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Nursing students' attitudes toward sexual and gender minorities

A literature review

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Abstract

Sexual and gender minorities have unique health disparities when compared to others. These adverse health outcomes are due to a minority stress created by discrimination, prejudice and stigmatization within the cultures of these marginalized groups. The gender and heteronormativity beneath the societies along with the health care systems around the world nourish the discrimination against sexual and gender minorities. Nurses as health care professionals participating extensively in the care of patients can have a significant impact on the care provided. Especially prejudiced attitudes can transfer negatively to the care provided for sexual and gender minorities.

The aim of this study was to explore nursing students' attitudes towards sexual and gender minorities. The purpose was to enhance the understanding of the existing attitudes as well as enhance the acknowledgement of different perspectives. The aim was to provide information that could be used to assess the current nursing curriculum from the perspective of permissive education and to support culturally competent care of sexual and gender minorities.

The study was executed as a literature review. The data search was conducted in the following two databases: JYKDOK and Cinahl. Four papers were chosen to be included in the review. The data analysis resulted in three main findings: permissive, intolerant and cultural attitudes. Nursing students were found to have rather negative attitudes towards sexual and gender minorities although a change to a more positive direction could be seen in the recent studies. The results of the review highlighted the need for further studies that would assess the current nursing curriculum and culturally sensitive education in order to enhance cultural competency among nursing students.

Keywords/tags (subjects)

Nursing student, attitude, sexual and gender minorities

Miscellaneous (Confidential information)

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1 Introduction

Equal rights of sexual and gender minorities, an umbrella term including others than heterosexuals and normative gender identities (Seta 2016), have been argued world widely for years, especially perceptions of gender identity and same-sex marriage have acquired public attention. Many governments and states have promoted equality through legislation including decriminalization of homosexuality, legalizing same-sex marriage and recognizing a third gender, a form of gender identity where person doesn't feel a belonging to either male or female sex. (Ilga 2017; Dittrich 2017; Dearden 2017; Wilde 2015). Despite the actions taken towards equality some have declared homosexuality as a trend (Roden 2016; CBS News 2015; PTK 12/2014 vp). The persistent social discrimination, prejudice and stigmatization towards sexual and gender minorities lead to theory of minority stress, a phenomenon of minority and majority values conflicting in the society experienced by minority groups. It is considered as a main cause of the adverse health outcomes of sexual and gender minorities. (Meyer 2016, 1356-1358; Dentato 2012.) When seeking quality care sexual and gender minorities encounter personal and structural obstacles (AHRQ 2012, 241).

Nurses form important relationships with patients to provide high-quality care (Salmond & Echevarria 2017, 22). However prejudice and negative attitudes can adversely affect nurse-patient relationship and therefore transfer negatively to the care provided (Fletcher 2015, 100). As nursing students represent the future nurses, their knowledge and skills working with sexual and gender minorities will be in an important role. However there are few combined research reviews on the topic of health professionals' attitudes towards the marginalized groups. Therefore this paper aims to assess student nurses' attitudes toward sexual and gender minorities. The purpose of this research is to provide understanding of the nursing students' perceptions. This information can be used to assess current status of nursing curriculums and to enhance education of minorities specific health needs and furthermore to ensure culturally competent high-quality and sensitive care for sexual and gender minorities.

2 Specific health needs of sexual and gender minorities

2.1 Sexual and gender minorities in health care

Sexual minorities as a term include all other than those defining their sexual orientation as heterosexuals. Sexual orientation is a feature indicating to whom person is delighted on, fell in love with or feels emotional or erotic attraction. Since sexual orientation is qualified on the base of own and object's sexuality it's comprehensive and sometimes hard to define. In addition it's a fluid factor which might change over time and doesn't have any specific boundaries. Furthermore sexual orientation is a character defined by all personally. (THL 2017a.)

Gender minorities as in the case of the sexual minorities is a wide term since everyone experiences their gender identity uniquely. Others strongly experience only male or female characteristics while others identify factors from both sexes. In some cases gender identify won't fit inside of the sexes the current culture has created. Moreover person can experience being androgynous. People experiencing belonging to the sex they've been assigned at birth are called cisgenders, where the prefix cis comes from Latin meaning 'this side' whilst prefix trans means 'the other side'. As a result people feeling otherwise form the gender minority including transsexual, transgender, and gender nonconforming people. (THL 2017b; WPATH 2011, 1; Lääketieteen termit 2017.)

Health disparities of sexual and gender minority population

LGBT is an initialism which is used to refer to sexual and gender minorities (Ard & Makadon 2012, 1-2). As mentioned in the article of National LGBT Health Education Center (2016, 3) most of the health care professionals have encountered sexual or gender minorities in their work whether they are aware of it or not. Connolly and Lynch (2016, 186) refers to Carr and others (1999), Eliason and Schope (2001) and

Gibbons and others (2007) indicating that a significant amount of homosexual men won't reveal their sexual orientation for their health care professionals. This invisibility can lead to difficulties in discovering the special health needs of sexual and gender minority individuals (National LGBT Health Education Center 2016, 3-4). However with education and reflection of personal attitudes, cultural competent care can be provided to marginalized groups similarly as to any other group using health care services (Ard & Makadon 2012, 10).

Individuals belonging to sexual or gender minorities experience unique health disparities (Institute of Medicine 2011, 1). To understand the impacts of health disparities, future nurses need to familiarise themselves with the social, structural and interpersonal challenges faced by sexual and gender minorities. Understanding of these disparities regarding sexual and gender minorities allows nurses to provide effective and competent care. (National LGBT Health Education Center 2016, 6-11.) These health disparities are result of minority stress combined with inadequate health care. Individuals from social minority positions that are usually stigmatized experience excess stress compared to those not stigmatized by the surrounding society. (Seta 2015, 19; Ard & Makadon 2012, 3.) Stigma among prejudice and discrimination generates an unhealthy and stressful social environment described as the minority stress. The stress process includes encountering prejudice events, assumptions of rejection, hiding and concealing, internalized homophobia and improved coping strategies. Minority stress is chronic since it is related to the structures of the society and therefore beyond the capability of the individual facing it to be changed by. (Meyer 2003, 1-4.) However structural interventions to decrease stigma have been shown to have positive wide outcomes, that individual interventions usually can't reach (Cook, Purdie-Vaughns, Meyer & Busch 2014, 106). For example passing the same-sex marriage in Massachusetts decreased medical care and mental health visits significantly among homosexual men with and without a partner (Hatzenbuehler, O'Cleirigh, Grasso, Mayer, Safren & Bradford 2012, 287-288). Minority stress rising from the factors of sexual orientation and gender identity for many individuals cross with inequities of other minority elements such as ethnicity, social class and race (Institute of Medicine 2011, 1).

Health disparities faced by sexual and gender minorities include problems from various health sections such as sexual, mental and somatic areas. General health disparities of sexual and gender minorities are shown in the Table 1.

Most general health disparities among sexual and gender minority population
High rates of sexually transmitted disease
High rates of mental health problems
Increased risk of committing suicide
High rates of substance abuse and smoking
Increased risk of violence victimization
Increased risk to become homeless
Decreased use of preventive health services
High rates of unhealthy weight control/perception
Additional barriers faced by sexual and gender minority elders

Table 1. Health disparities amidst sexual and gender minorities (National LGBT Health Education Center 2016, 4-6; Ard & Makadon 2012, 3-5)

