TURUN
YLIOPISTO
UNIVERSITY
OF TURKU

TOWARDS LGBTQ+ INCLUSIVE JUNIOR HIGH SCHOOL NURSING

Development of a Theoretical Model

Minna Laiti

TURUN YLIOPISTON JULKAISUJA – ANNALES UNIVERSITATIS TURKUENSIS
SARJA – SER. D OSA – TOM. 1766 | MEDICA – ODONTOLOGICA | TURKU 2023

TURUN
YLIOPISTO
UNIVERSITY
OF TURKU

TOWARDS LGBTQ+ INCLUSIVE JUNIOR HIGH SCHOOL NURSING

Development of a Theoretical Model

Minna Laiti

TURUN YLIOPISTON JULKAISUJA – ANNALES UNIVERSITATIS TURKUENSIS
SARJA – SER. D OSA – TOM. 1766 | MEDICA – ODONTOLOGICA | TURKU 2023

University of Turku

Faculty of Medicine
Department of Nursing Science
Nursing Science
Doctoral programme in Nursing Science

Supervised by

Professor Sanna Salanterä, PhD
Department of Nursing Science
University of Turku
Turku, Finland

Professor Salla Sariola, PhD
Sociology
University of Helsinki
Helsinki, Finland

Reviewed by

Professor Imelda Coyne, PhD
School of Nursing & Midwifery
Trinity College Dublin
Dublin, Ireland

Docent Päivi Kankkunen, PhD
Department of Nursing Science
University of Eastern Finland
Kuopio, Finland

Opponent

Adjunct Professor Jari Kylmä, PhD
Faculty of Social Sciences | Health Sciences
Tampere University
Tampere, Finland

The originality of this publication has been checked in accordance with the University of Turku quality assurance system using the Turnitin OriginalityCheck service.

Cover Image: Nalle Mielonen

ISBN 978-951-29-9562-2 (PRINT)
ISBN 978-951-29-9563-9 (PDF)
ISSN 0355-9483 (Print)
ISSN 2343-3213 (Online)
Painosalama, Turku, Finland, 2023

In diversity
there is beauty
and there is
strength.

Maya Angelou

To LGBTQ+ youth

UNIVERSITY OF TURKU
Faculty of Medicine
Department of Nursing Science
Nursing Science
MINNA LAITI: Towards LGBTQ+ Inclusive Junior High School Nursing – Development of a Theoretical Model
Doctoral Dissertation, 126 pp.
Doctoral Programme in Nursing Science
December 2023

ABSTRACT

LGBTQ+ youth as a minority group has been shown to have unmet health and support needs in healthcare, however, little is known about LGBTQ+ youth in junior high school (JHS) nursing. The aim of this study was to develop a theoretical model describing LGBTQ+ inclusive JHS nursing.

This study comprised three qualitative sub-studies, in which LGBTQ+ inclusive JHS nursing was explored through an integrative literature review (n= 18), an online survey study about the experiences of Finnish LGBTQ+ youth (n= 35) in JHS nursing, and a focus group interview study about the perceptions Finnish JHS nurses (n= 15) of supporting LGBTQ+ youth. Data analysis methods used in this study were deductive descriptive analysis and inductive thematic analysis. To develop a theoretical model, the findings of the sub-studies were used as the empirical knowledge in the model, and the structure of the model comprised five patterns of knowing in nursing (*emancipatory*, *ethical*, *empirical*, *personal*, and *aesthetic*).

LGBTQ+ inclusive JHS nursing is multidimensional, in which emancipatory knowing presents the awareness of inequalities of LGBTQ+ youth and ways to reduce inequalities; empiric knowing the evidence-based LGBTQ-inclusive knowledge, education, and competence in using them; ethical knowing the ethical and moral considerations and actions with LGBTQ+ youth; aesthetic knowing the acknowledgement of the uniqueness of LGBTQ+ youth, and having an LGBTQ+ inclusive atmosphere and confidential relationship with them; and finally personal knowing presents the JHS nurse's inner awareness of themselves as a professional and in relation to LGBTQ+ youth.

LGBTQ+ inclusiveness has been recognized as important, but it has received little attention in previous research. To create equality in school nursing and support the work of school nurses, further research is needed in the European nursing context, in LGBTQ+ inclusiveness promoting practices and nursing education in general.

KEYWORDS: LGBTQ+, sexual and gender minorities, sexual orientation, gender identity, inclusive, adolescents, junior high school, school nursing, qualitative research, nursing models

TURUN YLIOPISTO
Lääketieteellinen tiedekunta
Hoitotieteen laitos
Hoitotiede
MINNA LAITI: Kohti sateenkaari-inklusiivista yläkoulun kouluterveydenhoitoa –Teoreettisen mallin kehittäminen
Väitöskirja, 126 s.
Hoitotieteen tohtoriohjelma
Joulukuu 2023

TIIVISTELMÄ

Sateenkaarinuorten (LGBTQ+) on osoitettu olevan vähemmistöryhmä, joiden terveyteen ja hyvinvointiin liittyvät tarpeet eivät aina tule huomioiduksi terveydenhuollossa, mutta sateenkaarinuorista yläkoulun kouluterveydenhoidossa tiedetään vähäisesti. Tutkimuksen tarkoituksena oli kehittää teoreettinen malli, joka kuvaa sateenkaari-inklusiivista yläkoulun kouluterveydenhoitoa.

Tutkimus koostui kolmesta laadullisesta osatutkimuksesta, jossa sateenkaari-inklusiivisuutta tarkasteltiin integroivan kirjallisuuskatsauksen (n=18), suomalaisten sateenkaarinuorten yläkoulun kouluterveydenhoidon kokemuksia selvittävän kyselytutkimuksen (n=35), ja suomalaisten yläkoulun kouluterveydenhoitajien näkemyksiä sateenkaarinuorten tukemisesta (n=15) selvittävän fokusryhmähaastattelututkimuksen avulla. Aineistojen analysoinnissa hyödynnettiin deduktiivisen kuvailevan analyysin ja induktiivisen temaattisen analyysin menetelmiä. Osatutkimusten tulokset muodostivat teoreettisen mallin empiirisen tiedon sisällöt. Teoreettisen mallin rakenne muodostui hoitotyön viidestä keskeisestä tiedonalueesta (*emansipatorinen, eettinen, empiirinen, henkilökohtainen, ja esteettinen*).

Sateenkaari-inklusiivinen yläkoulun kouluterveydenhoito on moniulotteinen. Emansipatorinen tiedonalue edustaa tietoisuutta sateenkaarinuorten eriarvoisuudesta ja keinoista sen vähentämiseksi, empiirinen näyttöön perustuvaa sateenkaari-inklusiivista tietoa, koulutusta ja näiden hyödyntämistä, eettinen toimintaa eettisten ja moraalisten näkökulmien pohjalta, esteettinen tietoisuutta sateenkaarinuorten ainutlaatuisuudesta, sateenkaari-inklusiivista ilmapiiriä ja luottamuksellista suhdetta nuoriin, sekä henkilökohtainen tiedonalue edustaa kouluterveydenhoitajan sisäistä tietoisuutta itsestään ammattilaisena ja suhteessa sateenkaarinuoriin.

Sateenkaari-inklusiivisuus on tunnistettu tärkeäksi, mutta se on saanut vähäistä huomiota aiemmassa tutkimuksessa. Yhdenvertaisen kouluterveydenhoidon toteuttamiseksi ja kouluterveydenhoitajien työn tukemiseksi, lisätutkimusta tarvitaan eurooppalaisen hoitotyön, sateenkaari-inklusiivisuutta edistävien käytäntöjen ja hoitotyön koulutuksen näkökulmista.

AVAINSANAT: LGBTQ+, seksuaali- ja sukupuolivähemmistöt, seksuaalinen suuntautuminen, sukupuoli-identiteetti, inklusiivisuus, nuoret, yläkoulu, kouluterveydenhoito, hoitotyö, laadullinen tutkimus, hoitotieteen mallit

Table of Contents

Abbreviations

ALLEA	All European Academies
AIDS	Acquired immunodeficiency syndrome
APA	American Psychiatric Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Diseases
ILGA	the International Lesbian, Gay, Bisexual, Trans and Intersex Association
HIV	Human Immunodeficiency Virus
JHS	Junior high school
LGBTQ+	Lesbian, gay, bisexual, trans, queer and questioning, plus other sexual and gender-diverse people
OHCRH	Office of the High Commissioner for Human Rights
OPH	the Finnish National Agency for Education
PrEP	Pre-exposure prophylaxis
SETA	LGBTI Rights in Finland
STI	Sexually Transmitted Infection
STM	Ministry of Social Affairs and Health
TENK	Finnish National Board on Research Integrity
THL	National Institute for Health and Welfare
UNICEF	United Nations Children's Fund
WAS	World Association for Sexual Health
WHO	World Health Organization

List of Original Publications

This dissertation is based on the following original publications, which are referred to in the text by their Roman numerals I-III:

I Laiti, M., Pakarinen, A., Parisod, H., Salanterä, S. & Sariola, S. Encountering sexual and gender minority youth: An integrative review. *Primary Health Research & Development*, 2019; e30: 1–13.

II Laiti, M., Parisod, H., Pakarinen, A., Sariola, S., Hayter, M. & Salanterä, S. LGBTQ+ Students' Experiences of Junior High School Nursing in Finland: A Qualitative Study. *The Journal of School Nursing*, 2021 Dec; 37(6):491–502. First published online on March 17, 2020.

III Laiti, M., Pakarinen, A., Parisod, H., Hayter, M., Sariola, S. & Salanterä, S. Supporting LGBTQ+ students: A Focus Group Study with Junior High School Nurses. *The Journal of School Nursing*, First published online in March 2022.

1 Introduction

According to the Convention of the Rights of the Child (1989), every child (persons under the age of 18) has the fundamental right to grow and develop into a healthy individual, free from discrimination. They have the right to express their views in all matters affecting them, right to freedom of expression, right to receive information and to access to health care services, and to enjoy the highest attainable health. Children's right to health includes physical, mental, social, and spiritual dimensions (World Health Organization WHO, 2023a). Adolescence is the period between the ages of 10 to 19, in which rapid changes occur physically, cognitively, and psychosocially. These changes include, for example, puberty and puberty-related bodily changes, sexual maturation, formation of sexual identity (Tolman, 2011; Beckett & Taylor, 2019) and formation of self-image and gender identity. (Tolman, 2011; Diamond et al., 2011; Beckett & Taylor, 2019.)

Sexuality is an essential part of human life, health, and well-being. Central aspects of sexuality and sexual health include physical, emotional, mental, and social well-being, sexual pleasure, intimacy, eroticism, and reproduction with the positive and respective recognition of diverse sexual orientations and sexual relationships. (WHO, 2006; World Association for Sexual Health WAS, 2015; Ford et al., 2021.) In the Declaration of Sexual Rights, all people, including adolescents, have sexual rights. These rights include the right to equality and non-discrimination, the highest attainable standard of sexual health and social security, sexuality-related information and education, freedom of expression and opinion, and the right to enter marriage with the free and full consent of the intended spouses. (WAS, 2015.) The development of sexuality in adolescence involves exploring one's own sexuality and forming first relationships, in which adolescents can safely experience their sexuality (Tolman, 2011; Beckett & Taylor, 2019). Identity formation also includes the aspect of gender identity, which refers to a person’s inner sense and definition of self as a girl/woman, boy/man, or other (Sell & Conron, 2020). Gender identity formation begins in early childhood (Bussey, 2011; Diamond et al., 2011; Beckett & Taylor, 2019) and in adolescence gender identity forms again, as adolescents experience physical changes in their bodies due to puberty and hormonal changes. During this period, they face questions about which gender they identify with, if either, and

whether they have conflicting feelings about their gender identity, and the existing gender norms (Beckett & Taylor, 2019; Lips, 2019).

The healthy growth and development of adolescents can be supported by primary healthcare services. School health services as a global health service can provide a comprehensive and a convenient opportunity to reach children and adolescents and support their health and well-being as these services are commonly placed at or near the school environment (WHO, 2021). In Finland, school health services, including school nursing, are part of student welfare in the Finnish education system (Finnish National Agency for Education OPH, 2014). In school nursing, school nurses work focuses on promoting and following students' development, growth, and health, and ensuring the safety and health of school communities (Ministry of Social Affairs and Health STM, 2004; National Institute for Health and Welfare THL, 2023). School nurses play a pivotal role in schools, as they have open office hours available for students to visit during school days (Hietanen-Peltola et al., 2019; THL, 2023).

Adolescents belonging to sexual and gender minorities are often referred to with the term *LGBTQ+ youth* (lesbian, gay, bisexual, trans, queer and questioning, plus other sexual and gender-diverse people). LGBTQ+ youth are a minority group, who have been, and somewhat still are, a vulnerable youth group experiencing different inequalities when compared to their heterosexual and cisgender peers. This vulnerable and unequal position is associated with discrimination, stigmatization, marginalization, and intolerance based on sexual orientation and gender identity (Smalley et al., 2018; Spurlin, 2019; Stall et al., 2020). These prejudices have also occurred in healthcare (McClain et al., 2018; Beyrer, 2020) since the definitions and norms around sexuality, sexual orientation, and gender identity are historically, and culturally shaped social constructs (Foucault, 1984; Dahnke, 2010; Diamond et al., 2011; Eliason, 2014; Burr, 2015a; Lips, 2019). Therefore, the understanding of homosexuality, transgender, and sexual and gender diversity has not always been consistent, and this has caused inequalities for LGBTQ+ people, including LGBTQ+ youth (Beyrer, 2020).

The awareness of sexual and gender diversity has increased, and therefore the social acceptance of the diversity of sexual orientations and gender identities has improved (McClain et al., 2018; Stall et al., 2020), and this recognition has supported the health and well-being of LGBTQ+ people. However, the Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe and Central Asia (ILGA-Europe, 2023) reported that LGBTQ+ human rights and the living circumstances of LGBTQ+ people can vary significantly between countries, and even within one country. Finland has been mapped to be one of the most progressive countries regarding LGBTQ+ human rights (ILGA-Europe, 2023). However, Finnish studies regarding LGBTQ+ youth in schools (Lehtonen, 2003; Alanko, 2014; Taavetti, 2015), LGBTQ+ youth health and wellbeing (Luopa et al.,

2017; Jokela et al., 2020) have reported that LGBTQ+ youth are still facing inequalities in Finland from several aspects (Lehtonen, 2003; Alanko; 2014; Taavetti, 2015). Moreover, the preparedness of mental health and substance abuse professionals to encounter LGBTQ+ youth (Hästbacka & Siren, 2017) is lacking as well as the skills to provide care for LGBTQ+ youth (Hästbacka & Siren, 2017). Despite these studies, no previous research has focused on LGBTQ+ youth in Finnish junior school nursing and its role in supporting the health and well-being of LGBTQ+ youth.

This study was conducted in the field of nursing science. In this study, I focus on exploring junior high school nursing as a public health service supporting the health and wellbeing of LGBTQ+ youth (THL, 2023). Throughout this study, I use the term LGBTQ+ youth, but I recognize that sexual and gender diversity is not a static and fixed range of identity categories, but a constantly evolving self-concept in time and culture (Foucault, 1984; Eliason, 2014; Burr, 2015a; Lips, 2019); therefore, throughout the study I have used "+" to mark this recognition.

2 Background

The background of the study comprises three parts. In the first part, I describe the essential societal concepts of the study, which are *Sexual and gender diversity in adolescence*, *LGBTQ+ people as a minority group in healthcare*, and *Junior high school nursing*. With these concepts, I familiarize the reader with the context of the study. In the second part, I describe the five patterns of knowing in nursing, developed by Chinn and Kramer (2015), as these will be used as a framework in structuring a theoretical nursing model in this study. Finally, I review the existing empirical studies on LGBTQ+ youth in school nursing and identify current gaps in the research.

2.1 Sexual and gender diversity in adolescence

When discussing sexual and gender diversity, it is important to recognize that the definitions of sexuality, sexual orientation, gender identity, and gender expression are historically, and culturally shaped social constructs (Foucault, 1984; Dahnke, 2010; Diamond et al., 2011; Eliason, 2014; Burr, 2015a; Lips, 2019), and are continuously evolving (Diamond et al., 2011; Eliason, 2014; Bosse & Chiodo 2016). Therefore, the understanding and social acceptance of sexual and gender diversity has not always been the same, and this has caused inequalities for those people who are part of sexual and gender minorities (Beyrer, 2020). However, the awareness of sexual and gender diversity has increased, and therefore the social acceptance of diverse sexual orientations and gender identities has improved (McClain et al., 2018; Stall et al., 2020).

In this section, I describe sexual and gender diversity in adolescence based on the current understandings in the literature. I do not limit my descriptions to a particular discipline or theory, but rather discuss them as societal phenomena in multidisciplinary discourses. However, I focus my descriptions on the Western context, as this study has been conducted in a Western healthcare context.

2.1.1 Sexual diversity

Sexuality is an essential part of human life. The central aspects of sexuality and sexual health include physical, emotional, mental, and social sexual wellbeing, sexual pleasure, intimacy, eroticism, and reproduction, and also incorporate a positive and respective recognition of diverse sexual orientations and sexual relationships free from coercion, discrimination, and violence. (WHO, 2006; WAS, 2015; Ford et al., 2021.) Consequently, every individual, including adolescents, have the stated right to live according to their sexual identity and sexual orientation, to access sexuality-related information and services to attain and maintain their sexual health (WAS, 2015). However, sexual diversity and the recognition of different sexual orientations as a normal part of sexuality has not always been self-evident.

Sexuality has, throughout history, been linked with the existing social and cultural understanding and definition of normal sexuality; this includes the accepted ways and contexts to perform sexuality, and who is allowed to be sexual (Foucault, 1984; Spurlin, 2019). In the history of Western societies, sexuality has been controlled and restricted by institutions such as the church, medical science, and psychology, especially in the cases of women and sexual minorities (Foucault, 1984; Hart& Wellings, 2002). Heterosexuality has long been considered to be the main, normal, and natural sexual orientation, which has led to a general assumption that all people are heterosexual, and thus other sexual orientations are exceptions to this norm (Jackson, 2006). This norm, referred to as heteronormativity, has been identified as influencing different structures in society, and the representations and discourses around sexuality (Jackson, 2006). It has also affected the ways in which adolescents are taught about sexuality in schools (Lehtonen, 2003; Hobaica & Kwon, 2017; Kosciw et al., 2019). Thus, sexual diversity has not always been seen as part of normal sexuality-related development in adolescence. Currently, however, the literature on adolescent sexuality has moved towards a more inclusive view, and sexual diversity is being considered as normal (Beckett & Taylor, 2019).

Sexuality-related development is one of the most significant developmental processes for adolescents. Becoming a sexual being is part of identity formation, which is a complex process for adolescents, as they need accept and deal with new feelings, sexual desires, and physical changes. Simultaneously, they need to cope with the attitudes and messages about sexuality they receive from their families, schools, culture, media, and other contexts. (Beckett & Taylor, 2019.) Sexuality-related development can be viewed from *intrapersonal*, *interpersonal*, *social*, and *sociocultural* levels (Tolman, 2011). By examining these levels, we can understand how sexuality-related development varies between individuals, cultures, and points in time. For example, sex education and discussions around sexuality have moved from non-existent to being more open and franker, nevertheless sexuality is still a difficult topic to discuss. (Beckett & Taylor, 2019.)

At the intrapersonal level, adolescents experience pubertal development, body image construction and the relationship of both of these to one's own sexuality, gender, and sexual identity (Tolman, 2011). Sexual identity refers to individual and social processes, by which adolescents acknowledge their needs, preferences and values related to several aspects: sexuality, sexual orientation, sexual expression, and activities (Dillon et al., 2011). The interpersonal level includes adolescents' explorations of their sexuality in romantic and sexual relationships. These explorations have typically been discussed in the context of health-related risk behavior and risk prevention. However, adolescents nowadays consider intimacy and pleasure in diverse ways, and to an even greater extent, through thoughtful and careful decision-making. (Tolman, 2011.)

The social level encompasses the roles of family and peers (Tolman, 2011). Both family and peers can have sexual norms and attitudes that influence the personal views of adolescents on sexuality. In families, adolescents can have trustworthy adults, who can offer them the freedom to ask questions regarding sexuality. However, families can also have factors, that do not support an atmosphere in which to discuss sexuality. (Tolman, 2011; Beckett & Taylor, 2019.) In peer groups, adolescents may experience the social pressure to prove themselves and acquire status through sexual experience (Beckett & Taylor, 2019); although peers as a younger generation can also offer an accepting atmosphere towards sexual diversity (Savin-Williams, 2011; Paasonen & Spišák, 2018).

The sociocultural level encompasses the messages and attitudes adolescents receive about sexuality from the surrounding world, including the media, the social media, religion, and politics (Tolman, 2011). Many of these messages can be mixed and conflicting. (Beckett & Taylor, 2019). For youth who are part of a sexual minority, sexuality-related development can be more distressful than their heterosexual peers due to the existence of prejudice and the unacceptability of sexual diversity. Distress can also be caused by adults labelling sexual diversity as a passing phase in adolescence (Meyer, 2003; Beckett & Taylor, 2019). These attitudes can give sexual minority youth an impression that their sexual orientation is not considered normal, and thus causing them minority stress (Meyer, 2003).

Sexual diversity, in this study, refers to a diverse spectrum of sexual orientations that are usually considered sexual minorities. In addition to *heterosexuality*, *homosexuality* (gay and lesbian) and *bisexuality*, sexual diversity recognizes the constantly evolving nature of sexuality, such as *pansexuality*, *queer identities*, and *asexuality*. Recent literature has recognized that among adolescents there is an increasing agreement that sexuality is not just identifying with fixed categories. For adolescents today sexuality is a fluid, ongoing process, and adolescents can shift into and out of different sexual orientations or refuse to identify with any of them. They may actively question how to define their sexual orientation, and they may engage

in same-sex sexual activities without identifying with the orientation describing same-sex attraction. (Tolman, 2011; Savin-Williams, 2011; Bosse & Shiodo, 2016; Paasonen & Spišák, 2018.)

2.1.2 Gender diversity

When discussing gender diversity, we need to first explore the concepts of sex and gender, and how these two are distinct, but connected to each other. In Western societies, the commonly accepted definition divides people into two categories: woman (female) and man (male). Women and men have been considered as the opposites of each other, and completing each other through biological (reproductive organs, secondary sex characteristics, genes), behavioral (woman being feminine and performing femininity, men being masculine and performing masculinity), and sexual differences (women and men are sexual counterparts and heterosexuality is the assumed sexual orientation). (Lips, 2019.) However, this categorization has been criticized as being stereotyped and seeing gender as simply binary, which excludes people who do not fit into the binary definition by their biology, behavior, self-identification, or sexuality (Lips, 2019; Spurlin, 2019).

Concepts *sex* and *gender* describe two distinct dimensions of people being a woman, a man, or other. *Sex* refers to the biological characteristics of a woman, a man, or other. This includes hormones, chromosomes, secondary sex characteristics, and genitalia. Sex is defined at birth mainly through external genitals (*female/male*), and this defines a newborn baby's expected gender. (Diamond et al., 2011; Lips, 2019; Sell & Conron, 2020.) *Gender* refers to the social, cultural, and personal aspects of how an individual is considered a woman, a man, or other. Gender is strongly related to the existing social and cultural gender norms and roles. Gender norms and roles vary historically and culturally in different societies, and thus gender can be considered a *social construct*. (Burr, 2015b; Lips, 2019; Sell & Conron, 2020.)

