analysis, however, sexual practices were deemed only a

significant risk factor among young gay males, while heterosexual women had an equally high

risk for contracting the disease (Rosenberg & Biggar, 1998, p. 1894). This discrepancy alone

became an excuse for the public to condemn LGBT individuals and to deny this community the

freedom to openly discuss its sexuality.

As a result, many LGBT patients have withheld any information alluding to their sexual

preferences from healthcare providers. What has resulted as a consequence is a self-fulfilling

prophecy where the perceived HIV-LGBT stigma prevents patients from disclosing their sexual

practices. With a lack of knowledge on the sexual practices of their patients, healthcare workers

are unable to institute preventative measures, increasing LGBT HIV transmission rates and

further perpetuating the belief that this is a disease exclusive to the LGBT population (Meyer &

Northridge, 2007, p. 613).

Despite the legalization of same-sex marriage, the passage of anti-discrimination laws, and even progressive legislation addressing gender identity expression, this community remains reluctant to self-disclose (Schuster, Reisner, & Onorato, 2016, pp. 101-102). Most notably in the medical context, an increased risk for HIV and other sexually transmitted diseases, suicide, and even some types of cancer are seen commonly within the LGBT community (Substance Abuse and Mental Health Services Administration, 2016, p. 103). Healthcare providers can educate, screen, and treat members of this population to combat the higher experience rates of health disparities. However, these healthcare professionals cannot do so if the patient population is unwilling to disclose their cultural affiliation. This unwillingness can stem from a variety of sources, but fear of discrimination due to a global history of prejudice is arguably most influential (Grigorovich, 2015).

Due to these issues, members of the LGBT community are less likely to seek healthcare overall. The Institute of Medicine disclosed a deficit in the understanding of transgender health needs among clinicians. The American Psychological Association affirmed the importance of transgender patients in 2013, lifting its classification of transgenderism as a mental illness and citing a need for "gender-affirming treatments" in the clinical care of transgender individuals (Schuster, Reisner, & Ornato, 2016, pp. 102-103). The 2013 annual National Health Statistics Survey reported that, compared to their heterosexual counterparts, bisexual women and lesbians aged 18-64 were less likely to have a consistent source of healthcare altogether (Ward, Dahlhamer, Galinsky, & Joesti, 2014, pp. 1-10).

When LGBT patients do not feel comfortable in a healthcare environment, they may go without treatment, preventative care, or even yearly consultation. As is visible in Russia and

other countries that suppress or prosecute the LGBT community, HIV, as well as other health concerns attributed to the population, run rampant (Clark, 2014, n.p.). While the United States, statistically, has lower rates of diseases such as HIV/AIDS, there are still other health concerns regarding the LBGT community and its poor relationship with healthcare workers (Global HIV and AIDS Statistics, 2017). It is evident that a magnanimous mindset plays a role in the welfare of this culture, and therefore, could enhancing the competency of healthcare individuals further lower the health risks associated with this particular demographic?

Problem and Purpose Statement

Fear of discrimination and prejudice leads to a hesitancy to confide one's sexuality and lifestyle practices to healthcare professionals, a reluctance to seek medical attention, and selective censorship when disclosing one's medical history. The purpose of this systematic review is to showcase the relationship among gaps in cultural competency, the absence of disclosure from LGBT patients, and the heightened level of specific health issues within the LGBT community. The question for this research is how do the different components of cultural competency within nursing influence the self-disclosure of LGBT patients?

Definition of Variables

Both dependent and independent variable were identified, and their relationship was delineated to answer the research question. The independent variable, cultural competence, was examined to determine its influence on the sexual and gender identity disclosure of LGBT patients. The dependent variable, LGBT patient disclosure, is the component which changes based on the manipulation of the independent variable. To better understand the basis of this paper, the definitions of these variables are as follows.

"Cultural competence" refers to an awareness of the unique, defining characteristics of the populations for which health professionals provide care and from which they wish to enroll clinical research participants (O'Brien, R. L., Kosoko‑Lasaki, O., Cook, C. T., Kissell, J., Peak, F., & Williams, E. H., 2006, pp. 674-682). Cultural competency also entails understanding the importance of the social and cultural influences on the health beliefs and behaviors of patients (Betancourt, R. J., Green, A. R., & Ananeth‑Firempong II, O, 2003, pp. 293-302). Concepts relevant to cultural competency include an awareness of cultural disparities, sensitivity to those differences, a working knowledge of culture, and the initiative to make culturally informed actions in response to these concepts. As a result, culturally competent care calls for a multi-faceted, dynamic level of communication among patients and providers: a level of interaction that necessitates the "continual learning" of healthcare personnel in their efforts to better respond to, assess, and serve a diversifying body of patients (Shiu-Thronton, 2003, p. 1361; Cultural Competence in Research, 2010, n.p.).

"Disclosure," in the context of the LGBT community, refers to the divulgence of one's gender identity and/or sexual orientation to others (Kosciw, Palmer, & Kull, 2014, p. 167). One's gender identity refers to the gender he or she feels most comfortable identifying as; this may or not coincide with his or her biological gender (Schuster, Reisner, & Onorato, 2016, p. 101-102). Also, disclosure may refer to one's sexual orientation; this entails which gender(s) a person is sexually attracted to. "Lesbian" refers to women attracted to other women, "gay" refers to men attracted to other men, and "bisexual" refers to a man or woman attracted to both men and women. For a person who identifies within the LGBT demographic, this is a significant milestone in shaping his or her identity (Kosciw, Palmer, & Kull, 2014, pp. 167-168). Disclosing

one's LGBT identity is often referred to in popular culture as "coming out [of the closet]" as a reference to the historical taboos that surrounded LGBT identity and expression (Kluttz, 2014, p. 789, 801; Kosciw, Palmer, & Kull, 2014, p. 169).

Methodology

The search strategy implemented for this systematic review of research was conducted from February 2016 to August 2017, utilizing electronic literature databases as well as government websites and institutions. The databases used include EBSCOhost, CINAHL Plus with Full Text, Google Scholar, MEDLINE with Full Text, and BIOMED central. The majority of articles were published between the years of 2011 to August of 2017 for the broadest range of acceptable results. Due to the limited availability of resources, the date range was extended to 2009 to include several articles which provided necessary statistical references and were crucial to compare LGBT demographic changes.

This systematic review utilized the following search terms: LGB*, homosexual, transexual/transgender, cultural competency, nurs*, healthcare disparities, discrimination, disclosure, LGBT rights, America/United States, sexually transmitted disease, HIV, sexual minorities, sexually transmitted infections, gay marriage, transgender bathrooms, and politics. Terms were used singularly and in combination with each other to generate the largest pool of results and increase specificity. Additionally, different forms and tenses of words were used to broaden search results.