Sexual and gender minorities are more likely to encounter challenges when proceeding into the health care system than heterosexuals. Sexual and gender minority individuals can fear discrimination, stigmatization and prejudice and therefore they do not seek medical attention. Sometimes a lack of knowledge and culturally incompetent care inhibit sexual and gender minority people from receiving individualized quality care. (National LGBT Health Education Center n.d., 5.) These factors lead to low rates of preventive health service use among sexual and gender minorities. Especially women who have sex with women (WSW) are ten times less likely to participate in cervical cancer screenings than their heterosexual counterparts in the USA (Peitzmeier 2013, 4). Also transgender people require an extra attention when talk-

ing about screenings since their screening guidelines depend whether they've received hormonal therapy or have undergone gender-affirmative surgeries (National LGBT Health Education Center 2016, 11). The high rates of sexually transmitted diseases (STD's), such as human immunodeficiency virus (HIV), hepatitis A and B and syphilis, among men who have sex with men (MSM) and male-to-female transgender individuals could be explained with low rates of preventive vaccinations, increased rates of unprotected sex and decreased admission to antiretroviral therapy for HIV, which many are due to social discrimination, structural and legal factors in addition to inadequate culturally competent care. (Ard & Makadon 2012, 3-4; Lee 2000, 407; Dean, Meyer, Robinson, Sell, Sember, Silenzio, Bowen, Bradford, Rothblum, Scout, White, Dunn, Lawrence, Wolfe & Xavier 2000, 120-121.) However as countries perceive sexual and gender minorities in different light, these minority group individuals face several reasons behind the health disparities in various parts of the world. For example in the USA sexual and gender minority individuals might have problems accessing basic care due to a financial shortage caused by unemployment, homelessness or lack of insurance (National LGBT Health Education Center n.d., 5). These financial barriers to achieve adequate care are caused by the insurance run health care system in the USA. As in contrast to many other countries for example to Finland problems accessing the health care system are rather due to fear of discrimination than financial factors since the Act on the Status and Rights of Patients guarantees adequate health care to all permanent residents (L 17.8.1992/785, 3 §). Despite the factors resulting to barriers to seek care, poor admission to health care services is known to be costly for the individual but also to the society (AHRQ 2012, 213).

Sexual and gender minority youth have reported high rates of violence and victimization such as bullying. In addition studies show that adult and adolescent sexual and gender minority individuals face physical and sexual victimization due to their minority status. As a consequence of this victimization and minority stress, sexual and gender minorities have a higher prevalence of mental health problems than their heterosexual peers. (Burton, Marshal, Chisolm, Sucato & Friedman 2013, 398-400; Marshal, Dietz, Friedman, Stall, Smith, McGinley, Thoma, Murray, D'Augelli & Brent 2011, 121-122; Whitbeck, Chen, Hoyt, Tyler & Johnson 2004, 340-341.) Prejudice, stigma and

discrimination can predispose sexual and gender minority people to loneliness and anxiety which can lead to depression and even to suicidal acts. (Valdiserri, Holtgrave, Poteat & Beyrer 2018, 14; National LGBT Health Education Center 2015 & Meyer 2003.) Especially sexual and gender minority youth are at greater risk of committing suicide compared to heterosexual counterparts. Every adolescent faces challenges in their lives while growing up but in addition to normal changes in mood youth belonging to sexual or gender minorities encounter additional burden which they need to carry, resulting to higher rates of mental health problems and suicides. However family support and social acceptance within a person's own social group increases self-esteem, leads to improved health outcomes and decreases substance abuse, depression and suicidal thoughts. In other hand challenging phase of coming out to parents and their possible rejection explains the increased numbers of sexual and gender minority youth homelessness, which furthermore provokes attempted suicides. (Marshall 2016, 205; National LGBT Health Education Center 2016, 6 & Dyck 2012, 3.)

Sexual and gender minority individuals are at higher risk of substance abuse, excessive drinking and smoking than heterosexual peers. It is believed to be caused by the need to cope with minority stress, similar to many other health disparities. Reasons for substance abuse and smoking can be divided into two main assumptions, drinking to forget and to fit in. Lesbians are shown to have higher rates of heavy drinking since the acceptable social venues have expectations and positive approach to substance use. On the other hand homosexual men are more likely to use excessive amounts of substances due to victimization. (Dermody, Marshal, Cheong, Burton, Hughes, Aranda, & Friedman 2014, 35-37; Meyer 2003, 9; Dean et al. 2000, 121-122.)

Minority stress has also been indicated as a contributing factor to unhealthy weight management among sexual and gender minorities. Eating disorders are believed to be associated with feelings of shame and in addition to normal appearance pressures sexual and gender minorities experience excess shame due to a minority position. (Bayer, Robert-McComb, Clopton & Reich 2017, 42-43.) Homosexual men have an increased risk of bulimia or anorexia similarly to heterosexual women due to the social

pressure of appearance. On the other hand lesbians usually don't emphasize appearance as high as heterosexual women and therefore are more likely to be overweight or obese. Problematic eating behaviours have negative impacts on physiological and psychological health including lower metabolic rate and depression. (Watson, Adjei, Saewyc, Homma & Goodenow 2017, 27-30; Dean et al. 2000, 118-119.)

More studies are needed from sexual and gender minority elderly health disparities since they are often hidden and underserved population with unique health care needs. Many elderly belonging to sexual or gender minority have lived a lifetime with the criminalization of homosexuality and more negative society against them, which have left many health problems. (Rowan & Beyer 2017, 577-581.) Lack of family and social support, financial security, physical safety and fear of loneliness are challenges elderly sexual and gender minority individuals are facing. Social isolation is known to cause unfavourable health outcomes, decreased quality of life, decline in cognition and even mortality. (Czaja, Sabbag, Lee, Schulz, Lang, Vlahovic, Jaret & Thurston 2015, 1115-1116.) Therefore recognising the unique health needs and the reasons behind of this specific elderly group are important for adequate and sensitive care (Emlet 2016, 20-21).

2.2 Attitudes and their effects on health care

What are attitudes?

Researchers have debated on the definition of attitude over decades. According to Cooper, Keller and Blackman (2016, 5-7) Zanna and Rempel (1988) offered a definition: *An attitude is the categorization of a stimulus object along an evaluative dimension.* This is the foundation where modern science bases their definitions nowadays. Categorization refers to evaluation of the attitude object, which can be anything including concrete matters such as people, places, things or other concepts like ideas, situations or actions. Object is evaluated in the dimension of favourable or unfavourable manner. Evaluation is a process where attitude object, thoughts and emotive experiences affects either together or separately. When evaluation is considered to

reckon with any or all origin of information, affect, behaviour or cognition, it is considered to be the widest definition of attitude meanwhile providing flexibility to the term and its use. (Ibid; Oskamp & Schultz 2005, 7-9.)

Even most of our attitudes are held in our memory and bases on prior experiences, evaluation of situations and creation of new attitudes can be made at the moment. Attitudes control our attention and categorizes objects to improve our decision-making into less stressful and higher quality results. (Cooper et al. 2016, 25-82.) Even attitudes affect our decision-making, they won't always correlate on our behaviour. The stronger the attitude the more it will guide our behaviour. Also other functions indicates whether our behaviours are influenced with attitudes. These functions include practical views of attitudes, whether attitudes increase value, self-monitoring when attitudes offer social respect or adjustment to situations. In other words in some cases attitudes affects our behaviour greatly whereas in others it does not, it all depends on the situation and the individual. (Ibid. 58-168.) To understand attitudes and their consequences it is important first to understand the values and beliefs beneath (Bob 2015, 8).

Attitudes are learnt and they can be conscious or unconscious, precise or inaccurate, rational or irrational. Our surroundings modify and form our attitudes, which can be acquired from our parents, surrounding people and media. Despite the stable characteristics of attitudes they can be changed. The more person is exposed to a certain attitude the more likeable it becomes. A message is more likely to affect attitudes when it is convincing such as familiar, repeated or has emotional attraction. Human beings try to achieve cognitive consistency since irregularity is psychologically experienced uneasy. Due to the need to consistent between beliefs, attitudes, values and behaviours our attitudes are organized and changed constantly. However discomfort due to cognitive inconsistency either changes attitudes, behaviour or beliefs or justifies them to create comfortable situation. New attitudes can be learnt by paying attention to a new information or perspective, understanding it and third by accepting its content. (Hodges & Logan 2012, 65-70)

Nurses' attitudes impact on health

Nurses cover a huge percentage of health care professionals in the field, only in the United Kingdom there were over 400 000 nurses compared to a bit over 180 000 physicians in 2015 (Eurostat 2017a; Eurostat 2017b). Due to the great number of nurses working in the field of health care their attitudes have a huge impact on the care of the patients. Providing current evidence-based knowledge to nursing students about health issues concerning sexual and gender minority people their expertise can be further advanced to provide cultural competent and individualizes care to minority patients in the future (Butler, McCreedy, Schwer, Burgess, Call, Przedworski, Rosser, Larson, Allen, Fu & Kane 2016, 33).

