Social Justice and Social Determinants of Health: Lesbian, Gay, Bisexual, Transgendered, Intersexed, and Queer Youth in Canada

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TOPIC: *While nurses address lesbian, gay, bisexual, transgendered, intersexed, and queer (henceforth LGBTIQ) patients' health needs, the professional nursing practice value of social justice provides a larger role for nurses in identifying and minimizing social barriers faced by LGBTIQ patients.*

PURPOSE: *This paper examines the social and health-related experiences of LGBTIQ youth in Canada, a country which has removed many of the social and legal barriers faced by LGBTIQ in countries such as the United States. An awareness of the Canadian LGBTIQ experience is instructive for nurses in different countries, as it reveals both the possibilities and limitations of social legislation that is more inclusive of LGBTIQ youth.*

SOURCES: *Review of literature in PubMed, Academic Search Premier, government documents.*

CONCLUSION: *The literature reveals that exclusion, isolation, and fear remain realities for Canadian LGBTIQ adolescents. The Canadian experience suggests that negative social attitudes toward LGBTIQ persist despite progressive legislation. The value of social justice positions nurses to constructively intervene in promoting the health and well-being of LGBTIQ youth in the face of social homophobia.*

Search terms: *Canada, LGBTIQ, nursing values, social justice, youth*

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Nursing, Social Justice, and LGBTIQ Youth

Epidemiological evidence has established that lesbian, gay, bisexual, transsexual, intersexed, and questioning queer (henceforth LGBTIQ) youth face greater risks to their health and well-being than do their heterosexual age-mates. Although nurses therefore interact with LGBTIQ youth as patients, the values of professional nursing practice warrant a larger role for nurses beyond the treatment of these patients' medical issues. As articulated by the World Health Organization (WHO) and the American Association of Colleges of Nursing (AACN), the value of social justice obligates nurses to identify and minimize social barriers to health, faced by all vulnerable groups, including young people, especially vulnerable groups such as LGBTIQ youth. Canada, having eliminated many legal barriers faced by the LGBTIQ community in the United States, may serve as a model for a more just society concerning LGBTIQ youth (Elliott & Bonauto, 2005). However, feelings of exclusion, isolation, and fear persist for Canadian LGBTIQ youth despite such legal progress (Commission des Droits de la Personne et des Droits de la Jeunesse du Québec [Commission of the Rights of the Person and Rights of Youth of Quebec], 2007), as legislative acceptance of the civil and human rights of sexual minorities has outpaced widespread social acceptance of those rights. In the face of this situation, nurses must work to realize the value of social justice on a political, institutional, and personal level.

We will begin by discussing the social determinants of LGBTIQ adolescent health before discussing the social and political situation for LGBTIQ adolescents in Canada, and their ramifications for nursing practice. Throughout the discussion, these issues will be examined in the light of the nursing value of "social justice," understood as the professional obligation to fight disparities in health care that result from social bias or inequity.

Social Determinants of Health and LGBTIQ Youths

Biomedical models view disease as the result of factors such as infection, degeneration, or trauma. This perspective

is complemented by another model, one that examines the social factors essential to the preservation and optimization of health, prevention of disease, and guarantee of maximum quality of life. In the United States, such inequalities are typically regarded in terms of unequal access to medical prophylaxis and treatment. This tends to focus attention on the poor, ethnic and language minorities, native groups, and rural residents, leaving socially entrenched, "legitimated" inequities (such as those against sexual minorities) unchallenged (Muntaner, 1999). However, Lyman (2005) suggests that researchers in the UK and Canada approach the problem of unequal health status from a more productive perspective by looking at social rather than medical factors in describing health disparities.

As defined by the WHO, the social factors that determine health are "peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity" (Raphael, 2006). While LBGTIQ youth are not the focus of the WHO's work, they nevertheless clearly confront serious challenges to these social determinants of health, with deleterious health consequences.