The cumulative total of search results for each topic ranged from less than 10 to over 17,000. The total number of articles that appeared to answer the research question and were deemed adequate and pertained to the sample studied was twenty-eight. If an article title from the

results was relevant to the research, the article's abstract was read to determine if it was consistent with the objective of the systematic review.

When the criteria above was met, articles were read in full and critiqued for quality and rigor. Literature that deviated from the given topic or held no valuable statistics, facts, or information relevant answering to the research question, they were excluded. Inclusion material was peer-reviewed, scholarly or published by a government institution, available in English, and was within an acceptable publication date range from 2011 to 2017. Exceptions existed with sources outside of the date range when reputable news agencies added relevant information or if the article provided context to the current social climate regarding LGBT rights and affairs. The literature also had to pertain to the LGBT community directly, and the full text had to have been accessible.

Findings Section

Of the twenty-eight articles included in this literature review, eleven studies used qualitative research methods (Baker & Beagan, 2014; Baldwin, Dodge, Schick, Sanders, & Fortenberry, 2017; Bowland, Foster, & Vosler, 2013; Cahill, Singal, Grasso, King, Mayer, Baker, & Makadon, 2014; Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015; Owen-Pugh & Baines, 2014; Portz, Retrum, Wright, Boggs, Wilkins, Grimm, Gilchrist, & Gozansky, 2014; Poteat, German, & Kerrigan, 2013; Rounds, Mcgrath, & Walsh, 2013; St. Pierre, 2013; Venetis, Meyerson, Friley, & Shields, 2016) and eleven were systematic reviews of literature (Callahan, Hazarian, Yarborough, & Sánchez, 2014; Camacho, 2012; Chaplic & Allen, 2013; Keuroghlian, Ard, & Makadon, 2017; Krehely, 2009; Levine & Committee on Adolescence 2013; Lim, Brown, & Kim, 2014; Lim & Hsu, 2016; Orgel, 2017; Pompili, Lester, Forte, Seretti, Erbuto,

Lamis, Amore, & Girardi, 2014; Schwinn & Dinkel, 2015). Five quantitative studies were

included, with three utilizing an experimental approach (Cornelius & Whitaker-Brown, 2015;

Hardacker, 2013; Leyva, Breshears, & Ringstad, 2014) and three using a descriptive approach

(Cornelius & Carrick, 2015; Shetty, Sanchez, Lancaster, Wilson, Quinn, & Schabath 2016). One

mixed methods study (Fredriksen-Goldsen, Emlet, Kim, Muraco, Erosheva, Goldsen, &

Hoy-Ellis, 2012) was used.

　　　　The key statistical data for the 28 studies are documented in Table 1, which includes

authors, year published, type of research, sample or reference size, and the findings.

Table 1

Summarized Findings

Author/Date	Type of Study/ Level of Evidence	Sample Size/ Reference Size	Findings
Baker, K. & Beagan, B. (2014)	Qualitative Ethnography (IV)	24 physicians 38 LGBTQ- Women Interviews	When HCP don't assume LGBT patients are heterosexual/gender normative or ask direct questions disclosure is positively influenced.
Baldwin, A.M. (2016)	Qualitative Phenomenology (III)	510 LGBT-women	The presence of non-discrimination laws increases disclosure of sexual orientation.
Bowland, S.S., et al. (2013)	Qualitative Ethnography (IV)	27 lesbian and gay Christians	Lesbian and gay Christians feel comfortable discussing their sexuality when the provider exhibits self-awareness, culturally sensitive terminology, non-judgmental attitude, and positive application of scriptural teachings awareness.

Author/Date	Type of Study/ Level of Evidence	Sample Size/ Reference Size	Findings
Cahill, S. et al. (2014)	Qualitative Phenomenology (IV)	301 community Healthcare Patients	Use of sexual orientation and gender identity (SOGI) questions is encouraged and approved, increasing patient disclosure.
Callahan, E. et al. (2014)	Systematic Review of Research (IV)	28 references	Incorporating SOGI into the Electronic Health Record will

Author/Date	Type of Study/ Level of Evidence	Sample Size/ Reference Size	Findings
Camacho, A. (2012)	Systematic Review of Research (IV)	93 Sources	improve culturally competent care. Numerous health issues for LGBT community remain unaddressed or Under-addressed.
Carabez, R. et al. (2015)	Qualitative Ethnography (IV)	268 nurses in-person interviews	Gender inclusive forms facilitate cultural competency and need to be included in nursing education.
Chaplic, K. C. & Allen, P. J. (2013)	Systematic Review with Narrative Synthesis (IV)	14 studies	Direct questioning of sexuality promotes self-disclosure.
Cornelius, J. & Carrick J. (2015)	Quantitative Descriptive (IV)	190 nursing students interviews	Developing care plans that include sexual preference in the health assessment questions in nursing school curriculum increase cultural competency in nursing students.
Cornelius, J. & Whitaker-Brown, C. (2015)	Quantitative Experimental (III)	38 nursing students	LGBT education sessions within nursing curriculum improved post-test LGBT knowledge scores 20-84%; improved knowledge scores were linked with an increased level of concern for LGBT health issues/needs.
Fredriksen-Goldsen, K. et al. (2012)	Mixed Methods Descriptive (IV)	2,439 LGB older adults (50 and up)	Lifetime victimization, financial barriers to health, internalized stigma, etc. are predictors for poor health outcomes among LGBT patients.
Hardacker, C.T. et al. (2013)	Quantitative Experimental (III)	500 nurses/ healthcare providers	Implementation of HEALE curriculum for LGBT cultural competency training increased nurse/healthcare staff cultural competency evaluation scores by 6.4 points on average (8.7%).
Keuroghlian, A. et al. (2017)	Systematic Review of Research (IV)	43 articles	Caring for the health needs of LGBT include creating an affirming healthcare environment. Clinical skills should be taught through focused education.
Krehely, J. (2009)	Systematic Review with Narrative Synthesis (IV)	36 Sources	LBGT people are significantly more at risk for healthcare disparities than heterosexual people.

