L.G.B.T. and Mental-Health Nursing Care

A Qualitative Research Project

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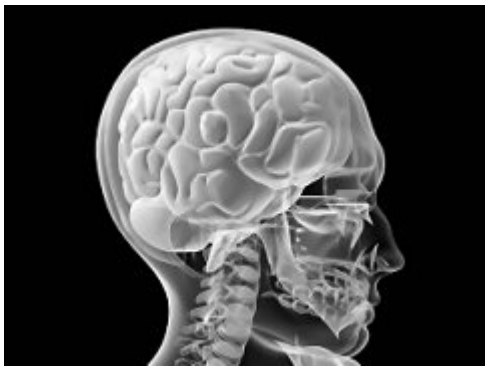
Trans and other sexuality and/or gender diverse-identified (L.G.B.T.) people [1] experience higher than average rates of some mental-health issues. It is not surprising that ongoing and widespread socio-cultural stigmatisation and marginalisation can have enduring personal consequences.

These include anxiety and depression - up to and including suicide. What may be surprising is that it is not uncommon for L.G.B.T. people who access mental-health services to report the experience of active discrimination and consequently unsatisfactory care. Readers may remember the ads in recent issues of *Polare* that invited mental-health nurses to participate in my research into what sort of mental-health nursing care we provide to L.G.B.T. people and how we might contribute to improving the care experience. This article provides a brief and preliminary look at the progress of the research project.



Some also expressed discomfort in caring for trans people - not because they felt negatively towards them but rather because they knew themselves to be unfamiliar with, and ignorant about, any trans-specific needs.

Bad environments contribute to bad health. Marginalised social status, poor social support structures and abuse ranging from verbal attacks up to a lifetime experience of oppression and the possibility of being murdered are the kinds of psychosocial health determinants with which L.G.B.T. people are familiar - at the very least as sub-cultural anecdotes and, for many, from personal experience (e.g. Dysart-Gale, 2010).

Many of the heterosexual nurses in the project struggled with the idea that it is not unusual for L.G.B.T. people to report feeling unsafe and unsupported and therefore reluctant to disclose their sexual and/or gender diverse status.

The most commonly reported associated mental-health problems for L.G.B.T. people include substance misuse, depression, and stress and anxiety disorders (e.g. Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002). It is important to remember that identification as being sexuality and/or gender diverse is not the problem.

Some L.G.B.T. people attribute their mental-health issues to psychosocial problems associated with their sexuality and/or gender. Examples include the gay person who internalises social stigmatisation as self-hatred, or the trans person who becomes seriously depressed having been rejected and ostracised by family and friends. It should also be noted that unrelated mental-health problems such as schizophrenia can also affect L.G.B.T. people.

Such people can be doubly stigmatised. Not only do they represent a marginalised socio-cultural sex/gender minority, they can also be rejected by, and isolated from, other L.G.B.T. people who, like elements of the rest of the population, stigmatise them for being mentally unwell.

Negative experiences of mental-health care reported both anecdotally and in the health research literature by L.G.B.T. people include various expressions of homonegativity on the part of health professionals (Fish, 2006). Obviously this is counter-productive to delivering better health outcomes in a system that describes itself as providing holistic, individualised care.

Predictably, the consequences of continuing to experience stigmatising and discriminatory behaviour in health care environments include L.G.B.T. people feeling unsafe, invalidated and unsupported (Plater, 2006). But then, how could a care environment be therapeutic for individuals who fear to disclose important aspects of their lives? Even if sexuality and/or gender diversity is of no immediate relevance, recognition, understanding and accommodation of sub-cultural aspects of a person's life will need to be incorporated into mental-health recovery plans to improve their quality of life.

Typically the behaviour of individual health professionals is singled out for criticism by L.G.B.T. people, perhaps because subjectively people interact with other people, not systems. Little is written about the lack of organisational or institutional support for staff that could, perhaps, counteract the attitudes and behaviours they bring into the health care milieu from the wider, discriminatory socio-

cultural environment. Similarly, there is very little support for L.G.B.T. people at the level of health policy that could require and inform competent health care practices [2].

There is a lack of guidance and a limited supply of educational materials available for the members of multi-disciplinary health care teams to help them to become better informed on how to support competently L.G.B.T. people. For example, in my own profession, neither the Royal College of Nursing Australia nor the Australian College of Mental-Health Nurses (A.C.M.H.N.) provides specific guidance on how best to support L.G.B.T. people who access health services.

My aim with the current qualitative research project is to explore the role and views of the mental-health nurses who provide care to L.G.B.T. people. Mental-health nurses work in the full range of mental-health services available in Australia, yet they have not previously been asked to contribute to research on this topic. In this project, participants have been asked to reflect on their practical experience in working with L.G.B.T. clients and to suggest what institutional and organisational improvements they believe might improve the experience of care for L.G.B.T. people.

To date, there are nineteen mental-health nurses participating in this research. Their expertise ranges from having spent years and even decades in mental-health nursing in a variety of health care environments, ranging from community case management to crisis intervention as well as acute and chronic inpatient care. They include several nurses who responded to the ads in *Polare*.

