

Exploring Gay Male Youths' Perceptions of Stigma in the Therapeutic Relationship at a Gay
Men's Sexual Health Clinic

By
Jessica Watts, RN, BScN

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Faculty of Health Science
School of Nursing
University of Ottawa
Ottawa, Ontario

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Abstract

Since 1999, youth have experienced an increase in HIV incidence. Gay male youth, in particular, are a priority sub-population because they accounted for the highest exposure category in 2008 among youth. Due to the lack of studies on gay male youth who are susceptible to HIV, and the reality that most previous research on stigma may no longer reflect the contemporary context, nursing based research was undertaken. Utilizing critical theory, stigma within the therapeutic relationship was investigated through eight semi-structured interviews with gay male youth who were recruited through a gay men's sexual health clinic in Ottawa, Canada. The results of this research showed that while stigma, whether perceived stigma or the fear of stigmatization, was still felt by these participants in some interactions, overall, these youth had positive experiences with the health care system, particularly within the context of the gay men's sexual health clinic.

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Chapter One – Statement of Problem

Introduction

Since 1997, the global incidence of human immunodeficiency virus (HIV) appears to have stabilized (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2010). In 2009, an estimated 2.6 million people worldwide were newly infected with HIV bringing the total number of people living with HIV to an estimated 33.3 million (UNAIDS, 2010). This is down from the estimated 3.2 million people newly infected in 1997, when the epidemic appears to have peaked (UNAIDS, 2010). Within Western and Central Europe, more specifically, an estimated 31,000 adults and children were newly diagnosed with HIV in 2009, while 70,000 individuals were newly diagnosed in North America (UNAIDS, 2010). Therefore, an estimated 100,000 individuals were newly diagnosed with HIV in 2009 in these regions, compared with 97,000 in 2001 (UNAIDS, 2010).

Within Canada specifically, there were an estimated 2300 to 4300 individuals diagnosed with HIV in 2009 bringing the total number of people living with HIV to an estimated 67,000 (UNAIDS, 2010). While HIV incidence globally has been somewhat stable in the last five years, there has been a resurgence of new HIV infections in high-income countries, including Canada, among the epidemiological surveillance category of men who have sex with men (MSM) (UNAIDS, 2010). For example, the incidence of HIV has increased in the United States and Canada since 2001 among MSM (Hall et al., 2009). In Ontario, specifically, there were 1620 new HIV infections diagnosed in 2008; about half of these new infections, an estimated 745, were among MSM (Remis, Swantee & Liu, 2010). Within Ontario, the incidence of HIV infection in this population has increased 70% since the low of 438 new infections in 1996 (Remis, Swantee & Liu, 2010). Lastly, in Ottawa,

where this research took place, there were 140 new cases of HIV diagnosed in 2008, with 42.9% of new cases being among MSM (Remis, Swantee & Liu, 2010).

Youth, defined here as people between the ages of 15 and 29, have also experienced an increase in HIV incidence (Public Health Agency of Canada [PHAC], 2010a). In 2009, people aged 15 to 24 accounted for 41% of new HIV infections worldwide, which is up from 40% in 2008 (UNAIDS, 2010). In Canada, youth accounted for 39.5% of HIV incidence in 1985, which steadily decreased to 20.8% in 1999. Since 1999, however, the proportion of HIV incidence for youth has increased from 21% to 23% (PHAC, 2010a). Within the youth population, gay male youth are a priority sub-population because they accounted for the highest exposure category in 2008 among youth, with 53.9% of HIV incidence in youth being among young men who have sex with men (YMSM) (PHAC, 2010a).

Because epidemiological data suggests that gay male youth appear to have a heightened chance of contracting HIV (PHAC, 2010a) based on their probability of exposure to HIV, i.e., based on their potential to engage in sexual contact with a person who is HIV-positive, these persons constitute an important research subpopulation. Researchers believe that early HIV detection and treatment can improve the health of not only individuals living with HIV, but also the population as a whole by decreasing onward HIV transmission (Fisher, 2008) and decreasing costs to the health care system associated with late diagnosis, such as increased hospitalization and non-HIV drug therapies (Krentz, Auld & Gill, 2004). Specifically, for individuals living with HIV, those who are diagnosed late experience an increase in morbidity, such as opportunistic infections and complications (Fisher, 2008), and a greater risk of short-term mortality compared to those diagnosed early (Fisher, 2008; Girardi, Sabin & Monforte, 2007). Specifically, those who present late are more likely to

develop multiple illnesses within a short period of time, and are more likely to require hospitalization with their first AIDS event (Girardi, Sabin & Monforte, 2007). Therefore, it is important to examine how gay male youth perceive currently available HIV prevention services.

Current research, which demonstrates the potential HIV prevention benefits of enabling gay male youth to access HIV testing services include, for example, Miller, Rosenberg, Rutstein & Powers' (2010) work, which found that individuals in the early acute stage of HIV infection play a disproportionately high role in HIV transmission, and that detection of these individuals through HIV testing could consequently play an important role in HIV prevention. A quantitative study by Marks, Crepaz & Janssen (2006), moreover, which examined the relative contribution of people aware of being HIV-positive versus those unaware in transmitting new HIV infections in the United States, found that the transmission rate for those who were unaware of their HIV-positive status was 3.5 times higher than those who knew they were HIV-positive. Similarly, a meta-analysis by Marks, Crepaz, Senterfitt & Janssen (2005) highlighted that participation in sexual behaviors that easily transmitted HIV was substantially reduced after individuals were diagnosed with HIV. Therefore, according to the foregoing authors, an increase in HIV-positive status awareness is desirable from an HIV prevention perspective.

Notwithstanding the potential HIV prevention benefits that arise when people know they are HIV-positive, the existing literature suggests that problems with health care service delivery negatively, particularly within the therapeutic relationship, affect the health-care seeking behaviours of youth. For example, research has shown that fear of perceived stigma has discouraged individuals from undergoing HIV testing (Kinsler, Wong, Sayles, Davis, &

Cunningham, 2007). However, there has been little research on perceived stigma in relation to nursing practice specifically (Kinsler et al., 2007), which constitutes a major gap in the literature because nurses are involved in HIV testing in many Canadian cities. Indeed, examining stigma within the nurse-patient therapeutic relationship is important because it is within this relationship that most patient care and HIV prevention activities take place (College of Nurses of Ontario [CNO], 2009; Registered Nurses Association of Ontario [RNAO], 2002). For example, a study by Murphy, Mitchell, Vermund & Futterman (2002) of HIV-positive and susceptible HIV-negative adolescents, which examined HIV testing patterns at 15 sites in the United States, found that 53.1% of HIV-positive adolescents and 66.1% of HIV-negative adolescents chose to undergo HIV testing due to the recommendation of their health care provider. Another study by of primary care pediatric practices in Washington, DC, found that adolescents were more comfortable discussing sexual health issues with their physicians when their physician initiated the discussion in the context of the general health examination (Boekeloo, Schamus, Cheng & Simmens, 1996).

As this relates to HIV, nurses could earn the trust of gay youth through candor and the therapeutic relationship, many of whom are vulnerable to HIV for many of the aforementioned reasons (PHAC, 2010a). If trust in the therapeutic relationship is reduced, however, gay youth may not be open about their sexual activities and other practices, such as drug use, that may make them susceptible to contracting HIV (Green & Platt, 1997); they may also delay HIV testing and necessary treatment (Black & Miles, 2002). Therefore, the therapeutic nurse-patient relationship needs to be examined with the sub-population of gay male youth to adequately understand how it is affected by the presence or absence of stigma, especially the effect of stigma on youth's openness to health care workers' suggestions for

HIV testing.

Research Objectives

1. To explore stigma from the perspective of gay male youth who attend a gay men's sexual health clinic where gay male youth can/do access sexually transmitted infection (STI)/HIV counseling, testing, and treatment services.
2. To explore stigma within the therapeutic relationship from the perspective of gay male youth
3. To explore how stigma effects the health-care seeking behaviours and attitudes towards the health-care system of gay male youth

Research Questions

1. Do gay male youth experience stigma within the context of the therapeutic nurse-client relationship? If so, what is their experience?
2. What is the perceived effect of stigma on the therapeutic relationship with gay male youth?
3. Do gay male youth feel that stigma affects their health-care seeking behaviours?
4. Does their experience of stigma have an effect on their attitudes towards the health-care system?

Epistemological Stance

Paradigms provide lenses, processes, frames, and patterns of beliefs through which scientific inquiry is accomplished (Weaver & Olson, 2006). One such paradigm is critical theory, where phenomena are studied through the eyes of the individual within their own personal lived situations or environments (Weaver & Olson, 2006).

Although a complete discussion of critical theory is beyond the scope of this thesis,

one important point to note is how critical theory relates to nursing. The ontology of the critical theory paradigm is relativism based on specific, historically-constructed realities (Lincoln & Guba, 2003). In the dialogue between two individuals, the nurse and the patient, this paradigm puts forth the pattern of belief that individuals come from their own unique background that is based on an array of economic, social, ethnic, and other historical factors. In this way, the interaction that occurs within the context of the therapeutic relationship will be in reference to, and built upon, their reality. These realities develop from years of experience (Lincoln & Guba, 2003). In this way, the individual is not a blank slate (i.e., a *tabula rasa*) to be written on, but rather a person who brings their previous experiences to the interaction just as their nurse brings their own experience.

Critical theory gives a unique ontological understanding of stigma within the context of the therapeutic relationship. In this case, reality is considered a socially-based mental construction (Guba, 1990), which is consistent with many different theories. Goffman's (1963) theory of stigma, based on qualitative research, is consistent with critical theory because it considers stigma to be a socially, economically, and historically constructed phenomenon that varies over time and place. The ontology of critical theory also posits that multiple realities exist and that many interpretations of reality are possible (Guba, 1990). This idea is well suited within Goffman's (1963) theory of stigma because the reality of stigma is different for each individual who experiences it. Stigma is not embedded in an attribute; instead, stigma, such as the stigma associated with being a young gay man, is placed upon an attribute by society (Goffman, 1963). Therefore, multiple realities could exist for those who possess a similar trait, and one society could stigmatize this feature while another could accept it.

From the epistemological standpoint of critical theory, the researcher and the participant create the research process together (Guba, 1990). This approach lends itself well to research on the perception of stigma in the therapeutic relationship with gay male youth in which the participant and the researcher create the results together through guided interviews. How the youth constructs the perception of stigma, and their perception on how this affects their relationship and trust in the nurse, is of particular importance. Because the data collection will rely on guided interviews, the study will be of a qualitative nature. In summary, the ontology and epistemology of critical theory are entwined in the sense that each individual, researcher, or participant, comes from a subjective background in which their own personal reality is situated (Lincoln & Guba, 2003); no two will be the same.

Chapter Two - Literature Review

To adequately explore the experience of stigma in the therapeutic relationship between gay male youth and health care workers, a thorough review of the literature was undertaken. It is presented in the following sections. First, the incidence and prevalence of HIV, as well as youth susceptibility to HIV, were explored to situate the current study within the existent epidemiological data. Second, the concept of risk was examined to define this concept and the idea of susceptibility. Third, the therapeutic relationship was explored because it is the focus of this research. Fourth, the concept of pastoral power was reviewed to provide an additional understanding about the power differential in the therapeutic relationship. Fifth, the existing literature on stigma, as well as on stigma and HIV, were examined to provide a detailed understanding of the extant conceptualizations of stigma. Finally, existing gaps in the literature were identified. Each of these sections is presented in turn.

Incidence and Prevalence of HIV

Because at any given time, a subset of persons living with HIV will be unaware that they are HIV-positive, epidemiologists around the globe estimate (often based on prevalence studies, statistical estimates, and antibody level testing of people recently diagnosed with HIV) the number of individuals both living, and newly infected, with HIV (PHAC, 2010b). Based on these estimates, since 1997, the global incidence of HIV, which is the number of new cases per designated period (per annum in this case) appears to have stabilized (UNAIDS, 2010). In 2009, an estimated 2.6 million people worldwide were newly infected with HIV, bringing the total number of people living with HIV to an estimated 33.3 million (UNAIDS, 2010). This figure is down from the estimated 3.2 million people newly infected in 1997, when the epidemic appears to have peaked (UNAIDS, 2010).

More specifically, within Western and Central Europe, an estimated 31,000 persons were newly diagnosed with HIV in 2009, while 70,000 individuals were newly diagnosed in North America in the same time period (UNAIDS, 2010). Therefore, an estimated 100,000 adults and children were newly diagnosed with HIV in 2009 in these regions, compared with 97,000 in 2001 (UNAIDS, 2010). This brings the prevalence, or total number of adults and children living with HIV in 2009, to 820,000 in Western and Central Europe and 1.5 million in North America (UNAIDS, 2010). These prevalence numbers have increased since 2001, when 630,000 people in Western and Central Europe and 1.2 million people in North America were living with HIV (UNAIDS, 2010).

Within Canada, specifically, there were an estimated 2300 to 4300 individuals diagnosed with HIV in 2009, bringing the total number of people living with HIV to an estimated 67,000 (UNAIDS, 2010). While HIV incidence globally remains relatively unchanged in the last five years, there has been a reappearance of new HIV infections in high-income countries, including Canada, in the specific sub-population of men who have sex with men (MSM) (UNAIDS, 2010).

In Ontario, specifically, about half of the new infections in 2008, an estimated 745, were among MSM (Remis, Swantee & Liu, 2010). Also, the incidence of HIV infection in this population has increased 70% since the low of 438 new infections in 1996 (Remis, Swantee & Liu, 2008). Lastly, in Ottawa, where this research was conducted, there were 140 new cases of HIV diagnosed in 2008, with 42.9% of new cases being among MSM (Remis, Swantee & Liu, 2010). This brings the prevalence of MSM living with HIV in Ottawa to an estimated 1,190 (Remis, Swantee & Liu, 2010).

Moreover, youth have experienced an increase in HIV incidence (PHAC, 2010a). In

2009, people aged 15 to 24 accounted for 41% of new HIV infections worldwide, which constituted an increase of 1% since 2008 (UNAIDS, 2010). Similarly, in Canada, youth (those aged 15 to 29 based on the aforementioned PHAC definition) have begun to account for a greater proportion of the number of individuals diagnosed with HIV. While in 1985, youth accounted for 39.5% of HIV incidence, this figure steadily decreased to 20.8% in 1999. Since 1999, however, the proportion of HIV incidence for youth has increased from 21% to 23% (PHAC, 2010a). Within the youth population, gay male youth are a priority sub-population because they accounted for the highest exposure category in 2008 among youth, with 53.9% of HIV incidence in YMSM (PHAC, 2010a). In the early years of the epidemic (1985-1990), MSM youth accounted for approximately 70% of the proportion of HIV incidence among the three main exposure categories (MSM, intravenous drug users, and heterosexual contact). By 1999, the proportion of HIV incidence among these exposure categories in youth was nearly equal. However, in 2008, MSM youth once again accounted for about half of the HIV incidence among these three categories (PHAC, 2010a).

In the above epidemiological data, PHAC (2010a) defined youth as those between the age of 15 and 29. PHAC further subdivided this population into two groups: 15 to 19 and 20 to 29. Regarding HIV, the incidence and prevalence was higher among those 20 to 29 years of age (PHAC, 2010a). Therefore, the age group 20 to 29 will be the population of focus for this thesis. However, for the purposes of this literature review, to provide a thorough understanding of the concept of stigma in youth, studies that encompass anywhere within the full age range of youth (aged 15-29) will be included. For the purpose of clarity, the age range of each study will be listed.

Youth Susceptibility to HIV

Based on the above incidence and prevalence statistics, youth (aged 15-29) are a specific sub-population affected by HIV. Those who inject drugs, gay male youth, and street involved youth have an even higher vulnerability of contracting HIV (PHAC, 2010a). Indeed, of the Canadian youth who tested positive for HIV in 2008, 53.9% (n=172) were MSM and 19.4% (n=62) were intravenous drug users (PHAC, 2010a).

According to the UNAIDS Report on the Global AIDS Epidemic (2010), only 34% of young men and women globally possess accurate and comprehensive knowledge about HIV, based on five basic questions, including an understanding of HIV transmission. This is far below the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) target of 95%, which was set in 2001 (UNAIDS, 2010). In fact, only 10 countries, of which Canada is not included, achieved comprehensive knowledge of HIV among 15-24 year olds above 60% in 2009; these countries included Sweden, Saint Lucia, Tuvalu, Namibia, Cape Verde, Norway, Liberia, Belarus, Eritrea, and Chile (UNAIDS, 2010). Similarly, the 2006 HIV/AIDS Attitudinal Tracking Survey of 303 Canadian youth, aged 16-24, found that only 69% of respondents correctly answered that sex between men was a mode of transmitting HIV, and only 78% correctly answered that unprotected sexual contact between a man and a woman was a method of transmitting HIV (Ekos Research Associates, 2006). In addition, the Toronto Teen Survey, which involved interviews with 1216 Toronto youth (aged 13-18) between December 2006 and August 2007, found that while 78% of these youth reported learning about HIV/AIDS in school, HIV/AIDS remained one of the top three topics about which they would like more information (Flicker et al., 2009).

In addition to inconsistent levels of HIV knowledge, Canadian youth have shown

varying levels of condom use, casual sex, and multiple sexual partners (PHAC, 2010a). For example, 50% of Canadian youth stated that they had not used a condom the last time they had sex (type of sex not specified in study), and reported the highest rates of having multiple sexual partners in all age groups (Ekos Research Associates, 2006). In the 2005-2006 Youth At Risk Study, which involved 529 youth, 24% reported consistent condom use in the last six months (Marshall et al., 2009). Despite these factors, 77% of youth in Canada perceived themselves to be at low-risk for contracting HIV, while 20% perceived themselves to be moderately at-risk for contracting HIV (Ekos Research Associates, 2006). The main reasons given for rating their risk category as low or moderate included having only one partner (37%), not being sexually active (25%), always using condoms (24%), and not using drugs (16%). Notwithstanding these youths' perceptions of their level of risk for contracting HIV being low, the concept of risk as a political, social, cultural, subjective and objective entity has not been adequately explored. Therefore, the concept of what it means to be 'at-risk' for HIV will be discussed next.

