Heterosexism and Health Care: A Concept Analysis

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BACKGROUND. The concept of heterosexism is used in a variety of ways in healthcare literature. The lack of consensus of the term makes identifying when and how it impacts the health care of lesbian, gay, and bisexual people difficult. A lack of clarity of the concept could also hinder effectiveness of education, awareness, and research tool development efforts.
PURPOSE. The purpose of this concept analysis is to offer a synthesized definition of the term *heterosexism*, including its relation to and distinction from related concepts like homophobia and heteronormativity.
METHODS. The authors use Walker and Avant's eight-step concept analysis method: select a concept, determine the aim of analysis, identify all uses of the concept, determine defining attributes, construct a model case, construct additional cases, identify antecedents and consequences, and define empirical referents.
CONCLUSION. The results of the analysis reveal focus areas for future research, tool development, and suggestions for improvements in nursing clinical practice.

Introduction

Lesbian, gay, and bisexual (LGB) people represent populations who are medically underserved and at increased risk for health problems. A myriad of factors contribute to the increased vulnerabilities of LGB persons, ranging from disproportionately high numbers of those without health insurance (Heck, Sell, & Gorin, 2006), to higher rates of sexually transmitted diseases, including HIV (Centers for Disease Control and Prevention. National Center for HIV/AIDS, Viral Hepatitis, STD, & TB Prevention, 2010). Explorations of more overt forms of oppression like homophobia that may contribute to health disparities in LGB people are readily found in the literature (Christensen, 2005; Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007). Yet there is a subtler and perhaps even more prevalent form of oppression that may impact the health disparities of LGB patients—heterosexism. Examples of heterosexism abound in health care. From a check box on an intake form that only offers "Married" or "Single," to a nurse practitioner automatically asking sexually active female patients about which birth control they use, LGB persons often face the assumption that they are heterosexual unless and until they state otherwise (Fish & Bewley, 2010; Saulnier, 2002; Sinding, Barnhoff, & Grassu, 2004).

The sequelae of heterosexism against LGB people includes blocking access to health care, decreasing the efficacy of communication between provider and patient, and decreasing the quality of care received (DeHart, 2008; Saulnier, 2002). Despite a basic awareness of the negative impact of heterosexism on a population already disproportionately burdened with a lack of access to health care and increased incidence of disease, heterosexism remains a misunderstood and vague concept (Walls, 2008). In the literature, the term *heterosexism* is used synonymously with either *homophobia* or *heteronormativity*, even though the terms are used to describe distinct phenomena (Pharr, 1997; Spaulding, 1999). Missing from the literature are sufficient attempts and tools to operationalize heterosexism to

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examine the specific effects it has on LGB people in the healthcare system. Confusion over the definition of the term, as well as an understanding of how it functions in health care, contributes to its invisibility as a concept.

Methods

To conduct the analysis, this author will use Walker and Avant's adaptation of Wilson's concept analysis (Rogers & Knaft, 2000). The analysis includes eight steps: select a concept, determine the aim of analysis, identify all uses of the concept, determine defining attributes, construct a model case, construct additional cases, identify antecedents and consequences, and define empirical referents (Walker & Avant, 1988).

Uses of Concept

In its most basic form, heterosexism is the belief that everyone is, or should be, heterosexual and alternative sexual orientations are unnatural and deviant (Pharr, 1997). The phrase was coined in the early 1970s as a term related to sexism and racism to describe the discrimination faced by anyone with non-heterosexual orientation or behavior (Herek, 1990). Other definitions of the term broaden its scope to include not only overt discrimination, such as marriage laws that exclude same-sex unions, but discrimination that occurs unintentionally caused by a lack of awareness that LGB people exist. For example, the omission of "domestic partner" as a check box on a medical form in a medical practice is considered heterosexist. Callahan, Mann, and Ruddick (2007) describe heterosexism as everything from "unreflective pervasive bias to deeply embedded normativity to unjust social privilege to cruel and deliberate social exclusion of sexual and gender minorities and to heterosexual bigotry of the most virulent and violent kind" (Callahan et al., 2007, p. viii).