Gender identity refers to a person's inner sense and definition of them self as a girl/woman, boy/man, or other (Sell & Conron, 2020). Gender identity formation begins in early childhood, when children identify the existence of gender categories, and most children adept the socially and culturally approved gender norms and identities (Bussey, 2011; Diamond et al., 2011; Beckett & Taylor, 2019; Lips, 2019). However, not all children identify within these norms, and some of them identify with a gender that does not align with the sex assigned at birth (Diamond et al., 2011; Beckett & Taylor, 2019; Lips, 2019). In adolescence, gender identity formation occurs again, as adolescents experience physical changes in their bodies due to puberty and hormonal changes. During this period, they face questions about which gender they identify with, if either, and whether they have conflicting feelings about

their gender identity, and the existing gender norms. (Beckett & Taylor, 2019; Lips, 2019.) If conflicting feelings cause psychological distress to the adolescent, they are experiencing gender dysphoria (American Psychiatric Association APA, 2022), which may require gender-affirming care. However, not all adolescents who experience gender dysphoria need gender-affirming care: some benefit from social affirmations (choosing their pronouns, name and being referred according to them), and legal affirmation (changing gender markers on one's official ID documents). Gender-affirming care includes hormonal treatment, and for some adolescents, gender-affirming surgeries become relevant in adulthood. (Diamond et al., 2011; APA, 2022.)

Gender diversity in this study refers to a diverse spectrum of gender identities, that are usually considered gender minorities. Similar sexual diversity, gender diversity is recognized to be more common in the worldview of adolescents, where gender is not only limited to the binary categories of girl/woman—boy/man. Gender identity can be a fluid and nuanced self-concept that forms in adolescence, with the language describing gender identity constantly evolving. (Diamond et al., 2011; Bosse & Shiodo, 2016; Beckett & Taylor, 2019.) Gender diversity includes a fluid, ambiguous spectrum of gender identities, gender expression and gender performativity. It acknowledges that some people are cisgender, in which case their sex assigned at birth (female/male) aligns with their gender identity (woman/man), and some people are transgender, that is, having a gender identity not congruent with sex assigned at birth, or the social and cultural gender norms. (Smalley et al., 2018; Sell & Conron, 2020.) Gender diversity encompasses identities such as *trans*, *transgender*, *nonbinary*, *gender non-conforming*, *genderqueer*, *genderfluid*, *agender*. Furthermore, intersex is sometimes included in gender diversity. Intersex refers to people, who are born with diverse variations in sex-related characteristics, and who do not align with the typical gender binary definitions (Office of the High Commissioner for Human Rights OHCHR, 2015).

2.2 LGBTQ+ people as a minority patient group in healthcare

When discussing the health and healthcare of LGBTQ+ people, including adolescents, it is important to reflect on certain social phenomena and events to understand the position of LGBTQ+ people as a vulnerable group in health care. This reflection is necessary because the social and cultural structures defining sexuality and gender has had an influence on Western medicine and nursing. In this section, I focus on describing the health and healthcare of LGBTQ+ people from the perspective of health disparities, minority stress, sexual health, and mental health.

Health disparities and minority stress of LGBTQ+ people

Literature has recognized that among LGBTQ+ people there are several distinct health problems, and the risk and prevalence of these health problems are higher than the general population (Kralik & Skinner, 2018; Stall et al., 2020). These health problems cause health disparities for LGBTQ+ people, which means that their health and wellbeing is disproportionally lower than the majority of the population. Health disparities examine the health problems and risky health behavior from two aspects; they identify the crucial health problems within a community and incorporate the social justice issues involved. (Stall et al., 2020.)

When LGBTQ+ people, or some other community, has a greater propensity to certain health problems, it is important examine the possible underlying causes as to why some communities experience more health problems than others. This allows public health researchers and developers to understand the health status and health inequalities of communities, so as to provide effective interventions to improve the health and wellbeing of these communities. Among LGBTQ+ people, many societal phenomena have influenced their health disparities. Social marginalization, discrimination, stigmatization and unequal access to health services and information has resulted in LGBTQ+ people having higher risks for sexual, mental, and physical health problems. (Stall et al., 2020.)

Minority stress theory aims to explain the inequalities and health disparities of LGBTQ+ people. Minority stress refers to increased levels of stress, which members of minority groups experience due to structural discrimination, fear of discrimination and experiences of social marginalization and stigma. Literature has identified that minority stress is associated with health disparities and health risk behavior, such as poorer mental health, internalized homophobia, and substance use among LGBTQ+ people. (Meyer, 2003; Cohn et al., 2018.) A recent study on the physical health of sexual and gender minorities (Flentje et al., 2022) found that lower levels of minority stress was associated with better physical health. Another study (Green & Dorison, 2022) examined the association of LGBTQ-based minority stress with suicide among LGBTQ youth, and the findings revealed that youth who experienced four types of minority stress (housing instability, perceived discrimination, physical threat and abuse, and attempts at LGBTQ identity change by caregivers) had nearly 12 times greater odds of attempting suicide. Transgender and nonbinary youth had higher odds of experiencing three or more types of minority stress than other LGBTQ youth (Green & Dorison, 2022). LGBTQ+ adults have been found to have higher rates of smoking, alcohol use and substance use (Poteat & Stahlman, 2020), which are suggested to be associated with minority stress. Smoking, alcohol use and substance use are all considered to be coping methods for the experience of discrimination, homophobia and transphobia towards LGBTQ+ identities (Kralik& Skinner, 2018; Poteat & Stahlman, 2020).

Sexual health of LGBTQ+ people

Sexual diversity has not always been accepted by Western society and Western healthcare; homosexuality was considered a crime in Finland until 1971 (LGBTI Rights in Finland Seta, 2023a) and the American Psychiatric Association classified homosexuality as a mental disorder until 1973 in the Diagnostic and Statistical Manual of Mental disorders (DSM) (Cohn et al., 2018; Spurlin, 2019). Therefore, gay, lesbian, bisexual and people with same-sex attraction might still not disclose their sexual orientation to healthcare professionals or seek sexual health services due to the discrimination and stigma related to their sexual orientation (McClain et al., 2018). This may also have influenced the way in which LGBTQ+ people have been reported as having a higher risk for sexually transmitted infections (STIs), and the focus on the sexual risk behavior in health research (Beyrer, 2020).

LGBTQ+ sexual health is closely linked to the global AIDS pandemic. When the first cases of HIV were clinically found in 1981, many of the infected patients were gay men or drug users using injections. This created a strong stigmatization of homosexuality, and gay men experienced social prejudice, isolation and homophobia (Spurlin, 2019). The AIDS pandemic also influenced transwomen of color, who were placed in an even more vulnerable position than gay men due to stigma, social exclusion and economic marginalization (Poteat & Stahlman, 2020). Before a possible treatment method was discovered, millions of people died globally died from AIDS including many gay men and transwomen. Nowadays HIV positive people can have a very different life, as the current treatment of HIV can prevent the HI-virus from developing into AIDS. Furthermore, pre-exposure prophylaxis (PrEP) medication can be used to prevent HIV infections. (WHO 2023b).

Mental health of LGBTQ+ people

A higher risk of mental health problems has been found to occur among LGBTQ+ people globally (Poteat & Stahlman, 2020). In the history of homosexuality and transgender, both were pathologized as mental disorders in the DSM (Cohn et al., 2018; Spurlin, 2019), and in the International Classification of Diseases (ICD), gender identity related dysphoria was categorized as a mental disorder until 2019 (WHO, n.d.). This pathologizing has influenced the mental health of LGBTQ+ people and reflect the societal stigma and unacceptance of sexual and gender diversity. This has increased the minority stress among LGBTQ+ populations. (Meyer, 2003.) Furthermore, research has shown that especially gender minority youth have an increased risk for mental health problems, such as depression, anxiety and suicidal ideation (Peterson et al., 2017; Jokela et al., 2020). The risk for mental health problems is linked to transgender youth having increased risk of being bullied (Pampati et al., 2020; Bower-Brown et al., 2023) and experiences of discrimination

and harassment (Wilson et al., 2016). Research has also found that a safe school environment (Shattuck et al., 2021), family acceptance (Katz-wise et al., 2016; Wilson et al., 2016) and social transition (Olson et al., 2016; Russell et al., 2018) are associated with better mental health and well-being of gender minority youth.

2.3 Junior high school nursing

In this section, I describe the context of this study, which is junior high school (JHS) nursing as a public health service for adolescents. Every child and adolescent has the right to grow and develop into a healthy individual (United Nations Convention of the Rights of the Child, 1989), and this is ensured by, for example, acceptable, equitable, appropriate, and effective health services (WHO, 2023a). One of the common health services targeted to adolescents is school healthcare, which, according to World Health Organization, can globally provide a convenient opportunity to reach children and adolescents. School health services that are comprehensive and are implemented appropriately, can support the health equity of children and adolescents. (WHO, 2021.) In Finland, school health services, including school nursing, are part of student welfare in the Finnish education system (OPH, 2014).

Education in Finland is publicly funded, and its purpose is to ensure that all children have equal opportunities in their education. Finnish primary and lower secondary education (perusopetus) comprise grades 1–9. (Eyridice, 2023.) Previously, grades 7–9 were often referred to as junior high school, and during this period students are typically 13–15 years old. Thus, I use the term "*junior high school*" throughout this study, to refer to the period between 13–15 years in the life of adolescents. Finnish primary school has value guidelines based on the Convention on the Rights of Child (United Nations, 1989; OPH, 2014). The value guidelines state that every student is equally valuable and has the right to become their unique self, and the aim of education is to support each student's individual growth and development, and to be a safe and equal environment for all (OPH, 2014).

As part of Finnish schools, student welfare comprises a multidisciplinary collaboration between professionals in education and in social and health services. The purpose of school welfare is to promote students' learning, psychological and physical health, and social wellbeing. (OPH, 2014.) School welfare covers services in school psychology, school counselling, and school healthcare and nursing, and they are provided in or near the school environment for students and their families (Hietanen-Peltola et al., 2019; THL, 2023). Student health services are part of Finnish primary healthcare (STM 2023a), and since the beginning of 2023, their organization has been transferred to the wellbeing services counties (STM, 2023b).

School healthcare includes different services for students and their families. It is a statutory health service with the core tasks of monitoring and promoting the individual growth, development, health, and well-being of the students. It also supports the family in raising the child, early identification and support of the student's needs, promotion and monitoring of the health and safety of the school environment, oral health care and special examinations necessary to determine the student's state of health. (Terveydenhuoltolaki 1326/2010; Valtioneuvoston asetus neuvolatoiminnasta, koulu- ja opiskeluterveydenhuollosta sekä lasten ja nuorten ehkäisevästä suun terveydenhuollosta 338/2011; THL, 2023.) In addition to the school health care services, every second year in Finland, follow-up data on students' health, well-being, school attendance, inclusion and assistance is collected nationwide through the School Health Promotion study. The School Health Promotion Study is organized by the National Institute for Health and Welfare THL. Using the data collected in the School Health Promotion study, the aim is to map the health and well-being of Finnish children and young people and strengthen the planning and evaluation of health promotion in schools, municipalities and at national levels. (THL, n.d.)

Finnish students have periodic health examinations in every grade. In the junior high school, all 8th graders (14 years old) have an extensive health examination, organized by the school physician and school nurse, to which the student's family is also invited to attend (Valtioneuvoston asetus neuvolatoiminnasta, koulu- ja opiskeluterveydenhuollosta sekä lasten ja nuorten ehkäisevästä suun terveydenhuollosta 338/2011; Hietanen-Peltola & Saarinen, 2021). In addition to the monitoring of students' physical health, the extensive health examination aims to support puberty-related development, and discuss with students sexuality, sexual health, bodily changes and self-image formation, health behaviour, and social and family relationships. The health examination also includes a meeting between the school nurse and the student to create a confidential and private occasion for students to discuss and ask about topics they find important. (Hietanen-Peltola & Saarinen, 2021).

Finnish school nurses' educational background is in public health nursing, and their work focuses on promoting and following students' development, growth, and health, and ensuring the safety and health of school communities (STM, 2004; THL, 2023). Furthermore, school nurses work with students' families by informing families about health-related topics and supporting the connection between students and families. School nurses play a pivotal role in schools, as they have open office hours, and students can visit them during school days. Students may visit in order to ask and discuss various topics with the school nurse, and an open-minded and confidential atmosphere is a prerequisite for creating a genuinely responsive and caring connection with students. (Hietanen-Peltola et al., 2019; THL 2023.) Building

a confidential relationship between the student and the school nurse requires that the school nurse respects the student's rights, including: the right to information that supports health and well-being, the right to be heard in matters concerning themselves, the right to make age-appropriate decisions and the right to privacy. (Hietanen-Peltola et al., 2019; Terveydenhoitajaliitto, 2016.)

2.4 The theory of five patterns of knowing in nursing

In this section, I describe the theory of five patterns of knowing in nursing (Chinn & Kramer, 2015). The purpose of this section is to describe the framework that is used in the structure of the theoretical model. I chose the theory of five patterns of knowing in nursing as it is suitable for describing school nursing from multiple dimensions, and especially emancipatory knowing is suitable for understanding LGBTQ+ youth as a vulnerable minority group, who still face inequalities in their lives.

As nursing developed into an independent discipline, nursing scholars developed disciplinary-specific theories about knowing, which is unique to nursing (Chinn & Kramer, 2015). One of the theories is the fundamental patterns of knowing in nursing, originally developed by Barbara Carper (Meleis, 2012a). The theory of fundamental patterns of knowing in nursing is based on the idea that nurses need different kinds of information when taking care of patients, families, and promoting health and wellbeing in different clinical settings and societies. Information is gained from various sources, and the facilitation of information occurs in actions, movements, expressions, and many other ways nurses interact with patients. However, all the information nurses have cannot be categorized as something they learn from books or formal education. Nursing also includes information which nurses gain and use unconsciously or intuitively, and thus we can speak about knowing in nursing. Knowing in nursing is defined as "a particular and unique awareness that grounds and expresses the being and doing of a person". (Chinn & Kramer, 2015.)

In Carper's theory, knowing in nursing is divided into four patterns, personal, ethical, empiric, and aesthetic. The theory was further developed by Chinn and Kramer (2015) who added a fifth pattern of knowing into the theory, which is emancipatory knowing. Chinn and Kramer considered emancipatory knowing fundamental to nursing, as nurses need to have knowledge and understanding about social justice and equality, thus, emancipatory knowing is connected to other four patterns of knowing (Chinn & Kramer, 2015). As LGBTQ+ people can be a vulnerable group with specific health disparities and inequalities than the general population (Stall et al., 2020), emancipatory knowing is an essential pattern of

knowing in constructing theoretical knowledge about LGBTQ+ inclusive nursing. Therefore, I chose the theory of five patterns of knowing in nursing (Chinn & Kramer, 2015; Figure 1.) as the background for the theoretical model construction.

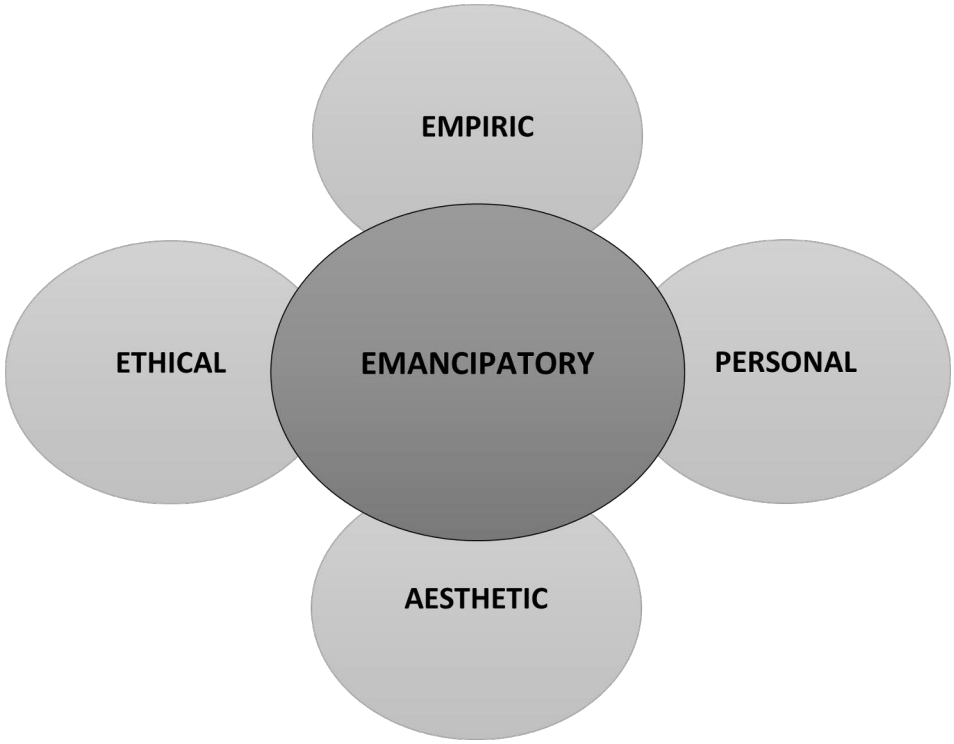

Figure 1. Five patterns of knowing in nursing, modified from Chinn and Kramer (2015).

Empiric, ethical, aesthetic, personal, and emancipatory patterns of knowing in nursing are interconnected and used simultaneously in nursing. Nursing is understood as a field, where nurses need different types of knowing to master their work and treat patients comprehensively. Furthermore, all the patterns of knowing are necessary, and each includes knowledge that cannot be replaced by knowledge from another pattern. Empiric knowing is considered to be the scientific knowledge of nursing, ethical as the component of moral knowledge, aesthetic knowing as the art of nursing, personal knowing is knowledge of the self and others. Finally, emancipatory knowing includes the knowledge and the capacity to recognize inequalities, injustice and seek liberation from complex social and institutional unfairness to improve all patients' health and wellbeing. (Chinn & Kramer, 2015.)

Empiric knowing in nursing is the most identified pattern of knowing nurses use and need in practice. It includes the disciplinary knowledge, nursing as a science,

the anatomical and physiological knowledge about human bodies, health and illness, and medical knowledge. In nursing, evidence-based practice has increased its significance, thus empirical knowing in nursing is much appreciated and based on research. Empirical knowing is integrated into practice as nurses' scientific competence to use theories, interventions and techniques needed in varying nursing situations. (Chinn & Kramer, 2015.)

Ethical knowing in nursing focuses on the moral and ethical issues in nursing. This pattern of knowing includes knowledge about ethical principles and codes, patients' rights, and an understanding of ethics and morality. It is the component which is concerned with the clarifying values and exploring alternatives, which helps nurses to weigh their decisions carefully in situations that can be ethically complex. (Chinn & Kramer, 2015.)

Aesthetic knowing refers to "the art of nursing", since it is a diverse process of using a combination of different types of information in practice. It helps nurses to understand the uniqueness of people and their health, and nurses can carefully plan actions to achieve the desired outcome, such as treating a frightened and sick child, whose parents are worried about them. Aesthetic knowing requires understanding the deeper meanings in a situation, recognizing the uniqueness of people and their experiences, and mentally envisioning and rehearsing care situations. Aesthetic knowing gives nurses a competence to be flexible and intuitive to "read the room" and change their actions if the situation requires it. (Chinn & Kramer, 2015.)

Personal knowing in nursing is a dynamic process of self-knowing, which is shaped in relation to others. Personal knowing can be defined as a nurse being a wholeness, with their own understanding, perceptions, experiences, values, and other characteristics that have shaped them throughout life, and affect their interpersonal relationships with other people. With personal knowing, nurses can be aware of how their own characteristics shape their views about patients, health, wellbeing, how to be in harmony with them, and treat all patients equally. Personal knowing is inherent to nursing, since nursing practice is constituted of countless interpersonal relationships with patients, families, and communities. (Chinn & Kramer, 2015.)

Emancipatory knowing is nurses' awareness and critical reflection on inequalities, injustice, and ways to promote equality and equity in practice. Emancipatory knowing is a process, where it is essential to question and identify the possible underlying power dynamics, privileges, social and political contexts related to knowledge, health and healthcare of individuals, families, and communities. The awareness in emancipatory knowing requires nurses' understanding of social problems, and how they create inequalities for a patient or a patient group, including LGBTQ+ populations. Through this awareness, nurses can identify the existence of the problem by analyzing the social, political, and institutional structures in their practice. With emancipatory knowing, nurses can critically reflect what changes are

required to solve the problem in order to reduce inequalities, and to increase equitable and inclusive practices. Emancipatory knowing is integrated into other patterns of knowing (personal, ethic, aesthetical, empirical) as it needs to be grounded in other patterns of knowing to make changes and reduce inequalities in practice. (Chinn & Kramer, 2015.)

2.5 Review of empirical research on LGBTQ+ youth in school nursing

This section presents a review of the empirical studies that have focused on LGBTQ+ youth in a school nursing context. This review summarizes the existing empirical studies and the research evidence about LGBTQ+ youth in school nursing, and it identifies the current gaps in research that have guided the purpose of this study.

2.5.1 Literature search

I conducted systematic literature searches in three electronic databases (PubMed/Medline, CINAHL, PsycINFO) to map the empirical research on LGBTQ+ youth in school nursing contexts. The literature searches were done in April-May 2023 with search phrases combining free-text terms and database-specific key terms. (Appendix 1.) The limitations on the literature were that the publication type was an empiric research article, and the publication language was Finnish, English, or Swedish. The inclusion criteria for the articles were: 1) the study focused on LGBTQ+ youth or sexual and gender diversity, and 2) the study focused on school nursing, school healthcare, or the study clearly included a school nursing perspective.

In total, the database searches resulted in 5910 hits, and these were first screened at the title and abstract level, and then at the full text level. At the full text level, 21 empiric research articles were read through and screened in more detailed, and some of them were excluded as they failed to meet the second inclusion criteria. Finally, 12 empirical research articles were chosen to be reported in this review (Appendix 2.).

2.5.2 Review of empirical studies on LGBTQ+ youth in school nursing

The empirical research conducted on LGBTQ+ youth in school nursing is limited, as only 12 research articles were found (Appendix 2.). These studies were published rather recently since the publication years varied between 2006–2021. Interestingly, over half of the research articles (Cahill et al., 2020; Earnshaw et al., 2020; Reisner

et al. 2020; Neiman et al., 2021; Sava et al., 2021; Terao & Kaneko 2021) were published in 2020–2021, which indicates that research interest in LGBTQ+ youth has increased. However, three research articles (Earnshaw et al., 2020; Reisner et al., 2020; Sava et al., 2021) based on a larger research project and utilized same data in the articles. Except for one study (Terao & Kaneko, 2021), the studies were conducted in the United States, which limits the generalizability and transferability of the research evidence to other areas outside of the American context.