Author/Date	Type of Study/ Level of Evidence	Sample Size/ Reference Size	Findings
Levine, D. A. (2013)	Systematic Review of Research (IV)	51 Sources	Discrimination in LGBT community can lead to self-harm, verbal and physical abuse and lack of disclosure.
Leyva, V.L., Breshears, E.M., & Ringstad, R. (2014)	Quantitative Experimental (III)	112 LGBT service providers and users	Participants significantly increased in knowledge, skills, and positive attitudes about working with LGBT older adults.

| Lim, A. et al. | Systematic Review of Research (IV) | 44 articles | Detailed methods for the provision (2014) of culturally competent care were identified such as undergraduate nursing programs including LGBT content. |

| Lim, A. & Hsu, R. (2016) | Systematic Review of Research (IV) | 12 studies | Factors associated with negative and positive attitudes toward LGBT persons were identified. |

| Orgel, H. (2017) | Systematic Review w/ Narrative Synthesis (IV) | 23 studies | Analysis of cultural competency interventions and effectiveness; non-judgmental environment encourages disclosure. |

| Owen-Pugh, V. & Baines, L. (2014) | Qualitative Phenomenology (IV) | 16 professional counselors | Educational and clinical preparation about LGBT-specific care would improve providers' ability to assess and treat LGBT patients, and obtain disclosure of sexual orientation. |

| Pompili, M. (2014) | Systematic Review of Research (IV) | 19 articles | Bisexual individuals are at an increased risk for suicide and other mental/psychological issues clinicians should anticipate in care. |

| Portz, J.D. et al. (2014) | Qualitative Ethnography (IV) | 29 completed provider | The spectrum of openness (not assuming SOGI, using gender-neutral language interviews in assessments, active listening) can assist with LGBT elder cultural competence; also, collaborating with social workers. |

| Poteat, T. et al. (2013) | Qualitative Study Grounded Theory (IV) | 55 transgender person interviews | Transgender patients have uncertainty regarding healthcare workers' cultural competence, leading to a poor relationship between the two groups. |

| Rounds, K. et al. (2013) | Qualitative Study Ethnography (IV) | 11 LGBT patients, In focus groups | LGBT patients identified HCP behavior was better when HCP asked questions about patient preferences, recognized uniqueness of each LGBT patient, and was aware that not everyone is heteronormative. |

Author/Date	Type of Study/ Level of Evidence	Sample Size/ Reference Size	Findings
Schwinn, S., & Dinkel, S. (2015)	Systematic Review of Research (IV)	25 articles and online professional resources	Explored homophobia and heterosexism, fears/concerns of LGBT elders, and staff knowledge and barriers in care for LGBT elders. Assessment of environment, healthcare workers' competency, and the concerns of LGBT patients

			should be done in LTC facilities. Education on LGBT-centered care should be included in nurses' training.
Shetty, G. et al. (2016)	Quantitative Descriptive (IV)	108 providers	A majority of oncology healthcare providers lacked knowledge of LGBT health needs (<50%) & did not inquire patient sexual orientation/gender identity. Many felt these questions were unimportant because all patients should be treated the same.
St. Pierre, M. (2013)	Qualitative Ethnography (IV)	416 LGBT Women	Lesbians feel more comfortable disclosing sexuality when environment is perceived as LGBTQ-friendly and providers do not assume sexuality during assessment.
Venetis, M.K., et al. (2016)	Qualitative Ethnography (IV)	24 LGBT adults	Direct questioning of sexual orientation promotes self-disclosure

Actions that integrated culturally competent or incompetent care for LGBT patients were

identified in all of the studies. A majority of qualitative and quantitative studies analyzed the

lived-in experience and perceptions of LGBT individuals to determine which interventions

increased or deterred LGBT patient self-disclosure to healthcare personnel (Baldwin, 2016;

Bowland et al., 2013; Cahill et al., 2014; Fredricksen-Goldsen et al., 2012; Leyva et al., 2014;

Poteat et al., 2013; Rounds et al., 2013; St. Pierre, 2013; Venetis et al., 2016). Studies using

healthcare workers or nursing students as their sample groups evaluated participants' knowledge,

familiarity, and ability to provide culturally competent care for LGBT patients (Baker & Beagan,

2014; Carabez et al., 2015; Cornelius & Carrick, 2015; Cornelius & Whitaker-Brown, 2015;

Hardacker et al., 2013; Owen-Pugh & Baines, 2014; Portz et al., 2014; Rondal, 2004; Shetty et

al., 2016). The systematic review of literature interpreted the approaches of healthcare

professionals as conducive or hindering in promoting LGBT patient disclosure; the actions

evaluated in these studies included elements of both verbal and nonverbal communication in

interactions with LGBT patients (Callahan et al., 2014; Camacho, 2012; Keuroghlian et al., 2017; Krehely, 2009; Levine, 2013; Lim et al., 2014; Lim & Hsu, 2016; Orgel, 2017; Pompili et al., 2014). The predominant themes identified in the literature review included strategies that implemented culturally competent practices and thereby facilitated LGBT patient disclosure, as well as interventions and approaches that reflected a lack of cultural competency and, therefore, inhibited LGBT patient disclosure. Each of the recurring themes identified within the literature provided insights on how to use the aspects of cultural competency in nursing practice, and, consequently, improve the turnout of self-disclosure among LGBT patients.

Discussion

Assessment strategies implemented by healthcare personnel found to promote LGBT patient self-disclosure included the communication techniques used, the outward appearance of the assessment area, and the ideas or attitudes conveyed by staff throughout assessments. A communication principle that was found to promote the self-disclosure of LGBT patients was respecting a patient's sense of personal identity and use of identifiers, such as preferred pronouns (Carabez et al., 2013; Levine, 2013; Rounds et al., 2013; Chaplic & Allen, 2014). Utilizing an inclusive, neutral language in addition to referring to patients in accordance with preferred identifiers was associated with improved self-disclosure outcomes (Lim et al., 2014; Portz et al., 2014; Carabez et al., 2015; Rounds et al., 2013). Treating sexual behavior as a facet of overall health and being comfortable discussing the importance of it in health assessments was also a factor which promoted disclosure (Keuroghlian et al., 2017; Chaplic & Allen, 2013; Hardacker et al., 2014, Venetis, et al., 2016). Assessing specific health risks relevant to the LGBT community reflected proactive and responsive practice, further promoting self-disclosure (Pompili et al.,

2014; Portz et al., 2014; Hardacker et al., 2014). Additionally, written communication such as health assessment forms impacted LGBT patient disclosure, with forms including discussions of sexual orientation and gender identity, assessing alternative family structure, using "other" as a response option, and giving the opportunity to specify a personal preference or identification being especially beneficial in improving patient disclosure (Baker & Beagan, 2014; Cahill et al., 2014; Carabez et al., 2015; Chaplic & Allen, 2014; Hardacker et al., 2014 ;Lim et al., 201; Levine, 2013; Shetty et al., 2016). One study suggested inquiring the type of romantic relationships, sexual activities, and attractions of patients had a more productive effect on disclosure than intrusive questions about a specific sexual orientation gender identity (SOGI) label because patients were not pressured to self-label if they did not identify with the LGBT community yet (Chaplic & Allen, 2013). Forms with direct, open-ended questions dealing with sexual orientation and gender identity were found to be conducive to LGBT patient disclosure (Baker & Beagan, 2014; Cahill et al., 2014; Carabez et al., 2015). Furthermore, including opportunities for patients to self-identify on forms was shown to improve rates of LGBT patient self-disclosure (Portz et al., 2014; Lim et al., 2014).