Peace and shelter needs of LGBTIQ children are frequently jeopardized, as they may be forced from their homes by verbal or physical abuse when their sexuality is acknowledged (Rew, Whittaker, Taylor-Seehafer, & Smith, 2005); studies suggest that over 60% of violence against LGBTIQ youth is inflicted by family members (Illingworth & Murphy, 2004). Even children who remain at home are faced with bullying and marginalization in their schools and communities, risking the development of post-traumatic stress (DuRant, Krowchuk, & Sinal, 1998), disrupted access to education, and undermined social ecosystems. Economic security is jeopardized: LGBTIQ youth are overrepresented among homeless children (Whitbeck, Chen, Hoyt, Tyler, & Johnson, 2004) and frequently turn to prostitution for survival, putting themselves at risk for further violence and abuse, as well as sexually transmitted infections. Knowledge about prevention of infection is frequently inadequate. For example, Sullivan (1996) determined that gay street youth aged 13–17 in his sample were poorly informed about human immunodeficiency virus (HIV), with 13% unable to provide any correct information at all about HIV and its transmission or prevention. Mental health care is also threatened: one result of this situation is that LGBTIQ youth are at a much higher risk for suicide and mental health disorders than their heterosexual age-mates (McAndrew & Warne, 2004; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999).

Despite their increased healthcare needs, LGBTIQ adolescents are an underserved group. The extent to which misunderstanding, bias, and even homophobia among clinicians contribute to a choice to avoid clinical treatment is unclear. There are instances of gross homophobia and neglect of professional duty to provide care, as in the case of the transgendered woman Tyra Hunter, whom a Washington DC court found had died of injuries after being abused by paramedics at the scene of a car crash and receiving ER care that did not "follow nationally accepted standards of care" (Fernandez, 1998). Similarly, attention to the issue of sex assignment was aroused by the case of David Reimer, whose questionable treatment by psychologists following a botched circumcision contributed to both his suicide death and that of his twin brother ("David Reimer," 2004).

Examples of less egregious but more endemic homophobia in health care were provided by several studies of nurses in the early 1990s that suggested homophobia was a factor in nurses' reluctance to care of HIV/acquired immune deficiency syndrome (AIDS) patients (Smirnoff, Erlen, & Lidz, 1991). In another older study, 33% of first-year medical students disagreed with the statement "that there is a broad range of normal sexual behavior and that homosexuality falls within this range" (McDaniel & Carlson, 1995, table 2). These studies contrast with a more recent one that suggests that the majority of nurses have positive or neutral attitudes toward sexual minority patients (Roendahl, Innala, & Carlsson, 2004) and that student nurses expressing reluctance to work with AIDS patients showed no homophobic bias (Stewart, 1999).

Nurses are frequently gatekeepers of the clinical encounter, administering the typically heteronormative nursing assessment ("Are you married, widowed, single, or divorced?").

Nurses' attitudes may be especially critical in determining LGBTIQ adolescents' satisfaction with their health care. Nurses are frequently gatekeepers of the clinical encounter, administering the typically heteronormative nursing assessment ("Are you married, widowed, single, or divorced?"). Such inappropriate assessment instruments set the tone for the clinical encounter, and errors can be compounded when nurses utilize a heterosexual definition of family in regulating hospital visits, planning discharge, etc. Incorrect assumptions and unwillingness to make necessary adjustments to institutional procedures impede communication and reinforce heteronormativity (Roendahl, Innala, & Carlsson, 2006).

Within the clinic, heterosexuality appears to be the expected "default" norm. Neville and Hendrickson (2006) found that over 75% of the lesbians and gays in their survey reported that heath practitioners usually or always assumed their heterosexuality; more positively, the same proportion of

those surveyed also reported that their practitioners seem completely comfortable with their subsequent disclosure. Among young LGB informants, 33% found that their practitioners' attitudes toward their disclosure positively influenced their care; 62% discerned no influence on their care.