In most of the empirical studies, participants were school nurses (Sawyer et al., 2006; Mahdi et al., 2014; Cahill et al., 2020; Earnshaw et al., 2020; Reisner et al. 2020; Neiman et al., 2021; Sava et al., 2021; Terao & Kaneko 2021), other school health professionals (Sawyer et al., 2006; Mahdi et al., 2014; Cahill et al., 2020; Earnshaw et al., 2020; Reisner et al. 2020; Sava et al., 2021), or school healthcare administrators and directors (Garbers et al., 2018). Half of the studies included LGBTQ+ youth as participants (Rasberry et al., 2015; Rose & Friedman, 2017; Earnshaw et al., 2020; Reisner et al. 2020; Zhang et al., 2020; Sava et al., 2021).

Empirical studies from the perspective of LGBTQ+ youth in school nursing

The empirical research, in which LGBTQ+ youth have been participants, has studied several topics, such as; sexual health and sexual health services (Rasberry et al., 2015; Rose & Friedman, 2017), health needs of LGBTQ+ youth (Sava et al., 2021), supporting the mental health of LGBTQ+ youth in school-based health centers (Zhang et al., 2020), LGBTQ+ youth's experiences of being bullied (Earnshaw et al., 2020), reporting bullying to school health professionals and professionals responding to LGBTQ bullying (Earnshaw et al., 2020; Reisner et al., 2020). The findings of these studies showed that LGBTQ+ youth had unmet health-related needs (Rasberry et al., 2015; Rose& Friedman, 2017; Sava et al., 2021), and that they had encountered school nurses and health professionals with negative attitudes towards sexual and gender diversity (Earnshaw et al., 2020; Reisner et al., 2020). The research also indicated that school nurses had skills and knowledge gaps as regards LGBTQ+ health needs (Rasberry et al., 2015; Rose& Friedman, 2017; Reisner et al., 2020) and they lacked the knowledge to address and respond to LGBTQ bullying (Earnshaw et al., 2020; Reisner et al., 2020) or were not aware of the extent of the bullying (Earnshaw et al., 2020). Furthermore, if LGBTQ+ youth were unsure about school nurse's attitudes toward LGBTQ people, they considered it was not safe to talk about their same-sex attraction with the school nurse (Rasberry et al., 2015; Reisner et al., 2020). Therefore, the studies concluded it was important that school nurses show an open-minded and non-judgmental attitude towards sexual and gender diversity (Rasberry et al., 2015; Reisner et al., 2020). Some studies reported LGBTQ+ youth having positive experiences in school nursing (Rasberry et al., 2015;

Zhang et al., 2020), such as receiving the support they needed for their mental health (Zhang et al., 2020), STD testing (Rose& Friedman, 2017) and school nurses genuinely caring for them (Rasberry et al., 2015; Earnshaw et al., 2020; Reisner et al., 2020).

There seems to be an especial lack of empirical research conducted from the perspective of gender minority youth in school nursing. In this review, only one study (Neiman et al., 2021) was found that focused on this topic; the Neiman et al. (2021) study described school nurses' experiences of working with transgender and gender diverse students and their parents/carers. The findings of this study showed that school nurses had received some education in gender diversity, but they perceived that this education was inadequate to support their work. School nurses expressed a strong willingness to support transgender and gender diverse youth and their families, and the desire to access education and information that helped them to develop as professionals. (Neiman et al., 2021.)

In three studies (Earnshaw et al., 2020; Reisner et al., 2020; Sava et al., 2021) findings specific to gender minority youth were somewhat reported in the research article. In some studies, the number of gender minority youth out of all LGBTQ+ participants were unclear, as it was not reported in the research articles (Rose & Friedman, 2017; Zhang et al., 2020). It seems that LGBTQ+ youth were often combined as a monolithic minority group in the research (Sawyer et al., 2006; Mahdi et al., 2014; Rose & Friedman, 2017; Garbers et al., 2018; Cahill et al., 2020; Zhang et al., 2020, Sava et al., 2021) which may affect how generalizable the research findings can be considered for gender minority youth, or how much the findings can improve an understanding of their needs in school nursing.

Empirical studies from the perspective of school nurses

Empirical research, in which the participants have been school nurses, other school health professionals, health administrators and directors, has studied several aspects of LGBTQ+ requirements. These aspects include: the education and training needs in providing care for LGBTQ+ youth (Sawyer et al., 2006), professionals' preparedness to address LGBTQ+ youth health needs (Mahdi et al., 2014) and to provide HIV preventive care (Cahill et al., 2020), supporting gender minority youth (Neiman et al., 2021), providing consultation on sexual orientation (Terao & Kaneko, 2021) or culturally competent care for LGBTQ+ youth (Garbers et al., 2018), identifying health needs of LGBTQ+ youth (Sava et al., 2021), experiences of LGBTQ+ bullying and responding to these cases (Earnshaw et al., 2020; Reisner et al., 2020). The research findings showed that school nurses needed more knowledge, education, and training to provide care that responds to the health needs of LGBTQ+ youth (Sawyer et al.,

2006; Mahdi et al., 2014; Cahill et al., 2020; Terao & Kaneko, 2021; Sava et al., 2021). Moreover, informational sources and materials about these topics were needed in school nursing practice (Sawyer et al., 2006; Cahill et al., 2020; Reisner et al., 2020; Sava et al., 2021). All the school nurses had accepting attitudes toward sexual and gender diversity (Sawyer et al., 2006; Cahill et al., 2020; Earnshaw et al., 2020, Reisner et al., 2020; Neiman et al., 2021; Sava et al., 2021) except for one study in which the school nurses' attitudes were more likely to be negative than other health professionals' (Mahdi et al., 2014). School nurses expressed genuine care for LGBTQ+ youth and their families (Earnshaw et al., 2020; Cahill et al., 2020; Reisner et al., 2020; Neiman et al., 2021), but they realized their knowledge and skill gaps limited their competence in providing care (Sawyer et al., 2006; Cahill et al., 2020). In terms of LGBTQ+ bullying, school nurses did not necessarily witness bullying (Earnshaw et al., 2020), but they were aware of LGBTQ+ youth having a higher risk for being bullied (Earnshaw et al., 2020). They supported emotionally LGBTQ+ youth who had been bullied (Earnshaw et al., 2020; Reisner et al., 2020), but they indicated that in school there were limited protocols to report and respond to LGBTQ+ bullying (Reisner et al., 2020). School nurses also identified creating inclusive environments as being significant in securing a feeling of safety for LGBTQ+ youth (Cahill et al., 2020; Reisner et al., 2020; Sava et al., 2021).

2.5.3 Current research gaps

To conclude the review of the empirical research, I identified the following research gaps on LGBTQ+ youth in school nursing:

- Research on the topic has not been conducted in Nordic countries or in Europe.
- Previous research has more often focused on the perspectives of school nurses or health professionals than the perspectives of LGBTQ+ youth.
- The perspectives of gender diversity and gender minority youth are still rare in research.
- LGBTQ+ youth seem to be considered as a monolithic minority group in research, and research differentiating sexual minority and gender minority specific health is minimal.
- No studies were found that explored school nursing by combining the existing research literature, the perspective of LGBTQ+ youth and the perspective of school nurses.
- Previous research has not developed or tested any theoretical models or frameworks for this topic.

3 Aim of the study

The aim of the study was to develop a theoretical model describing LGBTQ+ inclusive junior high school (JHS) nursing. The theoretical model will allow an in-depth understanding to be created for this under-researched nursing phenomenon, which is important for the health and well-being of LGBTQ+ youth at a junior high school age. In future, the theoretical model can facilitate and guide further research, help to develop school nursing education, and update the guidelines and policies of school nursing.

This study includes three sub-studies (Paper I-III). The findings of the sub-studies constitute the empirical knowledge for the theoretical model. The structure of the theoretical model is based on Chinn and Kramer's (2015) theory of five patterns of knowing in nursing, and the empirical knowledge of the model is categorized into these five patterns.

The aims of the sub-studies are:

1. To describe the encounters of LGBTQ+ youth in healthcare based on the existing research. (Paper I)
2. To describe the experiences of Finnish LGBTQ+ youth engaging with JHS nurses. (Paper II)
3. To describe Finnish JHS nurses' perceptions of supporting LGBTQ+ youth. (Paper III).

The following research question guided the development of the theoretical model:

4. What are the elements of LGBTQ+ inclusive JHN nursing at the levels of of *emancipatory, ethical, empiric, personal,* and *aesthetic knowing in nursing*?

4 Materials and Methods

This chapter consists of three parts. First, I describe the materials and methods used in this study (Paper I-III, Table 1.). Second, I use reflexivity to describe my position as a qualitative researcher studying LGBTQ+ youth in JHS nursing. Finally, I describe the ethical considerations in this study.

Table 1. Designs, settings, samples, data collection methods and analysis of the sub-studies.

Sub-study/ Paper	Design	Setting	Sample	Data collection method	Data analysis
I	Integrative literature review	Primary healthcare from the perspectives of LGBTQ+ youth or health professionals	Scientific, peer-reviewed research articles (n= 18)	Systematic literature searches in six databases: Pubmed/Medline, CINAHL, Cochrane Library, PsychINFO, Eric, and Academic Search Premier (EBSCO)	Deductive descriptive analysis
II	Qualitative descriptive	LGBTQ+ youth in JHS nursing	Purposive and snowball sampling, Finnish LGBTQ+ youth (n= 35)	An online survey with demographic questions and open-ended questions	Inductive thematic analysis
III	Qualitative descriptive	JHS nursing in Southern Finland municipalities (n=4)	Purposive sampling, Finnish JHS nurses (n= 15)	Semi-structured focus group interviews (n= 4)	Inductive thematic analysis

4.1 Study designs, settings, and samples

I used two study designs to describe and explore this nursing phenomenon in the school nursing context. First, an integrative literature review (Whittemore & Knafl, 2005) was used to describe the existing research about encountering LGBTQ+ youth in healthcare (Paper I). Second, qualitative descriptive designs were used to explore the experiences of Finnish LGBTQ+ youth in JHS nursing (Paper II), and Finnish JHS nurses' perceptions about supporting LGBTQ+ youth (Paper III). I chose qualitative descriptive designs since this study focused on a nursing phenomenon, which is rarely studied in the field of nursing, especially from the lived experiences of patients and healthcare professionals (Patton, 2015).

I included two study settings to create an in-depth understanding of LGBTQ+ inclusive JHS nursing. First, as school nursing can be categorized as a primary healthcare service (WHO & United Nations Children's Fund UNICEF, 2018; STM, 2023b), primary healthcare was used as the setting in the integrative literature review to obtain a comprehensive understanding of the existing research (Paper I). Second, Finnish JHS nursing was used as the setting and studied through the perspectives of LGBTQ+ youth (Paper II), and JHS nurses (Paper III).

This study comprised three samples. The first sample consisted of international scientific articles. To find the relevant publications, systematic literature searches were done using six databases with the pre-determined inclusion and exclusion criteria. Articles were included if 1) they were a scientific, peer-reviewed publication 2) the publication language was English, and 3) the research focus was on the perspectives of LGBTQ+ youth in healthcare practices, or 4) the research focus was on the perspectives of health professionals working with LGBTQ+ youth. Articles were excluded, if 1) more than 50% of participating LGBTQ+ youth were younger than 10 years or older than 19 years, 2) the research focus was on a medical condition (e.g., HIV), or 3) the research focus was on a health problem (e.g., tobacco or substance use). The final sample consisted of 18 research articles. (Paper I.)

The second sample comprised Finnish LGBTQ+ youth, and two sampling strategies were applied in this sub-study. Purposive sampling (Patton, 2015) was used to reach LGBTQ+ youth around Finland who could contribute to the study by sharing their experiences in JHS nursing. Furthermore, a snowball sampling was used to reach additional LGBTQ+ youth, as they can be a hard-to-reach population in research (Goodman, 1961; Goodman, 2011). This was done by encouraging the participating youth to share information about the study with their peers. The eligibility criteria for LGBTQ+ youth were: 1) self-identification as an LGBTQ+, 2) 16—19 years old, 3) prior experiences with JHS nursing, 4) mother tongue Finnish or Swedish, 5) voluntary participation. Although junior high school students are typically 13—15 years old, we asked participants to provide retrospective experiences from when they were 16—19 years old. This was for ethical reasons, as

these LGBTQ+ youth could give their independent consent to participate, and their guardians did not need to be informed about the study. In total, n= 35 LGBTQ+ youth participated in the study; nearly half were 16 years old (40%, n= 14), and their gender identities were diverse as 42% (n= 15) chose "other" and wrote identity terms such as *genderfluid*, *nonbinary*, and *transmasculine*. Identifying as an LGBTQ+ was also diverse among the participants, as 49% of (n= 17) chose several identity categories. Furthermore, those who chose "other LGBTQ+ identity" (n= 8), described themselves, for example, as *pansexual*, *nongender asexual*, and *panromantic demisexual*. (Paper II.)

The third sample comprised Finnish JHS nurses, who were reached with purposive sampling (Patton, 2015) in four Southern Finland municipalities. The eligibility criteria for JHS nurses were: 1) prior working experience with JHS-aged adolescents, 2) mother tongue Finnish or Swedish, 3) voluntary participation. In total, n= 15 JHS nurses participated in the study; their working experience with JHS-aged adolescents ranged from six months to 29 years, about half of them (n= 8) had a bachelor's degree in public health, and the other half (n= 7) had a vocational qualification as a public health nurse. (Paper III.)

4.2 Data collections

I collected data using three different methods. First, to combine existing research about LGBTQ+ youth in healthcare without limiting the publication date or the used methodologies (Whittemore & Knafl, 2005). Data for integrative the literature review were collected between November 2017 and January 2018 from the following databases: Pubmed/MEDLINE, CINAHL, Cochrane Library, PsycINFO, Eric, and Academic Search Premier. Search phrases were formed with the following terms and their synonyms: sexual and gender minorities (e.g., homosexual, lesbian, transgender), adolescents (e.g., teen, youth, young), and healthcare practices (e.g., school healthcare, nursing). The screening and selection of research articles was carried out in two phases. First, I screened the systematic search results (N= 1421), removed the duplicates, excluded articles not relevant to the topic, and screened the remaining articles with the inclusion criteria. Second, the remaining articles meeting the inclusion criteria were screened at the title & abstract level, and then at the full text level. The second screening phase was first done independently with another researcher, and through discussion and consensus we selected the final articles. (Paper I.)

The experiences of Finnish LGBTQ+ youth were collected with a qualitative online survey. The survey consisted of demographic questions (age, gender identity, and identity as an LGBTQ+ person) and three open-ended questions to allow participants freely describe their experiences and thoughts regarding JHS nursing.

Replying to the survey happened anonymously, as the topic may be sensitive to LGBTQ+ youth as a vulnerable youth group (Ahern, 2005). A research call with an URL link to the survey was publicized in social media and the newsletter of Finnish LGBTQ+ human rights organization, Seta (Seta, 2023b), and the data collection occurred between September and November 2015. (Paper II.)

Supporting LGBTQ+ youth can be considered as part of school nursing from the points of health promotion, student growth and development, and sexual health (OPH, 2014; THL, 2023). I chose to interview JHS nurses in focus groups, since this enabled participants to share their perceptions, experiences, and thoughts through interaction with each other (Patton, 2015). A semi-structured interview guide consisted of two fictional warmup stories about the engagement of LGBTQ+ youth in JHS nursing, and seven questions related to the topic. Furthermore, at the beginning of the interviews, demographic information was collected from participants (educational background, working experience with JHS-aged adolescents). The recruitment of JHS nurses and the scheduling of focus groups were both done by contacting school nursing managers in the municipalities. Four focus group interviews were undertaken in 2019, three of the groups had three (n= 3) JHS nurses, and one had six (n= 6) JHS nurses. The interviews lasted from 45 to 49 min. and were audio-recorded with the permissions of the participants; the recordings were then transcribed verbatim. (Paper III.)

4.3 Data analyses

I used two qualitative analysis methods in the sub-studies. In the integrative literature review (Paper I), a deductive descriptive analysis was used to create an understanding of heteronormativity in the primary healthcare of LGBTQ+ youth. Heteronormativity has been identified as one reason for the invisibility of LGBTQ+ youth in healthcare practices (McIntyre & McDonald, 2012; Katz, 2014). The theoretical framework in the data analysis was based on a feminist paper about heteronormativity (Jackson, 2006). The paper explored the intersections between gender, sexuality in general, and heterosexuality in social dimensions, and the complexity of heteronormativity (Jackson, 2006). Using the theoretical framework, descriptions addressing heteronormativity and breaking heteronormativity were identified from the research articles, these were listed, and compared. Finally, two themes with five elements were identified in data analysis, and these were synthesized in Paper I.

To generate an understanding of LGBTQ+ inclusive JHS nursing as a phenomenon, from the perspectives of both LGBTQ+ youth and JHS nurses, I used inductive thematic analysis. In both sub-studies, data were imported to NVivo® software for the organization of the qualitative research data (Lumivero, 2023).

Inductive thematic analysis was done by following six stages: 1) familiarizing data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing a report of the analysis (Braun & Clarke, 2006). (Paper II-III.) Two interconnected main themes with four sub-themes were discovered from the experiences of LGBTQ+ youth in JHS nursing (Paper II), and four interconnected main themes with ten sub-themes were discovered from the perceptions of JHS nurses about supporting LGBTQ+ youth (Paper III). The themes and sub-themes from each sub-study were synthesized as thematical figures (Paper II-III).

The theoretical model was constructed in two phases in this doctoral dissertation. First, I read through the findings of the sub-studies several times and merged the findings in order to create larger categories. Second, I divided the categories according to Chinn and Kramer's (2015) five patterns of knowing in nursing: emancipatory, empirical, ethical, aesthetic, and personal. Simultaneously, I wrote notes on what each pattern of knowing included and then, by reflecting on the details of the study findings, allocated them to the patterns of knowing. I wrote narrative descriptions of each pattern of knowing, and the theoretical model of LGBTQ+ inclusive JHS nursing was assembled into a figure. The final theoretical model is presented and described thoroughly in Chapter 5 Findings.

4.4 Researcher's position of studying LGBTQ+ youth in JHS nursing

When conducting research, it is worth noting how the researcher is positioned in the phenomenon of interested. The researcher's position is, especially in qualitative research, strongly related to the whole research process. Therefore, qualitative research is not considered completely objective. (Berger, 2015; Patton, 2015.) Every researcher is situated somehow within the realities in which they conduct research, and it is relevant to engage in open reflexivity about the researcher's personal position, which can affect their interpretations. These positions can be, for example, age, race, gender, sexual orientation, personal experiences, knowledge, beliefs, and theoretical stances. (Berger, 2015; Patton, 2015). With open reflexivity, the researcher can enhance the ethically responsible research process, and the rigour of the findings from the perspective of validity, reliability, and generalizability (Berger, 2015).

Next, I use reflexivity to discuss my position as a researcher. I do this by disclosing positions that may have influenced the ways I designed and conducted the research, and the interpretations I made from data. By this means, I make visible my role in the creation of new nursing knowledge, possible biases, and secure the rigour of my research findings (Berger, 2015). I discuss my researcher position from three

aspects: 1) social constructionism as the background of my scientific thinking, 2) an insider position as a researcher sharing the experience of belonging to the LGBTQ+ community, and 3) an outsider position as having no professional experience working in JHS nursing.

4.4.1 Social constructionism as the background of scientific thinking

Social constructionism as a philosophy of science focuses on the critical examination of knowledge and understanding of the world. Critical examination is based on the idea, that knowledge and concepts are constructed in social interaction and processes, which makes them historically and culturally relative (Dahnke, 2010; Burr, 2015a). In social constructionism, knowledge and concepts are linked to the prevailing social and economic arrangements in time and in the culture (Burr, 2015a), which produces, among other things, power relations. Power relations are bound to agreements made in the community on what is socially acceptable and "normal". Social norms, and therefore communities and cultures can encompass inclusion, exclusion, and limits to what is an acceptable way of being (Burr, 2015a). This leads to a critical examination of the nature of knowledge as one, universal truth, since the perceptions and understanding of the world may vary between communities, cultures, and periods of time (Dahnke, 2010; Burr, 2015a).

With the concepts of sexuality, sex and gender, we can recognize their historical and cultural backgrounds in Western societies, and how they have changed as socially constructed concepts over time. In the history of sexuality, heterosexuality has long been defined as the sole normal, natural, and acceptable sexual orientation, while homosexuality has been defined as abnormal, unnatural, and unacceptable. (Foucault, 1984; Hart & Wellings, 2002; Smalley et al., 2018; Spurlin, 2019.) Knowledge about sexuality has been influenced by the institutions of Western societies, such as the Christian church and science (Foucault, 1984; Spurlin, 2019). This has created intimate power structures between individuals and authorities (Foucault, 1984; Spurlin, 2019), as religion, medicine and psychology have had the power to determine sexual norms, including the levels of sexual desires, thoughts, and actions (Foucault, 1984; Hart & Wellings, 2002; Spurlin, 2019). The distinction between biological *sex* and social *gender* is rather recent (Burr, 2015b; Lips, 2019), and a binary view of gender has dominated the way people are presumed to be and therefore categorized as women or men (Burr, 2015b; Lips, 2019). Further, gender identities not aligning with biological sex have long been diagnosed as a disorder in diagnostic classifications like DSM and ICD (WHO, n.d.; APA, n.d.; Spurlin, 2019). Today, we increasingly acknowledge that being a woman or man is constructed from several aspects, including biological, social, and personal aspects, and that

masculinity and femininity are socially constructed and shaped through history and culture (Diamond et al., 2011; Lips, 2019; Sell & Conron, 2020) Currently, gender diversity is increasingly acknowledged and accepted, especially among adolescents (Diamond et al., 2011; Bosse & Chiodo, 2016; Beckett & Taylor, 2019).

Social constructionism has been the background of my scientific thinking throughout the research process. It has served as a means of conceptualizing and understanding social phenomena, such as attitudes and discourses related to sexuality, gender and diversity. I have been able to identify power relations related to sexuality and gender in Western culture and history, where sexual and gender diversity has been controlled by appealing to biology, medicine, religion, or sexual and gender norms. As a result, homosexuality has been labelled either as a mental disorder or an abnormal sexual activity compared to heterosexuality, and in the case of the Christian church homosexuality is considered a sin (Foucault, 1984; Spurlin, 2019). Through social constructionism, I have explored the research topic from the following perspectives: how nursing and school nurses define sexual and gender diversity; how LGBTQ+ youth describe their sexual orientation and gender identity and what meanings these aspects of life have for the health and well-being of LGBTQ+ youth; how could we create a connection between these two groups (LGBTQ+ youth and school nurses) who have grown up in different times, and create LGBTQ+ inclusive school nursing.

4.4.2 The insider position when studying LGBTQ+ youth

The insider position refers to a situation, where the researcher shares the same or similar experiences as the research participants about the phenomenon. This can affect the ways participants are willing to share their experiences and thoughts to the researcher, and it can support a confidential researcher-participant relationship. As an insider the researcher has the possibility to communicate with participants through "talking the same language", ask specific and subtle questions about the phenomenon and gain in-depth information from the participants. In addition, the researcher can make interpretations from data, which would not be possible from an outsider position. (Berger, 2015; Stephenson & Riley, 2020.) With sensitive research topics, such as experiences of vulnerable and marginalized groups, the insider position can help the researcher to ask questions in a sensitive, non-offensive way. On the other hand, the insider position can create certain biases, such as "a dual identity", if the researcher belongs to the same minority group as the participants. In such a case, there is a risk that the researcher may not be aware of how the topic can affect their own wellbeing, or the choices they make during the research process. (Berger, 2015.)