The exam area itself was also found to play a factor in the comfort of LGBT patients, thereby persuading them to self-disclose to healthcare personnel. Posting the hospital's nondiscrimination policy in a visible location, having decor that included LGBT-inclusive imagery, keeping the exam area more private, and displaying patient rights on the wall were all components of the healthcare setting found to encourage LGBT patient disclosure (Lim et al., 2014; Chaplic & Allen, 2014; Hardacker et al., 2014; Levine, 2013; Schwinn & Dinkel, 2015, St. Pierre, 2013). Facilities which exhibit LGBT-inclusive imagery may display posters with

same-sex couples, use known symbols to suggest an area is LGBT-friendly, and have

LGBT-inclusive magazines in the waiting area (Lim et al., 2014; Schwinn & Dinkel, 2015).

Although some of these interventions involve the input of the facility and policy changes

outside the scope of a nurse, a nurse still holds some level of influence over the practices of

his/her institution. Mirroring the nursing process, healthcare systems also continually assess their

provision of service to a diverse group of patients. Assessment tools such as the Healthcare

Equality Index and Health Education About LGBT Elders (HEALE), when used to evaluate and

update institutional policies and procedures to increase LGBT-inclusivity, healthcare personnel

consequently progress in cultural competency, thereby improving LGBT patient self-disclosure

(Lim et al., 2014; Levine, 2013; Hardacker et al., 2014). Ultimately, a welcoming and inclusive

healthcare environment makes LGBT patients more comfortable in a healthcare setting, thus

cultivating an atmosphere conducive to LGBT patient self-disclosure (Carabez et al., 2015;

Keuroghlian et al., 2017; Lim et al., 2014; Callahan et al., 2014; Portz et al., 2014; Shetty et al.,

2016).

The attitude of healthcare personnel while assessing LGBT patients was also found to

play a role in patient disclosure, especially when opinions reflected cultural knowledge or

competency. Positive or affirming attitudes involved emotional stability and objectivity,

including support for sexual equality, leaned towards politically liberal views, and were often

correlated with higher levels of education (Chaplic & Allen, 2013; Cornelius & Carrick, 2015;

Levine, 2013; Lim & Hsu, 2016; Baldwin, 2016). Recognizing that not all patients are

heterosexual, refraining from assuming a patient's gender or sexual orientation, being familiar

with LGBT terminology, and acknowledging the diversity and variability within the LGBT

community's members or subgroups were found to reflect elements of cultural competency and improve rates of LGBT patient self-disclosure (Carabez et al., 2015; Levine, 2013; Portz et al., 2014; Schwinn & Dinkel, 2015; Rounds et al., 2013, Venetis, et al., 2016).

Healthcare personnel who were knowledgeable on LGBT terminology, informed about the social determinants on LGBT health outcomes, and receptive to the health concerns of their patients fostered a comfortable atmosphere with LGBT individuals, prompting self-disclosure (Keuroghlian et al., 2017; Lim et al., 2014; Fredriksen-Goldsen et al., 2012; Pompili et al., 2014; Portz et al., 2014; Shetty et al., 2016; Hardacker et al., 2014; Poteat et al., 2013). It was also noted that if healthcare personnel who were comfortable discussing sex with patients and treated it as an integral aspect of patient health saw increased LGBT patient self-disclosure rates (Keuroghlian et al., 2017; Chaplic & Allen, 2013; Hardacker et al., 2014). Assessors who were willing to listen to the vocalizations of their patients, understanding of these concerns, comprehensive in data collection, and open to learning about the LGBT collective experience tended to have patients more inclined to self-disclose (Portz et al., 2014; Bowland et al., 2013; Chaplic & Allen, 2013; Hardacker et al., 2014).

In contrast with approaches that promote LGBT patient self-disclosure by applying the principles of culturally competent care, the literature assessed in this review also revealed practices which reflected a lack of cultural competency, impeding self-disclosure of LGBT patients. Themes identified in the literature which were not conducive for LGBT patient self-disclosure involved personnel having a lack of knowledge or experience with LGBT health dynamics, staff having an apathetic or insensitive attitude toward the LGBT demographic, and personnel facilitating a healthcare environment inhibitory to LGBT patient self-disclosure.

A lack of knowledge on the health dynamics and demographic data of the LGBT population was indicative of a lack of cultural competency, potentially associated with a lack of experience with LGBT patients; personnel who had a poor understanding of the LGBT population in the context of healthcare saw lower rates of patient self-disclosure. Ways personnel interacted with LGBT patients that outwardly expressed a lack of cultural proficiency or experience working with LGBT patients included being unfamiliar with gender-inclusive terminology, different sexual orientations, standard procedures and treatments undertaken by transgender patients, and the barriers to healthcare faced by LGBT individuals (Carabez et al., 2015; Fredriksen-Goldsen et al., 2012; Hardacker et al., 2014; Orgel, 2017; Owen-Pugh & Baines, 2014; Poteat et al., 2013; Portz et al., 2014; Schwinn & Dinkel, 2015; Shetty et al., 2016). Healthcare workers were frequently uninformed on the healthcare needs and issues of transgender patients, such as insurance obstacles patients may experience, the logistics of hormone therapy and sex-reassignment surgeries, and discrimination and disparities all LGBT patients may experience outside of a clinical setting (Hardacker et al., 2014; Leyva et al., 2014; Orgel, 2017; Poteat et al., 2013; Rounds et al., 2013). Frequently, however, this lack of knowledge and, consequently, cultural competence, stems from a weak educational foundation with limited direct experience interacting with LGBT patients as well as curricula not explicitly geared toward caring for LGBT patients. In nursing curricula, inadequate LGBT patient education was caused by limited clinical experiences and coursework devoted to caring for this at-risk demographic (Cornelius & Carrick, 2015; Cornelius & Whitaker-Brown, 2015; Krehely, 2009; Lim et al., 2014; Orgel, 2017; Lim et al., 2014; Owen-Pugh & Baines, 2014; Shetty et al., 2016).