A concept closely related to heterosexism is homophobia. Coined in the late 1960s, homophobia is defined as an individual's irrational fear and dislike of LGBT people that may lead to discrimination or violence (Scott, Pringle, & Lumsdaine, 2004). Heterosexism and homophobia are closely linked, and frequently used interchangeably in the literature. However, scholars make important distinctions between the terms. Homophobia exists on the microlevel as a psychological experience of an individual. It describes a person's aversion, fear, or dislike of homosexual persons, relationships, or behaviors (Spaulding, 1999). Heterosexism exists on a macro level, describing the sociopolitical processes that arise from homophobia that privilege heterosexual relationships over all others (Pharr, 1997; Spaulding, 1999). This privileging includes acts of systemic discrimination by the numerical majority (heterosexuals) that codify the belief in the superiority of heterosexuality and the marginalization of non-heterosexuality into laws, policies, procedures, societal norms, and traditions (Feigenbaum, 2007; Pharr, 1997; Spaulding, 1999).

Confounding the confusion further is a third term almost synonymous with heterosexism: heteronormativity. Coined in 1991, the term describes a norming phenomenon whereby heterosexuality is woven into the fabric of culture and society as the expected and normal sexual orientation (Warner, 1991). Martin (2009) describes heteronormativity as the everyday ways heterosexuality is "taken for granted as normal and natural" (p. 190). It encompasses institutions and practices that propagate heterosexuality as natural, and differing sexual orientations as unnatural (Martin, 2009). An example is how most mothers unknowingly socialize their children to grow up as heterosexuals, speaking of their future marriages and opposite-sex spouses before the child is even old enough to express a sexual orientation (Martin, 2009). In healthcare literature, heteronormativity is used interchangeably with heterosexism. Researchers often use one or the other term to describe the same phenomenon: policies and practices that assume and/or favor heterosexuality and leave LGB patients feeling invisible (Fish & Bewley, 2010; Irwin, 2007; Neville & Hendrickson, 2006; Rondahl, Bruhner, & Lindhe, 2009; Saulnier, 2002; Westerstahk & Bjorkelund, 2003).

Review of Literature

A review of the recent literature helps illuminate, define, and conceptualize heterosexism and its role in health care. A variety of databases including Nursing Proquest database, Academic Search Premier, Project MUSE, Wilson OmniFile, Pubmed, and the Cochrane Database were used. The articles chosen for inclusion in this review include qualitative and quantitative research articles that address heterosexism as it pertains to mental and physical health. Nine articles were chosen for inclusion in the review and organized into two themes: heterosexist attitudes of practitioners and heterosexism as experienced by LGB people.

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Heterosexist Attitudes of Practitioners

Raiz and Saltzburg's (2007) qualitative portion of a mixed-methods study of heterosexual, undergraduate social workers ($N = 150$) revealed that nearly a quarter of those studying for this helping profession had negative and heterosexist attitudes toward lesbians and gay men. The researchers administered a survey, as well as open-ended qualitative questions, to heterosexual, undergraduate social work majors from 12 institutions throughout the United States. The open-ended qualitative items explored attitudes toward lesbians and gay men, and support for relationship rights for this group. Herek's Attitudes Toward Lesbians and Gay Men scale and a relationship rights scale constructed for this study provided quantitative data. Researchers identified three themes: acceptance (n = 58, 38.7%); tolerance but with conditions (n = 60, 40%); and non-acceptance (n = 32, 21.3%). The authors concluded that attitudes under the category "tolerance with conditions" are most troubling, as those negative attitudes are harder to detect and address (Raiz and Saltzburg, 2007). The authors suggest this bias needs to be recognized as being the most common, and social work education and cultural competency training needs to address these subtle attitudes in social work students (Raiz and Saltzburg, 2007).