Cultures clash when two people with different attitudes, values or beliefs face. Health care is a favourable environment for such cultural collision, since patients vary greatly and nurses often encounter multicultural interactions. However nurses are expected to provide cultural competent care to all patients, a care that takes others' culture, beliefs, values and attitudes into consideration in a sensitive way that enables effective care. (Fletcher 2015, 38-59.) Nurses are expected to replace their personal attitudes with professional attitudes when providing care to avoid cultural clashes (Bob 2015, 3). To become cultural competent nursing provider one has to be aware of own attitudes and their origin. However this could be difficult since we can be unaware of our reactions towards specific situations before we encounter them. (Ibid.; Fletcher 2015, 4.) The less self-aware of our own perceptions we are, the more attitudes will effect to our behaviour (Bohner & Wänke 2014, 231).

As strong attitudes and beliefs are more likely to guide our behaviour, stigma according to Mill, Harrowing, Rae, Richter, Minnie, Mbalinda and Hepburn-Brown (2013, 1069-1070), Frazer, Glacken, Coughlan, Staines and Daly (2011, 601) and Parkers (1993, 16) can adversely affect nursing care. According to Parkes (1993, 16) homophobic, stigmatized and discriminated attitudes of health care professionals were

known to adversely affect to care already in the 90s. More recent studies also indicates that nurses holding prejudiced and stigmatized attitudes towards HIV provided different care to HIV positive individuals including excess safety procedures than patients without a diagnose. Also patients whom were assumed to be HIV carriers based on appearance were treated differently. In addition due to stigma HIV positive patients received lack of care, as only minimum amount of care was provided. (Mill et al. 2013, 1069-1070.) The effect of stigma to nursing care was also indicated by Frazer and others (2011, 601) indicating that majority of nurses would use unnecessary extra precautions if a patient was diagnosed with hepatitis C.

Discrimination against sexual and gender minorities doesn't limit to nurse-patient relationships, according to study provided by Stonewall 26% of nurses identifying to sexual or gender minority reported facing inappropriate behaviour from their colleagues due to their sexual orientation or gender identity. It's been shown that homophobic actions toward nursing staff affect negatively also to all patients, and not only sexual and gender minority individuals. (Erin 2016, 19-20.) Learning and development training for nurses have been known to increase work satisfaction, positive job attitudes and organizational commitment. Education has also been proved to improve self-confidence, which was stated previously as a developmental area by nurses feeling unsure with sexual and gender minority individuals. (Johnson, Hong, Groth & Parker 2010, 609–618.)

Stereotyping and prejudiced attitudes occur in each of us in some level. The bias produced by the stereotyping and prejudice can take place in every relationship between a nurse and a patient. Therefore the biases might transfer negatively to the care provided to the patients. However human beings are able to critically think and assess feelings aroused from categorization and prejudice. This recognition of biases and identification of influences enables limitation or elimination of attitudes negatively affecting the nurse-patient relationship and enables culturally appropriated health care provided to all. (Fletcher 2015, 100-121.)

Experiences of sexual and gender minorities regarding health care

Despite the improving positive attitudes toward sexual and gender minorities there's a fear of discrimination, stigmatization and being judged by health care professionals due to prevalent heteronormativity, and history of negative attitudes (Albuquerque, Garcia, Quirino, Alves, Belém, Figueiredo, Paiva, do Nascimento, Maciel, Valenti, de Abreu & Adami 2016, 6-7). In fact homosexuality have been criminalized and included to Diagnostic and Statistical Manual of the American Psychiatric Association (APA) until December of 1973 (Conger 1975). Even though homosexuality no longer exists on the WHO ICD-10 list it is illegal still in 72 countries, leading even to death penalties in 8 of them (Ilga 2017). This can at least partly explain the existing fear of discrimination in health care among sexual and gender minorities.

Due to heteronormativity, where people are assumed to be interested only of the opposite sex and normal relationship occurs only between male and female, and homophobia, which is fear, non-acceptance or irrational intolerance towards homosexuality, sexual and gender minorities are afraid of seeking health care services. (Valtanen 2009; Dean et al. 2000, 107.) According to Valdiserri and others (2018, 5), Stahlman and others (2016) identify that almost 30% of American MSM whom answered an internet survey were afraid of seeking health care services. In addition MSM who lived in rural areas were reporting higher levels of fears and were describing more often not seeking health care due to fear of discrimination. Jämsä (2008, 91) and Kuosmanen and Jämsä (2007, 34-35) reported similar findings among transsexuals in Finland.

Sexual and gender minority individuals seeking health care services can decide not to disclose their sexual orientation to their health care professionals due to internalized homophobia or fear of being stigmatized. Even though Connolly and Lynch (2016, 186) estimates that most of the gay men won't disclose their sexual orientation to health care professionals, Durso and Meyer (2013, 7-8) suggest that bisexual male and female are more likely not to disclose their sexual orientation compared to their homosexual peers. Various factors, including health history, sex, race and ethnicity,

educational level, immigration and parenthood status, were affecting the disclosure patterns. For example lesbians from various minority groups were less likely to disclose their sexual orientation. (Ibid.) Connolly and Lynch (2016, 190), found out that MSM disclosing patterns were affected by the age and gender of the health care providers, leading to more often revealing sexual orientation to younger female nurses than other health care providers. Gender non-conforming MSM in South Africa reported facing homophobia quite often at the health services. Although some of them announced confronting their health care provider for equal care when facing discrimination, some however refrained from the care. (Lane, Mogale, Struthers, McIntyre & Kegeles 2008, 432-433.) For student nurses learning how to create a welcoming and safe environment for the patient is important to enable sexual and gender minorities to reveal their sexual orientation and gender identity. It is needed for providing sensitive, competent and individualized care. (National LGBT Health Education Center 2016, 8-9.) According to Venetis, Meyerson, Friley, Gillespie, Ohmit and Shields (2017, 579) Röhndal (2011) suggested that concealing such an important information can adversely affect to patient health. This claim was supported by Cohen, Taylor, Weiss and Newman (2016, 98-99).

According to Finnish study on rainbow families over half of the responded transgender parents reported fear of discrimination in health care services and unsatisfying prenatal classes as a consequence of conservative and prejudiced view of gender. (Kuosmanen & Jämsä 2007, 34-35.) Other rainbow family parents were more satisfied with their maternity clinic visits, however 18% felt they didn't receive support as a parents and family (ibid. 56). A lack for competent care from health care professionals usually aroused from confusion or over carefulness toward sexual and gender minorities' family structures. Instead of making assumptions these family minorities were hoping more open conversations between them and their health care provider to create more holistic and effective nurse-patient relationship. (Jämsä 2008, 86-90.) Also according to Dahl, Fylkesnes, Sørlie and Malterud (2013, 676-678) in Norway co-mothers of the rainbow families experienced prenatal visits unpleasant. Nursing staff was reported to have lack of sensitivity and respect which created discomforted environment. Sharek, McCann, Sheerin, Glacken and Higgins (2014,

235-236) findings among sexual and gender minority elderly supported the discovery of insensitiveness. The study also indicated the presence of heteronormativity in health care and lack of knowledge towards sexual and gender minorities among nurses, which was experienced as uneasy. According to Rowan and Beyer (2017, 577) a study conducted in the USA suggested also a need for culturally sensitive health care among sexual minority elders. A video interview in Finland (Seta 2014) had similar findings, elderly sexual and gender minorities hoped for awareness and open-minded health care services. In addition by Czaja and others (2015, 1115) high rates to fear of discrimination in health care settings occurred and sexual and gender minority elders desired dignity and respectful care.

Many sexual and gender minority individuals hope for more sensitive and inclusive health care from nurses. Creating an inclusive environment for marginalized groups improves patient comfort and therefore enhances communication between a nurse and a patient. According to Dahl and others (2013, 676-678) sexual and gender minorities reported positive health care visits with nurses who created a welcoming atmosphere. Small gestures of support, such as eye-contact, relaxed appearance and trying their best, were viewed as positive factors in the nurse-patient relationship.