Risk

On the one hand, the concept of risk can be reduced to the act of distinguishing between probability and consequence (Alaszewski, Harrison & Manthorpe, 1998). On the other hand, the assessment of chance usually involves human judgement and decision making, therefore, making the ideas of subjective and objective risk inseparable (Watson, 1981). Building on this dichotomous understanding of risk, Lupton (1997) argued that risk actually has three classifications. First, there is the often-scientific presumption that risks are absolutely objective. Second, there is the belief that consequences follow actions, but that the meaning of these outcomes cannot be understood outside of their cultural significance.

Third, there are arguments that risks are the product of the social and cultural context in which risk exists (O'Byrne, 2008). Therefore, a practice or activity is not intrinsically risky (O'Byrne, 2008). Rather, it is deemed risky by the culture in which it exists (O'Byrne, 2008).

The third of Lupton's categories is similar to the work of Ewald (1991), who proposed that risk is both culturally and socially created. Therefore, nothing is inherently a risk, but everything could be a risk (Ewald, 1991). For example, one culture may perceive smoking as a risky activity, where smoking might be embedded in another culture as a socially acceptable practice. From this perspective, therefore, risk is not inherently detrimental, but a product of cultural and social norms.

Following the same line of thinking, Beck (1992) saw science as both the source of risks as well as the solution. For example, scientists not only create risks by positing statements such as 'smoking causes cancer' and 'obesity can lead to type two diabetes', but also they provide solutions to these risks by stating how to lessen these risks, such as smoking, diet, or exercise changes. Nursing research, similarly, could be seen as a method of creating risk, while clinical nursing could be understood as helping impose an aversion to these risks by engaging in health promotion or risk prevention practices with patients (O'Byrne, 2008).

Consequently, it is important to note that risk is not a neutral term, but a term with a political background. This is important to note for research involving those 'at-risk' for contracting HIV because society sees a vulnerability to HIV acquisition as inherently negative; HIV is considered a disease that should be avoided (O'Byrne, 2008). However, risk is not embedded in HIV, but rather, is the result of a collection of factors that make

society deem unacceptable the behaviour that lead to HIV acquisition, such as unprotected anal sex (Castel, 1991). Therefore, engaging in 'risky' behaviours, such as unprotected anal intercourse, appear, in society, to make one more 'at-risk' for contracting HIV. That is, the behaviour that puts one 'at-risk' for HIV are not inherently risky; rather, they are labeled as such by the culture in which they exist. This is consistent with the work of Beck (1999), who viewed risk as dependent on the culture and culturally determined values in which it exists.

However, Peterson (2007) has questioned the work of Beck, citing that, although the 'at-risk' individual is posited as autonomous and reflexive, there is no acknowledgment of the role of the expert (i.e., nurse) in regulating subjectivity, such as the 'risky' behaviours the individual engages in. In regards to acknowledging the role of the expert (i.e., nurse) in regulating 'risky' behaviour, one prime example is the role of the nurse and the use of power within the therapeutic nurse-patient relationship. This distinctive expert role will be discussed next followed by a discussion of power.

The Therapeutic Relationship

The therapeutic relationship is an interaction between a nurse, a patient, and, at times, a patient's family (McKlindon & Barnsteiner, 1999). This relationship is, furthermore, the foundation of professional nursing practice (McCormack, 1997). From the perspective of the College of Nurses of Ontario (CNO) (2009), the purpose of the therapeutic relationship is to provide nursing care that contributes to patients' health and well-being. The therapeutic relationship forms the framework in which all nursing activities are performed. It is based on trust, respect, professional intimacy, empathy, and the appropriate use of power (CNO, 2009). Establishment of the therapeutic relationship permits nurses not only to make therapeutic interventions, but also, in the process of creating the interaction between the

nurse and the patient, to become interventions themselves by contributing to patients' health and well-being (CNO, 2009; Wrigley, 1995).

However, it is important to note that while the goal of the therapeutic relationship is ultimately beneficent, the power dynamic in a therapeutic relationship is unequal due to nurses' authority, knowledge, access to confidential information, and perceived influence over other health care providers (CNO, 2009). Trust, therefore, is fundamental in the therapeutic relationship because patients are vulnerable in this relationship due to the aforementioned power differential (CNO, 2009). In turn, nurses must be non-judgemental, respectful of clients' dignity and worth, and have the skills, knowledge, and expertise required to provide proper patient care (CNO, 2009).

In addition, an effective therapeutic relationship depends on the comfort of both the patient and the nurse (Saddul, 1996). For example, Hitchcock and Wilson (1992) found that for 33 lesbian patients' (aged 18 to 68) to feel comfortable for open discussion with health care providers, they needed to perceive health care workers as accepting of their sexual orientation. If patients who identify as gay perceives otherwise, however, they may not be able to trust the health care worker, therefore, limiting adequate assessment, the appropriateness of care provided, and future health-care seeking behaviour of gay-identified persons (Saddul, 1996). Similarly, Mair (2003), in a qualitative study of 14 gay men (aged 22-51), who had undergone various forms of counselling and/or therapy, found that gay men self-censored what they told therapists, especially regarding sexual matters, when they did not have a good therapeutic relationship with the therapist. In addition, perceived homophobia from therapists prevented participants from being open about sexual issues (Mair, 2003). Despite the usefulness of these studies in demonstrating how important an

effective therapeutic relationship is for patients who identify as gay, the age of these studies constitutes a need to update the research in this area.

However, despite the many positive outcomes associated with developing a strong therapeutic relationship, such as the improvement of the patients' health and well-being, the use of, and unequal distribution of power within the relationship by the health care worker cannot be overlooked. Therefore, the concept of pastoral power will be discussed next to examine how power may be viewed within client-health care worker interactions.

Pastoral Power

There are many characteristics of pastoral power that distinguish it as a unique form of power. First, pastoral power is exercised on an individual, or group of individuals, rather than a territory. Second, it is a power that serves as a means to an end, and serves as an intermediary to reach that end. Third, pastoral power serves a purpose for the individual(s) on whom it is exercised. Finally, it is a power that is directed at each individual and the whole population (Foucault, 2007a).

To explain further, Foucault (2007a), developed his concept of pastoral power by analyzing the early Christian East, particularly the Hebrew culture, where the metaphor of God as shepherd and His people as flock was prominent. In this case, the term refers to the religious power that God possesses over people. In this way, pastoral power is essentially considered a beneficent power because it can prevail over enemies and provide for the flock. In fact, the essential significance of pastoral power is the salvation of the flock, with the act of leading this flock to food, or good pastures, being the number one task of a good shepherd. Therefore, the goal of the shepherd is not only to lead his flock to good pastures, but also to make sure they eat. Pastoral power, in short, is therefore a power of care

(Foucault, 2007a).

To continue this metaphorical explanation, the shepherds' job is to look after the flock, to make sure the sheep are not suffering, to treat the injured, and to find those who have wandered off. Pastoral power, therefore, manifests itself through duty; a duty to "keep watch" (Foucault 2007a, p. 127). The shepherd directs his care towards the flock, and never toward himself. In this way, the Shepherd is a servant; the intermediary between the flock and the steps, decisions, and actions that will lead to salvation. In many ways, the duty to 'keep watch' relates well to nursing. Just as shepherds watch over the sheep, nurses 'watch over' patients; instead of being an intermediary between the flock and their food, nurses are the intermediary between patients and their regaining, or maintenance of, health (i.e., salvation). Therefore, nurses are the servants who use pastoral power, and whose care is directed towards patients.

However, in the modern day shepherd-flock relationship, for nurses to care and help persons achieve optimal health (i.e., the modern-day form of salvation), each individual must submit wholly to this care (Foucault, 2007a). This is the basic principle of Christian obedience, where one individual who is being directed must submit to another individual, such as priests (or in this case nurses), who act as the intermediary between life and the sought-after goal of good health or salvation (Foucault, 2007b). This is the fundamental point of Christian obedience that Foucault (2007b) used to develop his ideas of pastoral power: not submission to a law, but rather, submission to someone because he is someone.

Further underpinning Foucault's (2007a; 2007b) conceptualization of pastoral power is that each member of the flock must be driven to seek out spiritual direction only when something was hard or difficult in their lives. In this way, spiritual direction was voluntary

and took place only when it was specifically sought out. In terms of nursing practice, patients only seek out nursing or health care when they are sick or in need of services. When spiritual direction occurred through confession, the pastor, serving as the shepherd within the Christian church, acted very much as a counsellor, helping the individual examine what had happened to him/her or what he/she had done through the filter of the discourse of proper behaviour. The aim of this examination of conscience was to allow individuals to take control of their life by understanding what they had done and how they could change future behaviour. The pastor, therefore, used his/her power to promote self-governance and to encourage each person to watch over him/herself. However, this process of spiritual direction fixes the position of pastor over flock member. Through this unequal distribution of power, and the process of spiritual direction, including an examination of the faults and merits of the individual, the pastor encouraged proper future behaviour from each person (Foucault 2007b).

When examining the concept of pastoral power, the parallels to nursing are apparent. Pastoral power stems from a desire for so-called positive outcomes for each individual, which is in direct relation to the fundamental aspects of nursing: providing care and achieving health (CNO, 2009). The patient first seeks out the care of the nurse when he/she feels he/she requires health care, submits to the care of the nurse, listens to the nurse's teachings, and obey the nurse's recommendations to achieve optimal health (i.e., modern-day salvation). In the process of providing care, pastoral power is, therefore, present between the nurse and the patient (Holmes & O'Byrne, 2006).

Through the knowledge gained from the patient submitting to their care, such as, the interaction that occurs within a sexual history interview (confessional), the nurse can 'direct

the conscience' of the patient (Holmes & O'Byrne, 2006). Considering that the goal of pastoral power in nursing is to help patients achieve optimal health, and to promote optimal health, nurses direct patients to engage, or not engage, in specific behaviours. For example, in the case of a sexual health clinic, nurses could teach patients to practice safer sex, for example, by using condoms, or by engaging in regular testing for sexually transmitted infections (STIs)/HIV (O'Byrne & Woodyatt, 2012). Not only will this promote the health of the patient due to early detection of STIs, but also it will encourage the patient to report regularly to the sexual health clinic for testing, thereby allowing the nurse to regularly 'check-in', or observe, monitor, scrutinize, encourage, or counsel the patient to ensure he/she is obeying their teaching. This is the patients' personal duty. In turn, this sequence ensures the continuous renewal of the pastoral power. However, patients may not return to the clinic if they perceive the STI/HIV testing process as stigmatizing (Cunningham, Kerrigan, Jennings & Ellen, 2009; Lichtenstein, 2003; Malta et al., 2007). Therefore, the concept of stigma will be discussed next.

Stigma

The term stigma is rooted in the Greek language, and refers to a mark or brand on the body, particularly one that brings discredit or shame (Weinstein, 1982). Historically, these marks or brands signified that the individual who possesses them had an inferior moral status (Goffman, 1963). Those who have stigmatizing marks or brands are, therefore, to be avoided, especially in public (Goffman, 1963).

Notwithstanding this historical depiction of stigma, Goffman (1963) described stigma as a form of social disgrace, rather than any actual mark on the body. Goffman (1963) further defined stigma as an undesirable or discrediting attribute associated with an

individual that reduces the individual's social status, and differentiated between three forms of such disgrace: abominations of the body; blemishes of character; and social impairments (Goffman, 1963). Abominations of the body include physical handicaps or deformities, while blemishes of character included, for example, mental disorders, alcoholism, or homosexuality (Goffman, 1963). Social impairments include ethnic background, religious beliefs, and socioeconomic status (Goffman, 1963). An important point in Goffman's (1963) descriptions is that stigma is not attached to a specific attribute; rather, for Goffman (1963), stigma is associated with the attribute within particular societies. Therefore, stigma varies between circumstance, time, and place (Goffman, 1963).

Since Goffman's initial definition of stigma, other scholars have added further insight to the contemporary definition of stigma. For example, Birenbaum and Sagarin (1976) defined those who are stigmatized as a group of individuals who are regarded negatively, either for having violated rules, having traits that are not highly valued, or for merely being who they are. Similarly, Alonzo and Reynolds (1995), based on their own review of the existing literature on the meaning of stigma, suggested that the outcome of stigmatization may be described as follows:

The stigmatized are a category of people who are pejoratively regarded by the broader society and who are devalued, shunned, or otherwise lessened in their life chances and in access to the humanizing benefit of free and unfettered social intercourse (p.304).

Adding to Goffman's (1963) original work, Alonzo and Reynolds (1995) outlined the specific outcomes of stigma: social exclusion and generalized devaluation. Stigma, therefore, results in individuals being set apart from their peers because they have, or are thought to have, a particular trait (Crocker, Major & Steele, 1998; Goffman, 1963). This means that stigmatization is a social process of labelling an individual or group as different or deviant or

as other than the mainstream (Goffman, 1963). Through this process, individuals become outsiders (Becker, 1963), a process which may also be internalized by the excluded (stigmatized) person. Indeed, individuals who feel they possess a stigmatizing characteristic may isolate themselves, and, therefore, lose social and emotional support (Black & Miles, 2002).

Another outcome of stigmatization for Goffman (1963) is that stigmatized individuals develop two social identities in public: the virtual and the actual. The virtual social identity is the identity that the non-stigmatized individual, i.e., the person who does not possess the stigma, gives to the stigmatized individual (Goffman, 1963). This identity comprises all the assumptions that non-stigmatized individuals make about who the stigmatized individual is, his/her attributes, and what he/she can do (Goffman, 1963). According to Goffman (1963), the actual social identity is, by comparison, the confirmation or disproof of the virtual social identity once the non-stigmatized and stigmatized individuals further develop their relationship (i.e., after their initial meeting).

Through the identification of the stigmatized individuals' virtual social identity, the non-stigmatized individual constructs a stigma theory about the person; a rationalization that explains the stigmatized individuals' socially constructed inferiority (Goffman, 1963). In addition, the non-stigmatized individual imputes on the stigmatized person a range of other imperfections based on the original stigmatized trait or attribute (Goffman, 1963). Therefore, a stigmatized person might also be viewed as immoral or careless based on his/her originally stigmatized attribute.

However, Goffman (1963) noted that there are individuals who the stigmatized person can turn to for support. First, they can frequently count on support from other individuals

who share their stigma (Goffman, 1963). Second, they can rely on support from ‘wise’ individuals, who are often non-stigmatized persons, who are sympathetic to stigmatized individuals for one reason or another. For example, health care workers, including nurses, may be considered ‘wise’ by individuals who are stigmatized as a result of a medical condition; e.g., HIV (Goffman, 1963). In such cases, nurses are considered ‘wise’ because, as health care workers, their position in society is to care for the sick, and they have the knowledge and training to do so. People living with HIV who require hospitalization will, therefore, interact with nurses and may form therapeutic relationships with them in the context of these interactions. The individual living with HIV may accept the nurse as the ‘wise’ individual in this situation when the nurse supports the hospitalized person’s needs. As will be noted below, however, previous research highlights shortcomings in this relationship. These will be discussed shortly.

Another important point about stigma is that even though being labelled as stigmatized may result in support from some individuals, the stigmatized individual does not necessarily agree with the stigma that has been imposed on him/her (Goffman, 1963). In fact, stigmatized persons may be insulted by the notion that they are anything less than ‘normal’, and proceed to stigmatize ‘normal’ individuals as the ones who are different (Goffman, 1963). For example, stigmatized individuals may see their stigma as a positive force that allows them to teach others about life (Goffman, 1963), such as when a person with a stigmatized trait shares his/her experience to educate others.

Regardless of whether or not the individual agrees with the label, the types of stigma experienced are not universally identical. In fact, within the extant literature, there are three types of stigma: perceived stigma, self-stigma, and enacted stigma. Perceived stigma refers

to an individual's fear that he/she will be subjected to discrimination and negative societal attitudes because he/she has a particular trait (Scambler & Hopkins, 1986). Therefore, an individual may engage in protective behaviours, such as refusal to disclose the trait, due to the potential for negative reactions from family or friends (Brown, Trujillo & Macintyre, 2003). Self-stigma, in contrast, refers to the shame the individual internalizes due to the stigmatizing ideas that are placed on him/her by society (Corrigan & Penn, 1999).

Stigmatization occurs in this instance when there is a perception by non-stigmatized individuals that the attitudes, beliefs, and values of society have been violated and can lead to prejudicial thoughts, behaviours, or actions from communities, health care workers, or family/friends (Brown, Trujillo & Macintyre, 2003). Perceived stigma may, in fact, may be a survival strategy that limits the experience of enacted stigma (Brown, Trujillo & Macintyre, 2003). For example, protective barriers, such as refusing to disclose the stigmatized trait to others, may protect the individual from others knowing of the trait. Lastly, enacted stigma refers to the actual experience of discrimination (Brown, Trujillo & Macintyre, 2003). For example, those who possess, or are thought to possess, a stigmatizing trait conceivably lose their job or experience social rejection (Brown, Trujillo & Macintyre, 2003).

However, non-stigmatized individuals do not view every stigma the same way. Katz (1979) argued that the response of non-stigmatized individuals to stigmatized individuals depends on perceptions of visibility, threat, sympathy, and responsibility. The visibility of the stigma refers to how obvious the stigma is, especially in social situations. The threat perceived by non-stigmatized individuals in response to stigma varies widely, from perceiving the threat of physical harm when interacting with stigmatized persons to reminding non-stigmatized individuals that they are also vulnerable to misfortune. The level

of sympathy non-stigmatized individuals have for stigmatized persons depends on the perceived negative effects of the stigma for each individual. Similarly, if the stigmatized individual is seen as responsible for causing their stigma, either through acts of immorality or negligence, then the level of sympathy given by the ‘normal’ individual is lowered (Katz, 1979).