Physicians in family practice assume patients have a traditional opposite-sex family and are heterosexual, and it is up to the patients to correct the provider if they are not heterosexual (Westerstahk & Bjorkelund, 2003). Westerstahk and Bjorkelund used a mailed questionnaire and follow-up focus groups to examine how family physicians in a metropolitan Swedish city approached history taking and interviewing patients with regard to their sexual orientation (N = 17, n = 10). A moderator asked three questions: how the practitioners create an open atmosphere, how they define family, and when and how do they talk about sexual orientation with a patient. The researchers used a discourse analytic approach to identify three main themes and several minor themes from the transcribed interviews. The focus group participants reported they conceived that a family meant a married woman and a man, most likely included children, assumed a pregnant patient had a male partner, and reported feeling surprised when their patient corrected their assumption about their heterosexuality (Westerstahk & Bjorkelund, 2003). One physician stated that he felt shocked when he learned he had assumed a lesbian patient was heterosexual, because he felt he was a tolerant person and now wondered what messages to the contrary he was giving to his LGB patients. Providers also expressed they were afraid to ask patients about their sexual orientation out of concern it would offend heterosexual patients. Participants suggested using open-ended questions and non-biased closed-ended questions when interviewing patients to better allow patients to define their sexual orientation and family status.

Impact of Heterosexism on Perceptions of LGB People

Several studies sought to examine how heterosexism impacts health seeking behavior and attitudes of LGB persons. A qualitative study involving 33 lesbian and bisexual women identified heterosexist attitudes from healthcare providers as one of five things that influenced their healthcare decisions (Saulnier, 2002). Researchers in the exploratory study interviewed 33 women as part of focus groups and a survey. Focus group sessions lasted between 60 and 90 min. Researchers used semistructured, open-ended questions such as "If you could interview potential providers, what information would you need from them to help you decide whether to use their services?" The researchers concluded that five themes shaped participants' decisions about healthcare providers: homophobia; heterosexism; tolerance; lesbian sensitivity; and lesbian affirmation (Saulnier, 2002). Specific to heterosexism, participants described feeling invisible, noted that they were assumed to be heterosexual unless they stated otherwise, and that provider questions and forms did not provide space to state sexual orientation other than heterosexual. Participants also reported that their same-sex partners were not recognized by healthcare providers and were not kept in the communication loop. One participant identified that by not asking about her sexual orientation, her healthcare provider did not have the information to appropriately counsel her on safer sex techniques when she was diagnosed with oral herpes. Researchers also concluded that negative treatment from practitioners influenced lesbian and bi-sexual women's decisions about which providers to use and who to avoid. Saulnier recommends that practitioners make decisions about charting a disclosure of lesbianism or bisexuality by discussing it with each individual patient. Furthermore, she recommended that partners need to be included as family members, agency policies that exclude same-sex families should be revised,

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intake forms should be made inclusive, and staff should be trained on providing services to same-sex patients and families.

An online survey of lesbian and bisexual women in the UK (Fish & Bewley, 2010) had similar findings to that of Saulnier (2002). Researchers surveyed over 5,000 women (*N* = 5,909) who identified themselves as lesbian or bisexual on 75 closed-ended questions for quantitative data and three open-ended questions about healthcare experiences and recommendations for improving services. From the qualitative data the researchers extracted four themes: heteronormativity in health care, improving attitudes among health providers, access equity, and raising awareness (Fish & Bewley, 2010).

Participants reported they were asked questions related to their sexual orientation in situations where they did not feel comfortable to disclose it, like during the physical exam portion of the visit (Fish & Bewley, 2010). The study also revealed that when lesbian and bisexual women disclosed their sexual orientation it was often ignored by the healthcare providers. Lesbian and bisexual women did not feel their providers understood lesbian and bisexual sexual habits, or consequential health risks that merited screenings. Some participants also revealed that their provider's known religious beliefs appeared to play a role in how they were treated (Fish & Bewley, 2010). However, not all of the findings indicated a negative healthcare experience for participants. Those who reported positive experiences identified their healthcare provider's willingness to listen and keep an open mind as important (Fish & Bewley, 2010). Participants also identified confidentiality and non-discrimination policies, inclusive intake forms, not assuming heterosexuality in their patients, and an accepting environment as important improvements needed in health care (Fish & Bewley, 2010).