Social Justice: A Nursing Value

Healthcare institutions reflect the culture in which they are situated (Foucault, 1994), and it must be anticipated that LGBTIQ youth will experience some degree of socially endemic homophobia in their clinical encounters. Nevertheless, research firmly suggests that the basis for a trusting, cooperative clinical relationship between nurses and LGBTIQ youth exists: gay and lesbian youth have been shown to be trustworthy and accurate when providing accounts of their sexual activity in their medical histories (Schrimshaw, Rosario, Meyer-Bahlburg, & Scharf-Matlick, 2006). Lesbian, gay, and bisexual patients value such trust, identifying practitioners' attitude toward their sexuality as the most important factor in choosing a healthcare provider (Neville & Hendrickson, 2006).

As with all therapeutic relationships, healthcare practitioners develop trust by viewing LGBTIQ youth as individuals, not solely as patients with health or social deficits. Mature nursing practice demands that therapeutic interactions with any client be based on more than the mere treatment or prevention of disease. Nurses work toward individual and community health on all levels. This mandate, articulated as *social justice*, guides nurses in eliminating disparities in health and in assuring equitable access to healthcare services (WHO, 2007). Homophobia represents a major cause of social injustice, and nurses are therefore professionally mandated to be vigilant in eradicating it from all phases of the healthcare encounter.

One goal is to ensure that vulnerable clients such as LGBTIQ youth receive adequate, culturally competent care. Social justice requires nurses to move beyond the clinical context and look at society as a whole to offset the social factors undermining the health and well-being of all LGBTIQ youth. As expressed in a policy statement by the AACN, "the value of social justice is particularly significant because it directly addresses disparities in health and health care . . . and serves as a prelude to influencing policy formulation at the systems level" (AACN, 2007, p. 9). While cultural competency and awareness of the social causes of health disparities must be promoted within the nursing curriculum, the AACN calls for a more comprehensive understanding of social justice, mandating nurses to work for social justice beyond the clinical setting, advocating for just policies within institutions, systems, and ultimately the nation.

There is much homosexual bias to be found in local and federal policies that affects LGBTIQ youth in the United States. In an obvious example, sex education programs funded by the U.S. government are obliged to teach abstinence until marriage in lieu of comprehensive, evidence-based programs that mention safer and alternative sex practices (Hopkins Tanne, 2005). While the questionable effectiveness of abstinence-only curricula jeopardizes all young people, such curricula pose particular dangers for LGBTIQ students, who are implicitly taught that heterosexuality is the only sanctioned sexual behavior and that their attraction to same-sex peers is illegitimate. This is particularly ironic, given the fact that these programs were implemented as a means of reducing the transmission of HIV/AIDS, which despite shifting epidemiological patterns, remains associated with homosexual activity. Locally, even religious discourse that makes a careful distinction between "the sinner and the sin" in an attempt to curb homophobic violence serves inexorably to reinforce the status of LGBTIQ youths' lifestyles as sinful and unacceptable (Illingworth & Murphy, 2004).

LGBTIQ Youth in Canada

As U.S. nurses look for ways to correct social injustice for the LGBTIQ youth in their communities, their attention may well turn north to Canada, where many of the restrictive laws that marginalize sexual minorities and limit young peoples' options have been repealed (Elliott & Bonauto, 2005). The legalization of same-sex marriage in 2005 has brought with it equality in the workplace, parenting, and family life. The move to legalization can be characterized as the natural result of the evolution of beliefs in Canadian society. Already by the 1980s, over 60% of Canadians viewed gay and lesbian equality in the workforce and private life as consistent with Canadian values of human rights. In the mid-1990s, Canadian courts recognized same-sex partners' rights to spousal and bereavement benefits (Matthews, 2005). Following the legalization of same-sex marriage in 2005, the 2006 Canadian census enumerated 45,300 same-sex couples, 53.6% of which are men (Milan, Vézina, & Wells, 2007).

More specifically addressing the concerns of LGBTIQ youth, Canadian public policies seek to identify and minimize the potential danger gay children may face from psychological abuse in schools, society, and even in homes where their orientation is not accepted (Saewyc, 2007). In the 1990s, provincial and local Boards of Education began implementing anti-homophobia interventions in schools, such as the Toronto Board of Education's resource guide, "Sexual Orientation: Focus on Homosexuality, Lesbianism and Homophobia" ("New Lessons,", 1997). Since 1995, Toronto has operated the Triangle Program, a high school program for LGBTIQ students suffering from homophobia in

traditional classrooms (Triangle Program, 2007). Other provincial and local school districts have followed suit with programs of their own (Émond & Bastien Charlebois, 2007).