As a researcher sharing the experience of belonging to the LGBTQ+ community, I recognize that this insider position has both strengths and limitations in this study. My knowledge about sexuality and gender diversity is wide-ranging, and I have used this knowledge throughout the research process. This wide-ranging knowledge has supported, for example, the designing of the online survey for LGBTQ+ youth. The online survey was designed to support the self-determination of LGBTQ+ youth as inclusively as possible by providing multiple options to describe their identity. For this reason, in the demographic data there was a freely formatted space to describe identity as an LGBTQ+ youth, in addition to the predefined identity options. (Paper II.) As a member of the LGBTQ+ community, I am aware of the importance of sensitive and considerate language when researching LGBTQ+ topics, and throughout this study I have used language that aims to be respectful, inclusive, and sensitive to LGBTQ+ youth. When I interviewed the JHS nurses (Paper III), I did not specifically disclose my personal connection with the LGBTQ+ community, but there is a possibility that JHS nurses may have realized it in our discussions, which may have affected the way they discussed LGBTQ+ youth and sexual and gender diversity. Furthermore, I recognize that my insider position may have shaped the ways in which I have approached the topic, the interpretations I have made from the data; moreover this "the dual identity" may have caused personal distress when researching a vulnerable minority group. In distressful moments, I have disclosed my thoughts to the supervisors of this study, who have supported my wellbeing through discussions with me.

4.4.3 The outsider position of studying JHS nursing

The outsider position refers to a situation, where the researcher is studying a phenomenon unfamiliar to them. The advantages of the outsider position are that instead of the researcher, it is the participants in the study who are the experts on the phenomenon. This can empower participants and promote a positive researcher-participant relationship. As an outsider, the researcher's approach can be more open-minded, and in the interviews, they can explore the phenomenon with innovative questions that researcher with an insider position might not consider. However, as an outsider the researcher can have challenges either in identifying all the important aspects of the phenomenon, or the language they use, which may be not sensitive enough when studying vulnerable groups or minorities. (Berger, 2015.)

I have no professional background or working experience in the field of school nursing, and therefore I approached the study context from an outsider position. As an outsider, I approached the JHS nurses in the focus groups with open-ended questions, the aim of which was to listen to their experiences and perceptions with genuine interest. Nonetheless, if my background had been in school nursing, the

interview questions might have been different and could possibly have explored the topic with "the language of school nurses"; and the discussions with the JHS nurses could have been more nuanced with a shared professional background.

4.5 Ethical considerations

In this section, I discuss the ethical considerations in this study from three perspectives: the principles of the ethically responsible conduct of research (All European Academies ALLEA, 2023; Finnish National Board on Research Integrity TENK, 2023), conducting research on sexual and gender minorities (Henrickson et al., 2020), and the ethical questions regarding adolescents as research participants (TENK, 2019).

4.5.1 The principles of the ethically responsible conduct of research

Throughout the research process of this study, the ethically responsible conduct of research was followed (ALLEA, 2023; TENK, 2023). I designed, conducted, and reported the findings of this study with every effort to be reliable, honest, respectful, and accountable (ALLEA, 2023; TENK, 2023). Since this study included human participants (Paper II-III), their privacy, autonomy, and dignity were respected (TENK, 2019; TENK, 2023), and the research proposals were reviewed by the Ethics committee of the University of Turku before participant recruitment began (27/2015; 6/2019). With the focus group study (Paper III), research permissions were also applied for from the municipalities before the recruitment of JHS nurses.

As the experiences of the LGBTQ+ youth were collected anonymously and online, they received written information about the study at the beginning of the survey, and they had the possibility to contact to me if they had any questions regarding the study, both before and after participation (Paper II). JHS nurses received written information about the study in the recruitment phase, and before the beginning of the focus group interviews, they received both written and oral information about the study (Paper III). The participation of LGBTQ+ youth (Paper II) and JHS nurses (Paper III) was based on being voluntary and participants were able to withdraw their participation at any time. Informed consent was collected electronically from LGBTQ+ youth prior to sending their replies to the survey (Paper II) and written consent from JHS nurses prior the beginning of the interviews (Paper III). The confidentiality and privacy of participants were secured throughout both sub-studies (TENK, 2019; ALLEA, 2023; TENK, 2023).

Regarding the integrative review of the existing research on encountering LGBTQ+ youth in healthcare (Paper I), the work of these researchers was respected

by referencing the studies appropriately (ALLEA, 2023; TENK, 2023). The chosen studies have been described honestly as the data of the review, and the studies have not been judged by the terminology they used (e.g., how they understand sexual and gender diversity), or research methodology. (Paper I.)

4.5.2 Researching sexual and gender minorities

The strength of researching LGBTQ+ people is the potential to provide validation to the existence of a minority group. LGBTQ+ people are still, in many cases, a vulnerable and invisible patient group, who have distinct health disparities compared to the general population (Henrickson et al., 2020; Stall et al., 2020). Through research it is possible to open and highlight the rich complexities in the health, wellbeing, and health disparities of LGBTQ+ people. These complexities can give valuable information to health policy makers, health care providers, service planners and developers when addressing possible health inequities and promoting inclusive health care (Henrickson et al., 2020). Ethically conducted research with LGBTQ+ people must include some specific questions, that a researcher needs to remember in every study phase. In this section, I describe the ethical questions of 1) the impact of heteronormativity and gender binary norms to LGBTQ+ people as research participants, and 2) the use of identity categories to refer to sexual and gender minorities.

When a researcher is focusing on LGBTQ+ people, it is crucial to maintain a critical observation of heteronormativity and gender binary norms in society, including healthcare and health related discourses, which may affect the ways LGBTQ+ people experience their lives, health, and wellbeing. Sexual and gender minorities can experience a potential risk to their health and wellbeing if their identities are disclosed in cultures or environments, where sexual and gender diversity is unaccepted, stigmatized or discriminated. (Beyrer, 2020; Henrickson et al., 2020.) Therefore, the researcher needs to be aware of the unacceptance of sexual and gender diversity that can create a barrier to LGBTQ+ people participating in research. In addition, in a worst-case scenario, the research can cause harm to the participating LGBTQ+ people by causing an undesired disclosure (Stephenson & Riley, 2020). It is crucial that the research proposal includes ways to protect the privacy of LGBTQ+ people, and the researcher needs to communicate this to the participants (Henrickson et al., 2020; Stephenson & Riley, 2020). In this study, I have made a number of efforts to protect the privacy of LGBTQ+ youth: by obtaining an ethical review for the research proposal from the Ethics committee (27/2015) prior to data collection, choosing the age range that allowed LGBTQ+ youth to give their independent consent without informing guardians, allowing the LGBTQ+

youth to reply to the online survey anonymously, and reporting the findings using pseudonyms for the participants (Paper II).

A relevant ethical question when researching sexual and gender minorities is the terminology with which they are to be referred. Recent literature has recognized that the taxonomy describing sexual orientation and gender identities is contested and fraught, and there is no consensus among researchers about what would be the most accurate term to describe sexual and gender minorities. (Eliason, 2014; Henrickson et al., 2020; Sell & Conron, 2020.) As terms describing sexual orientation and gender identity are bound to the historically and culturally constructed social concepts of sexuality and gender, terms such as queer, for example, have had different meanings in different times. Nowadays queer refers to a person whose sexual orientation, gender identity, or both, are not aligned with social norms, and the person may not want to label themselves as belonging to any fixed identity category; it may also demonstrate political resistance to the heteronormative and gender normative rules in society. In the 20th century, queer was strongly used as a pejorative slang word for male homosexuals, and thus older LGBTQ+ generations may find the use of this term offensive. (Eliason, 2014; Sell & Conron, 2020.)

To conduct ethically responsible research with LGBTQ+ people, it is important to recognize sexuality and gender as dynamic and diverse spectrums of identities, and that the understanding of sexuality and gender are continuously evolving (Henrickson et al., 2020). Young people who identify as LGBTQ+, may choose their identity categories in a more fluid and multi-faceted way than older LGBTQ+ people. Moreover, although young people are still forming their identity and self-image, they are evidently challenging the fixed identity categories regarding sexual orientation and gender identity. (Eliason, 2014; Paasonen & Spišák, 2018.) Young LGBTQ+ people, including adolescents, show openness and flexibility in self-defining, and accept that sexuality and gender can evolve throughout life rather than being firm, static identities that are formed in adolescence (Bosse & Chiodo, 2016; Paasonen & Spišák, 2018).

The use of certain language for sexual and gender minority identities needs to be considered throughout the research process with sensitivity, and the researcher needs to be transparent as regards their language choices. With inclusive language, the researcher enhances the recognition of participants' right to self-determination, and using the language of the participant community shows that the researcher respects their identities. (Henrickson et al., 2020; Stephenson & Riley, 2020.)

In this study, I have mostly used the term LGBTQ+, as its use in health research is, to some extent, common. In the integrative literature review, I used the term SGM (sexual and gender minorities), as I did not want to prioritise and refer only to the specific identity categories (Paper I). For the other two sub-studies, I decided to use the term LGBTQ+ (Papers II-III), as the term SGM was rather rarely used in the

health research at the time of my study. Furthermore, I wanted to use a term that is clear to health researchers. With the term LGBTQ+, I express as a researcher my recognition of sexuality and gender diversity as a spectrum, and in that spectrum other identities exist besides lesbian, gay, bisexual, trans, queer and questioning.

4.5.3 Adolescents as research participants

Conducting research with adolescents includes the ethical question regarding their autonomy as participants, informing guardians about the research and obtaining their consent for the adolescent's participation. Legally, a person under the age of 18 is a minor, and in addition to their consent, their guardians need to give consent for their child's participation. (Laki lapsen huollosta ja tapaamisoikeudesta 8.4.1983/361; Lastensuojelulaki 13.4.2007/417). According to Medical Research Act (488/1999) and Finnish Advisory Board on Research Integrity (TENK, 2019), 15-year-olds can give their independent informed consent about the participation, considering their age and maturity. However, guardians must be informed of the research their child is about to participate in. The principle of informing the guardians may be waived if it is, for example, justified for ethical reasons in research (Laki lääketieteellisestä tutkimuksesta 488/1999; TENK, 2019).

Before l collected the experiences of LGBTQ+ youth (Paper II), I needed to consider how to ensure their safety and privacy if they decided to participate in the study (Henrickson et al., 2020). LGBTQ+ youth are known to be at risk of experiencing unacceptance (Katz-Wise et al., 2016), and even violence (Jokela et al., 2020) in their families due to their sexual orientation or gender identity; thus, an identity disclosure to guardians would possibly have caused unnecessary harm to participants, or it would have occurred at a time when participants were not ready to come out. To minimize causing harm and to protect the right to privacy of LGBTQ+ youth, informing guardians and requesting their consent was excluded. Furthermore, the age range of the participants was set between 16 and 19 years, making it ethically reasonable to ask only LGBTQ+ youth for their consent to participate. (Paper II; Laki lääketieteellisestä tutkimuksesta 488/1999; TENK, 2019; Henrickson et al., 2020.) However, it was recognized that it would not be completely possible to exclude participants under 16 years of age from replying to the survey, however, clear information about the age range was given in the research call, at the beginning of the survey, and also when completing the demographic data, including participant age (Paper II). Furthermore, participation was carried out anonymously, and I did not know the identity of the participants. All information about the participants' place of residence or their IP address was not recorded on the survey system Webropol®.

5 Findings

In this chapter, I describe the findings of this study in two parts. First, I summarize the findings of each sub-study (Paper I-III, Table 2.), which together constitute the empirical knowledge of LGBTQ+ inclusive nursing. Then, I describe the theoretical model of LGBTQ+ inclusive JHS nursing (Figure 2.). The structure of the theoretical model constitutes the five patterns of knowing in nursing (Chinn & Kramer, 2015), and the findings of the sub-studies are categorized into these patterns of knowing.

5.1 Key findings of the sub-studies

In the integrative review (Paper I), the aim of the study was to describe encounters with LGBTQ+ youth in primary healthcare based on the existing research. My integrative review findings showed that the existing research included descriptions of heteronormative care and diversity-affirming care (Paper I; Table 2).

Heteronormative care included three elements. The first element*, the Effect of heteronormativity on health professionals' competence to work with LGBTQ+ youth*, was described as a lack of knowledge on topics relevant to the health of LGBTQ+ youth, as well as a lack of skills to provide care for LGBTQ+ youth. The second element, *False assumptions about LGBTQ+ youth*, described in several research articles as false assumptions concerning: sexual orientation, gender identity, and even stigmatizing LGBTQ+ identities with HIV, mental health issues, and labelling sexual and gender diversity as a phase in adolescence. The third element of heteronormative care, *Influence of heteronormativity on encounters with LGBTQ+ youth*, was mainly negative. The negative influence was described as health professionals' negative attitudes and disrespectful behavior to LGBTQ+ youth, mistreatment of LGBTQ+ youth, and worries of LGBTQ+ youth about health professionals' attitudes to them.

Diversity-affirming care included two elements. The first element was *Considerateness of health professionals towards LGBTQ+ youth*, which was described by both health professionals and LGBTQ+ youth in the research. Considerateness was an open-minded engagement of professionals with sexual and gender diversity topics in practice. It meant that LGBTQ+ youth were encountered and treated with respect, equality and genuine care. The second element, *Inclusive care of LGBTQ+ youth*, included aspects of health professionals, information, and health settings. Inclusive

health professionals were described as using inclusive language, they had knowledge about health issues related to sexual and gender diversity, as well as the lives of LGBTQ+ youth, and they engaged the youth with sensitivity. Inclusive information included topics such as LGBTQ+ specific sexual health and mental health, and information about identity disclosure to family members. Inclusive healthcare settings were described as settings that included signs of safe space for LGBTQ+ youth, health information leaflets about sexual and gender diversity, and medical forms using inclusive language.

In the qualitative study focusing on Finnish LGBTQ+ youth (Paper II), the aim was to describe their experiences of engaging with JHS nurses. According to my findings in that sub-study, two main themes with four subthemes were identified in the descriptions by the LGBTQ+ youth (Paper II; Table 2.).

The first main theme, ***JHS nurse engagement– A mixed or unsatisfactory experience***, included subthemes: *JHS nurses' attitudes and behaviors during consultations*, and an *Inconsistent preparedness to support LGBTQ+ youth*. JHS nursing seemed to be contradictory as regards LGBTQ+ youth; some had received help and support from JHS nurses and found the nurses had accepting attitudes to sexual and gender diversity. However, some LGBTQ+ youth had encountered JHS nurses who were judgmental of sexual and gender diversity, who assumed LGBTQ+ youth to be heterosexual and cisgender. In addition, the nurses lacked knowledge about topics relevant to LGBTQ+ youth. Many LGBTQ+ youth expressed that they had not received the information and support that they needed in JHS nursing regarding sexual and gender diversity.

The second main theme, ***Needs of LGBTQ+ youth for diversity-affirming JHS nursing***, included two subthemes: *LGBTQ+ health and support need recognition*, and the *Need for diversity-affirming information*. For LGBTQ+ youth, it was important that JHS nurses recognized sexual and gender diversity as normal, and that nurses took the initiative to discuss sexuality and gender without presumptions of sexual orientation or gender identity. As some LGBTQ+ youth found the school to be a conservative environment, they felt that JHS nurses should take an advocate role in talking to school personnel and peers about sexual and gender diversity generally. LGBTQ+ youth often felt sexual and gender diversity was excluded from discussions about sexuality and gender, and therefore they expressed the need for diversity-affirming information from JHS nurses. They wished that JHS nurses would show open-mindedness to sexual and gender diversity and offer relevant information for their health and wellbeing. Very often LGBTQ+ youth were obliged to search for information independently, and most of the information was in English.

In the focus group study with JHS nurses (Paper III), the aim was to describe their perceptions of supporting LGBTQ+ youth. According to my findings in that sub-

study, four main themes with several subthemes were identified in the perceptions of JHS nurses (Paper III; Table 2.).

The first main theme, ***JHS nurse's professional identity and practice***, included four subthemes: *Nurse's attitudes and values towards LGBTQ+*, *Skills and knowledge about sexual and gender diversity*, *Available resources with LGBTQ+ topics*, and *LGBTQ+ supportive nursing activities*. JHS nurses perceived sexual and gender diversity as normal in adolescence, they respected LGBTQ+ youth and considered them as equal to their peers. JHS nurses were aware that they had some knowledge gaps in sexual and gender diversity topics, but they were willing to look for additional information or obtain education on these topics. However, evidence-based information and education about LGBTQ+ topics were rare. The supportive nursing activities that JHS nurses included identification of the individual health and support needs of LGBTQ+ youth, sexual health counselling, relationship counselling and supporting their mental health.

The second main theme, ***Recognition of sexual and gender diversity in the school***, included two subthemes: *School climate and teaching*, and *Teachers' attitudes towards sexual and gender diversity*. JHS nurses perceived that schools were rather conservative institutions, and the recognition of sexual and gender diversity was not systematic. Some schools were progressive and LGBTQ+ inclusive, but other schools remained hetero- and gender normative, and some teachers even expressed judgmental attitudes towards LGBTQ+. In health education classes, sexual and gender diversity topics were not systematically covered, especially gender diversity.

The third main theme, ***Family acceptance process***, was identified as significant in supporting LGBTQ+ youth in JHS nursing. It included two subthemes: *Supporting identity disclosure to family*, and *Supporting family communication and connection*. JHS nurses perceived their role as being a safe adult, who would support identity disclosure to a family, if an LGBTQ+ youth was considering that option. This manifested as listening LGBTQ+ youth, respecting their rights and discussing how to proceed with the identity disclosure to the family. JHS nurses experienced that the identity disclosure may cause stress to LGBTQ+ youth, and they wanted to support family communication and connection by discussing sexual and gender diversity with family members, with the aim of emphasizing that diversity is normal in adolescence.

The fourth main theme, ***LGBTQ+ youth as school nursing clients***, included two subthemes: *LGBTQ+ youth as experts with LGBTQ+ topics*, and *Identity disclosure to JHS nurses*. As LGBTQ+ youth actively searched for information about sexual and gender diversity, they could have more information about the topics than JHS nurses. By regarding LGBTQ+ youth as experts, the JHS nurses felt they had an opportunity to learn more about sexual and gender diversity. JHS nurses showed appreciation to LGBTQ+ youth, and this could promote positive self-confidence in the youth. However, JHS nurses realized that not all LGBTQ+ youth wanted to

disclose their identity immediately to JHS nurses. It was important that LGBTQ+ youth could first ensure nurse's attitudes were not judgmental or intolerant of sexual and gender diversity. This was part of creating a safe and confidential relationship between LGBTQ+ youth and JHS nurse.

Table 2. The key findings of sub-studies (Paper I-III).

Paper/ Sub-study	Study topic	Key findings from data analysis
I	Encountering LGBTQ+ youth in healthcare	**Heteronormative care** • *The effect of heteronormativity on health professionals' competence to work with LGBTQ+ youth* • *False assumptions about LGBTQ+ youth* • *The influence of heteronormativity on encounters with LGBTQ+ youth* **Diversity-affirming care** • *The considerateness of health professionals towards LGBTQ+ youth* • *Inclusive care of LGBTQ+ youth*
II	Experiences of Finnish LGBTQ+ youth of JHS nursing	**Main theme: JHS nurse engagement– A mixed or unsatisfactory experience** • Subtheme: *JHS nurses' attitudes and behaviors during consultations* • Subtheme: *Inconsistent preparedness to support LGBTQ+ youth* **Main theme: Needs of LGBTQ+ youth for diversity-affirming JHS nursing** • Subtheme: *LGBTQ+ health and support need recognition* • Subtheme: *The need for diversity-affirming information*
III	Finnish JHS nurses' perceptions about supporting LGBTQ+ youth	**Main theme: JHS nurses' professional identity and practice** • Subtheme: *Attitudes and values towards LGBTQ+* • Subtheme: *Skills and knowledge about sexual and gender diversity* • Subtheme: *Available resources with LGBTQ+ topics* • Subtheme: *LGBTQ+ supportive nursing activities* **Main theme: Recognition of sexual and gender diversity in the school** • Subtheme: *School climate and teaching* • Subtheme: *Teachers' attitudes towards sexual and gender diversity* **Main theme: Family acceptance process** • Subtheme: *Supporting identity disclosure to family* • Subtheme: *Supporting family communication and connection* **Main theme: LGBTQ+ youth as school nursing clients** • Subtheme: *LGBTQ+ youth as experts with LGBTQ+ topics* • Subtheme: *Identity disclosure to JHS nurses*

5.2 A theoretical model of LGBTQ+ inclusive JHS nursing

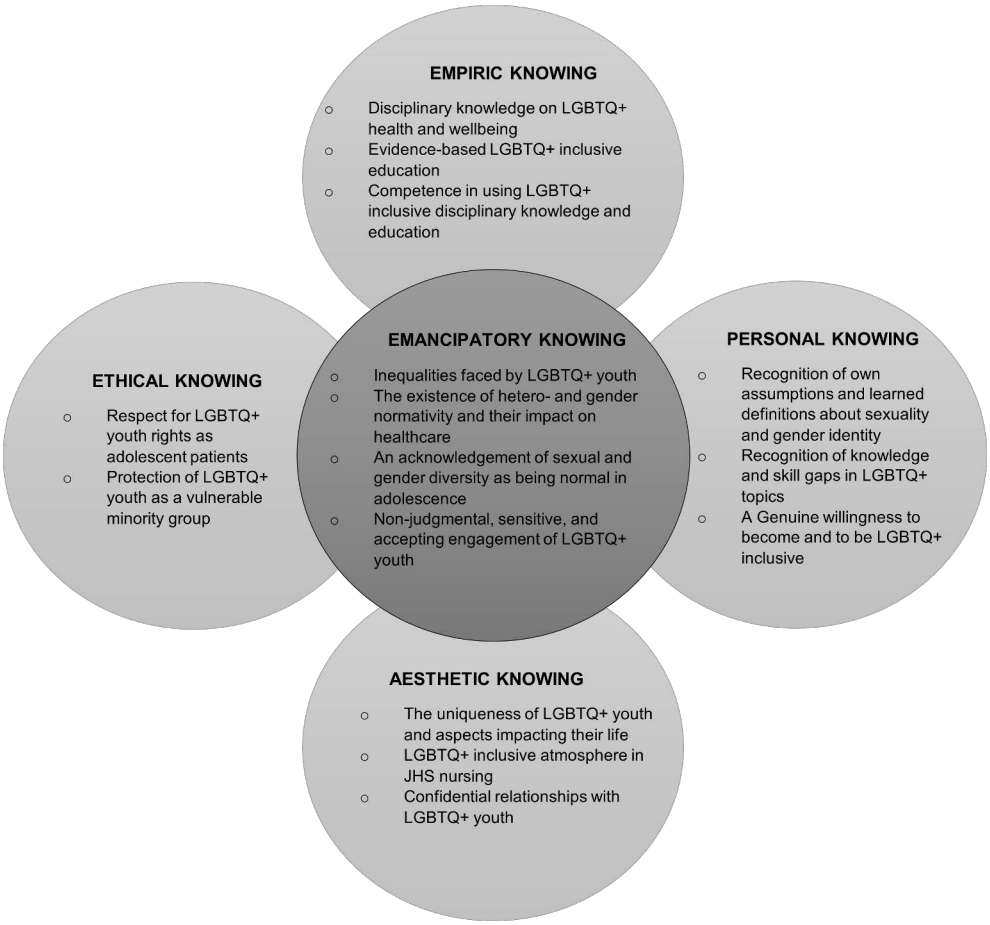

Figure 2. A theoretical model of LGBTQ+ inclusive JHS nursing.