A qualitative study about perinatal care in Sweden (*N* = 10) revealed lesbian participants mostly had positive experiences in the healthcare system (Rondahl et al., 2009). Researchers individually interviewed female volunteers on their sexual orientation, how out they were about their sexual orientation, and experiences as parents in the healthcare context related to pregnancy. All participants were out as lesbians or as a same-sex couple in the health context. Most of the participants expressed apprehension about coming out as a lesbian to their healthcare provider, but most reported it went well when they did disclose. Parenthood and education forms excluded two-mother families and assumed a father and a mother, according to participants, and language such as "mother and father" and "woman and man" was common on forms and in education (Rondahl et al., 2009). Finally, participants made suggestions for improving health including inclusive forms that do not assume heterosexuality, awareness training for medical staff, and education materials specific to the healthcare needs of lesbian mothers (Rondahl et al., 2009).

Gay men and lesbians who either were receiving or whose partner is receiving hospital nursing care reported assumptions of patient heterosexuality in a variety of ways in their encounters: waiting room materials, intake forms, and from attitudes of nurses (Rondahl et al., 2006). Researchers used a qualitative design and semi-structured interviews to examine the experiences of 10 men and 17 women (*N* = 27) who had either been hospitalized or been the partner of a patient in a hospital in the past 5 years. They found nursing staff tended to use opposite-sex pronouns when speaking to patients about their partners, such as asking a lesbian "what's his name." Participants also reported being treated as heterosexuals even after they disclosed their sexual orientation. For example, one participant reported being made to take a pregnancy test even after she disclosed she did not have sex with men (Rondahl et al., 2006). One male participant described how he listed his partner of over 20 years as his emergency contact, and then being asked by the nurse if he had any family or relatives he could list instead (Rondahl et al., 2006). Participants made several suggestions to improve the quality of health care for LGB patients. They included language that does not assume heterosexuality, inclusive forms, and awareness training, awareness that not all LGB are out to families and visitors. Participants in the research suggested healthcare providers ask patients how aware family and friends of the patient are of their sexuality and incorporate this information into the patient's care (Rondahl et al., 2006).

Dehart (2008) explored the link between homophobia, heterosexism, and breast health behavior in lesbians. A survey examining health beliefs, experiences of heterosexism and homophobia, and preventative health measures was administered to 173 women who identified as lesbians. Participants were asked about breast cancer screening, use of primary and gynecological care providers, use of complimentary care measures, and perceptions of heterosexism and

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homophobia in health care. Almost a quarter of the respondents believed healthcare providers assumed they were heterosexual, which they reported they felt affected their care. One in five participants reported that the frequency with which they sought health care was influenced by a provider's perceived heterosexism. The author concluded that the use of health services might be affected not only by health beliefs, but by a person' concerns about disclosing sexual orientation to a provider (Dehart, 2008). The researcher's recommendations include adding a "domestic partner" check box on forms offering boxes of "single" and "married," discussing documenting sexual orientation in the official medical record, and training on cultural competency for office staff at healthcare organizations.

A large survey of LGB persons in New Zealand explored participants' perceptions of primary healthcare services related to their sexual orientation (Neville & Hendrickson, 2006). Researchers developed and distributed a 133-item questionnaire to 2,269 people across New Zealand who were able to complete the survey electronically or on hard copy. The target group was men and women who had sex or sexual attraction to members of the same sex. The survey revealed that almost 84% of women and 65.8% of males reported that their provider "usually" or "always" assumed their sexual identity was heterosexual. More women than men reported that their healthcare provider was uncomfortable with their disclosure of their sexual orientation at 11.4% compared with 6.1%, respectively. More than half of both women and men reported that their provider's attitude toward their sexual orientation did not influence their health care negatively or positively (Neville & Hendrickson, 2006). The authors recommended awareness training of LGB issues for healthcare workers and in nursing school curricula (Neville & Hendrickson, 2006).