Project participants are a diverse bunch of dedicated and determined clinicians who personify the A.C.M.H.N. values of honesty, caring, trustworthiness and the pursuit of excellence. They are of many ages, genders and sexualities and other socio-cultural differences. They are city- and rurally-based, Indigenous and non-Indigenous, non-English-speaking and English-speaking migrants and people born in Australia.

They identify as lesbian, gay, bisexual, transgender, heterosexual and other. Their participation has required an intensive involvement and a major commitment of time and energy, including lengthy semi-structured interviews, taped group discussions, and the review of interviews and group discussion transcripts.

As health care professionals, the mental-health nurses in this project see themselves as responsible for the development of therapeutic alliances with individuals. They describe tailoring their care to suit individuals' needs and working with the over-arching objective of helping people to improve their quality of life. It is still early in the research process, yet some interesting themes are emerging. As might be expected there were some differences between the thoughts expressed by the L.G.B.T. participants and by the heterosexual participants.

Many of the heterosexual nurses in the project struggled with the idea that it is not unusual for L.G.B.T. people to report feeling unsafe and unsupported and therefore reluctant to disclose their sexual and/or gender diverse status. It was well recognised by these research participants that such reluctance would compromise their ability to develop a therapeutic alliance with clients.

Many were able to recall instances where the behaviour of a colleague had made them pause for thought. Yet, seeing themselves as caring, competent professionals, they could not see their own practice as potentially problematic. Sometimes we know that we are dealing with something about which we know little; other times we do not know that we do not know (Erlanger, Johnson, Banner, Dunning, & Kruger, 2008).

In the private interview stage of the research, the participating nurses expressed their intention to reflect on their practice, and on the processes and structures in their workplaces that might need to be changed to promote a more inclusive therapeutic approach that was conscious of L.G.B.T. people's issues with health care.

Several nurses spoke with frustration about having limited access to relevant information and suitable sources of referral for their clients.

Some also expressed discomfort in caring for trans people - not because they felt negatively towards them but rather because they knew themselves to be unfamiliar with, and ignorant about, any trans-specific needs. These nurses also tended to comment that while they knew and worked with and cared for L.G.B. people, they very rarely had the opportunity to interact with the much smaller population subset of trans people and that this contributed to their unfamiliarity with trans needs.

These ideas translated in the group discussion stage of the research into a recognition that what is missing is readily available information that could be used to support culture-specific needs of L.G.B.T. people, and also education materials that would enable a more nuanced approach to caring for L.G.B.T. people.

The L.G.B.T. nurses who participated in the project described their own efforts to educate their colleagues and create culturally welcoming and inclusive environments. Some spoke of their own struggles in working with homonegativity - up to and including their own fears of disclosure and the experience of being bullied.

Their strategies range from advising peers when their comments or practices appear discriminatory to ensuring their workplaces are stocked with relevant brochures and pamphlets from L.G.B.T. peak bodies.

In the private interviews several commented that they worried that giving the impression that a mental-health care environment was inclusive - for example, by having information materials on display - could give misleading impressions to L.G.B.T. people that they would be dealing with culturally competent service providers when this was not necessarily so. This idea was integrated in the group discussions with the consensus view that education for health care professionals in how to provide culturally competent care to L.G.B.T. people should be mandatory.

Participants formed the view that education should be included in course curricula at the university and college level and supported in

workplace training programs.

They concluded that these programs should be mandatory for all the members of the multi-disciplinary health care team because of the importance of the topic, the high turnover of health staff, and the increasing inclusion of culturally diverse migrants in the health workplace.

Participants also commented that leadership was required at the level of national and state governments' health policies and from nursing representative bodies such as the Australian College of Mental-Health Nurses to ensure provision of the resources necessary to support such training and education.

The research project is ongoing. I am up to the stage of collating and analysing the results of interviews and group discussions. At this stage it appears that a belief in the need for education and the development of political support to develop practice guidance and an appropriate allocation of organisational resources to support mandatory workforce education are the predominant views of the research participants. The idea that this education should focus on teaching people how to respond helpfully to cultural difference rather than simply arming them with facts and figures about particular cultural sub-groups demonstrates the nurses' commitment to providing therapeutic individualised care to L.G.B.T. people who need to access mental-health services.

Endnotes

[1] I acknowledge that the terminology used to identify and describe people of diverse sexual identification, sexual orientation and gender is likewise diverse - and disputatious. I also recognise that the acronym L.G.B.T. implies a commonality of issues and a coalition of purpose that may not exist among the various groups and individuals who have an interest in the field. I am using the acronym L.G.B.T. because it is inclusive and historically familiar. Finally, the "I" often used to signify an at least nominal inclusion of issues relevant to intersex people is perhaps noticeable by its absence. This is because a consideration of the issues faced by intersex people who access mental-health services is not included in this research project.

[2] This situation is the current focus of national policy discussions and readers are referred to the work of the National L.G.B.T.I. Health Alliance for further information.

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