5.2.1 Emancipatory knowing in LGBTQ+ inclusive JHS nursing

Emancipatory knowing is located at the center of the theoretical model, as it is essential that a JHS nurse understands the vulnerability of LGBTQ+ youth as a minority group, who face certain inequalities when compared to their peers. With emancipatory knowing, the JHS nurse can identify the causes beneath the inequalities, how these inequalities appear in health care, and what is needed to address inequality and promote LGBTQ+ inclusive JHS nursing. Emancipatory knowing is interconnected with other patterns of knowing and ensures that the JHS

nurse has an understanding of how their daily practice can be LGBTQ+ inclusive, as well as what LGBTQ+ inclusive JHS nursing encompasses in empirical, ethical, aesthetic, and personal knowing.

First, the JHS nurse needs to be aware of ***inequalities faced by LGBTQ+ youth***. These inequalities include threats and actual experiences of discrimination as the unacceptance of sexual and gender diversity still exists in different societies. LGBTQ+ youth can be stigmatized or marginalized in discussions, practices and education regarding sexuality, gender identity, and how they develop. These inequalities cause minority stress to LGBTQ+ youth about other people's reactions to their identity, and if the identity disclosure will have negative consequences in their life, such as being bullied.

Second, the JHS nurse needs to be aware of ***the existence of hetero- and gender normativity and their impact on healthcare***. Hetero- and gender normativity refers to the assumption that all adolescents are heterosexual, cisgender (girl/woman, boy/man), and that other sexual orientations and gender identities are exceptional or something that is not considered normal and natural. This causes inequalities in the healthcare of LGBTQ+ youth, such as: unequal access to health information and health services, the presumption that LGBTQ+ youth are heterosexual or identify within the girl/boy gender binary, mistreatment due to, for example, health professional's labelling LGBTQ+ identity as a phase or something that needs to be corrected. Due to hetero- and gender normativity, LGBTQ+ youth may not disclose their identity to health professionals, especially if they have prior negative experiences in healthcare regarding their sexual orientation or gender identity.

As the JHS nurse becomes aware of the inequalities of LGBTQ+ youth and hetero- and gender normativity, they can recognize ways to reduce these inequalities and promote LGBTQ+ inclusive JHS nursing. First, there is ***an acknowledgement of sexual and gender diversity as being normal in adolescence***, which manifests through the JHS nurse's understanding that being LGBTQ+ is normal, and that adolescents who identify as LGBTQ+ are not necessarily confused about their sexuality or gender identity. As sexual and gender diversity is acknowledged as being normal, the JHS nurse can then recognize that any of their patients can be LGBTQ+, even adolescents who have not disclosed it to the JHS nurse. Furthermore, when the JHS nurse is aware of hetero- and gender normativity, they can critically reflect heteronormative and gender normative definitions of sexuality, relationships, gender identity and gender expression.

The second way to promote LGBTQ+ inclusive JHS nursing is to foster ***non-judgmental, sensitive, and accepting engagement with LGBTQ+ youth*** in day-to-day encounters with the adolescents. Non-judgmental, sensitive, and accepting engagement manifests through the JHS nurse's open-minded and genuine willingness to address sexual and gender diversity topics with adolescents. The JHS

nurse treats each adolescent equally regardless of their sexual orientation, gender identity, or situations where they do not know the adolescent's sexual orientation or gender identity.

5.2.2 Empiric knowing in LGBTQ+ inclusive JHS nursing

Empiric knowing constitutes both knowledge and nursing actions that are relevant in LGBTQ+ inclusive JHS nursing. Empiric knowing integrates the information the JHS nurse has, and the practical use of that information, such as, using interventions and official guidelines when treating individual patients and their families, as well as understanding the patient as a holistic whole.

Disciplinary knowledge on LGBTQ+ health and wellbeing cover a range of topics significant to the health and wellbeing of LGBTQ+ youth. When considering sexual health, it is important that information about safe sex practices covers STI prevention of same-sex partners, including the use of condoms and dental dams. Sexual diversity includes information on different sexual orientations, sexuality as a diverse life-long process, of which diversity is a normal part. Gender diversity includes information about trans and nonbinary identities, the distinction between biological, social, and psychological aspects of gender, gender dysphoria and gender-affirming care processes regarding adolescents as minor patients. As LGBTQ+ people are in a vulnerable position compared to heterosexual and cisgender people, general information about LGBTQ+ people is also relevant to JHS nurses. This encompasses LGBTQ+ human rights, the societal position of LGBTQ+ people, and the equal freedom of choices in life, such as marriage and starting a family. Furthermore, information about LGBTQ+ specific health issues cover topics such as the higher risk of depression and anxiety, due to the unaccepting attitudes towards sexual and gender diversity LGBTQ+ youth can experience.

For the JHS nurse to have professional preparedness to be LGBTQ+ inclusive, nursing education needs to cover studies regarding LGBTQ+ health and wellbeing. As evidence-based practice is crucial in nursing and healthcare, ***evidence-based LGBTQ+ inclusive education*** is relevant for both under-graduate and further education levels. As sexual and gender diversity can be related to different stages of life (childhood, adolescence, adulthood, old age) different life events (e.g., growing up, relationships, marriage, pregnancy), and different aspects of health (physical, sexual, mental, social), evidence-based LGBTQ+ inclusive education should be comprehensive. Therefore, employers and health organizations should support JHS nurses by providing opportunities to obtain evidence-based LGBTQ+ inclusive education and information throughout their career.

Competence in using LGBTQ+ inclusive disciplinary knowledge and education is an integration of knowledge into various actions in JHS nursing

practice. It is the JHS nurse's ability to facilitate evidence-based, LGBTQ+ inclusive knowledge into different areas of their work. For example, as sexual health is one of the main areas of discussions with JHS aged adolescents, the JHS nurse needs competence to discuss comprehensively about sexual diversity and LGBTQ+ inclusive sexual health topics with all adolescents. Furthermore, discussions about physical development in adolescence includes gender diversity, and the JHS nurse needs knowledge about different gender identities, gender dysphoria and treatment of gender minority youth. Discussions should not be limited to the physical development of men and women and the puberty of girls and boys, but gender-related development is seen as a diverse process, in which adolescents can identify as something else than a girl/woman or a boy/man. Competence is also manifested in the LGBTQ+ inclusive language used by JHS nurses, such as partner. Knowledge about LGBTQ+ health related topics supports the JHS nurse's competence to identify LGBTQ+ youth specific health and support needs. Moreover, general information about LGBTQ+ can support the understanding of the reasons that can cause minority stress to LGBTQ+ youth, and how JHS nursing can support them.

5.2.3 Ethical knowing in LGBTQ+ inclusive JHS nursing

Ethical knowing considers the ethical and moral aspects of LGBTQ+ inclusive JHS nursing. Ethical knowing constitutes a clarification of JHN nurses' professional values, ethical principles, and a consideration of different alternatives in situations which may include ethical dilemmas. Ethical knowing in LGBTQ+ inclusive JHS nursing guides and directs how the JHS nurse can be ethically responsible in practice and what the priorities in LGBTQ+ inclusive nursing care are, and, whether some situations require advocacy.

Patients' rights are essential in nursing ethics, as they are crucial to the ethical codes of different nursing professionals, and they are legally defined rights. ***Respect for LGBTQ+ youth rights as adolescent patients*** constitutes aspects of self-determination, privacy, protection from undesired identity disclosure, and equal access to health services and health information. The right to self-determination is respecting LGBTQ+ youths' right to define their sexual orientation and gender identity. For LGBTQ+ youth, it is particularly important that the JHS nurse does not question their ability to define themselves and understands that sexual and gender diversity-related identities are as valid identities as heterosexuality or identifying within a girl-boy gender binary. For the safety of LGBTQ+ youth, it is important to respect their right to privacy, and right to be protected from an undesired identity disclosure. The identity of LGBTQ+ youth should not be disclosed to other people without their consent, since, for example, their family may not be aware of their identity. The JHS nurse needs to be aware that a safe identity disclosure may not be

possible in all families, and that a discussion with the family regarding identity should only occur when an LGBTQ+ youth indicates that they are ready. To support the connection between LGBTQ+ youth and their family, the JHS nurse needs to act as an LGBTQ+ advocate, if needed. Then JHS nurse needs to seek ways to promote family members' understanding that sexual orientation and gender diversity is not a concern, but a normal part of some adolescents' growth in becoming a unique person. Furthermore, as JHS-aged LGBTQ+ youth are legally minors, they have the right to make age-appropriate decisions about health and well-being. For example, if an LGBTQ+ youth discusses their identity disclosure to their family, the JHS nurse respects the LGBTQ+ youth by asking whether they are ready to engage in discussions with their family. The JHS nurse should then support the decisions of the LGBTQ+ youth, even if they are not willing to disclose their identity to family. Every adolescent, including LGBTQ+ youth, have the right to access health services and information supporting health, wellbeing, and growth. In LGBTQ+ inclusive JHS nursing this covers areas of physical health and development, mental health, sexual and reproductive health, psychosocial counselling, and guidance to other health services and information sources regarding sexual and gender diversity. Other health services encompass treatment of gender minority youth, who experience gender dysphoria and who are considering gender-affirming care, which is organized in Finland at two university hospital clinics.

Ethical knowing also comprises ***protection of LGBTQ+ youth as a vulnerable minority group***. LGBTQ+ youth may not be accepted as themselves in school, at home, or in other significant environments. Therefore, the JHS nurse can give protection to LGBTQ+ youth in the school environment by being a safe adult. It is important, that the JHS nurse speaks out if they observe any unacceptance, prejudice, or discrimination towards sexual and gender diversity from school personnel or peers. The JHS nurse as LGBTQ+ advocate signals to LGBTQ+ youth that they have at least one safe adult in school, which also promotes the creating of a trustful relationship between the nurse and LGBTQ+ youth. The JHS nurse can then help and support LGBTQ+ youth in stressful situations, such as with identity disclosure to family.

5.2.4 Aesthetic knowing in LGBTQ+ inclusive JHS nursing

Aesthetic knowing, also referred as "the art of nursing", is a diverse process in LGBTQ+ inclusive JHS nursing, in which the JHS nurse combines different types of information they have about LGBTQ+ youth in order to understand the uniqueness of each adolescent, their health, and their lived experiences. With aesthetic knowing, the JHS nurse can gain an understanding of the deep meanings in different life circumstances and aspects that are closely related to LGBTQ+ youth.

LGBTQ+ youth do not live in a vacuum but are in constant interaction with different people and situations, some of which can be positive for their health and well-being, while others can be harmful. Aesthetic knowing gives the JHS nurse the competence to be flexible in practice and adapt their actions if they discover something that they did not expect.

The uniqueness of LGBTQ+ youth and aspects impacting their life encompasses the acknowledgement that each adolescent, including LGBTQ+ youth, grows and develops as a unique individual. This applies also to sexuality and gender identity related development. The JHS nurse acknowledges that some LGBTQ+ youth may be at a stage in which they do not identify with a particular identity category, while other LGBTQ+ youth have a one or several identity categories that they identify with. Regardless of the stage, the JHS nurse respects every adolescent's self-determination. The development of sexual orientation and gender identity is seen as a diverse, life-long process, in which it is possible for adolescents to change their perception of their identity as LGBTQ+. This malleability and flexibility of identity is considered normal, and for LGBTQ+ youth sexual and gender diversity can be even more fluid than the previous generations.

LGBTQ+ youth have people and environments that are significant to them. In adolescence, much of their time is spent in school, where LGBTQ+ youth interact with their peers, teachers, JHS nurses, school social workers, and other school personnel. An accepting and LGBTQ+ inclusive school climate can support the health and well-being of LGBTQ+ youth. However, a lack of sexual and gender diversity recognition in school, and negative attitudes of peers and school personnel can cause LGBTQ+ youth experiences of isolation, loneliness, or bullying. The JHS nurse acknowledges the importance of a safe school environment for LGBTQ+ youth, and how the experiences of isolation, loneliness, and being bullied can affect their health. Even though family is important for LGBTQ+ youth, family members may not be aware of their identity. LGBTQ+ youth may stress about whether their family accepts them as LGBTQ+, and they may have past conflicts with parents about things related to their identity, such as appearance. It is possible, that the JHS nurse is the first person, to whom an LGBTQ+ youth discloses their identity, and therefore the JHS nurse is an important and safe adult for LGBTQ+ youth.

LGBTQ+ inclusive atmosphere in JHS nursing is a combination of LGBTQ+ inclusive signals and the JHS nurse's actions in creating a safe space. The nurse's office and waiting room can have informational posters, leaflets, and other material about sexual and gender diversity, indicating that JHS nursing is a safe space for everyone. A rainbow or Pride flag is a well-known symbol of LGBTQ+ people and using it in JHS nursing is a clear signal of an acknowledgment of sexual and gender diversity. In the meetings and health check-ups with adolescents, medical forms should include options to describe sexual orientation and gender identity diversely,

and materials for adolescents include topics of same-sex relationships, and diverse gender identities. Furthermore, an LGBTQ+ inclusive atmosphere becomes a reality in daily encounters, where the JHS nurse has various discussions about health and wellbeing with LGBTQ+ youth. The way sexual and gender diversity is included in these discussions, is a direct way to signal to LGBTQ+ youth that they are seen as normal as their peers.

Confidential relationships with LGBTQ+ youth are especially important when LGBTQ+ youth have had past experiences of health professionals, teachers, peers, or other school professionals belittling, ignoring, or even expressing unaccepting attitudes towards their identity. These experiences are common for many LGBTQ+ youth, and to make JHS nursing a comfortable place to discuss sexual orientation and gender identity topics, the JHS nurse needs to encounter adolescents with an open mind and talk about sexual and gender diversity authentically. This can inspire confidence in LGBTQ+ youth, making it easier to open up to the JHS nurse, which offers the JHS nurse opportunities to support LGBTQ+ youth, their health and wellbeing.

5.2.5 Personal knowing in LGBTQ+ inclusive JHS nursing

Personal knowing in LGBTQ+ inclusive JHS nursing is the nurse's inner awareness of themselves as a whole person. This means that the JHS nurse is honest about themselves and their characteristics and can reflect themselves in relation to others. This requires acknowledging and understanding their own values, skills and knowledge, experiences, and how they can develop as a health professional to LGBTQ+ inclusive. Personal knowing supports the JHS nurse to be genuine and authentic when engaging and caring for LGBTQ+ youth.

LGBTQ+ inclusive JHS nursing as personal knowing means that JHS nurse ***recognizes own assumptions and learned definitions about sexuality and gender identity***. All knowing is somehow personal: JHS nurse learns about sexuality and gender identity at a certain time and in a certain culture, and this learning occurs through their personal experiences and perceptions. Therefore, some JHS nurses may have learned more about sexual and gender diversity in their under-graduate education, while others may have educated themselves independently. It is also possible that JHS nurse may have grown up in a time when LGBTQ+ topics were considered taboo. Therefore, JHS nurses' understandings about sexual and gender diversity may differ from the ones that LGBTQ+ youth have; they can be outdated, for example, because the knowledge about diversity has increased very much in the 2000's. When the JHS nurse recognizes this, they can be honest to themselves about their knowledge and skills concerning LGBTQ+ topics.

Recognition of knowledge and skill gaps in LGBTQ+ topics is the JHS nurse's awareness of personal knowledge and skills and an understanding of the continuous learning process involved in their profession. Even if the JHS nurse has knowledge and skill gaps, it is not a barrier to becoming LGBTQ+ inclusive. The key is that the JHS nurse is open and honest personally and with LGBTQ+ youth about their competence, which then makes it possible to identify how to develop as a health professional. LGBTQ+ youth appreciate honesty and if some topic is unfamiliar to the JHS nurse, they can take time to seek more information and then meet again with the LGBTQ+ youth. It is also relevant to consider a consultation with an LGBTQ+ specialized health professional, such as a sex counsellor, who can share knowledge about sexual diversity.

A genuine willingness to become and to be LGBTQ+ inclusive means that the JHS nurse understands their role and importance for LGBTQ+ youth. They reflect themselves in their relationships with LGBTQ+ youth, and through this they can recognize their role as an important health professional in supporting individual growth and development. A genuine willingness to become LGBTQ+ inclusive is demonstrated by the JHS nurse's readiness to develop their knowledge and skills relevant to the health and wellbeing of LGBTQ+ youth. the JHS nurse recognizes that it is always possible to develop as a health professional, and this can occur by independently searching for information from various resources, or by attending further education focusing on LGBTQ+ topics. A genuine willingness to be LGBTQ+ inclusive becomes reality in reciprocal communication with LGBTQ+ youth. This encompasses building a JHS nursing a space where LGBTQ+ youth can feel the JHS nurse genuinely cares about them, the JHS nurse actively listens to LGBTQ+ youth, and they express authentically of seeing LGBTQ+ youth as normal as their peers.

6 Discussion

This study explored LGBTQ+ youth in JHS nursing, and specifically, what LGBTQ+ inclusive JHS nursing consisted of from the perspectives of emancipatory, empiric, ethical, aesthetic, and personal knowing in nursing. In this chapter, I discuss about the findings through reflection to the earlier literature and research, the trustworthiness of this study, the ethical considerations conducted in this study, and finally, I propose suggestions for future nursing research, nursing education, and healthcare guidelines and policy.

6.1 Discussion on the findings

The aim of this study was to develop a theoretical model describing LGBTQ+ inclusive JHS nursing. This study yielded, that LGBTQ+ youth were a scarcely researched minority group in healthcare and that in healthcare both heteronormative and diversity-affirming elements existed (Paper I). The study also found that for LGBTQ+ youth JHS nursing was an important health service, but it may not always provide the information and support they needed (Paper II). In addition, JHS nurses self-identified as accepting professionals, who were genuinely willing to support the health and wellbeing of LGBTQ+ youth; however, the nurses were lacking in education and evidence-based nursing information to support LGBTQ+ youth comprehensively (Paper III).

Regarding the theoretical model of LGBTQ+ inclusive JHS nursing, it was found that LGBTQ+ inclusive JHS nursing is a multidimensional reality. This reality comprised the JHS nurse's diverse knowledge, skills, and reflective thinking to understand LGBTQ+ youth as a vulnerable minority group, and the JHS nurse's role as a safe, significant, and supportive professional for LGBTQ+ youth. Furthermore, to create JHS nursing LGBTQ+ inclusive, it was important to recognize LGBTQ+ youth as unique individuals, sexual orientation and gender identity-related development as diverse life-long processes, and that LGBTQ+ youth have several relevant aspects besides health, such as school and family.

This study contributed to the development of new nursing knowledge from the perspectives of LGBTQ+ youth and school nursing. The contribution is relevant, as sexual and gender minorities are still facing inequalities, marginalization, and

stigmatization in healthcare (McClain et al., 2018; Spurlin, 2019; Beyrer et al., 2020; Poteat & Stahlman, 2020; Stall et al., 2020), but are still a rare focus in nursing research, especially LGBTQ+ youth. In nursing science, there is a need to develop knowledge that addresses the inequalities of vulnerable and marginalized groups, and identifies ways to reduce these inequalities in nursing practice (Meleis, 2012b). Marginalized groups, including LGBTQ+ people, have a history in which "their voices were stripped of, their power was stripped of, and their rights to resources were stripped of" (Meleis, 2012b). In this study, my effort has been to develop new theoretical nursing knowledge about the lived experiences of LGBTQ+ youth as healthcare patients and to address ways of reducing the inequalities of LGBTQ+ youth. Furthermore, I also aimed to create an understanding of the role of the JHS school nurse in LGBTQ+ inclusive nursing practice. Therefore, I collected research data from several sources to ensure that the theoretical knowledge is comprehensive, and it is not based on the findings of a single study. The theoretical model of LGBTQ+ inclusive JHS nursing is currently the first research-based theoretical model about sexual and gender minorities in nursing science, and it offers knowledge about a topic, that has been identified as important, but that has received little attention in research.

The theoretical model of LGBTQ+ inclusive JHS nursing developed in this study included several elements that have been identified in previous literature as central to the healthcare of LGBTQ+ youth. These include open-minded and nonjudgmental engagement and the creation of LGBTQ+ safe environments (Sawyer et al., 2006; Mahdi et al, 2014; Rasberry et al., 2015; Earnshaw et al., 2020; Neiman et al., 2021; Sava et al., 2021), professional knowledge and skills concerning LGBTQ+ health (Sawyer et al., 2006; Mahdi et al., 2014; Rasberry et al., 2015; Rose & Friedman, 2017; Garbers et al., 2018; Terao & Kaneko, 2021) that responds to their health-related needs (Cahill et al., 2020; Zhang et al., 2020; Neiman et al., 2021; Sava et al., 2021). While no previous school nursing-focused research has been done in Europe or the Nordic countries, the findings of this study were similar to the studies conducted in the American context. However, as this topic is as yet rarely studied in nursing, the theoretical model of LGBTQ+ inclusive JHS nursing offers a new, valuable, and empirical research-based knowledge about LGBTQ+ youth as nursing patients. It also presents what contents of the five patterns of knowing are relevant to providing LGBTQ+ inclusive JHS nursing care.

Emancipatory knowing in LGBTQ+ inclusive JHS nursing

Emancipatory knowing comprised the awareness of the inequalities LGBTQ+ youth face and the existence of hetero and gender normativity in healthcare. Through this awareness, JHS nurses can understand the vulnerability of LGBTQ+ youth, and they

can recognize ways to reduce inequalities and promote inclusive practices in JHS nursing. Emancipatory knowing is a crucial foundation of LGBTQ+ inclusive JHS nursing, and through the interconnection to other patterns of knowing, it directs the essential contents of empiric, ethical, aesthetic, and personal knowing. Previous literature has recognized the existence of healthcare inequalities as regards LGBTQ+ people (Beyrer, 2020; Sava et al., 2021). These inequalities include minority stress (Meyer, 2003; Green et al., 2022), hetero and gender normativity (McIntyre & McDonald, 2012; Spurlin, 2019), and that LGBTQ+ youth may not have access to the health information and services they needed (Cohn et al., 2018; Sava et al, 2021). These issues cause health disparities for LGBTQ+ youth, which can furthermore create mistrust of the health services. It is also known that LGBTQ+ people tend to avoid using health services, especially if they have past experiences of health services being unhelpful and hetero or gender normative (Stall et al., 2020). Therefore, it is crucial that JHS nurses acknowledge the vulnerability and inequalities affecting LGBTQ+ youth and recognize sexual and gender diversity as normal in adolescence. School nurses should also encounter all adolescents non-judgmentally, sensitively and show their acceptance of sexual and gender diversity. Elements of emancipatory knowing have been recognized in earlier studies, both from the perspectives of LGBTQ+ youth (Rasberry et al., 2015) and health professionals in school healthcare services (Cahill et al., 2020; Neiman et al., 2021).