2.3 Regulation of equal care

The United Nations' (1948) Universal Declaration of Human Rights declares all human beings equal and free in the matter of dignity and rights without discrimination of any kind. In addition it declares everyone having a right to adequate medical care. World Health Organization (WHO) states that everybody has a right to highest possible standard of health without discrimination to sexual orientation or gender identity. WHO is concerned about the basic health rights of transgender and intersex people being assaulted, and the access to health care services by marginalized groups without discrimination. (WHO 2017.) The group of diagnostics F66 "Psychological and behavioural disorders associated with sexual development and orientation" from the next International Statistical Classification of Diseases and Related

Health Problems (ICD-11) will be removed, which is currently being developed by WHO. Cochran, Drescher, Kismödi, Giami, García-Moreno, Atalla, Marais, Vieirah and Reed (2014, 676) rationalizes the extraction with unfounded characteristics of diagnoses based on only sexual orientation while the classification of other disorders can be made with remaining categories.

Different countries have established various laws protecting diversity and equality of people. However in which scales sexual and gender minorities are included does alter. In Finland for example constitution declares all equal and guarantees adequate health care to all individuals (L 11.6.1999/731, 6 § & 19 §). It is accompanied by Act on the Status and Rights of Patients which specifies the right to quality care to all without discrimination (L 17.8.1992/785, 3 §). Act of equality supports the other laws by stating discrimination against anyone illegal, including factors related to sexual orientation or other reasons (L 30.12.2014/1325, 8 §). In the United Kingdom equality act protects people from discrimination. It particularly specifies the illegality of discrimination based on sexual orientation or gender identity. (Government Equalities Office 2015.) However for example in the United States the civil rights act which protects people from discrimination does not include discrimination based on sexual orientation or gender identity (HRC 2018).

As there's a lot of regulation of patients' rights and overall laws against discrimination, many countries and organizations have created guides to help nurses enhance their professionalism. These guides represents the standards of ethics which nurses are expected to carry and implement in their nursing care. Their aim is also to help nurses making ethical decisions regarding their work. For student nurses the guides provides a collection of positive attitudes and ethics that professional nurses need to carry. (Nursing and Midwifery Board of Ireland 2014, 8-9; ICN 2012, 1-5.) Nurses main goal is seen to promote, maintain and improve the health of others. Nursing care is ethically considered high-quality and inclusive to all patients. Also maintaining competence and improving skills and knowledge is part of the nursing profession, stated by the guides as well as laws. (ANA 2015; Sairaanhoitajaliitto 2014; L

28.6.1994/559, 18 §.) Ethical guides for nurses emphasize the importance of nurses to respect their patients. Values, beliefs and customs of the patient or client need to be taken into consideration when providing care. Also nursing interventions needs to be carried out with cultural appropriate manner and valuing diversity. (Nursing and Midwifery Board of Australia 2018, 3; Nursing and Midwifery Council 2015, 4-5; Sairaanhoitajaliitto 2014; ICN 2012, 2.) The Nursing and Midwifery Council (2015, 4) in UK specifically remind nurses not to make any assumptions of their patients. Many ethical guide for nurses also highlights that discrimination is not allowed in nurse-patient relationships and it does include sexual and gender minorities as well (Nursing and Midwifery Board of Australia 2018, 4; ANA 2015; Nursing and Midwifery Board of Ireland 2014, 10-14; Nursing Council of New Zealand 2012, 9).

3 Aim, purpose and research question

The aim of this study is to explore the existing attitudes of nursing students toward sexual and gender minorities in the field of health care. Purpose of this study is to provide a picture of the nursing students' attitudes regarding the sexual and gender minorities to raise awareness of different perspectives. This information could be used to assess current nursing curriculum on behalf of permissive education to support nursing care of sexual and gender minorities.

Research question:

What kind of existing attitudes nursing students have toward sexual and gender minorities?

4 Research methodology

4.1 Literature review

A literature review is a logically introduced written document which bases on broad understanding of knowledge in a particular subject of study (Machi & McEvoy 2012, 4). In other words it reviews an existing literature of a subject to find currently best evidence to be summarized (Hewitt-Taylor 2017, 1-2). Summaries providing evidence-based knowledge are broadly used in the field of nursing since offering collected information regarding to health care advances healthier, safer and more effective practices used in nursing interventions (Le May & Holmes 2012, 12). Furthermore according to Nursing and Midwifery Council (2015, 7-17) of UK nurses are obligated to maintain knowledge and skills up to date with currently best evidence-based research.

Literature review seeks to answer a particular research question and its strengths include transparency and replicability (Onwuegbuzie & Frels 2016, 23-25). Literature review consists of predefined research question, throughout consistent literature review and critical assess of available information which provides high-quality evidence-based knowledge (Boland, Cherry & Dickson 2014, 3). Therefore in the field of health sciences the systematic literature review is most commonly used. (Onwuegbuzie & Frels 2016, 25.) Following the protocol of a literature review allows individuals seeking to evaluate and collect current knowledge of a subject to result in a rigorous review of literature on a specific topic (Hewitt-Taylor 2017, 2-3).

The literature review consist of six steps from topic selection to writing of the review. After chosen the research topic was searching the literature which included possible material selection, searching included material and processing the topic statement based on the material. Third step was to develop an argument with claims, evidence

and warrants to build the case for the literature review. Then the literature was surveyed by gathering, organizing and analysing of the data. After that literature critique took place where the current understanding of the research topic was analysed and assessed. Finally the last part of the literature review process, writing of the review itself. Consisting of two parts where the researcher first attempts to understand by reviewing the memorandum and then to be understood by writing the final draft. (Machi & McEvoy 2012, 4-162.)

4.2 Literature search

After searching the current literature, presenting background information and building the case by defining aim and purpose of this study and research question the literature was reviewed. For this purpose inclusion criteria (Table 2) was developed to conduct consistent and rigour literature search without bias in addition to search eligible, current and high-quality research articles. Any article which didn't fulfil the inclusion criteria was automatically excluded.

Inclusion criteria
• Full text available
• Published between 2008–2018
• Peer reviewed
• Written language English
• Answer research question

Table 2. Inclusion criteria

Keywords were needed to be developed to create search term to conduct the literature search in electronic databases. Keywords including LGBT, sexual and gender minority, nursing students and attitudes among others were used to create a Boolean search term accompanied by truncations.

Data search term:

("baccalaureate nurs*" OR "student* nurs*") AND (lgbt* OR glbt* OR "sexual minority" OR "gender minority") AND (attitude* OR prejudice OR homo*)

This allowed to search combinations of words on focused and precise manner and increasing results due to possible variations of the endings. (Hewitt-Taylor 2017, 77-85.) Data search term process can be seen in Appendix 1.

The data for the literature review was collected in mid-February 2018 using the electronic databases of JYKDOK and Cinahl Plus Full text (Ebsco). With the Boolean search term and inclusion criteria a total amount of 87 articles were found. Based on Boland, Cherry and Dickson (2014, 50-51) two staged article inclusion was made. First potentially articles were screened based on a title and abstract which followed a selection of the articles to be included to the final literature review based on the scanning of the full-text papers. After duplicates were removed a total amount of 4 articles were chosen to be reviewed. The amount of articles after each step can be seen in Table 3 and a list of selected articles in Appendix 2.

Database	Total amount of articles found	Chosen articles based on title and abstract	Articles chosen to be reviewed
JYKDOK	84	4	2
Cinahl Plus Full text (Ebsco)	3	3	2
In total	**87**	**7**	**4**

Table 3. Literature search and articles chosen after each step

4.3 Data analysis

After identifying relevant research papers answering the research question, the first step of data analysis process was to appraise the papers. This provided information of the validity and credibility of the papers and therefore the relevancy toward the research question. These information was used to determine the value of the findings to the literature review. (Aveyard 2014, 99-102.) To extract applicable data for the review the papers need to be read and re-read to become familiar with the context. By highlighting all the important aspects of the papers, main findings among weaknesses, study design, sample size and year and place were filled to data extraction table, which can also be seen in Appendix 2. (Ibid., 102-103; Bettany-Saltikov 2012, 96-98.)