A qualitative study comprised of interviews of 26 Canadian lesbians about their experiences with cancer care found that the majority of women did not report negative experiences; however, researchers identified themes when participants did report negative experiences that included: homophobic targeting or substandard care of lesbians; heterosexism or dismissal of lesbian identity and social context; and a lack of lesbian-positive psychosocial support (Sinding et al., 2004). The participants also revealed a number of strategies used when negotiating the healthcare systems as lesbians with cancer, including not coming out to avoid mistreatment and coming out in initial meetings with providers to make sure they would be comfortable treating a lesbian. Author and participant suggestions included practitioners using inclusive intake forms, the use of lesbian-positive signs, stickers, or nametags, intentional support for lesbian partners and families, and out lesbian and gay healthcare staff (Sinding et al., 2004).

Defining Attributes

Defining attributes are the characteristics associated with the concept that set it apart from similar concepts (Walker & Avant, 1988). A synthesized definition of heterosexism includes two characteristics. First, heterosexism incorporates a belief that heterosexual relationships are to be assumed, are preferred, and are normal (Pharr, 1997). Second, heterosexism is a sociopolitical construct manifest in laws, policies, and procedures whereby the heterosexual majority actively or passively excludes and discriminates against the non-heterosexual minority (Callahan, Mann, & Ruddick, 2007; Feigenbaum, 2007). The following case studies are intended to illuminate the defining attributes of heterosexism.

Model Case

Samantha, a 28-year-old female, uninsured, graduate student, went to see her primary care provider for a physical prior to starting a weight loss program. She had a same-sex partner with whom she had lived for 6 years whose employer offered health insurance benefits to spouses, but because the couple could not legally wed she was not eligible for the coverage. The health history form she filled out while in the waiting room asked her to disclose if she was sexually active. She marked yes. During the screening, the nurse asked Samantha what sort of birth control she used. She replied she used nothing. The nurse then asked Samantha if she was trying to get pregnant. Samantha said no. The nurse stared at Samantha blankly and stated, "Well if you're sexually active and are not using birth control you are going to get pregnant!" Samantha then disclosed to the nurse that her sex partner was another female.

In this model case both defining attributes of heterosexism are seen. The nurse assumed Samantha was heterosexual until corrected. The screening regarding sexual activity and contraception was based on assumed heterosexuality. The laws regarding her insurance eligibility, the screening procedures and the forms used by the clinic were based on systemic fea-

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tures of an establishment that excludes recognition of non-heterosexual relationships.

Contrary Case

Jeff, a 34-year-old male, went to his primary care provider's office for treatment for an initial office visit to establish care in a new town. While filling out his health history form, Jeff was asked to check a box for his relationship status that included the options "Single," "Married," "Partnered," and "Divorced." Pamphlets in the waiting room included safe sex brochures with both opposite-sex and same-sex couples pictured on them. When Jeff met with the nurse practitioner, she asked Jeff a number of questions about his health habits, including if he had sex with women, men, or both (Dinkel, 2005).

This example shows what happens when the defining attributes of heterosexism are not met. Multiple sexual orientations and definitions of families are considered in this office, and forms, educational materials, and screenings do not presume heterosexuality. There is neither an assumption of heterosexuality, nor are there policies or procedures that elevate a heterosexual orientation over other orientations.

Antecedents

Antecedents are events or elements that must precede the concept in order for it to occur (Walker & Avant, 1988). Antecedents to heterosexism are a binary gender system, heteronormativity, homophobia, and a heterosexual-dominant political power structure. A binary gender system where male and female are the only recognized normal gender expressions sets the table for heterosexism (Martin, 2009). Heteronormativity can then occur, where only opposite sex relationships are considered to be possible. This allows for the social norming of heterosexuality starting in a very young age in a variety of settings: home, school, church, media, pop culture, and more (Martin, 2009). Heteronormativity elevates the expectation and normalness of heterosexuality and casts any deviation from heterosexual into the category of "other" (Martin, 2009). With the categorization of "other," fear and misunderstanding fuel individual homophobia. Finally, in order for homophobia and heteronormativity to translate into heterosexism, the dominant group must have political, legal, and commercial access and authority to create, interpret, and enforce societal laws and policies, including those that comprise the healthcare matrix (Dodds, Keogh, & Hickson, 2005; Pharr, 1997).