Empiric knowing in LGBTQ+ inclusive JHS nursing

Empiric knowing comprised LGBTQ+ inclusive, evidence-based disciplinary knowledge and education about diverse topics, and competence in using the knowledge and education in daily JHS nursing practice. Disciplinary knowledge covered areas of sexual health, sexual diversity, gender diversity, and general information about LGBTQ+ people, and LGBTQ+ youth having higher risks for specific health issues. Previous research has identified these topics as relevant in the healthcare of LGBTQ+ youth (Sawyer et al., 2006; Rasberry et al., 2015; Neiman et al., 2021; Sava et al., 2021). However, several empirical studies have implied that health professionals, including school nurses, were lacking the skills and knowledge to provide health and support services to LGBTQ+ youth (e.g., Cahill et al., 2020; Terao & Kaneko, 2021 Sava et al., 2021). Furthermore, health professionals highlighted that there is a lack of education and training on LGBTQ+ topics (Sawyer et al., 2006; Neiman et al., 2021; Terao & Kaneko, 2021), and in this study the JHS nurses indicated the same issue (Paper III). These findings illustrated the relevance of empiric knowing in LGBTQ+ inclusive JHS nursing. Without evidence-based disciplinary information and education about sexual and gender diversity, school nurses may not be able to provide services supporting the health and wellbeing of

LGBTQ+ youth, or develop as LGBTQ+ inclusive health professionals. It is crucial that future under-graduate education and further education of school nurses include sexual and gender diversity. It is also important to offer training and opportunities for nursing students and graduated nurses to engage with LGBTQ+ youth, their families, and how to generally discuss LGBTQ+ health topics.

Ethical knowing in LGBTQ+ inclusive JHS nursing

Ethical knowing comprised ethical and moral considerations of LGBTQ+ youth and ethically responsible JHS nursing practice. It included, for example, respecting LGBTQ+ youth rights to privacy, self-determination, and the right to access health services and information. As LGBTQ+ youth are a vulnerable minority group, who are prone to discrimination due to sexual orientation or gender identity, undesired identity disclosure needs to be considered in every situation, even with their family. The reports of National Institute for Health and Welfare have recognized that LGBTQ+ youth are at high risk of conflicts with their families, which can result in violence, if family members do not accept sexual and gender diversity (Luopa et al., 2017; Jokela et al., 2020; Majlander et al., 2021). Empirical studies also support the importance of respecting LGBTQ+ youth rights and not disclosing their identity without their consent (Reisner et al., 2020; Neiman et al., 2021).

In terms of family relationships, family acceptance has been found to support better mental health of LGBTQ+ youth, especially transgender and gender diverse youth (Katz-Wise et al., 2016; Newcomb et al., 2019; Wilson et al., 2016). Therefore, ethical knowing also supports the family acceptance process, in which JHS nurses play a pivotal role as a safe adult that accepts LGBTQ+ youth as themselves. JHS nurses can support the connection between family members and LGBTQ+ youth, and act as an advocate for LGBTQ+ youth, if needed. This advocate role was described by JHS nurses in the focus groups study (Paper III), and previous empirical studies also support this advocate role (Neiman et al., 2021).

Aesthetic knowing in LGBTQ+ inclusive JHS nursing

Aesthetic knowing comprised acknowledgment of the uniqueness of LGBTQ+ youth, acknowledging various aspects of their lives, creating LGBTQ+ inclusive atmosphere in JHS nursing, and building confidential relationship between JHS nurse and LGBTQ+ youth. Together they constituted “the art of nursing”, which is the JHS nurse’s flexibility to adapt their actions to different situations in their work. It means JHS nurses are aware that each LGBTQ+ can have their own unique health-related needs and life circumstances, including circumstances that the JHS nurse may not be aware of. It includes the JHS nurse’s awareness that sexual orientation and

gender identity-related development is a diverse and life-long process, and LGBTQ+ youth can examine their identity through fluidity and flexibility. This development process has been recognized and discussed in the literature (Diamond et al., 2011; Dillon et al., 2011; Bosse & Chiodo 2016; Beckett & Taylor, 2019), which supports the findings of this study.

Aesthetic knowing in LGBTQ+ inclusive JHS nursing included the acknowledgement of the school climate and teaching in relation to LGBTQ+ youth. Both LGBTQ+ youth (Paper II) and JHS nurses (Paper III) described in the sub-studies, how schools as institutions were still conservative, and teaching and discussion around sexuality and gender identity was rare, especially gender diversity topics. Some schools were identified as LGBTQ+ inclusive, but this was considered to be more of a special effort than a systematic procedure. It was significant that the JHS nurses recognized the fact that the school climate is not necessarily supportive and safe for LGBTQ+ youth (Paper III), hence their role as a safe and supportive adult was important to LGBTQ+ youth (Paper II). Several empirical studies have reported schools as not always being safe places for LGBTQ+ youth (Reisner et al. 2020; Earnshaw et al., 2020; Sava et al., 2021). These studies also found LGBTQ+ youth as experiencing verbal, physical, and social bullying, although the school health professionals were not aware of the extent of bullying, or they did not witness the bullying. However, school health professionals were aware of LGBTQ+ youth having a higher risk for being bullied (Earnshaw et al., 2020). Gender minority youth and LGBTQ+ youth of color were reported to be especially vulnerable to becoming victims of bullying (Earnshaw et al., 2020; Reisner et al., 2020). However, discussions with JHS nurses (Paper III) revealed that the nurses perceived their possibilities to influence the school climate as rather low. Therefore, creating a school that is a safe place for LGBTQ+ youth requires commitment from all the professionals working in school, including teachers, social workers, and psychologists. When considering LGBTQ+ youth with intersecting identities, aesthetic knowing could be deepened in future by studying Finnish LGBTQ+ youth in school nursing from an intersectional perspective. With an intersectional perspective, it would be possible to obtain more information about how JHS nursing could be inclusive of LGBTQ+ youth, who may experience multiple types of bullying and harassment.

Creating an LGBTQ+ inclusive atmosphere in JHS nursing included small but relevant aspects for LGBTQ+ youth. Signals that give the impression that JHS nursing is a safe space could be Pride flags, a rainbow symbol, as well as JHS nurses expressing their open mindedness and acceptance of sexual and gender diversity. This was also described in the literature (Rasberry et al., 2015; Reisner et al., 2020). Furthermore, to be a safe adult for LGBTQ+ youth, aesthetic knowing included building a trustful and confidential relationship between the school nurse and the

LGBTQ youth. This confidential relationship was also described in empirical studies which focused on sexual health (Rasberry et al., 2015; Rose & Friedman, 2017; Cahill et al., 2020), reporting bullying to school health professionals (Reisner et al., 2020), and working with transgender youth and their parents (Neiman et al., 2021).

Personal knowing in LGBTQ+ inclusive JHS nursing

Personal knowing comprised JHS nurse's inner awareness of themselves as a heatlh professional and in relation to others. This awareness included aspects such as recognizing learned assumptions and definitions about sexuality and gender identity, recognizing one's knowledge and skills gaps in LGBTQ+ topics, and a genuine willingness to become and be an LGBTQ+ inclusive JHS nurse. All knowing is somewhat personal, as every JHS nurse has grown up in a certain time, culture, and society, and they have received education about sexuality and gender during their own primary school years, and in their nursing education. The ways that sexual and gender diversity has been understood and taught to JHS nurses, and their own assumptions and knowledge about sexual and gender diversity may differ from the current understanding. In personal knowing, the recognition of an individual's personal knowledge and skill levels can support JHS nurses to realize how they can develop as a professional to become LGBTQ+ inclusive. Interestingly, the earlier research and literature has not directly identified school nurses or school health professionals as reflecting their learned assumptions and definitions about sexual and gender diversity, but have reported descriptions by school nurses and school health professionals of their knowledge and skill gaps (Sawyer et al., 2006; Mahdi et al., 2014; Cahill et al., 2020; Reisner et al., 2020; Terao & Kaneko, 2021; Sava et al., 2021) their genuine care for LGBTQ+ youth (Earnshaw et al., 2020; Cahill et al., 2020; Reisner et al., 2020; Neiman et al., 2021) and their families (Neiman et al, 2021).

Finally, I want to reflect the findings of this study with the findings of the School Health Promotion Study (Luopa et al., 2017; Jokela et al., 2020) which has systematically collected data from the health and wellbeing of Finnish LGBTQ+ youth since 2017. In this study, Finnish LGBTQ+ youth were found to have several challenges in their lives and their health and wellbeing was lower than their heterosexual and cisgender peers. For example, LGBTQ+ youth had more experiences of loneliness and being bullied in schools, they were worried about their mental health, especially gender minority youth. Despite school healthcare being considered important, some LGBTQ+ youth did not consider the school nurse as an adult with whom they could share their worries and seek support. (Luopa et al., 2017; Jokela et al., 2020.) When the findings of this study are compared with the School

Health Promotion Study findings, there are many similarities, and they support each other. It seems that school nursing is not yet LGBTQ+ inclusive at a national level in Finland. There is a significant public health need in Finland to increase the equality of health services adolescents use regularly, including JHS nursing. Promotion of LGBTQ+ inclusive JHS nursing can be considered as an enactment of the increasing equality and reduction of inequalities in the health and wellbeing of adolescents. This aim is also in the line with the Finnish health and social services reform objectives (STM, 2023a).

6.2 The trustworthiness of the study

In this section, I discuss the trustworthiness of this study through credibility, transferability, dependability, and confirmability (Patton, 2015; Holloway & Galvin, 2017). Simultaneously, I discuss the strengths and limitations of this study.

Trustworthiness is a term used to describe the rigour of the qualitative research (Patton, 2015; Holloway & Galvin, 2017), as well as the methodological soundness and adequacy (Holloway & Galvin, 2017). In quantitative research reliability, validity, and generalizability is used to evaluate the rigour of the research, however, these may not be suitable for the evaluation of qualitative research and its findings (Patton, 2015; Holloway & Galvin, 2017). For qualitative researchers, validity and reliability are achieved by making the research process, analysis, and the interpretations from data as transparent as possible for the research community (Patton, 2015). The researcher is the main instrument in qualitative research, and consequently, qualitative studies do not achieve objectivity at a level where they can be completely replicated (Holloway & Galvin, 2017). However, qualitative research can be accurately and transparently reported, which enables other researchers to contextualize the findings to a particular phenomenon and population in order to understand how the researcher has positioned themselves and made interpretations from the data. Therefore, other researchers can conduct research with a similar sample, setting, and context (Patton, 2015; Holloway & Galvin, 2017). Trustworthiness consists of credibility, transferability, dependability, and confirmability, which are related to the social construction in understanding knowledge and its development (Patton, 2015; Holloway & Galvin, 2017). In the following, these perspectives are discussed from the point of view of this study.

6.2.1 Credibility

Credibility is used as an equivalent term to internal validity (Patton, 2015; Holloway & Galvin, 2017). Credibility means that the research focus, participant selection, data and its analysis are congruent with each other (Patton, 2015). In addition, it means

that research participants can recognize the findings as being compatible with their lived experiences. Credibility can be confirmed, for example, by member checking, which is the researcher's actions to check if they have correctly understood the participants' words and meanings. (Holloway & Galvin, 2017.)

In this study, member checking was conducted while I interviewed JHS nurses in the focus groups (Paper III). However, member checking was not possible with the LGBTQ+ youth due to the anonymous data collection and participation (Paper II), and this can be considered a limitation in this study. However, I chose to collect data anonymously from LGBTQ+ youth as an ethical decision to protect their privacy. Furthermore, member checking can be challenging in qualitative research, for example, when the data analysis has progressed to a point where the responses of individual participants can no longer be clearly distinguished, and the data is transformed into more abstract and theoretical data (Morse, 2015; Holloway & Galvin, 2017). In the study of LGBTQ+ youth (Paper II), my aim was to confirm credibility by adding an option to describe gender identity and identity as a LGBTQ+ in a free text field in the demographic questions. Additionally, participants had an option to choose several pre-determined identity categories (lesbian, gay, bisexual, queer, asexual, trans, nonbinary). These options appeared to be successful, as 42 % (n=15) of participants described their gender identity beyond girl-boy binary, and almost half of the participants (49 %, n=17) chose to describe their identity as a LGBTQ+ with several identity categories. Earlier literature supports these findings as LGBTQ+ youth do not necessarily reflect their gender identity or sexual orientation through fixed identity categories, but rather sexuality and gender are seen as fluid, flexible ongoing processes (Bosse & Chiodo, 2016; Paasonen & Spišák, 2018; Henrickson et al., 2020).

6.2.2 Transferability

Transferability is used as an equivalent term to external validity or generalizability (Patton, 2015; Holloway & Galvin, 2017). This means that the findings of one study can be transferred to similar contexts or realities. Transferable qualitative research findings can be relevant in another context, and researchers who carry out the same research in another context will be able to apply certain concepts developed by researchers of the original study (Holloway & Galvin, 2017).

In this study, the findings are partially transferable. The LGBTQ+ youth who participated were diverse in terms of gender identities and identities as LGBTQ+ youth, and both Finnish and Swedish speaking youth contributed to the study (Paper II). The total number of participants was also successful, as 35 LGBTQ+ youth participated, which brought richness to the data, and can be considered a strength in this study. However, there are two limitations that should be mentioned about the

LGBTQ+ youth as participants. First, most of the participants replied in Finnish, and no other identities were requested from the LGBTQ+ youth, such as race, ethnicity, socio-economic background. Consequently, the findings are not transferable to Finnish LGBTQ+ youth, who are for example experiencing a dual minority identity. An intersectional aspect when collecting the demographic information could have increased the transferability of the findings, as intersectionality examines different identities, how their intersections can produce a multiple minority status and therefore result in inequalities on multiple levels (Bosse & Chiodo, 2016; Henrickson et al., 2020; Stall et al., 2020). This could have offered more diverse knowledge from the Finnish LGBTQ+ youth.

Second, there has been discussions in the literature about what the relevant terms are when defining sexual and gender minorities and using such complex identity taxonomies in empirical research (Eliason, 2014; Henrickson et al., 2020; Sell & Conron, 2020). Researching "LGBTQ+ youth" as one unified group can be considered a limitation in this study, because even though sexuality and gender are partly interconnected parts of identity (Beckett & Taylor, 2019) they are distinct constructs (Bosse & Chiodo, 2016). It is known that sexual minority youth and gender minority youth have both common and distinct health needs and challenges in healthcare (Sava et al., 2021), and they experience different types of discrimination, and minority stress (Meyer, 2003; Sell & Conron, 2020). Thus, we need to be careful in combining participants' lived experiences from both sexual and gender minorities, and drawing conclusions based on the findings. However, the aim of this study was to describe and understand the diverse sides of the phenomena relevant to LGBTQ+ inclusive JHS nursing as this has not been studied in Finnish school nursing or in nursing science. Furthermore, it is worth noting that the research community has not reached any consensus about the best terminology when studying sexual and gender minorities (Eliason, 2014; Sell & Conron, 2020), thus I chose the term "LGBTQ+ youth" was for the purposes of this study.

The transferability of the findings from the JHS nurses' focus group study (Paper III) also include limitations. I conducted the focus group interviews in Finnish with the school nurses, so school nurses working in Finnish-Swedish schools are not necessarily represented in this study (Paper III). Furthermore, it is likely that the JHS nurses who participated in the study considered the study topic important in their work, and they already had accepting attitudes towards sexual and gender diversity. The participation was based on voluntariness, and the findings may not be representative at a national level, as literature has identified that nursing professionals can have negative attitudes towards LGBTQ+ populations (Mahdi et al., 2014). However, I interviewed the JHS nurses in two different health districts and in four municipalities, which can be considered a strength in this study.

With regard to the overall data in this study, it is significant to recognize that the experiences of LGBTQ+ youth (Paper II) and the perceptions of JHS nurses (Paper III) were partly in contrast to each other. The LGBTQ+ youth had limited positive experiences of JHS nursing, while the perceptions of JHS nurses were that they were mostly positive and accepting in their support of LGBTQ+ youth. There may be several reasons for this contrast. First, LGBTQ+ youth who participated may have had more unpleasant experiences in JHS nursing, and taking part in the study may have been a way of sharing and unpacking their experiences. On the other hand, it is worth noting that the data with the LGBTQ+ youth were collected in 2015, and the data with JHS nurses in 2019, and between these years several changes have happened in Finland in terms of the rights and equality of LGBTQ+ people (Seta, 2023a). Therefore, the experiences of the LGBTQ+ youth may have been different if data had also been collected in 2019. Second, JHS nurses' perceptions may have been more positive and accepting, as they were the ones for whom sexual and gender diversity were relevant and important part of their work, and who were progressive in their understanding of diversity. On the other hand, the focus group interview as a data collection method may also have influenced how school nurses replied to the interview questions, and individual interviews with the researcher may have produced different responses due to its more private nature (Patton, 2015).

6.2.3 Dependability

Dependability is used as an equivalent term to reliability (Patton, 2015; Holloway & Galvin, 2017). This means that the findings are consistent and accurate and to confirm dependability researchers need to openly describe their thinking and decision-making processes in the data analysis (Holloway & Galvin, 2017). This allows other researchers to evaluate the adequacy of the analysis, and even though the study cannot be replicated, it can be repeated by other researchers when they study similar contexts with similar participants (Holloway & Galvin, 2017). The methods for confirming dependability can include representing examples of the data analysis process and the abstraction of data, and quotations from the original data (Patton, 2015). In this study, I have demonstrated my analytical processes by giving examples of how the data was coded and the synthesizing themes obtained. I have also integrated an analytical approach in the presentation of findings and illustrated them with quotations from the LGBTQ+ youth and JHS nurses (Papers II-III). However, in the integrative review (Paper I) I could have demonstrated my analytical processes more and shown examples how research articles were analyzed with the theoretical framework of heteronormativity. In addition, I could also have presented how the identification of heteronormative and diversity-affirming care elements occurred step-by-step.

6.2.4 Confirmability

Confirmability is used as an equivalent term to objectivity (Patton, 2015; Holloway & Galvin, 2017), and it examines the ways in which the study findings and conclusions are achieved. Particularly that they are not based solely researcher's subjective interpretations and personal assumptions (Holloway & Galvin, 2017).

Peer reviews are one method to confirm confirmability. A peer review means that colleagues who are experienced in qualitative research or the study topic, can participate in the data analysis process, and the researcher can discuss their interpretations, and compare their findings with their colleagues (Holloway & Galvin, 2017.) In this study, I conducted the data analyses (Paper I-III) in collaboration with other researchers, two of whom were experts in qualitative research. This is a strength of the study, as it minimizes the influence of the researcher's own attitudes, beliefs, and their position on the phenomenon under study. Peer review was also conducted in the integrative review (Paper I), in which I and another researcher selected the final research articles and performed the quality appraisals on the articles.

Triangulation is another method to confirm confirmability. Triangulation can occur using several data sources, investigators involved in the study, research methods and the theoretical backgrounds of the interpretations (Holloway & Galvin, 2017) and it can increase the depth of the study (Morse, 2015). In this study, I have collected data from three sources: previous research (Paper I), Finnish LGBTQ+ youth (Paper II), and Finnish JHS nurses. In each sub-study, I have analyzed data and reported the findings in collaboration with several researchers. Furthermore, I chose to use three data collection methods in this study. Therefore, triangulation is a strength of this study.

6.3 Ethical considerations of the study

Research integrity consists of four basic principles, reliability, honesty, respect, and accountability (ALLEA, 2023; TENK, 2023). Furthermore, when human participants are involved in research, the integrity of the research needs to be considered through certain principles: respecting the participants' dignity, acknowledging their autonomy, and minimizing any possible risks, damage, or harm (TENK, 2019). When research involves participants under 18 years of age, as in this study, it is important to consider when minors can give their independent consent to their participation, or when their guardians need to be informed about the research, or guardians' consent is required (TENK, 2019).

In this study, I have carefully planned each sub-study and how they are conducted. I have reflected on the quality of this study by carefully considering the trustworthiness from the aspects of credibility, transferability, dependability, and

confirmability (Patton, 2015; Holloway & Galvin, 2017). In the data analyses and reporting of the findings, I carefully chose the data analysis methods that were appropriate in relation to the data and the aim of each sub-study. The development of a theoretical model was based on my long-term planning and reflection, and this occurred from the beginning of this doctoral thesis project to the completion of writing this doctoral dissertation summary.

Throughout this study, I have respected other researchers' work by citing their publications according to good research practices. In the integrative review especially (Paper I), I paid attention to the ways I reported the existing research and that I did it accurately by citing other researcher's work. When I collected data from the LGBTQ+ youth (Paper II) and the JHS nurses (Paper III), I aimed to describe the lived experiences of LGBTQ+ youth and JHS nurses in a truthful way, without ignoring the voice of any participant or distorting their descriptions. Furthermore, I have endeavored to reflect openly my researcher positions in this study, and to be constantly aware of the positions from which I was exploring the subject of my research (Berger, 2015; Patton, 2015).

I take full responsibility for conducting this study, in which I have respectfully aimed to improve the ability of the research community to hear the voices of LGBTQ+ youth as a minority group in healthcare, as I realized that as minors their voices are still unheard. To respect the rights of LGBTQ+ youth as research participants (Paper II), I chose to collect data without face-to-face contacts so they remained anonymous, and I reported the findings with pseudonyms and therefore did not reveal any data that would endanger their privacy. Data collection with an online survey also enabled the LGBTQ+ youth around Finland to participate at a location and time that was safe and suitable for them. I also made the decision that only LGBTQ+ youth between 16-19 years old could participate; thus, eliminating the need for their guardians to be informed about the study. This was an ethical decision to minimize the possible harm (Laki lääketieteellisestä tutkimuksesta 488/1999; TENK, 2019) that informing guardians could have caused those participants who had not yet disclosed their identity (Stephenson & Riley, 2020).

6.4 Suggestions for future research, education and healthcare guidelines and policy

Based on the findings generated in this study, the following recommendations are suggested for future nursing research, nursing education and healthcare guidelines and policy.

Recommendations for future nursing research:

- As most research evidence on LGBTQ+ youth in school nursing is based on an American context, there is a great need to conduct research on LGBTQ+ youth in school nursing from an European perspective. Research on LGBTQ+ inclusive junior high school nursing could be conducted in the similar school healthcare systems to Finnish school healthcare, for example, in other Nordic countries.
- As the theoretical model of LGBTQ+ inclusive JHS nursing is directed to school nurses, it would be important to study the model and its elements with LGBTQ+ youth.
- As the theoretical model describes the ideal LGBTQ+ inclusiveness in JHS nursing, it is relevant to conduct more research with school nurses and determine how the model could be used in real-life practices.
- The further development of the theoretical model could be conducted in collaboration with LGBTQ+ youth and JHS nurses through participatory action research, where both the youth and the nurses have active roles from the beginning of research process.
- After further development of the theoretical model, interventions, and education could be provided to school nurses about LGBTQ+ inclusiveness accompanied by development and testing through research.
- The theoretical model of LGBTQ+ inclusive JHS nursing could be implemented into different nursing contexts.
- There is an absence of research focusing specifically on gender diversity and gender minority youth, from both the perspective of their needs in school nursing, and how school nursing can support those who experience gender dysphoria.
- The literature has highlighted the relevance of intersectionality when researching on LGBTQ+ youth and the health disparities of LGBTQ+ people. Therefore, research including other identities (e.g., ethnicity, race, language, disability), their intersections and the association with inequalities in healthcare needs to be conducted in nursing with different LGBTQ+ groups. The intersectionality aspect could be included when considering the demographic questions in research, both in the qualitative, quantitative, and mixed methods.