Social acceptance has not kept pace with the law.

However, social acceptance has not kept pace with the law. Everyday life for Canadian LGBTIQ youth is still marked by slights, insults, or even physical attacks (Lemoire & Chen, 2005). Although the changes in Canadian law measurably influenced Canadians' acceptance of homosexuality (Matthews, 2005), attitudes have been slow to change among conservative social groups ("New Lessons," 1997). Van de Ven (1994) suggests that while individuals within the dominant culture learn that outright hostility toward homosexuals is unacceptable, such tolerance is not necessarily accompanied by introspection or coming to terms with cognitively unacceptable hostile feelings. "The result may be outward tolerance but underlying hostility, perpetuated in part by anti-discrimination policies . . . that put a premium on acceptable behaviours toward minorities . . . while all but ignoring 'inner' feelings" (p. 118). Homophobia thus remains a form of xenophobia, on par with racism or sexism. A sad lesson learned by Americans from the Civil Rights Era of the 1960s is that although people of color and women may be equal to white men before the law, the irrefutable truth is that women still earn between 75% and 95% of their male counterparts' salary in similar professions (Dey & Hill, 2007). Likewise, Canadian law is an imperfect mirror of civil society.

Promoting Social Justice for LGBTIQ Youth

As the literature suggests, ties of blood, long-standing friendship, and civic tolerance cannot guarantee LGBTIQ youth the social acceptance that inclusive legislation was intended to produce. Thus, it appears that nurses must work to realize the value of social justice on political and personal levels.

The Canadian Public Health Agency asserts that healthcare practitioners and institutions can act to influence the social determinants of health as knowledge brokers, leaders, communicators, and influencers (Public Health Agency of Canada, 2004). The first step toward becoming a knowledge broker is to assess one's own attitudes, beliefs, and level of knowledge. Nurses can begin by informing themselves about the experiences of young LGBTIQ patients. For example, browsing sites such as Amazon.com provides an overview of literature addressed both to LGBTIQ youth and those who care for them. Schrader and Wells' (2005) excellent and comprehensive annotated bibliography of English-language resources has been prepared for Canadian educators and is available from various web links. Likewise, Web sites geared to LGBTIQ youth also provide nurses with information about their experiences and concerns (e.g., Lesbian Gay Bi Trans Youthline at http://www.youthline.ca, or Youth Resource at http://www.youthresource.com/). A Google search of the key words "gay and lesbian films" identifies filmographies that portray various aspects of LGBTIQ experience (e.g., *Longtime Companion*, *My Beautiful Launderette*, *Sex: Unknown*). The resulting familiarity with LGBTIQ issues as portrayed in the media will enable nurses to better open dialog with LGBTIQ adolescents, as well as serve as resources and knowledge brokers within their clinics and communities.

As influencers, nurses can model clinically and culturally sensitive care within the healthcare setting. Besides influencing colleagues' behavior, nurses can also influence LGBTIQ youth directly by "assisting homosexual adolescents to affirm their identity in the face of social devaluation . . . [through] knowledge and resources to provide a corrective alternative view and the social experiences to sustain that view" (Sullivan 1994, para. 12). Illingworth and Murphy (2004) note that LGBTIQ youth frequently lack positive role models, which, combined with continual attacks on self-image and self-esteem, may lead to developmental and emotional problems. Instrumental in developing autonomy, they suggest, is the ability to form bonds of trust. While trust within the intimate family circle is essential, *thin trust*, or that formed within the general community, is no less vital. Thin trust is understood as the provisional trust that one accords to strangers, assuming that they will act in unthreatening, civil, and predictable fashion. Nurses can provide this much-needed thin trust in the clinical encounter by providing reassurance, positive regard, and knowledgeable information.