To provide findings for the research question thematic synthesis was used to summarize and synthetize the reviewed papers. The highlighted main findings of each paper were grouped under specific themes using open coding. Open coding is a process where the main findings of the study are described with terms that create the theme. Similar themes were then compounded together to create sub-categories and furthermore combined into main-categories that included all the main findings. Main-categories gave direct answer to the research questions which is crucial for the review. (Heyvaert, Hannes & Onghena 2017, 188-189; Aveyard 2014, 138-149.) Although the literature review summarizes the analysed papers, the meaning of the process is to offer broader perceptions and new angles to the concept that can't be achieved only by reading the individual papers alone. (Aveyard 2014, 138-139; Oliver 2012, 75.) Re-checking of the reviewed articles were needed to assure themes and sub-categories included all the main findings to ensure the accuracy of the development process. Clearly stated data analysis process increases transparency and rigor of the review. (Hewitt-Taylor 2017, 145-146; Aveyard 2014, 146-150) Data analysis process is illustrated in figure 1.

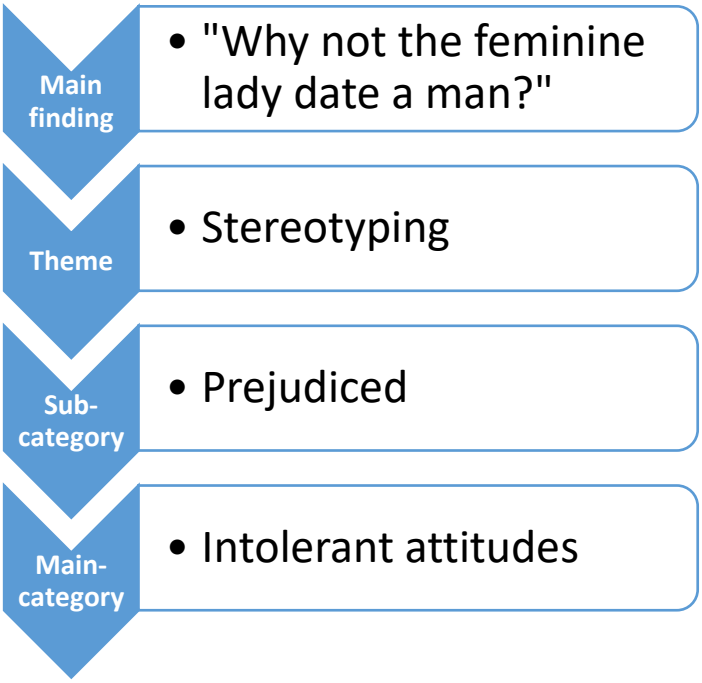

Figure 1. Example of data analysis process

5 Results

The main findings of this literature review developed by data analysis process consisted of three main perceptions which could be divided into three main-categories: permissive, intolerant and cultural attitudes. The attitudes and themes revolving around them could be seen to be caused by personal facts dividing into permissive and intolerant attitudes and attitudes that are controlled and shaped by the society we're living. These main-categories consists of sub-categories which can be seen in Figure 2. The results of the three main-categories are explained in the text by unfolding the evidence based on sub-categories.

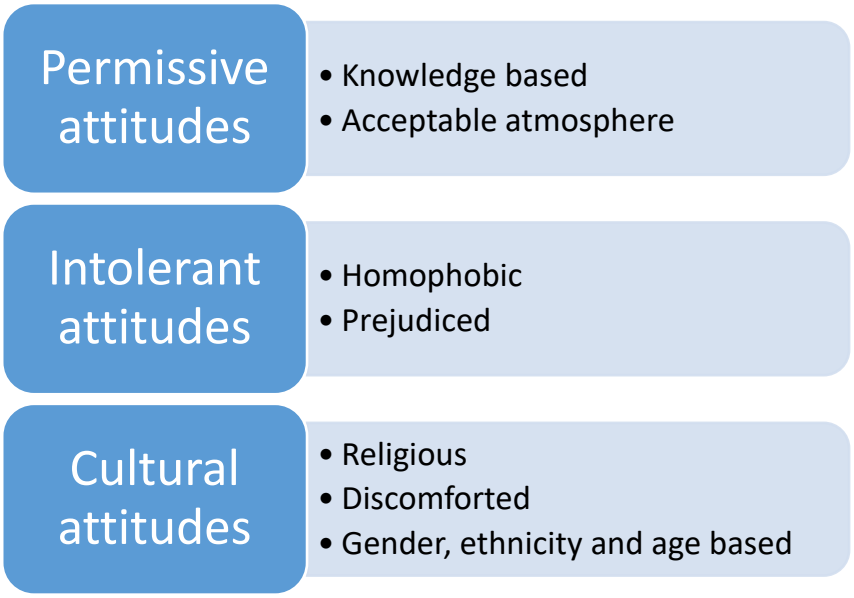

Figure 2. Data analysis results

5.1 Permissive attitudes

Knowledge based attitudes

Students that had a homosexual men or female as an acquaintance were more likely to have positive attitudes toward gay and lesbian individuals. Positive attitudes were shown in almost all of the items of the survey conducted in Greece. (Papadaki, Plotnikof, Gioumidou, Zisimou & Papadaki 2015, 750.) Also according to Lim and Hsu (2016, 149) Dinkel and others (2007) noticed a correlation between exposure to sexual or gender minorities and attitudes toward this marginalized group. The study was indicating a change to positive direction if participant had either personal or professional experiences of sexual and gender minorities. A study conducted by Rowniak (2015, 1235) also predicts the theme by revealing correlation between lack of familiarity and negative attitudes toward lesbians and gays. Participating to LGBT Pride Day health fair and interacting with the sexual and gender minorities also showed improved positive attitudes toward sexual and gender minorities among nursing students who hadn't had any experiences with them before (Tillman, Creel & Pryor 2016, 179).

According to Lim and Hsu (2016, 150) Strong and Folse (2015) demonstrate more positive attitudes among nursing students toward sexual and gender minorities after 45 minutes of education on the specific topic than beforehand. The claim is supported on the same paper by Cornelius and Carrick (2015) who suggest a noteworthy correlation between knowledge of the sexual and gender minority health disparities and comfort level of providing care for them. Cornelius and Carrick (2015) also suggest that RN to BSN nursing students who already have experience from nursing hold more positive attitudes toward sexual and gender minorities than standard undergraduate and graduate students. (Ibid.)

Acceptable atmosphere

Before the year 2000 attitudes regarding sexual and gender minorities tended to be negative or very negative according to Lim and Hsu (2016, 145). A study conducted in the Midwest of USA (Eliason 1998) disclosed evidence that nursing students had more negative attitudes toward sexual minorities than they had with racial minorities. However the same research estimated that half of the respondents indicated that sexual and gender minorities should have equality to rights and protection. According to the author the opinion of right to equality might nonetheless be biased due to social desirability. On the other hand in 1999 Steward reported from England predominantly positive attitudes and readiness to interact with sexual minorities by nursing students (Ibid., 149.)

In a study organized in Sweden (Röndahl 2004) showed that only few nursing students would refuse to care of sexual or gender minority patient if they had the choice. Nursing students in Australia displayed positive attitudes regarding homosexual men and women proposing cultural competent care by the authors Chapman and others (2012). (Lim & Hsu 2016, 149.) Comfort working with and acceptance towards sexual and gender minorities were also exhibited by Carabez and others (2015) in Western USA by indicating that majority of the student nurses were comfortable working with transgender patients by using their preferred pronoun (Ibid., 150). Although the development of positive attitudes of student nurses a research made in

Greece in 2015 indicated that nursing students had the most negative attitudes toward homosexual men and women compared to medical, social work and psychology departments (Papadaki et al. 2015, 747).

According to Dinkel and others (2007) in nine years attitudes toward sexual and gender minorities in Midwest of USA would have improved. A study results showed low rates of homophobia in area where used to have negative attitudes. However authors are suspecting the results to reflect neutrality and heterosexist attitudes, delicate form of discrimination. (Lim & Hsu 2016, 149.)