In addition to the different types of stigma identified above, Alonzo and Reynolds (1995), in their paper entitled *Stigma, HIV & AIDS: An Exploration and Elaboration of a Stigma Trajectory*, which was based on an analysis of current literature, conceptualizations, and research regarding the experience of individuals living with HIV and their caregivers, posited that stigma, when related to medical issues, also varied between different stages of the disease trajectory, which they term, in the case of HIV-related stigma, the stigma trajectory. The four phases of the stigma trajectory for these two authors included ‘at-risk’, diagnosis, latent, and manifest (Alonzo & Reynolds, 1995).

In the ‘at-risk’ phase, when individuals perceive themselves to be susceptible to HIV acquisition, people experience a form of pre-stigma fear, in which they worry about the social effects of being ‘at-risk’ for HIV. Individuals may also fear the social consequences of an HIV-positive status, such as rejection by family and friends, and perceived possible loss of civil liberties. The outcome of the ‘at-risk’ phase could therefore be an avoidance of HIV testing, and instead the preference for an ambiguous HIV-status (Alonzo & Reynolds, 1995).

In the diagnosis phase, upon learning of their HIV-positive status, individuals decide who to (and not to) disclose their HIV-positive status to. At this stage, individuals examine the identity consequences of being HIV-positive, such as their role in society, as well as the impending decline in health status. At this point in the HIV stigma trajectory, individuals

face the fact that their HIV-positive status is not longer disputable, and the potential for enacted stigma based on this newly emerging identity as an HIV-positive individual is realized (Alonzo & Reynolds, 1995).

In the latent phase, when the individual with HIV is asymptomatic physically, they may continue to experience internalized stigma associated with fear of rejection and isolation. While they may choose to conceal their diagnosis to avoid enacted stigma, Alonzo and Reynolds (1995) highlighted that this process is strenuous due to, first, the necessity of remembering which individual knows of the HIV diagnosis, and, second, the potential deprivation of social supports that ensues from selective HIV-positive status disclosure.

Finally, in the manifest phase, individuals are no longer able to hide their HIV-positive status, and they face the enacted stigma that may have been avoided up to this point. Social supports, such as friends, family, and co-workers, may be lost upon learning the diagnosis. However, Alonzo and Reynolds (1995) also noted that some individuals who withdrew support upon learning another's HIV diagnosis may be unable to remain angry at and withdrawn from the dying individual. These individuals may then return and offer support (Alonzo & Reynolds, 1995). Overall, as the individual moves through the phases of the stigma trajectory, they must learn to cope with their increasing sense of being stigmatized, or moving from being non-stigmatized to stigmatized (Alonzo & Reynolds, 1995).

In summary, the extant literature identifies that stigma leads to a social identity that emerges from a set of socio-political conditions, which can both affect how a person feels about him/herself and influence his/her interactions with others. To use Goffman's (1963) terms, a major undertaking for stigmatized individuals is the act of managing their 'spoiled identities', in which those who are stigmatized share similar learning experiences that

change the perceptions they have of themselves. As part of this process, stigmatized individuals learn what it means to have a stigma and what they need to do to conform to what society and non-stigmatized individuals expect (Goffman, 1963). How one manages stigma, including its concealment or denial, however, depends on an array of factors, including the stigmatized individuals' personality, the visibility of the trait, and group alignments, such as social or religious groups (Goffman, 1963). How one manages the stigma associated with HIV will be discussed next.

Stigma and HIV

Historically, stigma has been a common reaction to disease (Raizada, Somasundaram, Mehta & Pandya, 2004). Throughout history, there have been many examples of diseases that have carried significant stigma including leprosy (Scambler & Hopkins, 1986), tuberculosis, cancer, STIs, and mental illness (Brown, Trujillo & Macintyre, 2003; Raizada et al., 2004). HIV/AIDS is now one such stigmatized illness (Mann, 1989). HIV, in particular, has an insidious stigma because it is often associated with behaviours that bring criticism; e.g., non-mainstream sexual practices and/or substance use (Hayes & Vaughan, 2002). Therefore, the stigma associated with HIV may be more harmful because it is seen as being the consequence of individuals' decisions and practices; i.e., items which can be viewed as being under individuals' own control.

When Jonathan Mann was director of the World Health Organization (WHO) global program on AIDS, he identified the three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma (Mann, 1989). Mann (1989) reported that stigma undermines public health efforts to combat HIV transmission. In addition, this report found that stigma negatively affected individual preventative measures,

such as, condom use, HIV testing practices, care seeking after HIV diagnosis, quality of care given to people living with HIV/AIDS, and the perception of persons living with HIV/AIDS by their partners, families, and communities (Mann, 1989). Despite the age of this report, a recent meta-analysis, which included 21 articles about the question of living with HIV, Barroso and Powell-Cope (2000) identified stigma as one of six overarching themes that continue to affect the lives of people living with HIV.

Furthermore, stigma associated with HIV has an effect on individuals' social relationships. For example, friends and family may distance themselves from the individual living with HIV after learning about an HIV diagnosis (Crandall, Glor & Britt, 1997; Moneyham et al., 1996). Such a reaction can be very harmful due to the resulting social isolation (Crandall & Coleman, 1992). Tewksbury and McGaughey (1997), in an interview based study of 63 people living with HIV (participant ages not provided), found that individuals may also experience stigma through social labelling, in which persons living with HIV face disapproval due to inaccurate assumptions about HIV, its transmission, and its treatment.

Despite the existence of the foregoing literature, few studies exist on stigma and the unique sub-population of gay male youth who are vulnerable to HIV. The majority of existing literature on stigma and HIV in youth has focused on youth who are living with HIV. Accordingly, to ensure adequate sensitivity to and awareness of the current literature, this research will be presented. To begin, one focus group study of 25 adolescents and young adults living with HIV (aged 17-25) demonstrated that HIV-positive youth were likely to purposefully miss doses of their medication to hide their medications from others, rather than potentially disclose their HIV-status to family or friends (Rao, Kekwaletswe, Hosek,

Martinez, & Rodriguez, 2007). Dowshen, Binns and Garofalo, (2009) further identified that gay male youth living with HIV are a special population due to their vulnerability to multiple sources of stigma; stigma resulting from their HIV serological status, as well as their sexual orientation and gender identity. Indeed, in their quantitative, questionnaire-based study examining this population, Dowshen, Binns and Garofalo (2009) showed that gay male youth (aged 16-24) living with HIV had increased levels of depression and social isolation as their perceived stigma worsened. Also, in a survey study involving 40 African American gay male youth (aged 16-24), those who experienced heightened levels of stigma were more likely to engage in unprotected sexual behaviours while consuming drugs or alcohol (Radcliffe et al., 2010).

More specifically, within the health care system, individuals (aged 21-49) living with HIV reported stigmatizing experiences from health care workers due to the health care providers' fear of contagion and breaches in confidentiality (Green & Platt, 1997). This is alarming because breaches in confidentiality threaten nursing ethics, professionalism, and patient care (Black & Miles, 2002). Among health care workers and the general public, Brown, Trujillo and Macintyre (2003), in a literature review of 22 studies focusing on interventions to reduce AIDS-related stigma, found, first, that illness or death is the common fear, and, second, that this fear can cause health workers to refuse to treat individuals living with HIV, or to treat them abusively or with disdain (Brown, Trujillo & Macintyre, 2003). In addition, Forrester and Murphy's (1992) study of 360 nurses found that nurses had more negative attitudes and were less willing to work with patients with AIDS than patients with leukemia. Stigma from health care workers also stems from fear of 'catching' HIV and fear of death, which can result in suboptimal care of those with HIV or outright refusal to care for

them (Brown, Trujillo & Macintyre, 2003).

For Surlis and Hyde (2001), HIV-related stigma stems from how the individual acquired the disease, and, is a manifestation of the ignominy of homosexuality and illicit drug use. Although dated, a descriptive study of 136 inpatient nurses by Alexander and Fitzpatrick (1991) substantiated Surlis and Hyde's assertion: 70% of nurses felt uncomfortable establishing a relationship with a gay man with AIDS. In addition, a descriptive study of 114 nurses in various settings found that homophobia correlates with the fear of the AIDS contagion (Meisenhelder, 1994).

However, the foregoing attitudes and behaviours are by no means a reflection of the entire profession of nursing. Other studies have shown that many nurses believe patients living with HIV/AIDS should be treated fairly (Surlis & Hyde, 2001). For example, a study by Black and Miles (2002), which was conducted with 48 HIV-positive African American women, suggested that a therapeutic relationship with a nurse who is aware of stigma can help combat negative social reactions and make the decision to disclose, or not disclose, their HIV status easier for these women. Nevertheless, it is important to note that these studies are more than ten years old, suggesting that new research is needed to determine if health care workers and nurses still conduct themselves in stigmatizing manners. In addition, it is important to examine if this stigma from health care workers negatively affects the health care-seeking behaviours of gay male youth. This concept of stigma affected health care-seeking behaviours will be examined next.

Stigma and Health Care-Seeking

Studies have identified a link between stigma and delayed health care seeking. For example, qualitative studies have shown that perceived stigma may deter individuals from

seeking general STI testing and care (Lichtenstein, 2003; Malta et al., 2007). Lichtenstein (2003), who conducted six focus groups with African American health care workers, patients, and students (no age given) in the southern region of the United States, found that STI related stigma directly and indirectly affected willingness to be tested for STIs at public health clinics. In addition, Malta and colleagues (2007), who conducted 30 semi-structured interviews with heterosexual men, women, and men who have sex with men (aged 18-43) in Rio de Janeiro, Brazil, found that high levels of perceived stigma delayed individuals from seeking the STI-related health care. Fortenberry (2004) further highlighted that self-stigma, or imposing stigma on oneself, is a common reaction to STIs, and is simultaneously one reason that individuals avoid STI testing. Moreover, in a study of 142 sexually active African American youth (aged 13 to 19) the belief that others hold negative views about people with STIs influenced the time between recognition of symptoms and care seeking among females (Cunningham, Tschann, Gurvey, Fortenberry, & Ellen, 2002). Similarly, in a study of 594 sexually active youth (aged 15 to 24) male and female youth were less likely to access health care for STI screening if they perceived STIs as stigmatizing (Cunningham, Kerrigan, Jennings & Ellen, 2009). However, despite highlighting that STI-related stigma discourages individuals from seeking STI/HIV testing/treatment, there is very little in the literature regarding such stigmatization and nurses, which constitutes a major gap in the literature because nurses are often involved in the STI/HIV testing process. In addition, there is also limited information regarding perceived stigma and the specific population of youth, including gay male youth, who are vulnerable to HIV.

Gaps in the Literature

To summarize, youth, particularly gay male youth, are a population who are

susceptible to contracting HIV. However, little is known about how stigma affects the health care-seeking behaviours of gay male youth, as well as how stigma impacts the therapeutic relationship with the nurses these youth encounter. Within the current body of literature, much has been written in the area of stigma, HIV, and health care. Stigma can have many negative effects for those who are living with HIV, including delaying seeking health care and quality of care received, willingness to disclose HIV status, available social support (Brown, Trujillo, & Macintyre, 2003), and depression (Dowshen, Binns, & Garofalo, 2009). Stigma can also have a negative effect on those who are vulnerable to contracting HIV by delaying HIV testing (Brown, Trujillo, & Macintyre, 2003). In both youth and adult populations, perceived stigma of STIs/HIV, was repeatedly shown to delay STI/HIV testing (Cunningham, Kerrigan, Jennings & Ellen, 2009; Cunningham, Tschann, Gurvey, Fortenberry, & Ellen, 2002; Lichtenstein, 2003; Malta et al., 2007). Prompt HIV testing ensures access to the necessary treatment for those who test positive, such as drug therapy, which can influence the current and future health status of the individual living with HIV. Individuals who remain untreated for HIV have shown to progress to AIDS at an increased rate compared with others who receive the appropriate treatment (Rodriguez et al., 2006). Lastly, based on the aforementioned epidemiological data, delayed HIV testing and treatment can, moreover, worsen already elevated levels of HIV incidence and prevalence among gay male youth.

Based on the above literature, it is clear that nursing, and related disciplines, have advanced significantly in their understanding of stigma and HIV. However, significant gaps in this literature remain. First, many of these studies, particularly those referring to stigma and health care workers, date from at least ten years ago and the studies on which they

compare their evidence are exceptionally older. An article published in 2006 stated that nurses have done extremely well since the 1980s in coping with the HIV epidemic and providing positive care to HIV patients (Kendall-Raynor, 2006). However, there is a need to update the literature on the specific attitudes that nurses currently possess regarding individuals because data on HIV suggests that the public perception of HIV, and individuals living with HIV, has changed significantly since the epidemic first emerged in the 1980s (Kendall-Raynor, 2006). The majority of the research has focused on perceived stigma from ‘others’, while there has been little research on perceived stigma from health care workers, including nurses (Kinsler et al., 2007). Perceived stigma is the individuals’, and in this case the patients’, fear that they will be stigmatized by the nurse, which results in nondisclosure from the patient (Scambler & Hopkins, 1986). Second, there is little information in the literature regarding stigma from nurses directed at youth, particularly gay male youth, who are susceptible to contracting HIV. No information was located in the literature on how stigma of being gay affects the therapeutic relationship with this specific population.

Chapter Three: Research Design and Methods

Design and Data Collection

This research is qualitative in nature and based on grounded theory, a methodological approach which aligns with the focus of this study to examine stigma within the therapeutic relationship. This methodological approach aligns with the study because it acknowledges the individual perspective of each person, and the focus of this study is to explore stigma from the perspective of gay male youth. In this approach, data collection, analysis, and theory are reciprocal (Strauss & Corbin, 1990). In other words, a theory is not chosen and then proven. Instead, an area of study is selected, and the research and participant construct the findings through their interactions, with the overall goal of grounded theory being to build an organized understanding of a chosen area of investigation (Strauss & Corbin, 1990).

As part of this research approach, the idea of absolute truth is rejected. Truth, consequently, is considered to be unique to each individual (Polit & Beck, 2008). Within the research process, therefore, the researcher and participant bring their own personal experiences, beliefs, and convictions into the interaction or interview and construct a meaningful interpretation of a particular topic through dialogue and discussion (Lincoln & Guba, 2003). In this case, the topics of interest were HIV, stigma, and nursing practice. Each individual's truth was, therefore, understood as unique. If a different researcher conducted an interview with the same participant, the emerging data would not be identical. Rather, the data were constructed between the participant and the researcher to create a unique truth, which can not be replicated, but is based on both individuals' subjective experiences and realities. Such an epistemic position guided data collection, analysis, and synthesis.

Recruitment

Youth were purposefully recruited from a gay men's sexual health clinic in downtown Ottawa, Canada. This clinic offers STI/HIV counselling, testing, and treatment services (please note that individuals who are living with HIV and those who are HIV-negative both access these services; the testing that is performed simply varies as needed). Male youth were informed of the study by the receptionist during check-in at the walk-in clinic by an information letter that was given to each of them. See Appendix A. The information letter included the inclusion and exclusion criteria for the study. Potential participants were then asked by the receptionist to read the information letter and to return it to reception if they were interested in participating thus ensuring participant self-selection. At this point, the receptionist informed the clinic attendees that if they wished to participate, the interview would take place while they are waiting to be seen by the clinic staff, and that they would not have to return to the clinic to be interviewed. Additionally, the receptionist informed the potential participants that if they wished to participate, but did not wish to be interviewed at that time, arrangements could be made to complete the interview at a different time at the University of Ottawa. These details were also listed in the information letter. If the wait times were not greater than one hour (suspected maximum length of interview), the researcher was with another participant, or the clinic would be closing in less than one hour, participants were asked if they would like to arrange an alternate time for the interview to take place at the University of Ottawa. If the potential participants decided they were interested in participating in the study, the receptionist brought the participants behind the area that separates the waiting room from the patient rooms at the clinic where the researcher was waiting. The researcher then showed the participant to the interview room and verified

the inclusion and exclusion criteria with the participant before beginning the interview.

Please note that the researcher was on-site at the clinic for the full clinic hours during data collection.

Sample

The satisfaction of the following criteria were required for individuals to participate in this research:

Table 1-Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Male youth who lived in, or around, Ottawa. For the purpose of this study, those between the ages of 20 and 29 were considered youth (PHAC, 2010a). • They had contact with nurses within the previous two years • They had sexual contact with a male. The time when contact took place and the frequency of these contacts was not considered important for this research.	• They have not had sexual contact with a male • Are female • Are HIV positive. Please note that participants were considered HIV positive/negative if they self-identified as such. They were not required to submit proof of their serostatus. • Are non-English speaking

An estimated eight to twelve gay male youth were sought to complete this study, and eight gay male youth were interviewed upon completion. This number was chosen based on

the work of Guest, Bunce, and Johnson (2006), who highlighted that the majority of codes created in qualitative research stem from the first twelve interviews. In other words, Guest, Bunce, and Johnson (2006) identified that data saturation is often reached after an average of twelve interviews. Therefore, this number of interviews was selected *a priori* to ensure data saturation. Twelve interviews, in this case, were not required because the data were saturated after eight interviews. Indeed, no new codes were being added to the codebook by the eighth interview.

Gay male youth who are living with HIV are a special population due to multiple sources of stigma, including stigma resulting from their HIV status as well as their sexual orientation and gender identity (Dowshen, Binns, & Garofalo, 2009). Therefore, due to the uniqueness of this sub-population, gay male youth who are HIV-positive were excluded from this study. An adequate understanding of the experience of this group of persons would require a secondary study.

Data Collection and Analysis

Data Collection

To adequately understand the experience of stigma by gay male youth, semi-structured interviews were used to allow youths' initial answers to guide the direction of the interview to gain a more comprehensive perception of their understandings and perceptions.