As communicators, nurses act directly with LGBTIQ youth in therapeutic interaction. Working with LGBTIQ youth in Toronto, Lemoire and Chen (2005) have used Carl Roger's person-centered therapy as a starting point in working with LGBT adolescents. The Rogerian tenets unconditional positive regard, congruence, and empathy are directly relevant to nursing communication. Through unconditional positive regard, nurses encourage clients to disclose information without fear that disclosures will alter their positive judgment of the client as an individual. The principle of congruence guides nurses to be consistent in their thoughts and actions, acting in a nonjudgmental, authentic manner. Through the principle of empathy, a nurse's interactions with the LGBTIQ adolescent client is motivated by honest interest

in the individual and his or her experience, not by the desire to place the client within the neat parameters of a specific diagnosis. Lemoire and Chen build upon Roger's person-centered therapy, introducing specific therapeutic concerns for nurses working with LGBTIQ youth. These clients must be reassured that their sexual identity, although shared by a minority of the population, is nevertheless normal, natural, and healthy. Once the sexual identity of LGBTIQ youth has been normalized and validated, nurses must also use their position of trust to help them assess the risks of disclosing their sexual identity and explore communication strategies for such disclosure.

Finally, as leaders, nurses can advocate for the health and social needs of their LGBTIQ youth in clinical, institutional, and community settings. Within the clinical context, nurses can provide leadership in such projects as the development of inclusive, accurate nursing assessments; "Do you live with a partner?" elicits the same information about social support as "Are you married?" In contrast, the knowledge that families frequently are a source of intentional and unintentional psychological abuse for young LGBTIQ demands further assessment of the nature of family relationships for this population. Furthermore, within the healthcare institution as a whole, spousal benefits programs and inclusive community health outreach programs send strong messages to LGBTIQ that they are valued members of the community. Finally, on a community level, nurses can actively advocate for programs that develop LGBTIQ youths' self-esteem and autonomy. For example, McAndrew and Warne assert that while homosexual adults develop positive mechanisms for coping with homophobia, adolescent homosexuals may only have limited interaction with socially successful homosexual adults and thus not benefit from such positive role models (2004, p. 430). Illingworth and Murphy (2004) note that LGBTIQ youth find their strongest social network among their peers, an option mostly only for those living in large urban areas. Nurses can serve as bridges in initiating this generational and intergenerational dialog.

Conclusion

Homophobia and prejudice exert a negative impact upon the health and well-being of all LGBTIQ individuals; young people whose sense of personal and sexual identity is still in development are particularly vulnerable.

Homophobia and prejudice exert a negative impact upon the health and well-being of all LGBTIQ individuals; young people whose sense of personal and sexual identity is still in development are particularly vulnerable. The legal right to marry, and legally guaranteed access to education, career choice, and the achievement of other personal milestones are essential in developing LGBTIQ youths' sense of self-esteem and faith in their future. These are outcomes of particular interest to the discipline of psychiatric nursing. The nursing value of social justice mobilizes members of the profession to work for political changes that will remove existing barriers for LGBTIQ youth. Furthermore, social justice can inform the nursing research agenda, guiding qualitative and quantitative research to describe the subjective experience of LGBTIQ youth, develop, and assess the effectiveness of communication techniques, life-skills curricula, and other interventions to improve the lives of individuals in this vulnerable population.

However, as the experience of Canadian LGBTIQ youth reveals, legislation alone will not rid a society of homophobia. Nurses are socially and professionally positioned to work against homophobia in the clinic and the community. In the clinic, they combat homophobia by informing themselves about the psychosocial needs of LGBTIQ clients as part of their ongoing professional development. They maintain open and positive communication, and advocate for institutional policies that are fair and inclusive. Nurses further utilize their ethos to combat homophobia in the community. They can correct misinformation, prejudice, and homophobic speech by sharing research and evidence from their nursing practice. Perhaps most importantly, nurses can be nonjudgmental, tolerant, and supportive of LGBTIQ in both the clinic and the community. Thus, in working for social justice, nurses can build bridges of trust to patients and extend those bridges into the community at large.

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