The hostile attitude and insensitivity of health system staff towards the LGBT community influence the inappropriate conduct of workers when interacting with these patients. Their actions are borne from this, resulting in a lack of dignity towards patients and producing poor outcomes for LGBT patient self-disclosure. Demonstrating non verbal discomfort to patients was one such way personnel conveyed their subjective beliefs toward LGBT individuals in ways which hindered disclosure; for instance, if health system employees looked visibly confused, showed disgust, stared blankly, or avoided eye contact with patients, patients felt uncomfortable disclosing their gender identity and sexual orientation (Carabez et al., 2015; Rounds et al., 2013; Poteat et al., 2013). If healthcare workers made inappropriate comments, assumptions, and based their judgments on stereotypes and generalizations, they produced a patient-provider atmosphere not conducive to patient self-disclosure (Rounds et al., 2013; Poteat et al., 2013; Portz et al., 2014; Keuroghlian et al., 2017). Additionally, disregarding the need for inclusive verbiage in assessments and patient interactions, assuming heterosexuality or operating with a heteronormative mindset, and imposing heterosexual identities on patients were approaches shown to deter LGBT patient self-disclosure (Lim et al., 2014; Carabez et al., 2015; Leyva et al., 2014). Repeatedly asking heteronormative-specific health questions before a patient's gender identity or sexual orientation is known was found to contribute to a hesitancy to self-disclose (Owen-Pugh & Baines, 2014; Schwinn & Dinkel, 2015). Moreover, healthcare workers may attempt to impose a heteronormative identity on patients by verbally convincing or coercing patients into believing their sense of personal identity is a health dysfunction (Lim et al., 2014).

Harmful approaches to patient interaction and care delivery could be manifestations of internalized sexual stigmas, adverse views, and personal biases toward patients (Krehely, 2009;

Levine, 2013; Lim et al., 2014; Orgel, 2017; Poteat et al., 2013; Schwinn & Dinkel, 2015;

Rounds et al., 2013). Healthcare workers' internalized sexual stigmas, such as homophobia or a

heteronormative mindset, were shown to have detrimental effects on patients', especially

adolescents',self-concept, self-image, and willingness to disclose personal identity (Carabez et

al., 2015; Cornelius & Whitaker-Brown, 2015; Fredriksen-Goldsen et al., 2012; Krehely, 2009;

Levine, 2013; Orgel, 2017; Portz et al., 2014; Rounds et al., 2013). Cultural blindness, or the

belief that the provision of healthcare and the treatment of all patients is already entirely

equitable, perpetuates the ignorance of healthcare personnel, impedes the capacity of workers to

express empathy cultivate culturally competent practices (Hardacker et al., 2014). Overall,

negative attitudes towards LGBT patients were associated with factors such as socially

conservative political views, non-Caucasian ethnicity, limited experience with diverse people

groups, low racial awareness, adherence to a conservative religion such as but not limited to

Christianity, male gender, and younger age (Cornelius & Whitaker-Brown, 2015; Lim & Hsu,

2016). The effect of religious affiliation on one's attitude toward the LGBT community is

inconclusive because one of the studies claims that there is no correlation between the two

(Cornelius & Carrick, 2015).

An unwelcoming healthcare environment may also limit the information LGBT individuals

divulge with healthcare personnel (Carabez et al., 2015; Krehely, 2009). The decor of a

healthcare setting may communicate subliminal messages that convey inclusivity or a lack

thereof to LGBT patients; LGBT patients may then develop a poor impression of the facility in

its ability to care for their demographic (Lim et al., 2014; Schwinn & Dinkel, 2015). Images

displayed in an exam area which only involve heterosexual couples may further impose

heteronormative culture on LGBT patients, inhibiting the desire to self-disclose (Lim et al., 2014; Schwinn & Dinkel 2015). Overall, when healthcare systems are reluctant to recognize the LGBT population or provide LGBT specific services, a welcoming environment is hindered, impeding disclosure (Schwinn & Dinkel, 2015; Shetty et al., 2016).

Implications

Throughout an analysis of available research, methods that utilize culturally competent practice to facilitate the self-disclosure of LGBT patients to nurses and other healthcare workers were identified. In addition to the approaches as mentioned earlier from this systematic review of literature that may be implemented by individual healthcare workers, there are interventions that may be applied by larger institutions and organizations. The recognized approaches prompt further suggestions and implications for nursing practice, nursing education, and future research, which must be discussed. The following recommended methods integrate LGBT cultural competency and encourage LGBT patient self-disclosure by implementing changes which may be observed at a larger scale.

Nursing Practice

Therapeutic communication is an essential component of the nurse-patient relationship and, therefore, must be cultivated in the ongoing effort toward culturally competent care. When communicating with patients, an inclusive, neutral language should be utilized as well as respect for and use of the name or pronoun that a patient prefers to be identified by (Carabez et al., 2015; Lim et al., 2014; Portz et al., 2014; Rounds et al., 2013). An example of neutral and inclusive language may involve using the term "sexual and gender minority," (SGM) because it encompasses patients who are not exclusively heterosexual, who identify with a gender identity

contrary to their biological sex, as well as those who may not yet feel comfortable putting a label on their sexual orientation or gender identity (Bowland et al., 2013; Shetty et al., 2016). Other methods which illustrate culturally competent communication involve avoiding assumptions on a patient's sexuality, asking patients about their preferred identifiers, and actively listening to patient during the act of self-disclosure (Baker & Beagan, 2014; Bowland et al., 2013; Chaplic & Allen, 2014; Keuroghlian et al., 2017; Lim et al., 2014; Portz et al., 2014).

In nursing practice, a self-evaluation for personal bias or lack of neutrality should be done before assessing a patient to avoid detrimental interactions (Bowlan et al., 2013). Both healthcare workers and patients should understand that inquiring patient sexual orientation and practices during health assessments are necessary to provide appropriate and relevant care (Chaplic & Allen, 2013; Keuroghlian et al., 2017; Schwinn & Dinkel, 2015). Patients should also be assessed for cultural or religious beliefs that may cause internal conflicts in regards to their sexualities (Bowland et al., 2013). Comprehensive assessments of sexual histories and SOGI data should be routinely collected to update patient medical records (Hardacker et al., 2014; Portz et al., 2014). Assessments should include screenings for suicide risk and sexually transmitted infections, emphasizing that the care setting is a secure and confidential place to divulge these concerns (Hardacker et al., 2014, Pompili et al., 2014). After completing assessments, if risks are evident, further resources such as agencies, community-based organizations, social workers, support groups, and family should be identified for LGBT patients in need (Fredricksen-Goldsen et al., 2012; Pompili et al., 2014; Schwinn & Dinkel; Shetty et al., 2014). When healthcare systems implement facility-wide changes utilizing the principles of

cultural competency, the needs of LGBT patients can be better addressed, and self-disclosure rates can improve.