5.2 Intolerant attitudes

Homophobic attitudes

Overall homophobic attitudes were mostly influenced before the 20th century as a study organized by Eliason and Randall (1991) in Midwest USA indicates. The research assessed phobic attitudes of 120 female nursing students toward homosexual women. A quarter of the participants manifested they would refrain a social contact with lesbians. In addition half of the respondents had homophobic attitudes toward homosexual women initiating that the lifestyle of lesbians were unacceptable. (Lim & Hsu 2016, 149.) Despite homophobic attitudes were alleviated towards present day, religion remained its importance (Lim & Hsu 2016, 149; Papadaki et al. 2015, 743). Religious beliefs were associated with prejudice but also increased scores of negative attitudes and homophobia toward sexual and gender minorities. Homophobia were especially associated if religious beliefs were important for the participant. (Papadaki et al. 2015, 750.)

Prejudiced attitudes

When analysing the research papers themes such as stereotyping, assumptions, lack of knowledge and beliefs aroused. Prejudiced visions of sexual and gender minorities were reported in each of the analysed papers. A slightly decreased developmental

quantities of prejudiced mind set can be seen in the studies performed between 1999 and 2016. Steward (1999) indicates significant amounts of prejudice against sexual and gender minorities with AIDS and in correlation Eliason and Randall (1991) demonstrated the assumptions and prejudice of nursing students toward lesbians and AIDS. The study reveals prejudiced attitudes whereby lesbian would be in a great risk of getting AIDS. (Lim & Hsu 2016, 149.)

In addition a crucial amounts of nursing students attending to study in 2015 by Carabez and others appeared to have a lack of knowledge concerning sexual and gender minorities. A majority of the responded had an assumption which indicated that gender identity or sexual orientation wouldn't be an important factor for the marginalised group. (Lim & Hsu 2016, 150.) Faintly lower but still considerable amount of nursing students reported prejudiced beliefs toward sexual minorities in 2015 in California, USA. Sexual orientation was considered a personal choice rather than natural feature by most of the students whom participated to the survey. (Rowniak 2015, 1235.) However Tillman and others (2016, 178) reported only few stereotypical assumptions from nursing students when they tried to rationalize their experiences with sexual and gender minorities.

5.3 Cultural attitudes

Religious attitudes

As mentioned before strong religious beliefs were associated with homophobia, prejudice and negative attitudes toward sexual and gender minorities. In correlation agnostic or atheist perceptions of the nursing students predicted lower rates of homophobia than those with any religious beliefs. (Papadaki et al. 2015, 750; Rowniak 2015, 1236). However Rowniak (2015, 1236) remarks a finding that different religious groups represents different results with homophobia. His study suggest that non-Catholic Christians hold the most homophobic attitudes toward sexual and gender minorities followed by Catholic religion. Non-Christian Religion had the second lowest homophobia rates before the Agnostic/Atheist perceptions. Schlub and Martsolf

(1999) proposed a theory that religion itself wouldn't describe homophobic features but the motivation behind it (Lim & Hsu 2016, 149). Their study represented low rates of homophobia, even though low-graded, which they assumed was due to importance of spiritual motivation, since they noticed that intrinsic motivated believers of Orthodox Christian religion showed lower rates of homophobia than those whom where materialistically motivated.

With motivation to religious beliefs also active involvement was noticed to be influential factor among nursing students. Eliason (1998) and Schlub and Martsolf (1999) indicated higher levels of homophobia in correlation with church attendance and belief system of Christianity and overall conservative religions. (Lim & Hsu 2016, 149.) Compared to the other findings of religiosity establishing negative attitudes toward sexual and gender minorities, a study conducted in 2015 by Cornelius and Carrick provided dissimilar findings. Religion was not reported affecting to the attitudes of nursing student in this particular study. (Ibid., 150.)

Discomforted attitudes

Two of the four reviewed articles showed discomfort when providing nursing care to sexual and gender minorities (Lim & Hsu 2016, 145-150; Tillman et al. 2016, 178-179). However discomforted attitudes toward the minority groups was discovered to be influenced by few factors. When in 1980s discomforted attitudes aroused from dislike regarding homosexuals in the context of social distance and morality, in 20th century attitudes had gotten to more positive direction. Eliason and Raheim (2000) described uncomfortable feelings toward sexual and gender minorities. A major of the student nurses would feel uncomfortable providing care to this group and especially to individuals carrying HIV. It was also noted that lack of experience and knowledge correlates with discomforted attitudes toward sexual and gender minorities in the nursing care. In addition nursing students unawareness of sexual and gender minorities and their special health disparities increased fear of contagion when working with exposed individuals. (Lim & Hsu 2016, 145-149.)

After 2010s discomforted attitudes towards sexual and gender minorities did not arise from feeling uncomfortable but rather from insecure feelings (Lim & Hsu 2016, 149-150; Tillman et al. 2016, 178-179). Chapman and others (2012) noticed that a majority of nursing students didn't have confidence to support sexual and gender minorities to disclose possible parenting roles. Carabez and others (2015) indicated that a great deal of nursing students experienced to be unprepared working with sexual and gender minorities. (Lim & Hsu 2016, 149-150.) After nursing students had been in contact with sexual and gender minorities Tillman and others (2016, 178-179) discovered less insecure thoughts among student nurses toward providing care. Majority of the participants experienced personal confusion about the sexual and gender minorities when their expectations or beliefs didn't correspond to the reality. However for some students the discomforted feelings of confusion did not lead to positive curiosity but instead to shocking experience and internal anxiety.

Gender, ethnicity and age based attitudes

Male gender was associated with more negative attitudes toward sexual and gender minorities than with female nursing students. This was established in two studies by Eliason (1998) and Chapman and others (2012), especially negative attitudes were associated towards homosexual men. (Lim & Hsu 2016, 149.) Also Papadaki (2015, 745) supports the claim of gender based attitudes toward homosexuality. In contrast study conducted by Rowniak in 2015 (1235) proposed findings which indicated that male gender was not associated with increased negative attitudes toward homosexuality.

Ethnicity was founded to be affecting to attitudes in one study conducted in the USA (Rowniak 2015, 1236). The study indicates that nursing students with Asian or Pacific Islander ethnicity hold significantly lower positive attitudes toward sexual and gender minorities than did non-Hispanic Caucasians. In contrast with findings of Rowniak (2015) Chapman and others (2012) indicates that non-Caucasians hold more negative

attitudes than other ethnicities toward sexual and gender minorities (Lim & Hsu 2016, 148). However it is important to take into consideration the heterogeneity of the Asian/Pacific Islander population (Rowniak 2015, 1236). Rowniak (2015, 1235) also revealed a finding that increased age wouldn't affect negatively to the attitudes of nursing students towards the minority groups. Study condacted by Eliason (1998) correlates to the findings of Rowniak (2015) indicating that younger age was predicting negative attitudes toward sexual and gender minorities (Lim & Hsu 2016, 149).

6 Discussion

6.1 Ethical considerations

Strategy, approach or aspect used to analyse and act in compound challenges and issues are defined as ethics (Resnik 2015). Research ethics aims to maximise profit and minimise harm (Stewart 2011, 5). Ethics promotes the fundamental morals of research integrity appreciated in the field of research. For research to be ethically approved it needs to follow the ethical guidelines. Many organizations have created their own guides for conducting ethical research, but however the main principles remains the same to all the institutes. The main ethical principles are reliability, honesty, respect and accountability. When conducting a research accuracy must be obtained in every phase. The planning, conduction, data analysis, reporting findings and validity analyse of the research must be performed with meticulousness. Neglecting of the ethical guidelines will lead to lack of trustworthiness of the research. Research misconduct includes plagiarism, fabrication, and falsification. (ALLEA 2017, 3-9; World Medical Association 2015, 111; Roberts & Perez 2012, 15; Finnish Advisory Board on Research Integrity 2012, 28-31.)

This review was conducted following the ethical principles of JAMK (2013, 7) and Finnish Advisory Board on Research Integrity (2012, 30-31). Accuracy and meticulousness were preserved throughout the review to ensure validity and reliability. To avoid biases data search and analysis were carefully recorded and reported to perform transparent research process. The results were introduced as honest, open and accurate way as possible. In addition sources of other authors were appropriately cited and credited to avoid plagiarism. (Ibid.; University of Helsinki 2018; ALLEA 2017, 7.) However any possible misconduct of this literature review was not performed consciously.