Consequences

Consequences are events or incidents that occur as a result of the concept (Walker & Avant, 1988). Heterosexism in health care, such as medicine's historical view of homosexuality as a mental illness, has historically perpetuated and justified homophobic and heteronormative attitudes in society at large (Christensen, 2005). Up until 1974 homosexuality was considered a mental illness by the American Psychiatric Association, and was used as justification for countless discriminatory laws and policies against LGB people (Ault & Brzuzy, 2009). Today, heterosexist marriage laws exist in all but four states and the District of Columbia (Hutchinson, 2010). Research shows health insurance coverage is positively correlated with marriage, and women in same-sex relationships in particular are less likely to have health insurance coverage than their heterosexual counterparts (Heck et al., 2006). Furthermore, women in same-sex relationships seek health care less often than heterosexual women, and are less likely to have a regular provider of care, a disparity that could be attributed in part to discrimination and historical pathologizing of same-sex relationships (Dehart, 2008; Heck et al., 2006). Research reveals LGB persons are assumed to be heterosexual by their healthcare provider more than half the time (Neville & Hendrickson, 2006). These assumptions can lead to a lack of appropriate risk-related screenings and appropriate interventions (Fish & Bewley, 2010; Saulnier, 2002; Sinding et al., 2004). Heterosexism also negatively impacts communication between a provider and patient, leaving the patient feeling embarrassed, invisible, and their holistic health needs unmet (Fish & Bewley, 2010; Saulnier, 2002).

Empirical Referents

With such overlap and confusion between closely related terms like homophobia, heterosexism, and heteronormativity, it is not surprising that not much has been developed in the area of measurement to examine heterosexism alone as a specific phenomenon. One tool, the Multidimensional Heterosexism Inventory, attempts to operationalize subsets of heterosexism (Walls, 2008). Hostile heterosexism is the term Walls used to describe traditional homophobia, that in which people have overt negative attitudes and

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beliefs that they use to justify stigmatizing and segregating non-heterosexuals. From this definition, Walls adds four subsets. Paternalistic heterosexism is the attitude toward non-heterosexuals that is neutral or even positive; while at the same time stigmatizing and segregating LGB people. Positive stereotypic heterosexism is defined as positive attitudes toward LGB people that are based on stereotypes that are stigmatizing, such as all gay men are artistic or all lesbians are independent (Walls, 2008). Aversive heterosexism is the attitude that is dismissive or belittles the impact sexual orientation has on one's life, arguing that those seeking civil rights for LGB persons are seeking special rights. Walls defines amnestic heterosexism as less hostile than aversive heterosexism, in that it merely denies that discrimination against LGB people still exists in modern society. Walls conducted two studies to establish the validity and reliability of a 23-question survey that covered his four domains of heterosexism. He concluded the scale had good reliability, construct validity, concurrent validity, and divergent validity in identifying different types of heterosexist attitudes. However, his scale was only tested on undergraduate students and needs to be further tested in communities outside academia. Additionally, he writes that the scale needs to be tested for its ability to predict discriminatory behavior and not just attitudes (Walls, 2008).

Conclusion and Implications for Nursing Practice

Distinction between heterosexism and homophobia is important in that a practitioner who is not outwardly homophobic may be unknowingly creating barriers to care though the practice of heterosexism. Westerstahk and Bjorkelund (2003) discovered that some physicians who were making assumptions about heterosexuality in their practice were doing so in spite of their self-perception as an open-minded person. Because heterosexism does not require an overtly homophobic attitude on the part of an individual, the well-meaning nurse practitioner could be alienating patients unintentionally. Awareness of heterosexism as a concept is an important step in an advance practice nurses' evaluation of the equality of delivered care. Additionally, the current literature shows health disparities between LGB people and heterosexual counterparts exist, especially for women, but does not reveal why (Heck et al., 2006). Further tool development is needed to quantify the concept. Other opportunities for future nursing research includes examining the health outcomes of LGB patients identified as being victims of heterosexism in the health-care setting. Healthy People 2020 recognizes the health disparities that LGB people face, and sets goals for improving the health of this vulnerable population (U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion, n.d.) Additional education, training, and research on heterosexism will help nurse professionals meet these goals.

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