Education

An intervention that can benefit the nursing education system, equipping future nurses with knowledge of culturally competent practices, would be incorporating specialized training in caring for LGBT patients (Cornelius & Whitaker-Brown, 2015; Hardacker et al., 2014; Lim et al., 2014; Lim & Hsu, 2016; Shetty et al., 2016). Nursing school faculty must first review their current curricula and identify ways to add LGBT-related content (Callahan et al., 2014; Cornelius & Carrick, 2015). Nursing programs should deliberately include evidence-based knowledge on LGBT issues and culturally competent care by using simulation exercises, relevant curricula, and providing clinical experiences with LGBT patients (Callahan et.al., 2014; Keuroghlian et al., 2017; Leyva et al., 2014; Lim et al., 2014; Owen-Pugh & Baines, 2014). Relevant LGBT curriculum for nursing programs should integrate material on care specific to older LGBT adults, encourage proficient use of transgender terminology, assign care plans on LGBT patients, and include information on SOGI assessment techniques (Cahill et al., 2014; Camacho, 2012; Carabez et al., 2015; Cornelius & Carrick, 2015; Hardacker et al., 2014; Krehely, 2009; Rounds et al., 2013). Through improvements in nursing LGBT education, nurses will gain basic knowledge and an awareness of health concerns, terminology, and needs that apply to the LGBT community as a whole and each subgroup within it (Fredricksen-Goldsen et al., 2012; Hardarcker et al., 2014; Keuroghlian et al., 2017; Lim et al., 2014; Pompili et al., 2014, Portz et al., 2014; Shetty et al., 2016).

Exposure to LGBT patient care during clinical rotations offers opportunities for nursing students to be guided by faculty in processing, acknowledging, and confronting personal biases while alleviating discomfort with LGBT patients, ultimately applying culturally sensitive practice (Cahill et al., 2014; Callahan et al., 2014; Owen-Pugh & Baines, 2014). Educational experiences may also involve having LGBT clinical instructors or having students participate in panels where LGBT people from the community share personal experiences. These interactions facilitate two-way learning where both parties may learn about and from each other, contributing to an increased level of understanding and mutual acceptance. Additionally, in interacting with the LGBT community through these direct learning experiences, students can ask questions to openly LGBT individuals and gain first-hand knowledge of the LGBT patient demographic. (Baker & Beagan, 2014; Cornelius & Whitaker-Brown, 2015; Levya et al., 2014; Portz et al., 2014). Since cultural competency is a continual learning process, education should advance throughout a nurse's career (Lim et al., 2014; Schwinn & Dinkel, 2015). By recognizing LGBT patients are considered a "priority population," nurses acknowledge social determinants such as stigmas and discrimination influence the care provided to LGBT patients in the United States (Fredricksen-Goldsen et al., 2013; Lim et al., 2014; Portz et al., 2014; Poteat et al., 2013)

Future Research

Further investigation may involve identifying clinical guidelines rooted in evidence-based practice and utilize proven methods to better care for LGBT patients. Limited current research is available regarding the feedback of LGBT patients on healthcare provision by nurses specifically. Through expanded research on these topics, the overall knowledge base regarding LGBT patient care may be increased. In applying this enhanced information, practices

may be refined, tested, and clinical guidelines constructed. Studies that examine the personal biases of healthcare workers which obstruct the delivery of culturally competent care may provide further insight ways to improve the current status of LGBT patient care.

Strengths and Limitations

In the process of collecting, synthesizing and presenting meaningful evidence, strengths and flaws of this systematic review of literature have been identified. A respective strength of this literature review was that it was written under the guidance and mentorship of a doctorate of Nursing and an expert within her designated field. Additionally, the authors of this literature review were very interested in the topic and about the issues evaluated. This collective interest was nurtured over the course of two semesters of the academic calendar, providing the authors an adequate length of time to complete this project.

A limitation of this literature review was the lack of available research on the topics addressed. This review analyzed the experience of the LGBT population, a demographic only recently obtaining a sociopolitical presence. Due to the most pivotal legislative and social changes regarding the LGBT population occurring within the last five years, current and relevant research was limited. Another limitation of this systematic literature review was the inexperience of its authors. The authors of this study are undergraduates within their field of study, inexperienced in research at an upper level. Furthermore, there was a lack of resources available to the authors with university databases yielding few search results after the keywords were inputted. As a result, the authors had to seek additional databases outside of those provided by their academic institution.

Recommendations

Recommendations for the replication of this study include changes which may enhance

findings. These include utilizing access to a wider range of databases, consulting with experts in

the healthcare field, and conducting a survey of live subjects who could relay first-hand

experiences. Incorporation of future studies as the base of literature expands may also enhance

results.

Conclusion

The LGBT population is a patient group which must be accounted for in current nursing

practice. Although nurses are not directly liable for the inadequacies of their coworkers or

institutions, they must be liable, to a degree, for the health of their respective patients. The LGBT

demographic has been historically oppressed, harassed, and disadvantaged through

socio-political systems (American Psychological Association, 2017; Human Rights Campaign,

2016). This background has fueled hesitancy to fully disclose sexual practices and gender

identity, selective censorship in divulged information, and an overall reluctance to regularly seek

medical care and treatment. Nurses must be receptive to the health concerns of LGBT patients,

understanding of their collective experience, and responsive to their specific needs.

The literature suggests practices, some of which may be implemented by nurses

themselves, that may promote an environment conducive to LGBT patient disclosure. An

environment that is outwardly inclusive and affirming to this demographic may include decor

that implicitly facilitates an LGBT-friendly atmosphere; bathroom signs, posters, and other

subliminal messages conveyed within a room should abstain from heteronormative symbolism

(Lim et al., 2014; Portz et al., 2014). New nurses themselves, working within these settings, may

utilize terminology that conveys a level of LGBT cultural fluency. Being knowledgeable of

specific health risks within the LGBT demographic and performing interventions as indicated by these risks may facilitate improved patient outcomes and improve overall patient disclosure (Lim et al., 2014; Shetty et al., 2016; Hardacker et al., 2014; Keuroghlian et al., 2017). Additionally, nurses should treat sex as a component integral to a patient's health, rather than be evasive, visibly uncomfortable, and treat sex as a taboo.