Recommendations for nursing education:

School nurses and other nursing professionals are still lacking education, knowledge, and training as regards sexual and gender diversity and engagement with LGBTQ+ people in their work. Thus, the following recommendations for nursing education are suggested:

- Every nursing student should have the possibility to access education about sexual and gender diversity in their studies, including public health nursing students.
- In the future, all nursing education should systematically cover topics of sexual and gender diversity, engagement with LGBTQ+ people in various nursing situations and health services, and ways in which to promote LGBTQ+ inclusive practice.
- Educational programs and interventions on sexual and gender diversity need to be based on evidence-based knowledge.
- Further education for school nurses and other nursing professionals should be provided from the aspects of sexual and gender diversity, and further education needs to be accessible to everyone regardless of the health organization's financial resources.

Recommendations for healthcare guidelines and policy:

- Evidence-based, nursing-focused information sources/databases should be developed for nursing professionals and other health professionals about sexual and gender diversity, health and support needs of LGBTQ+ youth, gender-affirming care, the family acceptance process and providing care to LGBTQ+ youth.
- LGBTQ+ youth are offered more opportunities to participate in the development of health services that are relevant to them, including school nursing and school healthcare.
- As safe sex products distributed in school nursing are mainly condoms, other safe sex products, such as dental dams, are provided by school nursing to promote equality in the safe sex practices of adolescents.

7 Conclusions

This study has explored a nursing phenomenon from the context of LGBTQ+ youth in JHS nursing, which is an under-researched in healthcare, especially in Finland. The theoretical model of LGBTQ+ inclusive JHS nursing developed in this study provides a research-based, in-depth description of what LGBTQ+ inclusive JHS nursing is as a phenomenon, specifically from the perspectives of emancipatory, empirical, ethical, aesthetic and personal knowing in nursing. The theoretical model of LGBTQ+ inclusive JHS nursing is the first research-based theoretical model about sexual and gender minorities in a nursing context. The model offers knowledge on a topic that has been identified as important, but that has received little attention in earlier research.

For the LGBTQ+ youth, JHS nurses and school nursing as a health service were important sources of information and support. The participants' main wish was that JHS nurses would see and treat them as equal to their peers, JHS nurses would be safe adults, with whom they can discuss sexual and gender diversity related topics and seek support. The JHS nurses were found to be genuinely caring for LGBTQ+ youth and their families. They had a desire for further education and information which supports their work with LGBTQ+ youth, but opportunities for education and evidence-based nursing information were limited. Education and evidence-based information on sexual and gender diversity topics need to be increased for nursing students and nursing professionals, including school nurses. School nursing does not exist in a separate reality to the school, and therefore as the school climate, teaching and practices can influence the health and wellbeing of LGBTQ+ youth, JHS nurses can play a pivotal role in supporting them through advocacy.

This study showed that the research evidence on LGBTQ+ youth in school nursing is based on an American context, while research in an European context is lacking. Therefore, more research is needed about LGBTQ+ youth in the European healthcare systems, and to explore whether school nursing can respond the health and support needs of LGBTQ+ youth, and how school nursing can be developed to LGBTQ+ inclusive. There is also an absence of research on gender minority youth and LGBTQ+ youth with intersecting identities, such as LGBTQ+ youth of color; therefore, there is a great need for future research to consider these topics.

Acknowledgements

Conducting research does not happen in a vacuum or in the solitude of the researcher's mind, although it may feel like that, especially when conducting a PhD. This study could not have been completed without the continuous support, guidance and contributions of several people and communities.

This study was conducted in the Doctoral Programme in Nursing Science at the Department of Nursing Science, University of Turku. I want to thank Professor Emerita Helena Leino-Kilpi, the former Head of the Department for affording me the opportunity to work in an inspiring research community in 2018, 2020–2022. Helena, I remember the supportive words you said to me in a life situation, where I had to postpone my PhD plans: “I wish that you don’t exclude the possibility of doing a PhD completely, as I see you have a great potential to become a researcher, and you can do it if you want to.” In that lifetime, these words marked so much, and I decided to keep the option of doing a PhD open, and here I am today. I also want to acknowledge my former colleagues in the Department of Nursing Science. Thank you for all those years working together, sharing good laughs during coffee breaks, and of course having great discussions about science. I have learned so much from each of you, more than I can find words to describe.

I want to express my deepest gratitude to my incredible supervisors, Professor Sanna Salanterä and Professor Salla Sariola. Sanna, without your endless support, guidance, and care this dissertation would not have been completed. You have made me believe in myself and my abilities as a researcher time after time, even when my personal life has not been easy and conducting doctoral research has felt like an endless roller coaster. I admire your optimistic, enthusiastic, and innovative nature as a professor, researcher, and supervisor, and your wide expertise in health sciences. You have challenged my thinking with a stimulating approach, and our discussions have been inspiring, and philosophical. They have supported my growth as a researcher. Salla, I am extremely happy that Sanna and I decided to ask you to be my supervisor. Your expertise in feminism, social sciences and qualitative research has been an invaluable contribution to my doctoral research, as they are closely linked to LGBTQ+ health research. I have enjoyed all our discussions, and they have expanded my scientific thinking in a direction I never imagined I could reach. Like

Sanna, you have also supported me in moments, when my faith in my abilities has been tested.

My sincere thanks also go to my follow-up committee, Head of the Department, Associate Professor Anna Axelin. Anna, you have been an inspiring teacher since my master's studies, and your interest in research methodology had a significant influence on how I became interested in nursing research and started dreaming of a PhD. Our regular meetings have supported my growth as a researcher and helped to progress my doctoral research, but beyond that, we have had a very reciprocal and therapeutic dialogue about the state of the world, human rights, and equality issues in global health. I feel that you have become a mentor and a dear friend to me, and with whom I can always share my thoughts.

I express my sincere thanks and gratitude to Adjunct Professor Jari Kylmä for agreeing to serve as the official opponent to my doctoral defense. I also deeply thank the official pre-examiners of my doctoral dissertation, Docent Päivi Kankkunen from the University of Eastern Finland, and Professor Imelda Coyne from Trinity College Dublin. Thank you for contributing your time and expertise to read my dissertation and giving insightful comments on it.

I have been extremely privileged to meet and collaborate with Professor Mark Hayter from Manchester Metropolitan University. Mark, I am glad that my supervisor Sanna encouraged me to contact you. You have made a vital contribution to my PhD publications, which made the manuscripts and the final publications beautiful in a scientific sense. Furthermore, you have taught me a lot about qualitative nursing research and encouraged me to become a researcher in the field of adolescent sexual health and LGBTQ+ health care. I am indescribably happy you invited me to visit the University of Hull and Manchester Metropolitan University, and that you took such good care of me during the visits. I hope that our collaboration will continue, and I cannot wait to see what the future will bring to us.

My special thanks go to PhD Anni Pakarinen and PhD Heidi Parisod, who have supported me since the beginning of my master's studies as student tutors, supervised my master's thesis, and worked as irreplaceable mentors and co-authors in my PhD publications. You both have supported me so much during this journey, and it has been wonderful to share it with you. Furthermore, your passion for adolescent health promotion is a field, in which I believe we continue to collaborate in future.

Doctoral seminars in the Connected Health Utu research group have been an important source of support during my doctoral studies. I want to thank all fellow doctoral researchers in the seminars, and the supervisors of the seminars. I have always felt seminars were a safe and empowering space to share my thoughts, concerns, and questions about research, and it has been a pleasure to celebrate successful moments along this journey. Furthermore, I want to acknowledge my colleague doctoral researchers at the Department of Nursing Science, especially PhD

Riitta Rosio, MHSc Johanna Nyman, PhD Jaakko Varpula, PhD Jennifer Auxier, PhD Emilia Kielo-Viljamaa, MSc Noora Narsakka, MHSc Reetta Mustonen, and MHSc Saija Inkeroinen. We have had so much fun during workdays and free time, and we have supported each other countless times. Without peer support, doing a PhD would have been a lonely road, and you have provided a safe space to talk about anything in life.

This study could not have been possible without research participants. I am deeply grateful for the LGBTQ+ youth, who shared their lived experiences of junior high school nursing with me. You have made an essential contribution to nursing science, which still needs more evidence about how sexual and gender diversity could be included in healthcare. Also, I want to express gratefulness to the junior high school nurses, who were willing to share their thoughts about supporting LGBTQ+ youth in their work. You taught me so much about your work, your role in promoting adolescent health and well-being is very significant, and you have made a valuable contribution to this study.

This doctoral dissertation is dedicated to my beloved family, both biological and chosen one. You have always given me the love, support, and encouragement I needed to pursue my career in the direction, that feels right for me. Your words that I am enough have given me indescribable confidence and strength to carry on. My special thanks go to my dear mother Marja. You have recognized my curious, analytical, and researcher-like personality since my primary school years, and you always told me how proud you are of me, whichever career I chose to have. Thank you for your love. To my dear sister, Emppu, I want to thank you for always listening to me and visiting me during those thirteen years I lived in Turku. We had so much fun and with you, I felt the distance between Turku and Järvenpää was not that long. I also want to remember my beloved late godmother Maritta, who supported me in all the decisions and career choices I have made. Thank you, Maritta, I wish you could be here with me today, but luckily, I have countless warm memories with you, when you told me how proud you were as my godmother.

I am deeply grateful to my friends, including Annika, Sofia, Silja, Varpu, Elina, Anna M., Ulla, Linda, Hanna, and Jenni, who supported me through the difficult times and who brought joy and celebration to my life. You reminded me how there is life outside my doctoral studies, and that the care and love of friends is an essential part of this journey. Also, my godson Aatos deserves to be thanked, because with him I have been able to forget scientific problems at least for a while, laugh and learn new perspectives on life that as an adult I would never think of.

Last, but definitely not least, I want to express my love and gratitude to my partner Maj. You have brought an unspeakable amount of happiness to my life, and the scientific discussions with you have fed my scientific curiosity. You are such an intelligent mind, and I am grateful for every day I share with you. Your endless care,

support and love have been irreplaceable, thank you that you have believed in me, even in those times when I haven't. With you, I never feel alone as "a research geek".

This study was financially supported by the Doctoral Programme in Nursing Science at the University of Turku, which enabled me to work as a full-time doctoral researcher for several years. In addition, this study was funded by The Finnish Association of Nursing Research (Hoitotieteiden Tutkimusseura ry.); Turku University Foundation (Turun Yliopistosäätiö), Turku University Hospital Foundation (TYKS-Säätiö); and Department of Nursing Science, University of Turku.

Helsinki, 28 November 30, 2023
Minna Laiti

References

Ahern, N. R. (2005). Using the internet to conduct research. *Nurse Researcher, 13*(2), 55–70.

Alanko, K. (2014). Mitä kuuluu sateenkaarinuorille Suomessa? Nuorisotutkimusverkosto/ Nuorisotutkimusseura, julkaisuja 146, verkkojulkaisuja 72 & Seta, Seta-julkaisuja 23. Unigrafia.

ALLEA – All European Academies. (2023). *The European Code of Conduct for Research Integrity-Revised Edition 2023*. ALLEA- All European Academies. https://allea.org/wp-content/uploads/2023/06/European-Code-of-Conduct-Revised-Edition-2023.pdf

APA– American Psychiatric Association. (2022). *What is Gender Dysphoria?* Retrieved August 12, 2023 from https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

APA. (n.d.). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)*. Retrieved August 12, 2023 from https://www.psychiatry.org/psychiatrists/practice/dsm

Beckett, C., & Taylor, H. (2019). Who am I going to be? Adolescence, identity and change. Sexuality and gender. In Beckett, C., & Taylor, H., *Human growth & development* (4th ed.), (pp. 121–125). SAGE Publishing.

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234.

Beyrer, C. (2020). Human rights and LGBTQ health. In Stall, R., Dodge, B., Bauemeister, J.A., Poteat, T., & Beyrer, C. (Eds.), *LGBTQ Health Research. Theory, methods, practice* (pp. 25–36). John Hopkins University Press.

Bosse, J. D., & Chiodo, L. (2016). It is complicated: Gender and sexual orientation identity in LGBTQ youth. *Journal of Clinical Nursing*, *25*(23–24), 3665–3675.

Bower-Brown, S., Zadeh, S., & Jadva, V. (2023). Binary-trans, non-binary and gender-questioning adolescents' experiences in UK schools. *Journal of LGBT Youth*, *20*(1), 74–92.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Burr, V. (2015a). What is social constructionism? In Burr, V., *Social Constructionism* (3rd ed.), (pp. 1–30). Routledge.

Burr, V. (2015b). The case for social constructionism. In Burr, V., *Social Constructionism* (3rd ed.), (pp. 31–51). Routledge.

Bussey, K. (2011). Gender identity development. In S. J. Schwartz, K. Luyckx V. L. Vignoles S. J. Schwartz K. Luyckx & V.L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 603–628). Springer.

Cahill, S. R., Geffen, S. R., Fontenot, H. B., Wang, T. M., Viox, M. H., Fordyce, E., Stern, M. J., Harper, C. R., Johns, M. M., Avripas, S. A., Michaels, S., Mayer, K. H., & Dunville, R. (2020). Youth-Serving Professionals' Perspectives on HIV Prevention Tools and Strategies Appropriate for Adolescent Gay and Bisexual Males and Transgender Youth. *Journal of Pediatric Healthcare*, *34*(2), e1–e11

Chinn, P. L., & Kramer, M. K. (2015). *Knowledge Development in Nursing: Theory and Process.* (9th ed.). Elsevier Mosby.

Cohn, T.J, Casazza, S.P & Cottrell, E.M. (2018). The mental health of gender and sexual minority groups in context. In Smalley, K.B., Warren, J.C., & Barefoot, K.N. (Eds.) *LGBT health- meeting the needs of gender and sexual minorities* (pp 161–180). Springer Publishing Company.

Dahnke, M.D. (2010). Theory and Reality. In Dahnke, M.D. & Dreher, H. M., *Philosophy of science for nursing practice: Concepts and application* (pp. 173–188). Springer Publishing Company.

Diamond, L. M., Pardo, S. T., & Butterworth, M. R. (2011). Transgender Experience and Identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of Identity Theory and Research* (pp. 629–647). Springer.

Dillon, F. R., Worthington, R. L., & Moradi, B. (2011). Sexual Identity as a Universal Process. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of Identity Theory and Research* (pp. 649–670). Springer.

Earnshaw, V. A., Menino, D. D., Sava, L. M., Perrotti, J., Barnes, T. N., Humphrey, D. L., & Reisner, S. L. (2020). LGBTQ bullying: A qualitative investigation of student and school health professional perspectives. *Journal of LGBT Youth*, *17*(3), 280–297.

Eliason, M. J. (2014). An Exploration of Terminology Related to Sexuality and Gender: Arguments for Standardizing the Language. *Social Work in Public Health*, *29*(2), 162–175.

Eyridice (2023). *National Education Systems. Finland. Overview.* Retrieved 24 June, 2023 from https://eurydice.eacea.ec.europa.eu/national-education-systems/finland/overview

Flentje, A., Clark, K. D., Cicero, E., Capriotti, M. R., Lubensky, M. E., Sauceda, J., Neilands, T. B., Lunn, M. R., & Obedin-Maliver, J. (2022). Minority Stress, Structural Stigma, and Physical Health Among Sexual and Gender Minority Individuals: Examining the Relative Strength of the Relationships. *Annals of Behavioral Medicine*, *56*(6), 573–591.

Ford, J. v., Corona-Vargas, E., Cruz, M., Fortenberry, J. D., Kismodi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2021). The World Association for Sexual Health's Declaration on Sexual Pleasure: A Technical Guide. *International Journal of Sexual Health,* 33(4), 612–642.

Foucault, M. (1984). *The history of sexuality. Volume 1, An introduction*. Penguin books.

Garbers, S., Heck, C. J., Gold, M. A., Santelli, J. S., & Bersamin, M. (2018). Providing Culturally Competent Care for LGBTQ Youth in School-Based Health Centers: A Needs Assessment to Guide Quality of Care Improvements. *The Journal of School Nursing*, *34*(6), 424–429.

Goodman, L. A. (1961). Snowball sampling. *The Annals of Mathematical Statistics, 32*(1), 148–170.

Goodman, L. A. (2011). Comment: On respondent-driven sampling and snowball sampling in hard-to-reach populations and snowball sampling not in hard-to-reach populations. *Sociological Methodology, 41*(1), 347–353.

Green, A. E., Price, M. N., & Dorison, S. H. (2022). Cumulative minority stress and suicide risk among LGBTQ youth. *American Journal of Community Psychology*, *69*(1/2), 157–168.

Hart, G., & Wellings, K. (2002). Sexual behaviour and its medicalisation: In sickness and in health. *BMJ: British Medical Journal*, *324*(7342), 896–896.

Henrickson, M., Giwa, S., Hafford-Letchfield, T., Cocker, C., Mulé, N. J., Schaub, J., & Baril, A. (2020). Research Ethics with Gender and Sexually Diverse Persons. *International journal of environmental research and public health*, *17*(18), 6615.

Hietanen-Peltola, M.K., Rautava, M., Laitinen, K., Autio, E. (2019). (Eds.) *Kohtaaminen keskiössä – Lapsi- ja nuorisolähtöisyys opiskeluhuollon palveluissa* (p. 7). Terveyden ja hyvinvoinnin laitos.

Hietanen-Peltola, M.K. & Saarinen, M. (2021). *Kahdeksannen luokan laaja terveystarkastus.* Terveyden ja hyvinvoinnin laitos. Duodecim Terveysportti: NEUKO-tietokanta. https://www.terveysportti.fi/apps/dtk/nko/article/kou00013?toc=1112230

Holloway, I., & Galvin, K. (2017). Establishing Quality: Trustworthiness and Validity. In Holloway, I. & Galvin, K. *Qualitative research in nursing and healthcare (pp 303–319)*. John Wiley & Sons, Incorporated.

Hobaica, S., & Kwon, P. (2017). "This Is How You Hetero:" Sexual Minorities in Heteronormative Sex Education. *American Journal of Sexuality Education*, *12*(4), 423–450.

Hästbacka, N. & Sirén, I. (2017). *”Ehkä ne on senkin takia ollu hiljaa” Ammattilaisten valmiudet kohdata sateenkaarinuoria ja huomioida moninaisuutta päihde- ja mielenterveyspalveluissa.* Nuorisotutkimusverkosto/ Nuorisotutkimusseura, Julkaisuja (kenttä) nro 193. Unigrafia.

ILGA-Europe. (2023). *Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe and Central Asia 2023.* ILGA-Europe. https://www.ilga-europe.org/files/uploads/2023/02/annual-review-2023.pdf

Jackson, S. (2006). Interchanges: Gender, sexuality and heterosexuality: The complexity (and limits) of heteronormativity. *Feminist Theory*, *7*(1), 105–121.

Jokela, S., Luopa, P., Hyvärinen, A., Ruuska, T., Martelin, T., & Klemetti, R. (2020). *Sukupuoli- ja seksuaalivähemmistöihin kuuluvien nuorten hyvinvointi: Kouluterveyskyselyn tuloksia 2019.* Terveyden ja hyvinvoinnin laitos THL, Työpaperi 38/2020. https://www.julkari.fi/handle/10024/140742

Katz, A. (2014). Invisible minorities. *Oncology Nursing Forum*, *41*(4), 343.

Katz-Wise, S. L., Rosario, M., & Tsappis, M. (2016). Lesbian, Gay, Bisexual, and Transgender Youth and Family Acceptance. *Pediatric Clinics of North America*, *63*(6), 1011–1025.

Kosciw, J. G., Clark, C. M., & Menard, L. (2019). *The 2019 National School Climate Survey: The experiences of LGBTQ+ youth in our nation’s schools*. Gay, Lesbian and Straight Education Network GLSEN. https://www.glsen.org/sites/default/files/2021-04/NSCS19-FullReport-032421-Web_0.pdf

Kralik, N., & Skinner, D. (2018). Heath risk behaviors in the gender and sexual minority population. In Smalley, K.B., Warren, J.C., & Barefoot, K.N. (Eds.) *LGBT health- meeting the needs of gender and sexual minorities* (pp 27–42). Springer Publishing Company.

Laki lapsen huollosta ja tapaamisoikeudesta 8.4.1983/361. [*Act on Child Custody and Right of Access*]

Laki lääketieteellisestä tutkimuksesta 488/1999. [*Medical Research Act*]

Lastensuojelulaki 13.4.2007/417. [*Child Welfare Act*]

Lehtonen, J. (2003). *Seksuaalisuus ja sukupuoli koulussa: näkökulmana heteronormatiivisuus ja ei-heteroseksuaalisten nuorten kertomukset*. Yliopistopaino.

Lips, H. M. (2019). *Gender: The Basics* (2nd ed.). Routledge.

Lumivero. (2023). Products ->NVivo. https://lumivero.com/products/nvivo/ Retrieved August 12, 2023.

Luopa, P., Kanste, O. & Klemetti, R. (2017). *Toisella asteella opiskelevien sateenkaarinuorten hyvinvointi 2017. Kouluterveyskyselyn tuloksia.* Tutkimuksesta tiiviisti 25, syyskuu 2017. Terveyden ja hyvinvoinnin laitos.

Mahdi, I., Jenn Jevertson, M., Ronald Schrader, M., Nelson, A., & Mary Ramos, L. M. (2014). Survey of New Mexico School Health Professionals Regarding Preparedness to Support Sexual Minority Students. *Journal of School Health*, *84*(1), 18–24.

Majlander, S., Lehtonen, J., Luopa, P., Sares-Jäske, L., Teräsaho, M., Vihtari, J., Nenonen, T., Hyvärinen, A. & Klemetti, R. (2022.) *S*ateenkaarinuoret poikkeusaikana. In Nenonen, M., Gissler, M., Känkänen, P. & Isola A.-M. (Eds.) *Poikkeuksellinen nuoruus Korona-aikaan. Nuorten elinolot-vuosikirja 2022* (pp. 179–196). Nuorisotutkimusverkosto/Nuorisotutkimusseura, Terveyden ja Hyvinvoinnin laitos, Valtion Nuorisoneuvosto.

McIntyre, M., & McDonald, C. (2012). The limitations of partial citizenship: Health care institutions underpinned with heteronormative ideals. *Advances in Nursing Science*, *35*(2), 127–134.

McClain, Z., Thomas, R., & Yehia, B.R. (2018). Sociocultural and systematic Barriers to health for gender and sexual minority populations. In Smalley, K.B., Warren, J.C., & Barefoot, K.N. (Eds.) *LGBT health- meeting the needs of gender and sexual minorities* (pp 15–25). Springer Publishing Company.