After recruitment, the researcher introduced herself to the participant and showed the individual to the private room where the interview would take place. The researcher then went over the information letter and the consent form with the participants, and asked if they had any questions. This involved verbal assurance that all information would be kept confidential and that the interview would be recorded (Polit & Beck, 2008). In addition, the

researcher asked the participants if they would prefer to use a specific pseudonym during the recording. If they had no preference, they were referred to using an alphanumeric code to ensure anonymity. Due to the importance of details in grounded theory, including the use of the participants' own words, the interviews were recorded to ensure accuracy and high quality results. Therefore, if the participant did not wish to be recorded, they were not interviewed for this study. This was stated in the information letter and reinforced by the researcher when obtaining informed consent. The participants were then asked to complete a short questionnaire, which contained demographic-focused questions. See Appendix B. The researcher and participant then signed the consent form and proceeded with the interview. See Appendix C and D. At the end of the interview, the researcher thanked the participant for their time, and gave each participant a \$10 Tim Horton's gift certificate for participating.

In addition to the interviews, detailed field notes were kept to ensure comprehensive data collection. These notes consisted of both descriptive and reflective notes. The descriptive records included descriptions of observations made during the interview process (Polit & Beck, 2008), such as the participants demeanor and behaviours during the interview. The reflective records consisted of both theoretical notes, which are the researchers' thoughts, reflections, and first impressions on the data, and personal notes, which included the researcher's feelings about the process (Polit & Beck, 2008). The personal records were part of the reflexive journal, which is discussed in detail below. These notes were completed immediately following each interview.

Data Collection Location

Data collection took place at a gay men's sexual health clinic, a clinic specifically designed for men who have sex with men, regardless of their personal definitions of sexual

orientation, in downtown Ottawa. This clinic has several partners, all who provide resources to the clinic. The gay men's sexual health clinic is open Thursday evenings from 17h00 to 20h00, and the on-site clinicians provide STI screening and treatment, anonymous and/or rapid HIV testing, a group for queer youth, and a variety of other health promotion programs. Nurses, nurse practitioners, physicians, and one social worker staff this clinic.

Data Analysis

Guided by the research questions, a constant comparison approach to data analysis was used based on the work of Strauss and Corbin (1990). In this method of analysis, each interview was transcribed and coded based on a line-by-line reading to identify the thematic content of the interview. The analysis was completed after each group of interviews. A group of interviews was considered the number of interviews completed during one working day of data collection.

The reading included a content analysis utilizing the aforementioned work of Strauss and Corbin (1990), which is described in detail below. Due to the subjective nature of truth that was assumed in this project, interviews were analyzed separately initially, and then together after all of the interviews were completed. After the initial group of interviews, i.e., the number of interviews that was completed during one working day of data collection, the codes were sorted. Similar codes were grouped into themes, and these were entered into the codebook. All subsequent interviews were coded in this manner. See Appendix E.

Strauss and Corbin (1990) emphasized the use of three types of coding to form a grounded theory: open, axial, and selective. Open coding involved identifying concepts that were then expanded to include their properties and dimensions. Properties were attributes or characteristics that pertain to a specific category, while dimensions were the location of a

property on a continuum (Strauss & Corbin, 1990). In this context, open coding was accomplished by asking questions about the collected data, and comparing the identified concepts for similarities and differences based on their properties and dimensions. The concepts that were similar were then grouped to form categories (Strauss & Corbin, 1990). The open coding process also made use of ‘in vivo’ codes, which were words or phrases that participants used to describe certain phenomena. This allowed the research to become more personalized by using words that the participants used to describe certain phenomena as codes.

Practically, to ensure the integrity of the identified codes, the texts of different interviews were compared to ensure coding remained the same throughout the process. In addition, negative cases, i.e., cases that disconfirm the model, were examined and incorporated into the codebook (Ryan & Bernard, 2000). As new codes arose in the analysis, previous interview transcripts were re-examined to see if they had contained the newly identified code, but that it had been overlooked. The data were then placed on a grid, with the interview number on the horizontal axis and the code on the vertical axis. See Appendix E. New codes were added to this grid as they arose. ‘In vivo’ codes were displayed on this grid through the use of quotation marks. From this grid, the data were then funneled into the following categories: themes (global descriptions), sub-themes (middle-level classifications), and categories (tangible phenomena). In other words, similar codes were grouped together from the grid, placed in a new table, and labelled as sub-themes. In this new table, important quotes were listed, journal context given, and process identified. The sub-themes were then grouped together under the main themes, and related back to the core category to create the analytic story. See figure 2.

For example, the sub-theme of perceived stigma came up several times during the eight interviews that were completed. Original codes, which were identified from the line-by-line reading of the transcripts for this theme, included, for example, ‘nurse acting overly serious/emphasizing bleak outcome leads to stigma’, ‘emphasis on increased risk of HIV/illness for gay men equals stigma (promiscuity)’, and ‘nurses teaching safer sex is belittling’. These codes were all grouped together under the sub-theme of ‘perceived stigma’. Other codes were sorted together in a similar manner under the sub-theme ‘fear of stigmatization’, and these two sub-themes were grouped together to form a main theme entitled ‘experiencing stigma’ (see figure 2).

When no additional themes, sub-themes, or categories were added to the codebook, the data were considered saturated. As noted above, such saturation occurred after eight interviews. In essence, coding was a funneling process, where a large amount of unorganized data, the interview transcripts, were channeled to their basic categories.

After the open coding was completed, axial coding began. In axial coding, each category was expanded to include the conditions that gave rise to it, the properties and context that gave it dimension, and the action/interaction strategies that were used to handle, manage, and respond to the phenomenon, including the consequences of the action and interaction that were utilized (Strauss & Corbin, 1990).

As the final data analysis phase, in selective coding, a core category was selected and all of the other major categories were related back to the core categories and each other (Strauss & Corbin, 1990). The core category was selected based on the common denominator of the major categories. In other words, the major categories were identified as ‘experiencing stigma’, ‘spaces of stigma’, and ‘the nurse-patient relationship’, all of which

contain ‘experiencing stigma’ as the elements that ties them together. Therefore, experiencing stigma was chosen as the core category. These categories were then translated into an analytic story.

In addition to coding strategies, a grounded theory approach involves identifying process (Strauss & Corbin, 1990). In other words, when undertaking grounded theory studies, researchers must examine the data for signs of a change in conditions, and examine what changes this brings to the action and/or interaction. In essence, identifying process is how the researcher accounts for change in the data, or understanding how participants move from one described feeling into another. For example, if a participant were to describe a moment in their interaction with the nurse where he did, or did not, feel stigmatized, then that moment would need to be examined to understand what changes brought about that feeling in the participant. In this research, changes were then conceptualized into stages with a description of what makes the phenomenon move forward, backward, or stop altogether (Strauss & Corbin, 1990). Once this step was completed, data collection was considered complete.

Rigour

In qualitative research, there has been much debate about if, when, and how the terms rigour and validity can be applied. Some authors believe that traditional rigor and validity criteria are unrealistic in research that occurs in naturalistic settings (Polit & Beck, 2008). Following this line of thinking, and in line with critical theory, many of the traditional rigour criteria for qualitative research were deemed inappropriate. To explain further, while, traditionally, four criteria have been employed to establish trustworthiness in qualitative studies (i.e., credibility, dependability, confirmability, and transferability), in this research,

credibility and transferability were accepted, while dependability and confirmability were replaced with reflexivity (Polit & Beck, 2008).

First, credibility was used to establish rigour in the data analysis process by ensuring it is consistent with the data collection methods, assumptions of the paradigm, theoretical framework, and the findings. Credibility, therefore, helped ensure that there were no internal contradictions within the project. Second, transferability was established by providing an in-depth description of the research population and setting, thus allowing people in similar settings to use these findings. Ample direct quotes were also used when writing the research report for dissemination to increase transferability.

Third, due to the subjective nature of reality that was assumed within this project, and the fact that the researcher and interviewee are co-participants within the grounded theory lens, it was established from the outset that data cannot be stable over time or between researchers. Therefore, the rigour criteria of dependability was rejected. Also, confirmability, or objectivity on the part of the researcher, cannot be utilized due to the subjective nature of the research.

Fourth, as a substitute rigour criterion, reflexivity required the researcher to apply the techniques used for data analysis to personal behaviours, beliefs, and reactions (Bourdieu, 2004). To meet this requirement, a reflexive journal was kept prior, during, and after the research process. See Appendix F. This allowed a more comprehensive understanding of what induced these feelings. This journal was analyzed in conjunction with the interview data to enhance the context perspective of this research. The journal was analyzed through the same coding procedure that was utilized to examine and understand the interview data. A constant comparison approach was used by comparing the coded interview with the coded

journal entries that surrounded that interview. Therefore, context from the perspective of the researcher was given to the data when forming the grounded theory (Strauss & Corbin, 1990).

The process of reflexive journalling was consistent with the critical theory paradigm which informed this research. This paradigm emphasized the importance of viewing phenomena from an individual's perspective in their personal lived experience (Weaver & Olson, 2006). The researcher, as well as the participants, were considered to be products of their lived experiences who similarly see phenomena through a personal lens. It was therefore important to acknowledge and analyze the researcher's perspective through reflexive journalling.

Ethics

The Research Ethics Boards (REBs) at the University of Ottawa and Ottawa Public Health approved this project. Ethical integrity was upheld in this research in several ways. First, the consent forms, interview notes, questionnaires, and recorded interviews were kept in a locked cabinet, in the thesis supervisor's locked office at the University of Ottawa. The only individuals with keys to this cabinet and office include the researcher and thesis supervisor. Once interviews were transcribed, their data were also kept in this location. The recorded interviews were transferred from the recording device on to an external hard drive and kept in the above location for six months in case the researcher needed to verify the transcriptions. The interviews were erased from the recording device as soon as they were transferred to the external hard drive. After six months, the external hard drive recordings of the interviews were destroyed. Once interviews were transcribed, the printed transcribed interview documents were kept in this location. The electronic copies of the transcripts of the

interviews were kept on an external hard drive, and stored in the above location when the researcher was not using them for data analysis.

Second, the researcher, alert that discussing the topic of stigma may make the participants uncomfortable, watched for signs of strong emotional reactions (verbal and non-verbal) from the participants throughout the interview. If this was the case, the researcher revoked the question. Participants were also advised that they were not required to answer all questions, and that they may end the interview at any time. At the end of the interview, or if the participant showed signs of distress, the participant was offered a list of counseling hotlines, websites, and clinics available in the area if they wished to speak with someone. See Appendix G. Informed consent was obtained from each participant before the interview commenced.

Confidentiality and anonymity were ensured through the use of pseudonyms and alphanumeric codes. All interviews were conducted using a pseudonym to prevent identification. There was no identifying link between the consent forms and the data from each interview. Direct quotations were used in the dissemination phase of this research, such as presentations at conferences and scientific articles. However, pseudonyms were used, and there were no identifying links between these quotes and the participants.

If the name of a specific nurse or other clinician, or any individual, was mentioned by the participant during the interview, the name was kept confidential by the methods discussed above, such as keeping the data in a locked cabinet. In addition, the specific name of a nurse or other clinician was deleted during transcription, and was replaced with a pseudonym. Moreover, if the name of the nurse appeared in a direct quote that was used in the dissemination phase of this research, the pseudonym was used to ensure anonymity.

If the participants chose to withdrawal from the research project, their data were destroyed by securely deleting the interview recording and shredding any written notes and consent forms. The interview was deleted immediately and the paper documents were shredded within 48 hours. This was clearly stated in the information letter to participants.

Lastly, following the completion of the project, the data will be stored in the above location for five years. After five years, the above paper data (interview notes, consent forms, transcriptions, analysis notes, researcher journal, etc.) will be shredded, and the electronic files (interviews) will be securely deleted.

Chapter Four – Results

The following section details the results of this research. First, the participant demographics are presented. Second, a description and image of the data collection site are given. Third, the interview themes are presented, including experiencing stigma, spaces of stigma, and the nurse-patient relationship. Forth, a section on identifying process within grounded theory is presented. Finally, a summary of the results is provided.

Participant Demographics

Each participant completed an auto-administered survey at the beginning of his interview; the following findings emerged. The average participant was 23 years old, identified as homosexual or gay (87.5%), made less than \$10,000 total income in the previous year (50%), and was Caucasian (62.5%). Although the highest educational level obtained was a high school diploma for 87.5% of participants, most noted that they were attending a post-secondary educational program. For complete demographic results, see Table 2.

Table 2-Participant Demographics

		Mean/Median	Frequency	Percent	Cumulative Percent
Age		23.3/25+-4			
Sexual Orientation	Homosexual/Gay		7	87.5	87.5
	Bisexual		1	12.5	100
Education level	High School		7	87.5	87.5
	Bachelors		1	12.5	100
Income (CAD)	<\$10,000		4	50	50
	\$10,000-\$19,000				
	\$20,000-\$29,000		2	25	75
	\$30,000-\$39,000		0	0	75
			2	25	100
Ethnicity	Caucasian		5	62.5	62.5
	Asian		1	12.5	75
	Other		2 (1-Turkish/Caucasian, 1-not specified)	25	100

Description of data collection site

Participants were recruited from a gay men's sexual health clinic that was located in downtown Ottawa, Canada. It is open one evening every week. The entrance to this clinic is on a side street off a main road. The entrance is covered in murals; parking and bike racks are available out front. The clinic serves gay, bisexual, and other men who have sex with men, and provides STI/HIV testing and treatment for STIs.

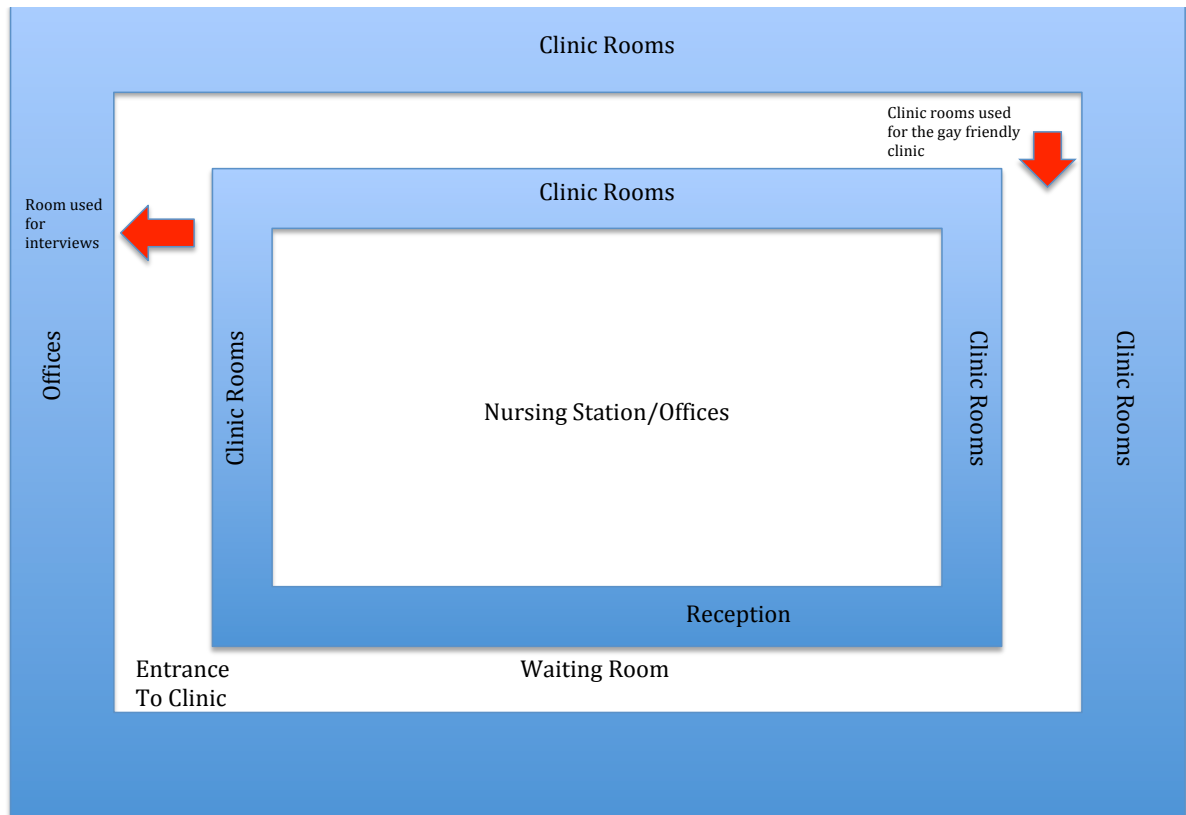
When individuals enter the aforementioned building, a greeter points them in the

direction of the clinic. When clients enter the clinic itself, the first space they enter is the waiting room. The space is beige with large windows on one side. These windows are tinted to provide privacy. To enhance privacy, the blinds on these windows are closed during clinic operations. Popular music is also played to make the space more welcoming. Many pamphlets are available in the waiting room, including pamphlets on STIs, HIV, risk reduction strategies (such as safe needle injection), and information on the HPV vaccine. A bowl of condoms is available for everyone to help themselves. In addition, an individual from the AIDS Committee of Ottawa is present in the waiting room. He sits at the pamphlet table and answers clients' questions.

The clinic space is a large square with the main nursing station and examination rooms in the middle and around the exterior. See Figure 1. The interviews for this project took place in one of the offices around the exterior. The interview room was beige with non-health related images on the walls. The room was equipped with a desk and two chairs. The door was closed and locked during the interviews. The room was located on the top left corner of the square, whereas the client care rooms used for the clinic were down the right side of the square. There was, therefore, no chance that the research interview could be overheard while the interview was being conducted. Because the gay men's sexual health clinic operated in the evening, the offices surrounding the interview room were empty.

Lastly, a variety of workers staff this clinic. In addition to the two aforementioned individuals in the waiting room and at the front door, the staff consisted of nurses, nurse practitioners, doctors, an administrator, and an individual responsible for administering anonymous HIV tests.