The literature strongly indicates a need for further education for nursing professionals which specifically addresses the LGBT patient population (Lim & Hsu, 2016; Cornelius & Whitaker-Brown, 2015; Hardacker et al., 2014). An understanding of this patient demographic can be promoted in nursing curricula by way of presentations held with or by members of the LGBT community, question-and-answer panels, and coursework with LGBT-inclusive content (Callahan et al., 2014; Portz et al., 2014; Lim et al., 2014; Owen-Pugh & Baines, 2014; Leyva et al., 2014). Students being able to meet and interact with this population has been shown by available literature as an effective method of improving LGBT cultural competency, inciting interest in the LGBT demographic, and training personnel better equipped to serve this population (Cornelius & Whitaker-Brown, 2015; Baker & Beagan, 2014; Leyva et al., 2014). Heteronormative culture has established the stereotypes that have led to misinformation and contributed to a lack of culturally competent healthcare for LGBT individuals (Forcier & Haddad, 2013; Hayman et al., 2014; Nava & Dawidoff, 2014; Clark, 2014; Schwinn & Dinkel, 2015). Education, by extension, fuels cultural competency, challenges these norms, and dismantles harmful generalizations. Nurses are not accountable for the problems within the entire system of healthcare, but through improved cultural competency, they can contribute to a solution that promotes LGBT patient disclosure and resolves LGBT-specific health risks.

References

American Psychological Association. (n.d.). Retrieved August 27, 2017, from

http://www.apa.org/topics/lgbt

Baker, K., & Beagan, B. (2014). Making assumptions, making space: An anthropological

critique of cultural competency and its relevance to queer patients. *Medical Anthropology Quarterly*, *28*(4), 578-598.

Baldwin, A. M., Dodge, B., Schick, V., Sanders, S. A., & Fortenberry, J. D. (2017). Sexual Minority Women's Satisfaction with Health Care Providers and State-level Structural Support: Investigating the Impact of Lesbian, Gay, Bisexual, and Transgender Nondiscrimination Legislation. *Women's Health Issues, 27*(3), 271-278

Betancourt, R. J., Green, A. R., & Ananeth‑Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports 118*, 293-302.

Bloch, H., Hersher, R., Domonoske, C., Kennedy, M., & Dwyer, C. (2016, June 13). 'They Were So Beautiful': Remembering Those Murdered In Orlando. Retrieved September 10, 2017, from http://www.npr.org/sections/thetwo-way/2016/06/12/481785763/heres-what-we-know-about-the-orlando-shooting-victims

Bowland, S. E., Foster, K., & Vosler, A. N. (2013). Culturally Competent and Spiritually Sensitive Therapy with Lesbian and Gay Christians. *Social Work*, *58*(4), 321-332.

Brewer, Paul R. (2014). Public Opinion about Gay Rights and Gay Marriage. *International Journal of Public Opinion Research*, *26*(3). Retrieved September 10, 2017, from https://doi.org/10.1093/ijpor/edu029

Cahill, S., Singal, R., Grasso, C., King, D., Mayer, K., Baker, K., & Makadon, H. (2014).

Do ask, do tell: high levels of acceptability by patients of routine collection of sexual orientation and gender identity data in four diverse American community health centers. *PLoS One*, *9*(9).

Callahan, E. J., Hazarian, S., Yarborough, M., & Sánchez, J. P. (2014). Eliminating LGBTIQQ health disparities: the associated roles of electronic health records and institutional culture. *Hastings Center Report*, *44*(s4).

Camacho, A. (2012). *Top health issues for LGBT populations information & resource kit*. Rockville, MD: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Center for Substance Abuse Prevention*.

Carabez, R., Pellegrini, M., Mankovitz, A., Eliason, M., & Scott, M. (2015). Does your organization use gender inclusive forms? Nurses' confusion about trans* terminology. *Journal of Clinical Nursing*, *24*(21-22), 3306-3317.

Centers for Disease Control and Prevention (CDC). (2016, November) HIV Surveillance Report, 2015 (No. 27). Retrieved March 22, 2017, from http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Chaplic, K. C., & Allen, P. J. (2013). Best practices to identify gay, lesbian, bisexual, or questioning youth in primary care. *Pediatric Nursing*, *39*(2), 99.

Clark, F. (2014). Discrimination against LGBT people triggers health concerns. *The Lancet, 383*(9916), 500-502. doi:10.1016/s0140-6736(14)60169-0

Cornelius, J. B., & Carrick, J. (2015). A survey of nursing students' knowledge of and attitudes toward LGBT health care concerns. *Nursing Education Perspectives*, *36*(3), 176-178.

Cornelius, J. B., & Whitaker-Brown, C. (2015). A Brief Learning Experience Designed

to Increase Nursing Students' Knowledge of and Attitudes Toward LGBT Health Care.

GSTF Journal of Nursing and Health Care (JNHC), *2*(1).

Cultural Competence in Research [Scholarly project]. (2010, October). In The Harvard

Clinical and Translational Science Center. Retrieved August 25, 2017, from

https://catalyst.harvard.edu/pdf/diversity/CCR-annotated-bibliography-10-12-10ver2-FIN

AL.pdf

Flowers, D. L. (2004, August 01). Culturally Competent Nursing Care. *Critical Care*

Nurse, 24(4), 48-52. Retrieved April 20, 2017, from

http://ccn.aacnjournals.org/content/24/4/48.short

Forcier, M. M., & Haddad, E. (2013). Health care for gender variant or gender

non-conforming children. *Rhode Island Medical Journal, 96*(4).

Fredriksen-Goldsen, K. I., Emlet, C. A., Kim, H. J., Muraco, A., Erosheva, E. A.,

Goldsen, J., & Hoy-Ellis, C. P. (2013). The physical and mental health of lesbian,

gay male, and bisexual (LGB) older adults: The role of key health indicators and

risk and protective factors. *The Gerontologist*, *53*(4), 664-675.

Gates, G. J. (2013, March 28). How Many People are Lesbian, Gay, Bisexual and

Transgender? Retrieved February 07, 2017, from

http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-man

y-people-are-lesbian-gay-bisexual-and-transgender/

Global HIV and AIDS Statistics. (2017, August 23). Retrieved August 27, 2017, from

https://www.avert.org/global-hiv-and-aids-statistics

Grigorovich, A. (2015). Negotiating sexuality in home care settings: older lesbians and

bisexual women's experiences. *Culture, Health & Sexuality*, *17*(8), 947-961.

Hardacker, C. T., Rubinstein, B., Hotton, A., & Houlberg, M. (2014). Adding silver to the

rainbow: the

development of the nurses' health education about LGBT elders (HEALE) cultural

competency curriculum. *Journal of Nursing Management*, *22*(2), 257-266.

Hayman, B., Wilkes, L., Halcomb, E., & Jackson, D. (2013). Marginalised mothers:

Lesbian women negotiating heteronormative healthcare services. *Contemporary

Nurse*, *44*(1), 120-127.