Meleis, A. I. (2012a). Our Syntax: An epistemological Analysis. In Meleis, A. I. *Theoretical Nursing: Development and Progress* (pp. 136–159). (5th ed.) Wolters Kluwer Health, Lippincott Williams & Wilkins.

Meleis, A. I. (2012b). Challenges and opportunities for a theoretical future. In Meleis, A. I. *Theoretical Nursing: Development and Progress* (pp. 354–370). (5th ed.) Wolters Kluwer Health, Lippincott Williams & Wilkins.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697.

Morse, J. M. (2015). Critical Analysis of Strategies for Determining Rigor in Qualitative Inquiry. *Qualitative Health Research*, *25*(9), 1212–1222.

Neiman, T., Sieve, L., Stenberg, L., Molesky, N., & Nic Rider, G. (2021). "Bridging the Gap": School Nurse Experiences Providing Care for Transgender and Gender Diverse Students and Their Parents/Guardians. *The Journal of School Nursing*, 105984052110254–10598405211025442. First published online June 23, 2021.

OHCRH–Office of the High Commissioner for Human Rights. (2015). *Free & Equal Campaign Fact Sheet: Intersex*. Retrieved August 12, 2023 from https://www.unfe.org/wp-content/uploads/2017/05/UNFE-Intersex.pdf

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. *PEDIATRICS*, *137*(3).

OPH – the Finnish National Agency for Education. (2014). *Perusopetuksen opetussuunnitelman perusteet 2014.* https://www.oph.fi/sites/default/files/documents/perusopetuksen_opetussuunnitelman_perusteet_2014.pdf

Paasonen, S., & Spišák, S. (2018). Malleable identities, leaky taxonomies: The matter of sexual flexibility. *Sexualities*, *21*(8), 1374–1378.

Pampati, S., Andrzejewski, J., Sheremenko, G., Johns, M., Lesesne, C. A., & Rasberry, C. N. (2020). School Climate Among Transgender High School Students: An Exploration of School Connectedness, Perceived Safety, Bullying, and Absenteeism. *Journal of School Nursing*, *36*(4), 293–303.

Patton, M. Q. (Ed.) (2015). *Qualitative research & evaluation methods.* SAGE Publications.

Peterson, C. M., Matthews, A., Copps-Smith, E., & Conard, L. A. (2017). Suicidality, Self-Harm, and Body Dissatisfaction in Transgender Adolescents and Emerging Adults with Gender Dysphoria. *Suicide and Life-Threatening Behavior 47(4), 475–482.*

Poteat, T. & Stahlman, S. (2020). *Global health/ LGBTQ Health*. In Stall, R., Dodge, B., Bauemeister, J.A., Poteat, T., & Beyrer, C. (Eds.) *LGBTQ Health Research. Theory, methods, practice* (pp. 37–46). John Hopkins University Press.

Rasberry, C. N., Morris, E., Lesesne, C. A., Kroupa, E., Topete, P., Carver, L. H., & Robin, L. (2015). Communicating With School Nurses About Sexual Orientation and Sexual Health. *The Journal of School Nursing*, *31*(5), 334–344.

Reisner, S. L., Sava, L. M., Menino, D. D., Perrotti, J., Barnes, T. N., Humphrey, D. L., Nikitin, R. V., & Earnshaw, V. A. (2020). Addressing LGBTQ Student Bullying in Massachusetts Schools: Perspectives of LGBTQ Students and School Health Professionals. *Prevention Science*, *21*(3), 408–421.

Rose, I. D., & Friedman, D. B. (2017). Schools: A Missed Opportunity to Inform African American Sexual and Gender Minority Youth About Sexual Health Education and Services. *Journal of School Nursing*, *33*(2), 109–115.

Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *Journal of Adolescent Health*, *63*(4), 503–505.

Sava, L. M., Earnshaw, V. A., Menino, D. D., Perrotti, J., & Reisner, S. L. (2021). LGBTQ Student Health: A Mixed-Methods Study of Unmet Needs in Massachusetts Schools. *Journal of School Health*, *91*(11), 894–905.

Savin-Williams, R. C. (2011). Identity Development Among Sexual-Minority Youth. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of Identity Theory and Research* (pp. 671–689). Springer.

Sawyer, R. J., Porter, J. D., Lehman, T. C., Anderson, C., & Anderson, K. M. (2006). Education and Training Needs of School Staff Relevant to Preventing Risk Behaviors and Promoting Health Behaviors Among Gay, Lesbian, Bisexual, and Questioning Youth. *Journal of HIV/AIDS Prevention in Children & Youth*, *7*(1), 37–53.

Sell, R., & Conron, K. (2020). Definitions: "Straight, that is not gay". Moving beyond binary notions of sexual and gender identities. In Stall, R., Dodge, B., Bauemeister, J.A., Poteat, T., & Beyrer, C. (Eds.) *LGBTQ Health Research. Theory, methods, practice* (pp. 61–90). John Hopkins University Press.

Seta– LGBTI Rights in Finland. (2023a). *Sateenkaarihistoria Suomessa.* Retrieved June 26, 2023 from https://seta.fi/ihmisoikeudet/sateenkaarihistoria-suomessa/

Seta. (2023b). *Seta.* Retrieved June 19, 2023 from https://en.seta.fi/

Shattuck, D., Hall, J. L., Dickson, E., Green, A. E., & Ramos, M. M. (2021). Implementing Evidence-Informed Practices to Make Schools Safer and More Supportive of Sexual and Gender Minority Youth. *Journal of School Health*, *91*(3), 258–261.

Smalley, K.B., Warren, J.C., & Barefoot, K.N. (2018). Gender and sexual minority health: History, current state, and terminology. In Smalley, K.B., Warren, J.C., & Barefoot, K.N. (Eds.) *LGBT health- meeting the needs of gender and sexual minorities* (pp. 3–14). Springer Publishing Company.

Spurlin, W. J. (2019). Queer Theory and Biomedical Practice: The Biomedicalization of Sexuality/The Cultural Politics of Biomedicine. *Journal of Medical Humanities*, *40*(1), 7–20.

Stall, R., Valdiserri, R.O., & Wolitski, R.D. (2020). Queering research. In Stall, R., Dodge, B., Bauemeister, J.A., Poteat, T., & Beyrer, C. (Eds.) *LGBTQ Health Research. Theory, methods, practice* (pp. 3–23). John Hopkins University Press.

Stephenson, R., & Riley, E. (2020). Engaging populations in LGBTQ health interventions. In Stall, R., Dodge, B., Bauemeister, J.A., Poteat, T., & Beyrer, C. (Eds.) *LGBTQ Health Research. Theory, methods, practice* (pp. 184–203). John Hopkins University Press.

STM– Ministry of Social Affairs and Health. (2004). *Kouluterveydenhuollon laatusuositus.* Helsinki: Sosiaali- ja terveysministeriön oppaita 2004:8.

STM. (2023a). *Primary health care.* https://stm.fi/en/primary-health-care Retrieved June 24, 2023.

STM (2023b). *Wellbeing service counties will be responsible for organizing health, social and rescue services on 1 January 2023.* https://stm.fi/en/wellbeing-services-counties Retrieved June 24, 2023

Taavetti, R. (2015). *"Olis siistiä, jos ei tarttis määritellä…" Kuriton ja tavallinen sateenkaarinuoruus.* Nuorisotutkimusseura/Nuoritutkimusverkosto, verkkojulkaisuja 81, Hybridit & Seta, Seta-julkaisuja 24. Nuorisotutkimusseura.

TENK – Finnish Advisory Board on Research Integrity. (2019). *The ethical principles of research with human participants and ethical review in the human sciences in Finland* (2019). Finnish National Board on Research Integrity TENK Guidelines 3/2019. https://tenk.fi/sites/default/files/2021-01/Ethical_review_in_human_sciences_2020.pdf

TENK. (2023). *The Finnish code of conduct for research integrity and procedures for handling alleged violations of research integrity in Finland.* Publications of the Finnish National Board on Research Integrity TENK 4/2023. https://tenk.fi/sites/default/files/2023-05/RI_Guidelines_2023.pdf

Terao, R., & Kaneko, N. (2021). Survey of school nurses' experiences of providing counselling on sexual orientation to high school students in Japan. *International Journal of Adolescent Medicine and Health*, *33*(6), 551–553.

Terveydenhuoltolaki 1326/2010. [*Health Care Act*]

Terveydenhoitajaliitto. (2016). *Terveydenhoitajan eettiset suositukset.* [*The ethical guidelines of public health nurse*] Retrieved June 24, 2023 from https://www.terveydenhoitajaliitto.fi/ammatti_ja_koulutus/terveydenhoitajan_eettiset_suositukset

Tolman, D. L. (2011). Sexual Health. In R. J. R. Levesque (Ed.), *Encyclopedia of Adolescence* (pp. 2667–2677). Springer.

THL – National Institute of Health and Welfare. (2023.) *Kouluterveydenhuolto*. https://thl.fi/fi/web/lapset-nuoret-ja-perheet/sote-palvelut/opiskeluhuolto/kouluterveydenhuolto Retrieved August 12, 2022.

THL. (n.d.) *Kouluterveyskysely*. Retrieved June 24, 2023 from https://thl.fi/fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/kouluterveyskysely

United Nations Convention on the Rights of the child, 20 November 1989. https://www.unicef.org/child-rights-convention/convention-text

Valtioneuvoston asetus neuvolatoiminnasta, koulu- ja opiskeluterveydenhuollosta sekä lasten ja nuorten ehkäisevästä suun terveydenhuollosta 338/2011. [*Government decree on maternity and child health clinic services, school and student health services and preventive oral health services for children and youth*]

WAS – World Association for Sexual Health (2015). *Declaration of Sexual Rights.* https://worldsexualhealth.net/wp-content/uploads/2021/09/declaration_of_sexual_rights_sep03_2014_b.pdf

Whittemore, R., & Knafl, K. (2005.) The integrative review: updated methodology. *Journal of Advanced Nursing, 52*(5), 546–553.

WHO – World Health Organisation. (2006). *Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002,* Geneva. Geneva, Switzerland: World Health Organization.

WHO & the United Nations Children's Fund UNICEF. (2018). *A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals.* https://apps.who.int/iris/bitstream/handle/10665/328065/WHO-HIS-SDS-2018.15-eng.pdf?sequence=1&isAllowed=y

WHO. (2021). *WHO guideline on school health services.* Geneva: World Health Organization.

WHO. (2023a). *Adolescent health.* Retrieved June 26, 2023 from https://www.who.int/health-topics/adolescent-health#tab=tab_1

WHO. (2023b). *HIV and AIDS.* Retrieved June 26, 2023 from https://www.who.int/news-room/fact-sheets/detail/hiv-aids

WHO. (n.d.). *International Classification of Diseases (ICD)*. Retrieved August 12, 2023 from https://www.who.int/standards/classifications/classification-of-diseases

Wilson, E. C., Chen, Y.-H., Arayasirikul, S., Raymond, H. F., & McFarland, W. (2016). The impact of discrimination on the mental health of trans*female youth and the protective effect of parental support. *AIDS and Behavior*, *20*(10), 2203–2211.

Zhang, L., Finan, L. J., Bersamin, M., & Fisher, D. A. (2020). Sexual Orientation–Based Depression and Suicidality Health Disparities: The Protective Role of School-Based Health Centers. *Journal of Research on Adolescence*, *30*(S1), 134–142.

Appendices

APPENDIX 1.

Appendix Table 1. Search phrases used in databases for the review of empirical studies.

DATABASE	SEARCH PHRASE	SEARCH RESULTS
CINAHL	(MH "Sexual and Gender Minorities+") OR (MH "Gender-Nonconforming Persons+") OR (MH "LGBTQ+ Persons+") OR (MH "Homosexuality") OR (MH "Gay Persons+") OR (MH "Lesbians") OR (MH "Bisexuality") OR (MH "Asexuality") OR (MH "Transgender Persons+") OR "sexual and gender minorit*" OR lgbt* OR "gender minorit*" OR homosex* OR gay OR lesb* OR bisex* OR trans* OR transg* OR transsex* OR queer OR genderqueer* OR nonbinary OR intersex* OR asex* AND (MH "School Health") OR (MH "School Health Services+") OR (MH "School Mental Health Services") OR (MH "School Health Nursing") OR "school health" OR "school healthcare" OR "school nurs*" AND (MH "Adolescence+") OR (MH "Young Adult") OR adolescen* OR youth* OR teen* OR young* OR "young adult*" OR student* OR pupil*	1,571
PUBMED/MEDLINE	("sexual and gender minorit*" OR lgbt* OR "gender minorit*" OR homosex* OR gay OR lesb* OR bisex* OR trans* OR transg* OR transsex* OR queer OR genderqueer* OR nonbinary OR intersex* OR asex* OR "Sexual and Gender Minorities"[Mesh] OR "Transgender Persons"[Mesh] OR "Bisexuality"[Mesh] OR "Homosexuality"[Mesh] OR "Intersex Persons"[Mesh]) AND ("school health" OR "school healthcare" OR "school nurs*" OR "School Health Services"[Mesh] OR "School Nursing"[Mesh] OR "Nursing Care"[Mesh]) AND (adolescen* OR youth* OR teen* OR young* OR "young adult*" OR student* OR pupil* OR "Adolescent"[Mesh] OR "Young Adult"[Mesh])	3,071
PSYCHINFO	((DE "Homosexuality") OR (DE "Sexual Minority Groups") OR (DE "Bisexuality") OR (DE "Gender Nonconforming") OR (DE "Intersex") OR (DE "Transgender") OR (DE "LGBTQ") OR (DE "Asexuality") OR (DE "Bisexuality") OR "sexual and gender minorit*" OR lgbt* OR “gender minorit*” OR homosex* OR gay OR lesb* OR bisex* OR trans* OR transg* OR transsex* OR queer OR genderqueer* OR nonbinary OR intersex* OR asex*) AND ((DE "School Nurses") OR (DE "Nursing") OR "school health service*" OR "school healthcare" OR "school nurs*") AND ((adolescen* OR youth* OR teen* OR young* OR “young adult*” OR student* OR pupil*))	1,268

APPENDIX 2.

Appendix Table 2. Empirical studies on LGBTQ+ youth in the school nursing context.

AUTHOR, YEAR, COUNTRY	AIM	METHODS	FINDINGS
Sawyer et al. 2006 United States	To conduct a national-level needs assessment identifying training and educational needs of school health professionals in providing health and mental health services to GLBQ students.	A quantitative descriptive study. Participants: School counsellors, school nurses, school psychologists, and social workers (N= 941). Data collection: A self-administrated questionnaire.	Most health professionals indicated that GLBQ students exist in their schools, and their attitudes towards GLBQ students were accepting and tolerant. Health professionals saw that they should be providing more health and mental health services for GLBQ students, but they identified several possible barriers related to service provision, including school climate, lack of knowledge, training, and skills needed to work with GLBQ students.
Mahdi et al. 2014 United States	To describe school health professionals' preparedness to address needs of LGBTQ students on the levels of knowledge, attitudes, and skills.	A quantitative correlational study. Participants: School nurses, counsellors and social workers (N= 183). Data collection: A self-administered questionnaire and The Attitudes Toward Lesbian and Gay Men (ATLG) scale.	Most professionals had moderate or high knowledge of LGBTQ youth health risks, and most professionals had more confidence to work with LGBTQ than experience about discussing health concerns with LGBTQ youth. School nurses had the lowest knowledge of LGBTQ students at being risk for suicide, depression, and discrimination, and school nurses were more likely to have negative attitudes toward gays and lesbians than other professionals.
Rasberry et al. 2015 United States	To inform school-centered strategies for connecting Black and Latino young men who have sex with men (YMSM) to HIV and STD prevention services. The study described	A cross-sectional mixed-methods study. Participants: Black and Latino YMSM aged 13–19 years (n= 447).	YMSM were most often willing to talk school nurses about HIV testing, STD testing, or condoms. However, YMSM felt least safe to talk about their sexual orientation to school nurses, especially if they were uncertain of nurses' perceptions about sexual minorities were, or nurses

	(1) the willingness and safety of YMSM in discussing sexual health and sexual orientation-related topics, (2) the experiences of YMSM with school nurses discussing about sexual health-related topics.	Data collection: A web-based questionnaire with 53 items, and semi-structured in-person interviews.	seemed to lack knowledge of LGBTQ issues.
Rose & Friedman 2017 United States	To examine African American sexual and gender minority (SGM) youth males' perceptions about school sexual health education and services.	A qualitative descriptive study. Participants: African American SGM males aged 18–21 years (n= 42). Data collection: Semi-structured focus groups and individual interviews. Participants attended either in focus groups or in interview.	SGM male youth indicated that schools have missed opportunities to educate SGM youth about sexual health. They identified several barriers to accessing sexual health education and services, including limited health information, school nurses not having knowledge about health issues that impact SGM youth.
Garbers et al. 2018 United States	To assess the ways in which school-based health centers (SBHCs) provide culturally competent care for LGBTQ youth, especially on structural, systemic, and interpersonal levels.	A cross-sectional quantitative study. Participants: Administrators and medical directors of SBHCs in grades 9-12 (N= 66) Data collection: A 41-item questionnaire, which was adapted from existing self-assessment instruments of cultural competence of environments and care for LGBTQ youth and adults.	Most of the SBHCs (n= 62) provided comprehensive services for youth, and even more SBHCs (n= 64) addressed at least one element of each competency levels (structural, interpersonal, systemic). Only two SBHCs took no steps to provide culturally competent care for LGBTQ youth. However, there was infrequent and inadequate provision of staff training especially with health needs and communicating with transgender youth.

Cahill et al. 2020 United states	To explore barriers and facilitators which youth-serving health professionals face in providing HIV preventive services and education for adolescent men who have sex with men (AMSM) and transgender youth.	A qualitative descriptive study. Participants: Youth-serving professionals (n= 44) consisting of school nurses, nurse practitioners, physicians, youth workers and school educators. Data collection: Two-hour online discussions and demographic data	Four categories emerged in online discussions of professionals: 1) effective strategies for building trust, 2) perceived barriers and facilitators to sexual health communication, 3) perceived barriers and facilitators to effective HIV prevention, 4) preferred content and format for HIV prevention tools.
Earnshaw et al. 2020 United States	To explore the perspectives of LGBTQ students and school health professionals (SHPs) on experiences of LGBTQ bullying, and SHPs responses to LGBTQ bullying.	A mixed-methods study. Participants: LGBTQ youth aged 14-22 years (n= 28), and SHPs (n= 19) including school nurses, social workers, school psychologists, guidance counsellor, and health education teacher. Data collection: A brief questionnaire with demographic questions, and separate online, asynchronous focus groups for LGBTQ youth and SHPs.	Both LGBTQ students and SHPs described on several types of bullying experienced by LGBTQ students. However, there was a disconnect in perceptions of LGBTQ bullying among LGBTQ students versus SHPs, as LGBTQ students reported a range of verbal, social, and physical bullying, but SHPs reported a minimal awareness of LGBTQ bullying in schools.
Reisner et al. 2020 United States	To identify factors that facilitate or impede SHPs' reporting and responding to LGBTQ bullying from the perspectives of LGBTQ students and SHPs.	A mixed-methods study. Participants: LGBTQ youth aged 14-22 years (n= 28), and SHPs (n= 19) including school nurses, social workers,	LGBTQ students and SHPs identified factors at multiple levels in the social ecological model: 1) individual level (knowledge, skills, and attitudes, 2) interpersonal (e.g., confidentiality and fear of being "outed", champion SHPs), and 3) structural (e.g., reporting and protocols, school culture of inclusivity).

	Facilitators and barriers were identified in the analysis based on the social ecological model.	school psychologists, guidance counsellor, and health education teacher. Data collection: A brief questionnaire with demographic questions, and separate online, asynchronous focus groups for LGBTQ youth and SHPs.	There is a need for an intersectional lens for SHPs when addressing LGBTQ student bullying of students who are transgender or LGBTQ students of color.
Zhang et al. 2020 United States	To examine whether school-based health centers (SBHCs) support the mental health indicators of sexual minority youth (SMY).	A quantitative correlational study. Participants: 11th graders (N= 13,608) in 137 public high schools in Oregon. Data collection: Data based on the 2015 Oregon Healthy Teens Survey; measures of demographic characteristics, school characteristics, mental health and sexual orientation were included in data analysis.	SMY were significantly more like to report past year depressive episodes (56.8 vs. 25.4%), suicide ideation (40.8% vs. 13.0%) and suicide attempts (18.2% vs. 4.7%) than non-SMY. Findings suggested that a significantly lower percentage of SMY students reported having a depressive episode, suicide ideation, and suicide attempt in the past year when an SBHC was present on school campus compared to when it was not. Therefore, access to SBHCs may be important health service to reduce the mental health disparities among SMY.
Neiman et al. 2021 United States	To describe school nurses' experiences working with transgender and gender diverse (TGD) students and their parents/guardians.	A qualitative descriptive study. Participants: School nurses (n= 23) working in public middle or high school. Data collection: Semi-structured interviews and survey collecting demographic data.	Most (61%) school nurses had some education in gender diversity, but only 40% reported it was employer encouraged, and 30% got reimbursement from attending to education. School nurses described their experiences through four themes: 1) gender-affirming education and interpersonal collaboration, 2) bridging the gap between TGD youth and parents/guardians, 3) gender-affirming care and confidentiality, and 4) navigating parental acceptance and gender-affirmation.

Sava et al. 2021 United States	To examine the school health needs of LGBTQ students from the perspectives of LGBTQ youth and school health professionals (SHPs).	A mixed-methods study. Participants: LGBTQ youth aged 14-22 years (n= 28), and SHPs (n= 19) including school nurses, social workers, school psychologists, guidance counsellor, and health education teacher. Data collection: A brief questionnaire with demographic questions, and separate online, asynchronous focus groups for LGBTQ youth and SHPs.	LGBTQ youth have several unmet health needs, and there were several issues related to their feelings of safety in school. LGBTQ youth and SHPs identified an urgent need for inclusive sexual health education and mental health services. Safe spaces and gender-affirming bathrooms and locker rooms were needed in schools. Information and guidance of gender transition, abusive relationships, sexual violence/harassment, substance use, and racism needs to be included in school health services.
Terao & Kaneko 2021 Japan	To examine the prevalence and correlated factors of school nurses when providing consultation on sexual orientation in Japanese high schools.	A cross-sectional quantitative study. Participants: Japanese school nurses (N= 360) working in junior or senior high school. Data collection: A self-reported survey questionnaire.	Over half of school nurses (61.1%) had no previous experience of providing counselling to students of sexual orientation. School nurses having previous experience of providing counselling, were more likely to have 10–29 years of working experience, they worked in senior high school, and they were more often provided counselling on transgenderism. From all school nurses, only 15.2% had learning experience of how to provide counselling on sexual orientation.

TURUN
YLIOPISTO
UNIVERSITY
OF TURKU

ISBN 978-951-29-9562-2 (PRINT)
ISBN 978-951-29-9563-9 (PDF)
ISSN 0355-9483 (Print)
ISSN 2343-3213 (Online)

Painosalama, Turku, Finland 2023