Figure 1-Clinic Layout



Interview Themes

Interviews occurred between October 2011 and January 2012, and were conducted at either the gay men's sexual health clinic or the University of Ottawa, depending on participants' preference. Several noteworthy themes emerged from these exchanges: (a) experiencing stigma (perceived stigma and fear of stigmatization), (b) spaces of stigma, and (c) the nurse-patient relationship. Please note, in these themes, when participants referred to nurses by name, the word nurse has been inserted into the quotation. For all other health professionals, or if the participant was unsure if he had interacted with a doctor, nurse, nurse practitioner, or other health professional, the term health care worker is employed. Figure 2 visually summarizes these results.

Figure 2-Results Summary



Theme #1: Experiencing Stigma

The participants discussed stigma in many different ways. Three participants described it as a negative feeling they experienced when they told a health care worker that they were having sex with men. For example:

[He was] kind of like grumpier [once I told him I was gay], grumpier (said this as if having a revelation), he seemed like a grumpy old man ... very stern face ... like you could smile more, you don't have to be such a tight ass kind of thing ... he wasn't cold, he was very grumpy, you know, very ... abrasive, very abrasive looking, so that made me feel uncomfortable, and that made me feel bad about myself (Travis, P1: 170-189).

In the above quotation, Travis described feeling uncomfortable and bad about himself once his sexual orientation was revealed within the client-health care worker interaction. Indeed, after he revealed his sexuality, Travis perceived the health care worker as “grumpy” and “abrasive”. In the above client-health care worker interaction, stigma was a feeling of uncomfortableness in which the participant felt “bad about himself” based on his sexual contacts with men. Another participant described experiencing stigma as a lack of respect from a physician:

You hear kind of the odd story of someone going somewhere and you know that doctor because they don't agree with that person's sexual orientation, they sort of don't treat them with respect or properly, and stuff like that (Adam P4: 456-460).

In the above quotation, Adam was not describing a situation when he had experienced disrespect, but rather, recounted that he has heard stories about some gay men's experiences. In the context of this analysis, however, the actual experiences are not important. Instead, the item of interest is Adam's description of stigma: experiencing a lack of respect from a health professional. Other participants described similar experiences. For example, Aaron described stigma as feelings of being judged, or made to feel guilty about sexual activity:

I did feel that these two nurses in question, these were separate cases, ... I did feel they

were a little cold, maybe not just towards me but in general, I felt some judgement ... it wasn't obvious but ... for some reason ... I feel that I was judged for my sexual activity (Aaron, P2: 142-150).

In the above quotation, Aaron noted that nurses, specifically, had previously judged him. Of particular interest, Aaron described this experience of stigma in relation to perceptions that the nurse was “cold” toward him. Again, for Aaron, stigma was, an experience rather than a specific action by nurses or other health care workers. It was the participants’ perceptions of an encounter, which manifested as a negative emotional experience.

Furthermore, three participants described the experience of stigmatization for reasons beside their sexual activities. Nevertheless, notwithstanding a change in the source of stigma, the participants still noted similar experiences: unwanted, negative feelings or perceptions.

The following exchange with Jonathan exemplified this finding:

I had been smoking pot for a long time, but for some reason it started giving me anxiety attacks, like really bad ones ... and I got an anxiety attack and I went to [named hospital] and the nurse was, well she saw in the file, I guess that ... the pot gave me an anxiety attack and I was waiting in the waiting area and then she came in angry in the waiting area with a flashlight and said to look at her and then she sort of did a big scene in front of the whole waiting room ... and that embarrassed me so much that I just went and saw the other nurse at the front and just left (Jonathan, P5: 269-295).

In the scenario described above, Jonathan described stigma as an embarrassing experience, which related to a nurse’s “angry” demeanor and public demonstration. Again, stigma was a negative sensation, feeling, or experience that arose from the perceptions of another’s actions.

In summary, the above quotations highlight the participants’ descriptions of stigma as a negative experience, which they identified using many different words, such as, embarrassment, judgement, or a lack of respect. Ultimately, therefore, the participants in this research described stigma and stigmatization as their interpretation of another person’s

behaviour as unwelcoming, negative, or cold. It is, for these participants, therefore, the perception of other's responses in a way that induces negative feelings, often about oneself.

Perceived Stigma

The first type of stigma the participants described, perceived stigma, can be summarized as the materialization one of the foregoing negative experiences, i.e., stigma as identified above in theme one. An important attribute of perceived stigma was that it was independent of other people's (i.e., health care professionals') intentions.

Participants also felt these negative experiences (stigma) from health care workers who behaved in, what some participants described as, an authoritarian or abrasive manner toward them:

I feel very shy with [my doctor], he knows I'm gay but it's sort of, it's not judgement, but, for example, with the mucous and bleeding, it was just like right away he said 'do you use protection when you have sex?', but [in a] very blunt way so it's just...very firm ... he doesn't really engage (Jonathan, P5: 199-228).

In the above quotation, Jonathan described the abrasive bedside manner of his physician. He noted that he did not think his physician intended to judge him, but he felt such stigmatization due to the physician's failure to engage.

Two participants described feeling this type of stigma when nurses/health care workers overly emphasized negative outcomes, such as STI or HIV acquisition, because these participants' sexual orientations were non-heterosexual:

I guess the one case with the nurse talking about the elevated HIV risk for gay males, that was the one case where I felt stigmatized ... It was the fact that [the nurse] highlighted that men's risk is higher ... I remember feeling like, this was all before she actually took the blood sample, I remember the way she spoke, ... she made the issue seem very grave and serious ... [and] I felt that before the result it wasn't really necessary (Aaron, P2: 387-430).

I think that might be one thing, actually, that's probably a really interesting point, every time I've gone to places where I've had bad experiences based on what I'd

believed to be judgment of my sexual orientation, dialogues have always been phrased ... in sort of a despair tone ... like this is going to happen to you, you have to watch out about this, you're going to have to get this done so we can see if you have this, you might have this, you know you're in a risk category for this, whereas here [at the gay men's sexual health clinic], it's not necessarily about that, it's about ok, well, you're just human (Rupert, P8: 593-605).

In the above examples, Aaron and Rupert described nurses and health care workers emphasizing the probability of contracting an STI or HIV as a result of the participants' sexual orientation. Aaron described the nurse emphasizing this possibility before any results of blood work were known, and it was his perception that this emphasis was a result his sexual orientation. Rupert discussed this further by his general comment on health care workers emphasizing the likelihood of contracting an STI or HIV when the health professionals work in institutions that he did not feel were gay friendly. Overall, such comments suggested that these participants felt stigmatized in these interactions with health care workers, regardless of the actual intent of the health care worker. Indeed, based on the data presented herein, it is impossible to know the health care workers underlying intentions.

Another point where the participants felt stigmatized was when the probability of gay men contracting HIV, as well as the link between promiscuity, HIV, and homosexuality, were emphasized:

I think [the emergency department physician] also thought I was quite promiscuous ... she asked me four times in a half hour window when my last HIV test was until I told her not to ask me again ... it's on file, it was like three weeks ago from another event, to be honest you don't even need to ask this, if it's not on my file you shouldn't be asking ... my [family] doctor knows I'm gay, she's asked me, ... but I don't care if you think I'm gay ... that won't make me either promiscuous or HIV positive (Marlin, P7: 259-291).

Here, Marlin described how he believed the health care workers assumed he was promiscuous because he was gay and presented with symptoms (yeast infection).

Additionally, he described that, contrary to the perceived opinion of the health care workers,

his sexuality neither affected his HIV-status nor his number of sexual partners. In other words, according to Marlin, being gay did not mean he was promiscuous or HIV-positive, which is what Marlin perceived health care workers assumed when working with gay patients. Aaron also described a health care worker who similarly focused on HIV among gay men:

I did feel that these two nurses in question, I did feel they were a little cold, maybe not just towards me but in general, I felt some judgement ... it wasn't obvious, but for some reason ... I feel that I was judged for my sexual activity ... In one case ... with one of the nurses ... she said that gay males are at higher risk for HIV because of the susceptibility of the intestinal wall to tearing ... and I felt that, making that distinction wasn't really necessary ... I felt like she was going on the basis that HIV care is more importantly directed towards gay men and not the general public .. [the nurse was] calm, quiet, soft spoken, but I could sense some intensity in her facial expression ... it's almost as though she didn't know she was judging ... I felt that she was saying it out of care but I felt that underneath that she was a little bit judgmental (Aaron, P2: 124-185).

In this example, Aaron described a health care worker who he perceived as placing an increased focus on HIV prevention in gay men than in other populations. Likewise, Rupert indicated his belief that informing health care workers of his sexuality has resulted in an increased emphasis being placed on his sexual health:

I was first going to see the doctors at [clinic name] for just sort of check-up purposes, as soon as it came up that I was gay, it was like 'you should get blood tests done', 'you should be tested for HIV', you should be getting all this stuff done which was something that they were not suggesting before they heard about my sexual orientation and I'm just thinking 'ok, that's kind of odd, you think that you'd probably want to say that to every student', but it seemed to me like the fact that I was gay was the main determining factor in why I should be tested for chlamydia and gonorrhea, and syphilis, and HIV, and all of these other things that I suppose would not have come up, or it felt like would not have come up ... It made me feel like I was somehow unclean, like a little bit like abnormal, I mean ... it was just like 'you've got to worry about this now', and this was before they even asked about my sexual history, as far as they knew, I could have been completely celibate, gay, but ... maybe I'd only had sex with one man, and maybe the only person that I had sex with was very careful, I mean none of these questions were asked beforehand, it was just like, 'you're gay so here's this' ... I don't think they were trying to judge me but it kind of felt like they were ... I felt like I was being judged (Rupert, P8: 97-132).

Above, Rupert reported that he felt stigmatized when health care workers linked promiscuity and contracting HIV with homosexuality. More specifically, and in the same way that Marlin (quoted above) commented that being “gay does not make him HIV-positive or promiscuous”, Rupert noted how a health care worker had linked gay men, promiscuity, and HIV before inquiring if he were sexually active. This is also similar to what Aaron described above when a nurse emphasized the probability of contracting HIV before testing a blood sample for STIs/HIV. Therefore, the participants’ experiences of perceived stigma manifested when they felt that clinicians made assumptions about them regarding promiscuity and HIV based on their sexuality identity, not their sexual activities. Rupert summarized this point as follows:

It’s an embarrassment of being who you are, not an embarrassment of what you’re doing, ... you’re ashamed to go in [to a clinic] and say ‘I’m gay’ because suddenly that attaches you to all these different risk factors and ideas regardless of how you’ve acted, regardless of how you comport yourself on a daily basis (Rupert, P8: 466-470).

Based on the above quotations, the participants reported feeling “judged” or “embarrassed” by nurses and other health care workers as a result of their sexual identities. It was, therefore, surmised that, because the judgement was felt before the sexual health history was taken, but after the client revealed he was gay, this judgement was not specifically attached to the participants’ sexual activity, but rather, to their non-heterosexual identities.

In addition, the participants felt negative emotions stemming from another focus of sexual health care: safer sex education. Jonathan described how nurses’ attempts to educate gay persons on the possible negative consequences of sex, at the gay men’s sexual health clinic, felt very condescending:

Well when they start teaching [about safer sex], I feel like I’m like kindergarten, it’s very child like ... because I know all about safe practices and what not, and I always

use condoms most of the time and, I do know the risks and what not ... I go every couple of months [to the clinic] so by this time I don't need to be told that condoms are safer (Jonathan, P5: 538-563).

In the above situation, Jonathan described feeling belittled, like “he was in kindergarten”, when a nurse attempted to educate him on safer sex techniques. Although the intention of the nurse was unknown, a negative emotion was felt because Jonathan perceived that he was being treated like a child.

Moreover, the participants noted that health care workers' lack of knowledge and/or experience working with gay individuals contributed to their perceptions of stigmatization:

I don't think they [at the clinic] meant to be mean, I think they're not used [to it] cause it is mostly families ... there's not many people my age going to the clinic ... so I think it was a lack of experience more than judgment, but again, they're paid quite well for their impartiality and they're paid quite well not to pass judgments, and that's how I feel they should be acting and I let them know that (Marlin, P7: 293-303).

I can't say that I've ever been treated in a specifically disrespectful manner [when discussing sexual health issues with nurses/health care workers] ... I would even say that [negative] reactions are not necessarily coming from a place of disrespect so much as they're coming from a place of misunderstanding, or maybe [a place] of ... unfamiliarity [working with gay men]. Or it just goes against what they're used to or what they expect ... it's kind of like they're in this medicalized context, but they still have to deal with ... the social relation ... There are certain social conventions that hold true outside of the medical office, once you walk in there they don't stop becoming true ... so I think that's more where that kind of thing comes from (Rupert, P8: 247-276).

In the above two excerpts, both Rupert and Marlin described feeling judged due to, what each felt was, a lack of knowledge and/or experience regarding the provision of health services for gay persons. However, both participants stressed that they did not feel that the health care worker intended to stigmatize. Instead, the participants felt judged due the health care workers' lack of familiarity with, and understanding of, gay clients.

Finally, participants reported feeling what was called perceived stigmatization from health care workers whose care the participants felt was the result of judgement. In a

quotation noted above, for example, Aaron, at the end of the quote, articulated this idea of judging through care:

... It's almost as though she didn't know she was judging ... I felt that she was saying it out of care, but I felt that underneath that she was a little bit judgmental (Aaron, P2: 124-185).

Rupert discussed this idea further:

I don't think they were trying to judge me but it kind of felt like they were ... I did feel like I was being judged ... I know that realistically that might not be the case, I mean, some of these people could have just been like 'well, this is a risk factor, I am assessing the risk factor, and recommending things based on this risk factor', completely divorcing it from the idea of judgement or whatever, but you know, if they were, I wouldn't have been able [to tell] ... it wouldn't have changed my feelings (Rupert, P8: 130-139).

Here, both Aaron and Rupert discussed how they perceived the care they received from health care workers, in these specific situations, to be judgemental. Thus, while health assessments and education are basic activities associated with providing nursing care, these activities left some participants feeling stigmatized. This perception of stigma through health assessments and education further suggested that stigma was a subjective perception. While one individual may perceive these activities as stigmatizing, another could view them as positive and useful experiences.

In summary, the participants perceived that they were being judged, or stigmatized, for a variety of reasons, including health care workers emphasizing the probabilities for gay men contracting HIV, and a demonstrated lack of knowledge and/or experience with gay clients. In addition, the participants reported feeling judged when health care workers provided some aspects of routine care, such as health education. Regardless of the intent of the health care worker or nurse, in the above situations, however, the participants felt stigmatized.

In addition to the general feelings of perceived stigma noted above, the participants

described feeling judged when they had to ‘come out’ to health care workers, i.e., inform health care workers they were having sex with men. One participant, Travis, talked about this process of revealing his sexual identity to his family physician:

[He was] kind of like grumpier [once I told him I was gay], grumpier (said this as if having a revelation), he seemed like a grumpy old man ... very stern face ... like you could smile more, you don’t have to be such a tight ass kind of thing ... he wasn’t cold, he was very grumpy, you know, very ... abrasive, very abrasive looking, so that made me feel uncomfortable, and that made me feel bad about myself (Travis, P1: 170-189).

In the above quotation, Travis discussed how he perceived the physician as “grumpier” and “abrasive” once he told him he was having sex with men. Another participant, Rupert, reinforced this point by discussing how health care workers “react” when he told them he was gay:

This clinic is great. This is a Godsend. I am happy every day that I come here that it’s still open because the practitioners just are so good at making feel at ease. ... But at places like [clinic name] and [clinic name], you go in and you get that reaction when you come out to them and at that point it’s kind of like ... yeah there is a little bit of embarrassment because this persons’ reacting and you’re like they’ve already shown me how they feel about this (Rupert, P8: 417-439).

In the two health care worker-client interactions discussed above, Travis and Rupert both felt stigmatized after they revealed their non-heterosexual orientations. In the following quotation, Rupert further explained his point about health care workers ‘reacting’ to his ‘coming out’:

I think that’s something that many health care providers don’t understand when gay people are going to their ... office and they’ve never seen that person before, you have to come out to them, because there’s this medical assumption, or maybe not medical assumption but social assumption, that I guess gets transposed into that medical environment that you’re going to see somebody who is heterosexual, and when nurses react to something like that, it doesn’t really fill you with confidence ... I would say when they react ... it would like ‘you should get tested for this’, I mean like sometimes it’s not even verbal, you can just see it on their faces, it’s just like ... emanates from them ... you’re having a nice congenial conversation and then you suddenly say something and then it goes quiet for a moment, and then you know after that the whole

conversation is awkward and I mean I think in any social situation people would feel judged (Rupert, P8: 206-245).

It is clear from the above quotations that these participants felt stigma from ‘coming out’ to health care workers, regardless of the intent of the health care worker involved. For both Travis and Rupert, their perceptions about health care workers’ stigma resulted in feeling judged and/or embarrassed and/or uncomfortable within the health care worker-patient interaction.

However, not all participants felt stigma when ‘coming out’ to health care workers.

Marlin described his experience as being fairly neutral:

My GP, she asked me she said ‘are you gay straight bi, who do you sleep with?’ I said men, she said fine, that was the end of the conversation ... and that’s usually how it goes with any doctors I have ... I was completely indifferent to it to be honest, it was neither bad nor good ... I think it was as good as it could have gone (Marlin, P7: 577-606).

In this example, Marlin described his experience ‘coming out’ to his family physician as uneventful. Therefore, Marlin did not perceive any stigmatization during this clinical interaction.

Marlin, furthermore, made an interesting point about gay men who feel uncomfortable discussing sexual health issues with health care workers:

I hear lots of stories about people having great doctors and great nurses and I think ... when people say their doctors are uncomfortable with them, I think they’re more uncomfortable themselves talking to their doctors, I think they’re projecting that uncomfortableness on their doctor (Marlin, P7: 571-575).