Two out of the three primary studies included into this review reported an approval granted by the institutions' institutional review board. In addition the third primary research indicated not needing a permission from the institutional review board due to methodological reasons. Participation to all of these primary studies were described to be completely voluntary. The only literature review of this research informed that studies included to data analyses process were carefully assessed with critical appraisal skills program to evaluate the quality of the content. All the studies in the review met the requirements of adequate quality but ethical approvals were not mentioned. A total of 26 tools were used in the studies of this research to evaluate the attitudes on nursing students toward sexual and gender minorities. Majority of the tools indicated scores estimating validity and reliability, although three tools did not provide content validity index. Funding of the studies included into this review were not mentioned, however one research informed offering gift certificates to encourage participation.

6.2 Limitations

All the 15 studies, excluding one, analysed for this review used a convenience sampling. This restricts the generalization of the results as mentioned by Tillman and others (2016, 179). The generalization of the results are also limited by the geographical location of the conducted studies. Most of the studies were performed in the United

States and only few elsewhere, more precise in Sweden, Greece, England and Australia. Most of the studies conducted in the USA located in the Midwest which is generally considered religious and conservative area. Also studies conducted by Papadaki and others (2015) and Rowniak (2015) were performed in conservative and religiously affiliated environment. This must be taken into consideration as discussed by Lim and Hsu (2016, 150) as quite many negative attitudes amidst nursing students aroused from these locations. The researchers of the reviewed articles also proposed the bias of social desirable results, which could have impacted the results and therefore provided more positive outcomes than the student nurses actually hold.

This review could lack of valuable and relevant studies, since research available only in English and free full text to students could be acquired. Boland and others (2014, 50) remark that screening and selecting the articles as well as analysing the final studies included to the review was limited to one perspective as there is no other author participating to the research process. In addition as an individual of sexual minority I have a non-financial conflict of interest in the results of this review. However according to Romain (2015, 123-126) disclosing conflict of interest and precisely following the regulation of rigorous research process, biases from conflict of interest can be reduced.

6.3 Discussion of the results

The results of this literature review shows overall negative atmosphere among nursing students towards sexual and gender minorities. From the 15 papers reviewed for this research only six indicated permissive attitudes. However it should be noted that studies performed after 20th century revealed permissive attitudes in half of the reviewed papers. This indicates a change to more tolerant atmosphere of the current nursing students in contrast for them predecessors. The permissive attitudes in the more recent studies imitate overall global attitudes of equality. In a recent survey of attitudes toward sexual and gender minorities performed in 77 countries revealed that over half of the respondents agreed that equal rights and protections should

cover everyone, not regarding their sexual orientation or gender identity. (Carroll & Robotham 2017, 6.)

The findings of this research suggest that knowledge of sexual and gender minorities, whether it's due to education or personal experiences, enhances positive attitudes (Lim & Hsu 2016, 149-150; Tillman et al. 2016, 179; Papadaki et al. 2015, 750). This is supported by Sekoni, Gale, Manga-Atangana, Bhadhuri and Jolly (2017, 6) and Porter and Krinsky (2013, 208-210) whom studies also indicated higher levels of knowledge and improved attitudes towards sexual and gender minorities after educational sessions. Also knowing a sexual or gender minority person have been shown to predict considerably more open mind set (Carroll & Robotham 2017, 6).

Despite of the progress towards positive and accepting attitudes regarding sexual and gender minorities among nursing students the results of this review indicated the impact of culture which toned the attitudes with negative shade. Culture shapes our values, attitudes and beliefs and therefore guide us through our everyday lives (Fletcher 2015, 3). The results of this review indicated discomforted attitudes among nursing students when providing care to sexual or gender minorities (Lim & Hsu 2016, 149-150; Tillman et al. 2016, 178-179). A part of this discomfort which according to Lim and Hsu (2016, 149-150) can be explained with the lack of knowledge can be improved with the education as mentioned earlier. However most of the discomforted attitudes are linked with the norms that our cultures have created and therefore facing situations that conflict with our own beliefs evokes difficulties (Fletcher 2015, 58-64). Heteronormativity has a status of a norm in many cultures. It is an institutional assumption that everyone are heterosexuals and heterosexuality is preferable and superior to other orientations. It is linked to gender normativity, the division of two genders supported by binary gender system in many countries. In addition females are assumed to be feminine in contrast to masculine males. (Moon 2010, 95; Valtanen 2009.) As Tillman and others (2016, 178-179) identified the nursing students felt confused when their cultural assumptions of sexual and gender minorities didn't match the reality. The discomforted attitudes from any deviations of the

norms can lead to discrimination. Even tolerant people can be affected by the cultural norms since heteronormativity have rooted deep into our societies.

Other aspect aroused in the results was religious attitudes. As well as culture, religion have same kind of effects to the attitudes of people as noted in many analysed papers. Many religion view sexual and gender minorities, especially homosexuality, as abnormal and sinful. This is caused by pursuing toward spirituality where body is most often denied. As sexuality is seen physical it's perceived as reprehensible unless it occurs in marriage as a purpose of reproduction. Therefore homosexuality have been seen as extremely sinful in many religions. (Lehto & Kovero 2010, 272.) Many people have an urge to religiosity and this could be seen among the nursing students in the reviewed papers, although as many studies were conducted in very religious areas and universities the importance of religion to nursing students can't be generalized. However the findings suggest that religiosity affected negatively to the attitudes against sexual and gender minorities. This is supported by (Perry & Snawder 2016, 799-800). Worthen, Lingiardi and Caristo (2017, 252) reported similar findings as Lim and Hsu (2016, 149) about church attendance indicating more negative attitudes toward sexual and gender minorities. Unlike the results of this review the global study indicated that majority of respondents would accept gender identity diversity and respect their religion at the same time. (Carroll & Robotham 2017, 59-64.) Although the importance of religion was not measured as with the nursing students.

The results of this research provided divided outcomes on gender affecting attitudes among student nurses (Lim & Hsu 2016, 149; Papadaki 2015, 745; Rowniak 2015, 1235). However men are believed to hold more negative attitudes towards sexual and gender minorities than women (Chi & Hawk 2016, 5-7). Rowniak (2015, 1235-1236) suggest that men seeking into the health care sector might have more tolerant attitudes than men choosing other professions. The studies reviewed didn't specify differences between the year group of the male nurses in the schools and their atti-

tudes. This might explain the various findings on male gender affecting attitudes toward sexual and gender minorities since a study by Lambert, Ventura, Hall and Cluse-Tolar (2008, 20) higher level students were shown to have more positive attitudes than did lower level students. Higher level students were considered to have more positive attitudes since they've studied longer which have predisposed them longer to social interactions at the university and education which could have included permissive content towards diversity.

Intolerant attitudes, the third main-category rising from the results of this review represent the most negative attitudes among nursing students towards sexual and gender minorities. As seen in the results even overall atmosphere have turned into more permissive directions strong prejudiced, stereotyped and homophobic attitudes still occurs among nursing students. (Lim & Hsu 2016, 149-150; Papadaki et al. 2015, 743-750.) Homophobic, prejudiced and stereotyped attitudes seen amidst nursing students mostly arise from unawareness. Although nursing students lack of knowledge about sexual and gender minority health disparities and tend to have negative attitudes rather less diversity education is offered.

Study conducted in the United States revealed the lack of education as most nursing curriculums didn't include any specific education about sexual or gender minority specific health concerns. Schools offering diversity education however responded to offering less than three hours of education within the whole degree. (Aaberg 2016, 16-18.) Study conducted in San Francisco revealed that 80% of responded nurses haven't had any training on sexual and gender minority specific health concerns. 20% were keen to have extra education about the topic, mostly as they felt insecure providing care without specific knowledge. (Carabez, Pellegrini, Mankovitz, Eliason, Ciano & Scott 2015, 325-328.) Therefore providing sexual and gender minority specific education to nursing students would improve their attitudes toward this marginalized group and enhance student nurses comfort to provide sensitive and cultural competent care. In addition to changes to nursing curriculums the atmosphere of societies should be changed to provide more acceptable environment for sexual and

gender minorities, as mentioned before enhanced tolerant environment decreases health disparities of sexual and gender minorities (Hatzenbuehler et al. 2012, 287-288). In the future a categorization free world should be considered, whether we really need compartments for sexual orientation and gender identities.