Hudson, R. B. (2011). Integrating Lesbian, Gay, Bisexual, and Transgender Older Adults

into Aging Policy and Practice. *Public Policy & Aging Report, 21*(3), 2-2.

doi:10.1093/ppar/21.3.2

Human Rights Campaign (2016). Growing Up LGBT in America: View and Share

Statistics. Retrieved February 07, 2017, from

http://www.hrc.org/youth-report/view-and-share-statistics

Keuroghlian, A. S., Ard, K. L., & Makadon, H. J. (2017). Advancing health equity for

lesbian, gay, bisexual and transgender (LGBT) people through sexual health education

and LGBT-affirming health care environments. *Sexual Health*, *14*(1), 119-122.

Kluttz, B. (2014). Outness and Identity in Context: Negotiating Sexual Disclosure in

LGBT Campaigns. *Sexuality & Culture*, *18*(4), 789-803.

Kosciw, J. G., Palmer, N. A. and Kull, R. M. (2014), Reflecting Resiliency: Openness

about Sexual Orientation and/or Gender Identity and Its Relationship to Well-Being and

Educational Outcomes for LGBT Students. *American Journal of Community Psychology*,

55: 167–178. doi:10.1007/s10464-014-9642-6

Krehely, J. (2009). How to Close the LGBT Health Disparities Gap. *Center for American*

Progress (2009): 1-9. Retrieved September 16, 2017, from

https://www.americanprogress.org/issues/lgbt/reports/2009/12/21/7048/how-to-cl

ose-the-lgbt-health-disparities-gap/

Levine, D. A., & Committee on Adolescence (2013). Office-based care for lesbian, gay, `

bisexual, transgender, and questioning youth. *Pediatrics, 132*(1), e296-e313.

Retrieved September 16, 2017, from

https://www.ncbi.nlm.nih.gov/pubmed/23796737

Lim, F. A., & Bernstein, I. (2012). PROMOTING AWARENESS of LGBT Issues in

Aging in a Baccalaureate Nursing Program. *Nursing Education Perspectives, 33*(3),

170-175. doi:10.5480/1536-5026-33.3.170

Lim, F. A., Brown Jr, D. V., & Kim, S. M. J. (2014). CE: Addressing health care

disparities in the lesbian, gay, bisexual, and transgender population: A review of

best practices. *AJN The American Journal of Nursing*, *114*(6), 24-34.

Lim, F. A., & Hsu, R. (2016). Nursing students' attitudes toward lesbian, gay, bisexual,

and transgender persons: an integrative review. *Nursing education perspectives*,

37(3), 144-152.

Meyer, I. H., & Northridge, M. E. (2007). *The health of sexual minorities public health*

perspectives on lesbian, gay, bisexual, and transgender populations. Boston, MA:

   Springer Science Business Media, LLC.

Nava, M., & Dawidoff, R. (2014). *Created equal: Why gay rights matter to America*. St.

   Martin's Griffin.

O'Brien, R.L., Kosoko‑Lasaki, O., Cook, C. T., Kissell, J; Peak, F., & Williams, E. H.

   (2006). Self‑assessment of cultural attitudes and competence of clinical investigators to

   enhance recruitment and participation of minority populations in research. *Journal of*

   National Medical Association, *98*(5), 674‑682

Orgel, H. (2017). Improving LGBT Cultural Competence in Nursing Students: An

   Integrative Review. *Association of Black Nursing Faculty Journal*, *28*(1), 14-18.

Owen-Pugh, V., & Baines, L. (2014). Exploring the clinical experiences of novice

   counsellors working with LGBT clients: Implications for training. *Counselling*

   and Psychotherapy Research, *14*(1), 19-28.

Pompili, M., Lester, D., Forte, A., Seretti, M. E., Erbuto, D., Lamis, D. A., Amore, M.

   and Girardi, P. (2014), Bisexuality and Suicide: A Systematic Review of the Current

   Literature. *Journal of Sexual Medicine*, *11*(8), 1903–1913. doi:10.1111/jsm.12581

Portz, J. D., Retrum, J. H., Wright, L. A., Boggs, J. M., Wilkins, S., Grimm, C., ... &

   Gozansky, W. S. (2014). Assessing capacity for providing culturally competent

   services to LGBT older adults. *Journal of Gerontological Social Work*, *57*(2-4), 305-321.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: a grounded theory

   of stigma in transgender health care encounters. *Social Science & Medicine*, *84*, 22-29.

Rosenberg, P., & Biggar, R. (1998). Trends in HIV Incidence among Young Adults in the

United States. *JAMA*. 1998; *279*(23):1894-1899. doi:10.1001/jama.279.23.1894

Rounds, K., Burns Mcgrath, B., & Walsh, E. (2013). Perspectives on provider behaviors: A qualitative study of sexual and gender minorities regarding quality of care. *Contemporary Nurse*, *44*(1), 99-110.

Schuster, M. A., Reisner, S. L., & Onorato, S. E. (2016). Beyond bathrooms—meeting the health needs of transgender people. *New England Journal of Medicine*, *375*(2), 101-103.

Schwinn, S., & Dinkel, S. (2015). Changing the culture of long-term care: Combating heterosexism. *OJIN: The Online Journal of Issues in Nursing*, *20*(2).

Shetty, G., Sanchez, J. A., Lancaster, J. M., Wilson, L. E., Quinn, G. P., & Schabath, M. B. (2016). Oncology healthcare providers' knowledge, attitudes, and practice behaviors regarding LGBT health. *Patient Education and Counseling*, *99*(10), 1676-1684.

Shiu‑Thronton, S. (2003). Addressing Cultural Competency in Research: Integrating a Community‑Based Participatory Research Approach. *Alcoholism: Clinical and experimental research*, *27*(8), 1361-1364.

St. Pierre, M. (2013). Coming out in primary healthcare: An empirical investigation of a model of predictors and health outcomes of lesbian disclosure. *Scholarship at UWindsor, Electronic Theses and Dissertations*. 4880.

Substance Abuse and Mental Health Services Administration, Results from the 2012

National Survey on Drug Use and Health: Summary of National Findings, NSDUH

Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse

and Mental Health Services Administration, 2013.

Venetis, M. K., Meyerson, B., Friley, B., & Shields, C. G. (2016). Characterizing Sexual

Orientation Disclosure to Health Care Providers: Lesbian, Gay, and Bisexual

Perspectives. *Health Communication*, 1-9.

Ward, B. W., Dalhamer, J. M., & Joestl, S. S. (2014). Sexual orientation and health

among

U.S. adults: National Health Interview Survey, 2013. (National Health

Statistics Report 77). Hyattsville, MD: National Center for Health Statistics.

Whitehead, J., Shaver, J., & Stephenson, R. (2016). Outness, stigma, and primary health   care

utilization among rural LGBT populations. *PloS one, 11*(1).