In this quotation, Marlin explained his opinion that feeling uncomfortable discussing sexual health issues with health care workers rests with the patient. While an interesting point, Marlin was the only participant who stated he had a positive and/or neutral experience ‘coming out’ to a health care worker. In the above quotations, the participants described

situations, particularly ‘coming out’ to health care workers, where they felt stigmatized.

Next, the assumption that one will be stigmatized are outlined.

Fear of Stigmatization

Based on the analysis of the participants’ interview data, fear of stigmatization was defined as a feeling that was experienced by the patient before an encounter with a health care worker. It was based on the participants’ assumption that these health professionals would stigmatize them. First, the participants felt this type of feeling as a general stigma from society:

I guess gay people, they ... obviously feel in there everyday life in some respect that they’re being judged a bit more harshly than somebody else or discriminated against or whatever (Adam, P4: 480-482).

[Stigma] happens in all facets of a gay persons life, you know, so basically ... at work, at school, with myself, with religion, with politics, with the macro level of society, with the micro level of my friends ... you’re gay, you know, even though society is getting way better at it, I would love to live to see the day where a gay person when he realizes they’re gay they see completely zero stigma, but ... it’s normal, that’s also our norm too, that we get judged (Travis, P1: 721-742).

In the above quotations, Travis and Adam both described general stigma stemming from society. Travis even stated that stigma was ‘normal’ for a gay person. Although this stigma was not felt from a specific individual, Travis and Adam described feeling a general judgement from society before any interactions with individuals occurred, both in and out of a health care setting.

Second, four of the participants discussed assuming that this general social stigma would also pervade situations with health care workers where the participants would need to reveal their sexual practices or identities. This experience of stigma was based on expectations about the health care worker-patient interaction. Travis described his experience:

At [the gay men's sexual health clinic] for sure [I feel accepted by nurses], ... my doctor, yes, cause I know she's a sexual health doctor so I feel very comfortable talking to her, but generally, I don't feel comfortable, let's say it's the blood nurse, or it's the vaccination nurse, for some reason they asked me like 'are you gay?' I would say yes, ... I would feel fine telling them, but ... lets say the blood nurse or the vaccination nurse asked 'what are your plans for tonight?' I wouldn't be like 'I'm going to see my boyfriend', ... I'd be like 'I'm going out with friends', I guess it wouldn't be [the nurses], I guess it's how gay guys just act in general with other straight people, you don't have to flaunt your gay life, or you just don't mention those kind of things sometimes, even though you're perfectly allowed in society, but sometimes, I just don't feel like talking about that, or trying to come out to every single person (Travis, P1: 549-565).

In the above situation, Travis described not wanting to "flaunt his gay life", especially to health care workers who do not need to know about his sexual identity for the purposes of providing care. Although he realized that he was "allowed" to tell the nurses, he did not feel he could or should discuss it with everyone. John and Adam discussed this point further by describing situations where they assumed they would be stigmatized if their sexual activities or identities were revealed:

I feel like it's hard to bring it up [my sexual activities], and hard to be open with [health care workers], but once you are open they don't judge and they are there to help you, but getting it out initially is hard ... [because] preemptively thinking they will judge you ... being like 'ok, if I do tell them that they might judge me', even though I'm sure they won't, but just in case they will (John, P3: 451-465).

I [am] used to going to [the sexual health clinic], [but the] first couple of times it was a [new] experience and I ... didn't say everything 100% or I made up a story in some way where I still got all of the factual stuff out... I usually had protected sex always but the one time ... I didn't, and that was a bit scary and I remember coming [to the gay men's sexual health clinic] and I got the test and everything was ok, and then probably a couple months after that ... it actually happened again, so then when I came back [to the gay men's sexual health clinic], they were like 'how many people have you had in the last ... x number of months', and I ... didn't say I had anybody else new, I just said I was ... here as a follow-up from the previous one, really there was somebody new, I just didn't want to say that because ... that's not really a good thing (Adam, P4: 291-314).

I feel like [being gay] it isn't anything [my family physician] needs to know, cause I feel like he knows my whole family, I know he can't tell anyone else, but I'd rather go to a different doctor who doesn't know my family to discuss stuff like that then to go

to him ... [I feel] like the way that we would interact would change ... he'd be more interested in my health, like ... more interested in the sexual promiscuity and make sure I'm tested and make sure I'm clean as compared to like a straight person where they just assume ... you're safe and protected (John, P3: 275-301).

Here, both Adam and John described the fear of being judged for their sexual activities and/or identities prior to a clinical interaction. To avoid such judgment, consequently, both John and Adam altered their sexual histories when describing their sexual activities to health care workers by either leaving out parts they perceived would generate stigma, or by withholding information regarding a new sexual contact. In addition, John discussed how he would not tell his family physician he was gay because the “interaction would change”, with the physician becoming “more interested in [John's] sexual health”. In both cases, Adam and John assumed they would be stigmatized and modified their actions with health care workers accordingly.

In summary, two different types of stigma were identified within nurse and health care worker-patient interactions: perceived stigma and the fear of stigmatization. The former was interpreted by the researcher as the feeling of having been stigmatized regardless of the intent of the health care worker, while the latter was the assumption that one would be stigmatized before the clinical encounter actually occurred. In the following section, the spaces where such perceptions of stigmatization occurred are examined.

Theme #2: Spaces of Stigma

This section examines the places where the participants experienced, or did not experience, stigma within the therapeutic nurse-patient relationship. In addition, the positive and negative characteristics of health care workers that the participants found to increase or decrease trust and/or stigma are also detailed.

Places of Inclusion and Exclusion

The participants, overall, had a positive view of the health care system in Canada. In addition to having a positive attitude towards this system, seven of the participants stated they were treated fairly when accessing health care. Travis, particularly, reported being treated “fairly and well” (P1: 570) within the health care system. Nathan, likewise, described the very existence of the gay men’s sexual health clinic as validation that he was being treated fairly:

I’d say so yes [nurses treat me fairly], ... I’ve never seen any reason otherwise. There’s the professionalism aspect, as far as being treated fairly, given that this is specifically a gay friendly clinic, I think that’s a very good thing ... it’s very nice that we have these resources and I feel like it helps those people who may otherwise not have access to fair resources ... I guess the mere existence of this facility would help with that ... my main reason for coming here is this is where I know I can go ... but yeah, I would say I’m more comfortable here as a whole ... because I do feel I’ll be treated fairly (Nathan, P6: 207-234).

For Nathan, the existence of a gay men’s sexual health clinic signals that he was treated fairly, and he stated that he felt more comfortable going to this clinical milieu than to the other health care centres. This sentiment was echoed by two other participants:

This [gay men’s sexual health] clinic is great, this is a Godsend, I am happy every day that I come here that it’s still open (Rupert, P8: 425-427).

My overall feelings [about the gay men’s sexual health clinic], I’m just really, really, really happy about it, just really really happy, that’s why I [go] here (Travis, P1: 584-585).

In the above two quotations, both Rupert and Travis stated that their experiences at the gay men’s sexual health clinic were very positive. A number of comments were made by the participants about why their experiences at the gay men’s sexual health clinic were positive:

I realize that [the gay men’s sexual health clinic] does a big part for the community, and without them a lot of people would be sort of lost ... I know a lot of men that come here specifically because it is a gay friendly clinic, but generally I come here because it’s convenient, and because they do the rapid test, and because I think they

have more expertise than my doctor (Marlin, P7: 368-388).

In the above quotation, Marlin described why he utilized the gay men's sexual health clinic as opposed to other health care centres. Specifically, he emphasized that the staff at the gay men's sexual health clinic have more specific STI knowledge than his general practitioner, that the clinic hours were convenient and that he could obtain rapid HIV testing at this testing locale. This statement was echoed by Travis:

[The nurse] was very clean about everything, like clean as in like when he did the test, it finished very cleanly, there wasn't a mess everywhere, like [other clinics I've attended] (Travis, P1: 46-49).

That's why I like [name of nurse] and the other nurses at the [gay men's sexual health] clinic, no matter who they are they all seem like they knew what they were doing, [at a regular clinic, the nurse] seemed very new, kind of like stumbling, ... and then she also administered the test really poorly which I was very unhappy about, but the people at the [gay men's sexual health clinic], they do things really well (Travis, P1: 76-82).

In his comments, Travis described actions of the nurses at the gay men's sexual health clinic, which he felt made the experience more positive, such as cleanliness, staff knowing what they were doing, and staff performing their tasks well. Other participants also commented on the actions of the gay men's sexual health clinic staff:

Generally speaking, because I come here somewhat frequently, I do know each of [the staff] well enough, it's become fairly routine, like you know 'hey, paperwork, samples, have a nice day', but I mean I get the feeling that the nurses, the staff that work here, they did take it upon themselves to set their time aside for this purpose, I mean obviously, everybody can see that they're giving up their evening as well, ... but it really comes across that they really enjoy being here (Aaron, P2: 223-230).

As far as I can tell [the nurses at the gay men's sexual health clinic] seem to enjoy their jobs, they seem to enjoy what they're doing, and they understand that ... testing for sexually transmitted diseases ... is a very sensitive thing and try their best to be as un-intrusive as possible while still addressing the issues that need to be addressed... they try their best not to be judgmental as far as I can tell (Nathan, P6: 69-79).

I went to [the gay men's sexual health clinic] one time, I had a great time there, I think I met [name of nurse] and he's a cool guy, like he made me feel really comfortable ... he was very friendly, very knowledgeable, he didn't pass judgement or anything like

that, so yeah, I would go see him again if I ever had to go back there (John, P3: 151-159).

In the above quotations, all three participants described positive experiences they had with staff at the gay men's sexual health clinic, and the attributes of this clinic that they perceived as positive. For example, the participants noted that staff at the gay men's sexual health clinic really seemed to enjoy being employed at this clinic, and that these health professionals were also friendly, knowledgeable, un-intrusive, and non-judgmental.

In addition to noting positive characteristics of staff, the participants also discussed positive aspects of the clinic atmosphere:

[At another] clinic, they almost turned me away! I was so mad! ... Mainly because they're like 'you know you got a test recently, like two months ago, we don't think we'll get a good result, it would be a waste of resources to administer the test again', which is fair, but I'm like 'I'm gonna come and do the test whenever the fuck I want', ... the fact that they almost turned me away, like I had to fight [to do] the test, but with my other doctor if I was within reason she'll ... just do the test, like no hassle, and [at the gay men's sexual health clinic] no hassle (Travis, P1: 248-263).

I talked to [the administrative assistant], the guy at the front, he was a cool guy, I felt confident being there, like comfortable, he didn't make a big deal or anything (John, P3: 209-214).

Yeah, because [the gay men's sexual health clinic] had someone who was saying you need to fill this [out], and they had someone even before that when you sort of looked disorientated if it's your first time and they'll say 'it's towards that way' and they sort of assist you with all the steps (Jonathan, P5: 130-135).

One of the nice things about coming [to the gay men's sexual health] clinic was on the paper you already get like 3/4 of the stuff out that I think the nurses read, like 'ok, so are you gay?' So you don't have to say that because they already know, so when you go in they're saying to you like 'oh ok, so you've had sexual relations with men and last time was this', so they already break the barrier, you don't have to say that [because] they already know, I think that would be a good thing to have even at other walk-ins too, I think that could also be something that might be a little easier for people if some of that stuff was already down on paper beforehand (Adam, P4: 323-336).

In the above examples, the participants discussed the reasons why the gay men's sexual

health clinic created the best atmosphere, including providing stress-free services, not emphasizing the reason for the clinic visit, providing assistance to new clients, and using paperwork which provided an outlet for clients to state what they felt were embarrassing details about why they were visiting the clinic. The last point prevented the clients from having to verbalize such items, and this, the participants noted, eased discomfort and embarrassment. Overall, the participants also described feeling comfortable attending the gay men's sexual health clinic:

The places that you become familiar with, [like the gay men's sexual health clinic], and just knowing that those places welcome, I don't know if I was going [to another clinic] ... they may not be sympathetic or whatever, but you sort of know that these places that only deal with sexual health they're very much immersed in it, they've had people obviously come back many times with positive results and they can empathize if you were to come back with the same thing, whereas somewhere else where they get like one person every few months that comes in for that, it's sort of hard for them ... [it's a trust thing, trust with the clinic] ... because I mean if there was enough people who didn't like the [gay men's sexual health clinic], there probably wouldn't be one (Adam, P4: 372-393).

Here, Adam described how comfortable he felt attending the gay men's sexual health clinic, and how this comfort led him to trust the clinic. The participants also described how receiving care from gay health care workers at the clinic led to feelings of increased comfort:

I really like the doctors at the gay friendly clinic because of their specialty in sexual health, so lets say you're getting a test and it's ... the doctors and nurses I had at the gay friendly clinic, [they] all get 100%, ... so I keep going back, I have full trust in [them], ... but then, when the health care worker is gay, ... something about it just felt so much more relatable that it would give you like a bonus, like 110%, like one health care worker we were talking [and he was like] 'you know, if you're really uncomfortable with receiving mouth-to-mouth infections, you really shouldn't be giving oral sex', then I'm like 'you may tell me that but I'm still going to do it', and then the guy just laughed and said 'yeah, me too', so I [laughed]... I just felt so comfortable, and felt very relatable, and then, with [name of nurse], we've never talked about anything like that, but there's something about him, like he knew the right questions to ask, like even though you're all probably trained to know the questions, [there's] something about him ... there's two kinds of knowing, like there's the knowing of technical knowledge, and there's the knowing of truly experiencing it for yourself, I feel like he had both which made me truly trust him (Travis, P1: 638-663).

In this comment, Travis felt that gay health care workers were more relatable and knowledgeable about gay issues. This statement was echoed by Adam and Jonathan, who discussed why they felt increased comfort with gay health care workers:

I guess gay people, they feel in there everyday life in some respect that they're being judged a bit more harshly than somebody else or discriminated against, and you know just when [I] come in ... that 'ok, this is a gay friendly place, [these are] people who understand what you're going through, they've probably been through the same thing as yourself and they can identify' ... I wouldn't say that just because it's a gay friendly clinic that means that everyone that works here is gay but ... I think you might be more inclined to think that ... just right off the bat [with a gay health care worker, it would be] like 'oh ok, I [know that] they're on the same level as me already' ... so it makes it easier (Adam, P4: 477-510).

At [the gay men's sexual health clinic] I saw two doctors that were male and I am assuming they were gay and I liked them because they were more friendly [and understanding] (Jonathan, P5: 376-391).

While Jonathan saw gay health care workers as more understanding, Rupert discussed how this understanding led to an increase in trust:

I trust the nurses [at the gay men's sexual health clinic], absolutely I trust the nurses here, they make me feel at ease, in fact it's really nice having nurses come in and health practitioners come in who are not only sympathetic but in some cases actually [gay themselves], there's one doctor I usually see, he's gay too, and it's really nice to just sit there and talk with somebody who understands my position, and whose going to be frank with me but not to the point where I feel like I'm doing something wrong or being stigmatized (Rupert, P8: 191-199).

In the above quotations, the participants discussed their interactions with health care workers at the gay men's sexual health clinic who they perceived to be gay. They described these gay health care workers as more relatable than those who were not perceived to be gay, because they have often been through similar experiences, and were able to provide more specialized knowledge as a result. This specialized knowledge was described by Travis as leading to an increased sense of trust in the health care worker:

I just felt so comfortable, and felt very relatable, and then, with [name of nurse], we've

never talked about anything like that, but there's something about him, like he knew the right questions to ask, like even though you're all probably trained to know the questions, [there's] something about him ... there's two kinds of knowing, like there's the knowing of technical knowledge, and there's the knowing of truly experiencing it for yourself, I feel like he had both which made me truly trust him (Travis, P1: 638-663).

According to Travis, the gay health care worker possessed knowledge of gay sexual health issues, which could not be learned except through personal experience. This created a distinct patient-health care worker relationship, which resulted in a unique sense of trust.

Theme #3: The Nurse-Patient Relationship

In the previous section, the places where gay male youth accessed health care services were discussed, including overall attitudes toward and treatment received by these services, with emphasis placed on the gay men's sexual health clinic. Now, a description of how stigma affected the therapeutic nurse/health care worker-patient relationship is provided.

Despite the experiences of stigma described by the participants, seven of the participants stated their belief that nurses are trustworthy. The one participant who did not state that nurses were trustworthy did not state that nurses were untrustworthy; he merely made no comment on trustworthiness altogether. Three participants felt that this trust in health care workers was immediate, and that they trusted nurses until they were given a reason not to:

I would say so, yes [I trust nurses], I've never had any reason to otherwise ... I guess I'm a very trusting person as a whole, but I have my cynicism's at the same time, although I've never had any situation where I feel like my trust has been breached with any doctor or nurse (Nathan, P6: 169-178).

Overall yeah [I feel comfortable utilizing the health care system], I mean because I really haven't had a really bad experience to be afraid (Adam, P4: 287-290).

Here, both Adam and Nathan described trusting health care workers and accessing health care because this trust had not been breached in previous experiences. Trust was given until

there were grounds to revoke it.

The participants gave several reasons for why they trusted nurses. Four of the participants described trusting nurses due to their code of ethics:

I like that they have confidentiality, so any [sexual health issues] I do discuss, like it won't really go anywhere else (John, P3: 262-273).

I guess [nurses would earn my trust] with their diploma ... and with ethics, cause ethics for me are very important, and I'm assuming nurses get courses on ethics ... and I'm assuming if they would break that trust they would get punished very badly (Jonathan, P5: 580-597).

My family uses [my physician] and I would know that anything I do say to her would never leave our confidence, she would never share anything I said to my parents ... but generally, ... I recognize how much effort you have to put in to be a doctor or a medical professional, and I respect the amount of work that she's put into it ... I knew that my information, I mean when I get HIV tests, I never make it anonymous because I would trust my doctors enough that I'm fine with them knowing any results I get (Marlin, P7: 75-87).