Conclusion

The results of this review indicated permissive and cultural attitudes among nursing students but also intolerant attitudes which need to be enhanced. However to understand the situation more globally more research is needed in this subject. In addition to fully uncover the current situation among student nurses attitudes more studies are needed as the atmosphere toward sexual and gender minorities is constantly changing. This research emphasized also the need to assess nursing curriculums on behalf of sexual and gender specific health needs education to ensure sufficient permissive and competent health care for sexual and gender minorities that nurses would feel comfortable providing.

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Appendices

Appendix 1. Data search and search term process

	Articles found by databases:		
Search terms:	**Cinahl Plus Full text (Ebsco)**	**JYKDOK**	**Pubmed**
(nurse* OR "health care professionals") AND (experience OR perception OR attitude OR view OR knowledge) AND (lgbt* OR glbt* OR gay OR transgender OR queer OR transsexual OR lesbian OR "sexual minority")	54	17065	35
("nurse* experience" OR "health care professional experience" OR "nurse* attitudes" OR "health care professional attitudes" OR "nurse* knowledge") AND (lgbt OR glbt OR "sexual minority" OR gay OR lesbian OR bisexual)	11	298	109
"nurse* attitude*" AND lgbt	0	38	
nurse AND lgbt AND (experience OR perception OR attitude OR viewOR knowledge)	3	955	
nursing attitudes AND lgbt	2		3
(nurse OR nursing) AND (lgbt OR sexual minority OR gender minority) AND (experience* OR attitude*)	12	34329	
(lgbt OR "sexual minority" OR "gender minority") AND (nurse experience* OR nurse attitude* OR nurse knowledge*)	2	103	0
(nurse* OR nursing) AND (experience* OR attitude*) AND (lgbt “gender minority” “sexual minority”)		1311	
"nurs* attitude*" AND lgbt		40	0
"nurs* attitude*" AND (lgbt OR homosex*)	5	133	0
"nurs* attitude*" AND (lgbt OR "gender minority")	0	42	0
"nurs* attitude*" AND (lgbt OR "sexual minority" OR "gender minority")	0	48	0
nurs* attitude* AND (lgbt OR "sexual minority" OR "gender minority")	2	2806	7
("nurs* attitude*" OR "nurs* experience*") AND (lgbt OR "sexual minority" OR "gender minority")	0	97	
("nurs* experience*" OR "nurs* attitude*" OR "nurs* knowledge") AND (lgbt OR glbt OR "sexual minority" OR "gender minority" OR sexuality)	39	938	0
("nurs* attitude*" OR "nurs* experience*") AND (lgbt OR glbt OR "sexual minority" OR "gender minority")	4	103	**PubMed** EXLCUDED due to poor results
("nurs* experience*" OR "nurs* attitude*" OR "nurs* knowledge") AND (lgbt OR glbt OR "sexual minority" OR "gender minority")	7	130	
("nurse* experience" OR "health care professional experience" OR "nurse* attitudes" OR "health care professional attitudes" OR "nurse* knowledge") AND (lgbt OR glbt OR "sexual minority" OR gay OR lesbian OR bisexual)	11	283	
("nurs* experience*" OR "nurs* attitude*" OR "nurs* knowledge") AND (lgbt OR glbt OR "sexual minority" OR "gender minority" OR sexuality)	39	938	
("nurs* experience*" OR "nurs* attitude*") AND (lgbt OR glbt OR "sexual minority" OR "gender minority" OR sexuality)	26	677	
("nurs* experience*" OR "nurs* attitude*" OR "nurs* knowledge") AND (lgbt OR glbt OR "sexual minority" OR "gender minority" OR homosex*)	12	302	
("nurs* experience*" OR "nurs* attitude*" OR "nurs* knowledge") AND (lgbt OR glbt OR "sexual minority" OR "gender minority" OR homosex*)	12	300	
("nurs* experience*" OR "nurs* attitude*" OR "nurs* knowledge") AND (lgbt OR glbt OR "sexual minority" OR "gender minority")	5	130	
("nurs* experience*" OR "nurs* attitude*") AND (lgbt OR glbt OR "sexual minority" OR "gender minority" OR homosex*)	7	240	
nurs* AND (experience OR attitude) AND (lgbt* OR glbt* OR "gender minority" OR "sexual minority")	30	4829	
Search terms: (focusing on students)			
nursing AND student AND attitudes AND lgbt	3	601	
nurs* student AND attitude* AND lgbt	3	944	
nursing student AND attitude* AND lgbt	3	644	
nursing student AND attitude AND lgbt	3	250	
nursing AND "student attitude*" AND lgbt	3	32	
nursing AND ("student attitude*" OR "student experience*") AND (lgbt OR "gender minority" OR "sexual minority")	3	104	
nursing AND ("student attitude*" OR "student experience*") AND lgbt	3	86	
("baccalaureate nurs*" OR "student* nurs*") AND (lgbt* OR glbt* OR "sexual minority" OR "gender minority") AND (attitude* OR prejudice OR homophobia)	3	81	
("baccalaureate nurs*" OR "student* nurs*") AND (lgbt* OR glbt* OR "sexual minority" OR "gender minority") AND (attitude* OR prejudice OR homo*)	3	84	Final data search term

Appendix 2. Chosen articles and data extraction

Author	Lim, F. A. & Hsu, R.	Tillman, K., Creel, E. & Pryor, S.	Papadaki, V., Plotnikof, K., Gioumidou, M., Zisimou, V. & Papadaki, E.	Rowniak, S. R.
Year and country	2016, USA (including studies from USA (9), England, Sweden and Australia)	2016, USA	2015, Greece	2015, USA
Title	Nursing Students' Attitudes Toward Lesbian, Gay, Bisexual, and Transgender Persons: An Integrative Review.	The Lived Experience of Second-Degree Baccalaureate Nursing Students Providing Care to Members of an LGBT Community.	A Comparison of Attitudes Toward Lesbians and Gay Men Among Students of Helping Professions in Crete, Greece: The Cases of Social Work, Psychology, Medicine, and Nursing	Factors Related to Homophobia Among Nursing Students
Design	An Integravite Review	Semistructured interviews	Questionnaire using the ATLG scale	Online survey
Sample size	12 papers (1981-2015); 9 qualitative, descriptive and correlational, 3 interventional (pre- and posttest)	7 second-degree baccalaureate nursing students	548 undergraduate students which 16,1% nursing students (n.88). From them 12,7% males (n.11)	90 (17 males, 73 females)
Main findings	Before 2000 conducted studies show more negative attitudes, Christianity correlates with homophobia, attitudes developed from dislike to insecurity, some positive attitudes toward S&G minorities all along	Experiences with S&G minorites created confusion, anxiety and schock. Assumptions, strereotyping and beliefs occurred, majority had tolerant and acceptive attitudes	Nursing department hold most ne.attitudes, male have more neg. attitudes than female, more positive attitudes if acquainted with lesbian or gay, students whom religious was really important hold more neg. attitudes & prejudice	Religiosity and lack of familiarity increase neg. attitudes, increased age or being male is not associated with neg. attitudes, Asian/Pacific Islander have more negative attitudes than non-Hispanic Caucasian
Limitations	According to authors: lack of probability sampling, all expect on study (Anderson 1981) used convenience sampling, predominance of Christianity narrows generalizability of other religions. Others: many studies were conducted in conservative and religious areas	According to author: results not generalizable but transferrable due to convenience sample. Others: small sample size	According to authors: possibility that questionnaire was answered also non-heterosexuals which was not a purpose, never can be certain if giving prejudiced answers were avoided, most prejudiced refused to answer. Others: Greece has overall very negative atittudes toward S&G minorities	According to author: Small sample size, convenience sample, religiously affiliated university