In the above examples, the participants discussed respect for confidentiality, ethics, and professionalism as reasons why they trusted nurses and other health care professionals.

Jonathan also tied in knowledge and post-secondary education as reasons why nurses were trustworthy. Five other participants also mentioned nurses having extensive knowledge and/or experience combined with passion and caring, which resulted in a greater degree of trust:

I feel like the [health care workers] who really are there for gay men, or for STIs, they just have a breadth of knowledge about that, but also a passion too, a passion and a level of caring that makes you trust them ... so I trust them and I feel comfortable with them so that's why I go back [to the gay men's sexual health clinic] (Travis, P1: 344-348).

... I would probably say that I personally, [I would] trust [nurses] right away cause they do kind of have that level of ... they're sort of a little bit ahead of you I feel ... so it's kind of like a teacher or a lawyer (Adam, P4: 520-535).

Generally every nurse I've ever met ... has had some sort of pleasant disposition ... so I think that's sort of a qualification for being a nurse ... being altruistic to some degree

... [they earn my trust] by having a university education (Marlin, P7: 414-429).

Here, the participants explained how knowledge and/or experience led them to trust nurses.

They also described how a caring disposition and passion for the job also created that trusting environment.

In addition, the participants listed many positive characteristics of nurses and other health care workers. One of the main positive characteristics, which was mentioned by seven of the participants, was that health care workers treated the participants as regular individuals, with STI/HIV testing being a conventional practice:

I still would feel comfortable [talking to a non-sexual health care worker], you know if it was about a cough ... but ... with the STI thing I think I would be a little bit more embarrassed ... but I know doctors and nurses they see everything, they see a ton of people naked, they get this all the time, ... but for some reason I still think I'd get embarrassed and just be like 'I had sex, sorry', ... but at the [gay men's sexual health] clinic, ... their badge says I specialize in taboo things ... then it makes me feel ok, I'm ok (Travis, P1: 454-470).

I was with this person, and then a month later I was with somebody else, and then you know, ... maybe one time by accident it would be unprotected or whatever and ... it's just not something that I've ever talked to my GP about before so it's new, it would be very kind of new territory, ... like at the [gay men's sexual health clinic] that's all they deal with, it's just every client they get is the same story with variance (Adam, P4: 90-100).

Just the fact that [the physician] was able to not just explain what I needed to know but also to relieve my concerns and not make me feel like I was, you know, some weirdo who goes around performing really abnormal and crazy behaviors that are incredibly high risk, I was just another person who happened to be sexually active (Rupert, P8: 516-520).

In the above examples, the participants discussed how nurses and other health care workers made them feel like regular individuals when seeking STI/HIV testing. They believed that nurses and physicians, especially those who work at the gay men's sexual health clinic, provided these services to gay men all of the time, so accessing these services was a routine practice. However, Nathan discussed how the very existence of the gay men's sexual health

clinic meant that gay men were being treated as “special”, and, therefore, that the care they received was not routine:

I’d say I’m treated as a normal person, yes, you could argue that this being a gay clinic you know, you could go to the extreme of I’m being treated as “special” but I don’t get that impression myself no (Nathan, P6: 273-282).

Although Nathan stated that he does not generally believe that he was being treated as “special”, he raised an interesting point: the existence of this clinic reinforces a linkage between homosexuality and STIs/HIV. Although services at the gay men’s sexual health clinic portray STI/HIV testing as routine, it is thus possible for these services to be perceived in this way as well.

In addition to making STI/HIV testing routine, the participants noted many other positive characteristics of nurses and health care workers with whom they had good relationships. Overall, the participants reported that nurses and other health care workers were friendly:

[My family physician], he’s a good guy, like I’ve known him for a long time, [he’s] pretty friendly, he does the job right and kind of keeps me like, like not entertained, but I’m not sitting there waiting for him to do stuff to me, but I’m interested and talking to him (John, P3: 72-75).

Here, John described the physician not only as friendly, but also as someone who used distraction to keep him “interested”. Three other participants mentioned the importance of health care workers using distraction:

Well [the nurse], he’s nice, he talks to me, he talks to me especially when I’m doing the test, when I’m getting my blood drawn he’ll talk to you, it gets my mind off of [it], he’ll chat with me, also he’s very professional, like very well dressed, but not professional in the sense that he’s distant or cold (Travis, P1: 40-45).

Yes, ... if we’re talking it’s less awkward [doing an STI test]... the one that I really like when they talk is when I do the HIV [test] ... for that two minutes [of waiting], it’s really important ... I need to talk cause I always feel like fainting during that two minutes, ...cause you will get an answer right away if it be positive (Jonathan, P5: 455-

477).

For Travis and Jonathan, health care workers' use of distraction was important because it focused their attention away from the STI/HIV testing so they did not have to concentrate on unknown results. Travis also mentioned the importance of health care workers being professional but approachable, a positive characteristic that was mentioned by two other participants:

Generally I find [nurses] to be very conversational [when discussing sexual health issues], also I would say very professional at the same time, whenever I get an HIV test, they always said 'ok, so you have someone you can go to if you need to go talk to someone, us giving you this test isn't going to cause you to get upset and do anything regretful', etc., they always go through the process of what they need to say (Nathan, P6: 115-123).

Seven of the participants also discussed the importance of nurses and health care workers being knowledgeable:

There's something about nurses that is very like, sort of like they've seen everything and nothing can really shock them, and [they're] very human and have a lot of knowledge (Jonathan, P5: 565-573).

In the above quotation, Jonathan discussed the importance of nurses possessing a large amount of knowledge. However, he also discussed how he sees nurses as regular people who are desensitized. Aaron and Adam echoed these statements:

My assessment [of how I feel around nurses] is not really any different from the way I would feel around anyone else. It's more so just based on who they are as a person, but their being a nurse doesn't really affect the way I would feel about them providing care to me (Aaron, P2: 245-251).

I think that for [nurses] ... they get like desensitized ... like anything you want to throw at them it's not the first time, that they've heard it before ... so they're ... very open, ... so to them it's sort of nothing new, they're used to it so I think that ... they're open minded (Adam, P4: 412-437).

Four participants also reported that they liked it when nurses behaved in a friendly way or made jokes to make them feel more comfortable:

At [the gay men's sexual health clinic] ... they're more like personal to you, not like a health care [worker]-health care recipient interaction, but more like 'we're here to help you', like we aren't [just a] health care provider but we are like general people that care about you (John, P3: 375-379).

I really like when, just in general, nurses are very like lively and they make jokes, I like it when they're very friendly and warm and not cold (Jonathan, P5: 251-253).

Nurses were described by the participants as using many effective communication techniques to form positive relationships with patients. These included maintaining a neutral expression, only asking pertinent questions, and using a two-way working relationship:

[A nurse's] reaction is pretty contemplative [when discussing sexual health issues], just like listening, so like ok, um-hm, um-hm, no judgement, nothing good though, nothing like 'oh cool' with a smile on their face, nor is there a frown it's just neutral, which I would expect (Travis, P1: 525-531).

Well, as far as I can tell [nurses] seem to enjoy their jobs, they seem to enjoy what they're doing, and they understand that this is very sensitive, as well as very specific testing for sexually transmitted diseases and such, they understand it's a very sensitive thing and try their best to be as un-intrusive as possible while still addressing the issues that need to be addressed (Nathan, P6: 67-78).

I really like to engage, like in dialogue, just about anything, and I like when [nurses] seem to like be interested in what I'm saying even if it's just anything, and I often will talk, will ask like where they did like their studies and I like to say what I'm studying and just engage in any conversation (Jonathan, P5: 429-444).

The participants also appreciated when nurses were comforting, calming, gave hope, or empathized:

Just the fact that [the physician] was able to not just explain what I needed to know but also to relieve my concerns and not make me feel like I was, you know, some weirdo who goes around performing really abnormal and crazy behaviors that are incredibly high risk, I was just another person who happened to be sexually active (Rupert, P8: 516-520).

I guess I detect a feeling of empathy [from nurses] I suppose ... we're all human after all (Nathan, P6: 81-92).

Overall, the participants thought that nurses and health care workers were friendly, used distraction appropriately, knowledgeable, desensitized, used effective communication

techniques, and provided empathy and hope.

In addition, half of the participants stated that there was no stigma (i.e., their interpretation of another person's behaviour as unwelcoming, negative, or cold in a way that induced negative feelings) present in the majority of their interactions with nurses and/or other health care workers, and, in fact, most of these interactions were positive:

Yes, I mean, about the gay friendly clinic, yes [I am treated respectfully], undoubtedly, with my favorite doctor undoubtedly, I was just thinking about my other experiences, that's why I hesitated, with just with that one doctor, the one I don't like, he wasn't disrespectful, but he could have been more respectful ... he made me feel uncomfortable and judged, but he's the outlier, everybody else is good, A+ (Travis, P1: 426-438).

[Health care workers are] great, like I'm a fan of the health care we have in Ontario, they're all positive and they love their job which helps ... they're always like smiling and cheerful, never like negative to you or negative to the atmosphere (John, P3: 235-244).

I mean overall I don't think that there's some kind of big anti-gay sentiment in the medical community or anything like that. I think that overall nurses want to ... make sure every patient is taken care of (Adam, P4: 514-517).

In these statements, the participants described how the majority of their interactions with health care workers had been positive, and that, generally, they had a positive view of nurses and that they had had stigma-free interactions with them.

Despite the many positive characteristics of nurses and health care workers that the participants described, some negative characteristics were also mentioned. One of these characteristics, which was mentioned by three of the participants, was a lack of communication:

[The nurse] literally just came in to administer the vaccine, she kind of just did it then left and I'm like ok fine, it's not like I need anything else from her, or any more information, or I didn't need a personal relationship, but you know, it still would have been nice, it made me feel ... kind of like, kind of like a machine ... but like that's so extreme, ... but it was like hinting at that, she kind of just went in, went out, so it was hinting at that feeling (Travis, P1: 200-212).

[The physician was] very quick, he was obviously very busy, my entire GI appointment to organize a possible colonoscopy and an ultrasound for my stomach was only 15 minutes ... like he knew what he had to do, he asked the questions, he didn't want to know what I did, he didn't wonder about stressors, he was just in [and] out, and I'm not used to that, I'm used to doctors who have time to ask questions and see how their patients are doing which is what my GP does (Marlin, P7: 113-122).

In the above situations, Travis and Marlin described interactions with health care workers, in both sexual health and non-sexual health situations, which were very quick, and as a result, lacked communication and rapport building. In addition, three participants discussed that some nurses seemed embarrassed when they were discussing sexual health issues with them, or criticized them for their sexual activities. For example, Marlin, Rupert, and Travis stated:

No, I love embarrassing [nurses] especially. I love it! ... If you can clean up someone's mess in their bed, you can hear about the fact that I need to be treated for an STD, get over it ... like, you sponge bath homeless men sometimes when they come in, deal with this (Marlin, P7: 528-538).

I don't think there was one uniform mode of behavior [of nurses when they were discussing sexual health issues], except of course that they were all helpful, they all tried as best they could to be helpful, I don't think I've ever encountered a nurse who was outright dismissive, although there were definitely some nurses that were more helpful than others, probably because ... they were more ready to engage the subject matter, where as some ... because they felt uncomfortable talking about it or maybe because it was just so unfamiliar, that they were just like 'you're going to do this and that will be that' (Rupert, P8: 308-317).

[The physician] kind of made me feel bad, essentially, like I did something, and then he said 'oh that was a mistake you shouldn't have done that', and I'm like 'oh, I'm sorry', you know, but other nurses, even though everybody knows you shouldn't do this, you shouldn't do that, they more focus on the positive, like, next time, do this, more like constructive criticism (Travis, P1: 123-128).

Overall, the participants described several characteristics of nurses that they felt were negative, such as, a lack of communication, not taking time to build rapport, embarrassment when discussing sexual health issues, and criticizing sexual activities.

In summary, the participants discussed being treated fairly and well by the health care

system, and had overall positive experiences, particularly at the gay men's sexual health clinic. The participants reported that they trusted nurses, and appreciated that nurses and other health care workers treated them as regular individuals, with STI/HIV testing being a conventional practice. However, one participant reported that the existence of the gay men's sexual health clinic signified gay men were treated as "special". This raised an interesting point that the existence of the gay men's sexual health clinic further links STI/HIV testing with gay men.

Identifying Process

An important point in grounded theory analysis is identifying process, where a certain moment is analyzed to understand what makes a phenomenon move forward or stop altogether. In other words, what makes, or does not make, a feeling (phenomenon) change. In this case, moments described by the participants were analyzed to examine what makes a positive health care worker-patient interaction turn from neutral/positive to stigmatizing. Participants, as described in the above results, viewed the moment they revealed their sexual identity to health care workers as the moment the interaction became stigmatizing. Therefore, the action of telling the health care worker they were gay resulted in a perceived negative behaviour from the health care worker, which induced negative feelings within the participant. This was seen as a form of perceived stigma, or the feeling of having been stigmatized. Also, the participants described health care workers placing increased emphasis on their risk for HIV/STIs after they revealed their sexual identity, but before they described their sexual health histories. This caused the interaction to turn from neutral to stigmatizing, and was also seen as a form of perceived stigma. In both of these situations, the patient-health care worker interaction processed from neutral/positive to stigmatizing based on

action of the health care worker.

Summary of Results

Overall, stigma does exist in some interactions between nurses/health care workers and gay male youth. In this research, it was the individual feeling of stigma internalized by the patient within the health care worker-patient relationship and was often felt as judgment. More specifically, and notwithstanding a variable vocabulary to describe stigma, the participants ultimately described a perception of another's (i.e., health care workers) actions as being negative as a result of this other person finding out something about them, something that was often a non-mainstream behaviour or characteristic (e.g., sexual identity). This stigma took many manifestations, including perceived stigma and the fear of stigmatization. The former was interpreted by the researcher as the feeling of having been stigmatized, while the latter was the assumption that one would be stigmatized before the clinical encounter occurred. In response to this stigma, the participants often sought sexual health care from a gay men's sexual health clinic, which was overwhelmingly considered a positive experience by the participants. In fact, the overall attitude towards the health care system and treatment by the professionals within this system was reported as good. The participants also described their trust in nurses and health care workers, and the positive or negative characteristics of these clinicians and interactions that helped solidify this trust. Finally, the participants stated that despite the stigmatizing feelings they had experienced, on the whole, the majority of their interactions with nurses and health care workers had been positive and free of stigma.

Chapter Five-Discussion

The results of this research demonstrated three noteworthy findings. First, it illustrated that stigma is a personal experience; no two participants experienced stigma in the same way. In addition, stigma is a perception that can be influenced by location, such as a gay men's sexual health clinic that is perceived as non-stigmatizing, or by health care workers who are perceived, to use Goffman's (1963) term, as "wise" or "unwise". Second, the aforementioned results highlighted that the gay men's sexual health clinic, when examined within the aforementioned concepts of risk and power, could be interpreted as a manifestation of bio-power. Specifically, this clinical setting can be understood as an apparatus wherein pastoral power can be extended when nurses encourage individuals to engage, or not engage, in behaviours to achieve optimal health (i.e., salvation). Third, these data showed that despite the participants viewing the association between gay men and HIV as stigmatizing (see themes one and two), these same participants did not view the gay men's sexual health clinic as a manifestation of stigma even though this clinical setting is ultimately a health care milieu designed to offer HIV testing to gay, bisexual, and other men who have sex with men. These three findings will be discussed in detail.

Discussion Point 1: The Personal Experience, The Sympathetic Clinic, and The Wise Nurse

Each individual who participated in this research, including the researcher, was a product of his or her own, historically-constructed reality, and this was demonstrated regarding their description of stigma. No two participants described the feeling of stigma in exactly the same way. Rather, the participants employed multiple descriptors to recount their experiences, including such terms as judgment, discomfort, or embarrassment. For example, one participant, Travis, described how interacting with a health care worker who became

“abrasive” after he revealed his sexual identity, made him feel bad about himself. Another participant, Jonathan, discussed how he felt judged and embarrassed when a nurse revealed his drug use to other individuals by “making a big scene” in the waiting room. Even though the participants described stigma in different ways, the findings were interpreted to indicate that participants were describing the experience of stigma as a feeling that is unique to each person. This finding of multiple types or experiences of stigma is consistent with the extant literature, which highlighted many different types of stigma, such as perceived, self, and enacted (Brown, Trujillo & Macintyre, 2003; Corrigan & Penn, 1999; Scambler & Hopkins, 1986).

Moreover, this research suggested that many of the gay male youth interviewed did experience stigma within therapeutic nurse-patient relationships, particularly when they had revealed their sexual identities or orientations to health care workers. Rupert, in particular, described a negative, non-verbal, reaction when he revealed his sexual identity to health care workers. Many of the participants experienced stigma that was interpreted as a perception of stigmatization, or stigma that is felt as a negative emotion by the individual. In these cases, regardless of the health care worker’s intentions, which is impossible to confirm without questioning the health care workers involved, the participants who gave these descriptions felt stigmatized. As Rupert explained, while a health care worker may not think he or she is stigmatizing a patient, but rather, assessing and making recommendations based on allegedly objective risk factors, the health care workers’ intentions did not change the participants’ feeling of being stigmatized. Again, this led to the conclusion that the experience of stigma was unique to each individual.

According to Scambler and Hopkins (1986) part of the participants’ experiences of

stigma referred to a fear of being subjected to discrimination because of a particular trait; in this case, their sexual orientations. In this research, the experience of stigma, which included a fear of such stigmatization, in which the participants anticipated stigma before even interacting with health care workers, was based on the assumption they would be stigmatized for being gay. Based on these beliefs, participants described how they engaged in protective behaviours to avoid stigma; e.g., they reported withholding information regarding their sexual orientations or activities to minimize the negative reactions they expected would ensue from such revelations or disclosures. For example, Adam noted that he altered his sexual history when seeking STI testing because he was worried he would be judged by health care workers; similarly, John described how revealing the details of his sexual history to health care workers made him apprehensive about being judged. This finding of nondisclosure to avoid judgement was consistent with the work of Brown, Trujillo and Macintyre (2003), who described how individuals with particular, socially marginalized, traits often use or adapt protective behaviours, such as nondisclosure, to avoid the negative reactions they anticipate from family and friends. These protective barriers were described as a survival strategy to avoid the consequences, such as job loss or social rejection, which could ensue if others knew of the socially undesirable trait (Brown, Trujillo & Macintyre, 2003). With these participants, the fear of negative reactions from health care workers elicited the use of the protective behaviours. Therefore, the fear of stigma caused participants to develop and employ protective barriers for instances when health care worker may or could stigmatize the participant. Lastly, it is important to consider other previous research which has highlighted that these negative reactions may be more likely to occur if the individual is judged as being responsible for their trait, such as contracting an STI when

the individual did not use a condom (Katz, 1979).

However, within critical theory, one can understand that the participants' expectations regarding stigma within interactions with health care workers may often relate to previous experiences of stigma within the same or similar circumstances. Because individuals construct new experiences based on historical experiences, participants who had previously experienced stigma in interactions with health care workers would likely come to expect or anticipate it in the future. In response to previous experiences of stigma, accessing health care services at a gay men's sexual health clinic could be understood as one such protective barrier against future stigmatizing experiences. The literature repeatedly showed that stigma deterred individuals from undergoing STI/HIV testing (Cunningham, Kerrigan, Jennings & Ellen, 2009; Cunningham, Tschann, Gurvey, Fortenberry & Ellen, 2002; Lichtenstein, 2003; Malta et al., 2007; Mann, 1989).

Notwithstanding such experiences of stigma, including the corresponding fear of being stigmatized, the participants stated extensively that they did not experience stigma at the gay men's sexual health clinic. This one location seemed to limit the experience of stigma, and the participants described this as a sense of acceptance and trust towards this clinic. Indeed, the participants discussed feeling more comfortable accessing STI/HIV testing services at the gay men's clinic than at general health centres, and they expressed positive feelings about the clinic. Such findings are consistent with Goffman's (1963) work, which highlighted that stigma can vary between places. In this case, Goffman's work is therefore clearly applicable in understanding variances in the experiences of stigma between places of inclusion, e.g., the gay men's sexual health clinic, and other spaces of exclusion, such as sexual or non-sexual health clinics aimed at the general population.

Furthermore, the participants discussed many characteristics of the staff that they perceived to be positive, and which, in turn, limited the experience of stigma. These included being friendly, knowledgeable, un-intrusive, and non-judgmental, especially in regards to providing counseling aimed at sexual practices, not sexual orientations. For Adam, it was the possession of in-depth STI knowledge in particular that led to an increased trust in the gay men's sexual health clinic and its staff. Lastly, the participants discussed positive aspects of the clinic atmosphere which were interpreted as contributing to this space being one of inclusion, including providing easy access to services, not emphasizing the reason for the clinic visit, providing assistance to new clients, and using paperwork that provided an outlet for clients to state what some described as embarrassing details. Overall, the gay men's sexual health clinic provided a place of inclusion for the participants in this study.

In addition, participants reported that during their interactions with health care workers, in particular those at the gay men's sexual health clinic, they felt like engaging in regular STI/HIV testing was a conventional practice due to the environment of normalization of sexual health and STI/HIV testing the clinic created. For example, Travis described how he felt like he had to apologize for being sexually active when he attended other clinics, and further noted how he normally becomes embarrassed when discussing his sexual health, but at the gay men's sexual health clinic, he felt as though discussing such issues was acceptable. Rupert also explained how a physician in a community health care setting made him feel comfortable when discussing sexual health matters by avoiding making him feel like "some weirdo" who was engaging in abnormal sexual practices. Therefore, the health care workers at the gay men's sexual health clinic were reinforcing their roles as 'wise individuals' by making the participants feel less stigmatized (Goffman, 1963).

Based on the results of this research, in providing gay men with a clinic specifically for gay men, the participants described experiences wherein they interacted with health care workers who Goffman (1963) would describe as 'wise'. 'Wise' individuals are non-stigmatized people who, due to their position in life, are sympathetic to the plight of stigmatized persons and are accepted by them (Goffman, 1963). Goffman (1963) explained how specifically, nurses are expected to be such 'wise' individuals because they have experience and training working with patients with a particular stigma who make patients feel less stigmatized than they would if they were surrounded by persons who are not 'wise'. In this research, health care workers, particularly nurses, were considered by the participants to be what Goffman (1963) described as 'wise' individuals. Indeed, the participants overwhelmingly stated that they trusted nurses and felt accepted by them, treated fairly by them, and were comfortable around them. Overall, the participants reported that most of their interactions with nurses and other health care workers were stigma free, thus enforcing their role as 'wise' individuals.

In conclusion, the common theme from this research is that stigma is a unique emotional response related to a negative experience; the experience of it is interpreted and internalized differently by each participant. For example, it may have been interpreted as judgment, shame, embarrassment, belittlement, or a different feeling altogether. Moreover, stigma, was interpreted as being based solely on perception or interpretation. The individual perceived stigma regardless of the intent of the health care worker. This finding places the health care worker in an interesting situation. Even though the health care workers influence patients' experiences of stigma, if stigma is indeed a perception, then the actions of the health care worker, in some situations, mean little. In many cases, it does not greatly matter

how health care workers behave, but how those behaviours are perceived and interpreted by patients, and whether or not patients perceive the health care worker as ‘wise’. Therefore, the experience of stigma and stigmatization is not simply based on health professionals’ intentions and actions, but, more appropriately, it relates to patients’ perceptions—both before and after the fact—of the interactions they have had with health care workers (O’Byrne & Watts, in press). In conclusion, stigma is the perception of one individual that another person is judging them. Therefore, to summarize succinctly, if an individual thinks that a health care worker will stigmatize them, they already have; the feeling of stigmatization creates the reality of stigmatization, and this, in turn, induced protective behaviours, such as self-editing what the individual discloses to health care workers and attending the gay men’s sexual health clinic, which was perceived as a place of inclusion and barrier to stigmatization.

Discussion Point 2: The Deployment of Pastoral Power

As discussed above, the participants interviewed for this research had an overall positive attitude regarding accessing STI/HIV testing services at the gay men’s sexual health clinic. However, when the two concepts of risk and pastoral power (as defined in Chapter 2—Literature Review) were added to this examination of stigma within the therapeutic nurse-client relationship, a modified interpretation of these results emerged. These two concepts highlighted that the gay men’s sexual health clinic examined in this project can be considered a manifestation of bio-power.

To begin, one participant discussed how the very existence of the gay men’s sexual health clinic could be interpreted as gay men being treated as “special”:

I’d say I’m treated as a normal person, yes, you could argue that this being a gay clinic you know, you could go to the extreme of I’m being treated as “special” but I don’t get

that impression myself no (Nathan, P6: 273-282).

According to Goffman (1963), stigma materializes when individuals are set apart from their peers because they possess a particular trait. In this case, the participant described how the gay men's sexual health clinic could be viewed as providing 'special' services to a 'special' population; i.e., to gay men. In addition to providing 'special' services, providing a clinic especially for gay men has another visible side effect: the segregation of gay men from the rest of the population. Therefore, although the gay men's sexual health clinic provided sexual health care to the gay community, the fact that gay men were set apart from their peers and provided with a specific clinic may be interpreted as stigmatizing.

To explain further how this clinic can be considered as a manifestation of bio-power, one must remember that Foucault's concept of pastoral power has two main underpinnings. First, it relies on people choosing to seek assistance from individuals who are deemed to have the authority and expertise to help, and, second, this concept indicates that the help provided by the foregoing authority figures enables persons who seek assistance to obtain, or at least move toward, some form of salvation (Foucault 2007a; 2007b). Based on their desires for positive health outcomes for each individual patient, nurses 'direct the conscience' of individuals when care is sought, such as, when the participants attended the gay men's sexual health clinic. Specifically, in this research such "direction of the conscience" was evident in the participants' descriptions about situations when nurses and other health care workers encouraged them to engage in, or not engage in, certain behaviours, such as using condoms to avoid STIs/HIV, to achieve an outcome that the nurses believed to be desirable: that is, optimal health, which is the modern-day form of salvation.

In the current context, therefore, visiting sexual health nurses for STI/HIV testing and treatment is the first step in the pastoral power sequence. Nurses have the training, expertise, and skill to undertake such testing, and to provide counselling about treatments, and so forth. Furthermore, the participants reported that they accessed services from nurses for these very reasons. For example, Marlin stated that he accessed the gay men's sexual health clinic because the staff there had more STI knowledge than his family physician.

However, stigma, even if experienced in anticipation, undermines such service usage in some cases, and, consequently, undermines pastoral power (Cunningham, Kerrigan, Jennings & Ellen, 2009; Cunningham, Tschann, Gurvey, Fortenberry & Ellen, 2002; Lichtenstein, 2003; Malta et al., 2007; Mann, 1989). Pastoral power has no effect if no one submits to its process. For example, when participants withheld pertinent information from health care workers as a protective barrier because they feared stigmatization, they did not fully submit themselves to the process of pastoral power; they anticipated stigma and proactively, behaved accordingly. Therefore, when the aforementioned results are examined from a bio-power perspective, it is possible to state that stigma must be reduced—through the construction of such gay men's sexual health clinics—for pastoral power to function.

In the context of pastoral power and its second attribute, i.e., salvation, this concept relates to diminishing the risk of STI/HIV acquisition and transmission. In other words, salvation, herein, relates to the optimization and maintenance of health by means of STI/HIV avoidance. Based on the data collected in this project, the idea of risk, and the methods by which the *risks* associated with STIs/HIV can be reduced, were evident throughout the data collection setting; e.g., the presence of persons from a local AIDS service organization, free condoms, pamphlets regarding STI/HIV prevention, and rapid and accessible STI/HIV

testing and treatment services. Considering that risk is considered a product of the cultural and social context in which it exists, and a practice is deemed risky by the culture in which it exists (O'Byrne, 2008), therefore, although the gay men's sexual health clinic decreases the risk of STI/HIV acquisition and transmission by promotion safer sex practices, it also propagates the very risk it aims to reduce by promoting a mainstream cultural association between STI/HIV risk and homosexuality. In other words, the gay men's sexual health clinic created an environment, by the aforementioned presence of STI/HIV risk reduction materials, where STI/HIV testing was a regular occurrence. Indeed, the participants noted how the clinic environment and staff created a setting in which STI/HIV testing was normal. However, the participants also discussed how health care workers associating gay men with HIV to be stigmatizing, but this clinic appears to do just that by placing an emphasis on HIV testing for gay men. Therefore, the clinic is the source of risk as well as the solution (Beck, 1992).

In this way, the decreasing stigma, while still focusing on risk, exemplifies the circular process inherent in pastoral power: (1) ensure that people access services, i.e., submit to pastoral power, and (2) then focus the pastoral exchanges on enhancing salvation, i.e., focus clinical work on decreasing STI/HIV acquisition and transmission. In other words, encouraging patients to engage in regular STI/HIV testing not only promotes health, i.e., salvation, due to its ability to facilitate early STI/HIV detection, rapid access to drug therapies, and thereby diminish secondary opportunistic infections, complications, and progression to AIDS (Fisher, 2008; Rodriguez et al., 2006), but also regular STI/HIV testing continues the circular process of pastoral power by encouraging individuals to continually report to nurses for such testing and examination. Based on the results of this research, the

latter sequence appears to be working because these participants continually reported to the gay men's sexual health clinic for STI/HIV testing.

In summary, therefore, when examined through the lens of pastoral power and risk, the gay men's sexual health clinic can be viewed as a manifestation of bio-power. However, the presence of bio-power should not diminish the many aforementioned positive aspects of this clinic, but serve as an alternative view and nuanced understanding of this health care provision.

Discussion Point 3: The Paradox of the Gay Men's Sexual Health Clinic

Upon initial examination, the gay men's sexual health clinic is seen as a haven for the participants in this study. Indeed, they reported good experiences seeking STI/HIV testing services at this location, felt comfortable attending, and had few negative experiences of stigma. Therefore, the gay men's sexual health clinic may, in fact, increase STI/HIV testing among this specific population, which epidemiological data has demonstrated as being susceptible to HIV acquisition (PHAC, 2010a; PHAC, 2010b; Remis, Swantee & Liu, 2010; UNAIDS, 2010) by decreasing their experiences of stigma, which the literature has shown to decrease such testing (Cunningham, Kerrigan, Jennings & Ellen, 2009; Cunningham, Tschann, Gurvey, Fortenberry & Ellen, 2002; Lichtenstein, 2003; Malta et al., 2007; Mann, 1989).

However, the participants in this study discussed, at length, the stigmatizing effect when health care workers made automatic linkages between HIV and gay men. For example, Aaron discussed how he perceived health care workers to place an increased focus on HIV prevention in gay men because a nurse emphasized his probability of contracting HIV before testing a blood sample for STIs/HIV, while Rupert explained how informing his family

physician of his sexuality resulted in an increased emphasis on sexual health. In addition, Rupert described how health care workers linked gay men, promiscuity, and HIV before inquiring if he was sexually active. Overall, the participants described a negative emotional reaction, i.e., experiences of stigmatization, when they perceived that health care workers made assumptions regarding HIV and their sexual identity.

Herein lies the paradox: The participants disliked when health care workers emphasized HIV due to their sexual identity. However, the very existence of the gay men's sexual health clinic appears to do just this. The clinic provides an entire space dedicated to STI/HIV testing specifically for gay men therefore propagating the link between HIV and gay men. Despite reinforcing this link, the participants in this study did not perceive the clinic itself as stigmatizing, further confirming the work of Goffman (1963), who put forth that stigma is independent of location.

Overall, the participants viewed their experiences at the gay men's sexual health clinic as positive and stigma-free, while routinely perceived stigma at many other locations, such as general population sexual health clinics, general health centres, physician offices, and hospitals. However, it seems statistically unlikely that all gay men had exclusively good experiences at the gay men's sexual health clinic, and exclusively bad experiences, i.e., feelings of stigmatization, at all other health care access points. This limitation will be discussed next.

Limitations

The major limitation in this research stems from the participants themselves. Everyone who was interviewed for this study spoke well of the gay men's sexual health clinic, and had a positive attitude towards it. Therefore, this research is missing the voice of dissent. In other

words, individuals who had bad experiences at this clinic, or had negative experiences and chose not to return, are not captured in this sample. Therefore, additional research is needed to capture the opinion of these dissenting individuals.

In addition, the interviewer, and in this case the researcher, created the situation through the designing of the research project and the initiation of the interview process. As soon as an interview occurred, the feelings, beliefs, and subjectivities of the interviewer and the interviewee, based on their own individual subjective realities, combined to construct the data (O'Byrne, 2008). However, critical theory, in which this research was situated, accepts that each individual creates reality, based on their own personal, historically constructed, experiences (Lincoln & Guba, 2003). However, to increase the rigor of this research, reflexive journalling was used to acknowledge the researcher's perspective.

In addition, the thesis supervisor, Dr. Patrick O'Byrne, is an employee at the gay men's sexual health clinic in which interviewees were recruited and interviews conducted. Therefore, the possibility existed that he would know some of the participants. Therefore, the interviews were conducted on the opposite side of the clinic (see figure 1) so he would not see/hear the interview participants. He did not view the signed consent forms ensuring participant anonymity.

It is of importance to note that member checking was not utilized in this project for several reasons. First of all, to perform member checks, the participants would have been required to give the researcher their phone number/email, which would have reduced their anonymity. Also, as each participant possesses their own subjective reality, asking if another individuals' subjective reality is, in fact, true for them was a violation of this research lens.

Lastly, to increase the transferability of this research, ample direct quotes and a

detailed description of the participants and research setting were provided. However, it is important to acknowledge that these results are unique to the specific participants of this study, and therefore cannot be generalizable to the gay population as a whole. However, within critical theory, individual realities, such as the realities that these participants shared in the data collection process are accepted. Therefore, this was not considered a limitation for this study.

Recommendations

Notwithstanding the foregoing limitations, several recommendations and future directions emerged from these results. The points raised below, particularly those in relation to clinical practice and education, provide suggestions on how stigma may be reduced in practice with this population. However, it is important to note that stigma was interpreted as a perception in this research regardless of the actions of the health care worker. Therefore, these suggestions may or may not reduce the unique feeling of being stigmatized with this specific population. The following is a series of recommendations for administration, research, clinical practice, and education stemming from this research.

Firstly, before specific recommendations are discussed, a broad recommendation is required. This gay men's sexual health clinic, although generally viewed as positive by these participants despite perpetuating the link between HIV and gay men, does nothing to change the homophobia present in broader society that necessitated the clinics' very existence. Therefore, further interventions are required for nurses and other health care workers to help change these general societal opinions.

Administration

Throughout the data collection process, the participants continually described the

positive experiences they had when coming to the gay men's sexual health clinic. One participant discussed how the form that he filled out upon entering the clinic helped create this positive experience. He talked about how this form provided an outlet to state embarrassing details about why he was visiting the clinic, such as last sexual contact with a man and number of sexual contacts in the last x number of months, so he did not have to voice them when he saw the nurse. This eased his discomfort and embarrassment while attending the clinic. Using the gay men's sexual health clinic form as a template, other walk-in clinics could provide gay male youth with a more positive experience by providing this written outlet.

In addition, another participant described how the presence of a greeter at the front door of the clinic was very helpful and increased their comfort with attending the clinic, especially if it was their first time. Another participant discussed how services at the gay men's sexual health clinic were trouble-free; unlike another clinic he had attended, no one questioned his right to have the STI test at the gay men's sexual health clinic. Overall, providing trouble-free services, and a greeter at the front door, increased the comfort these two participants experienced when utilizing this clinic, and could increase the comfort of gay male youth at other clinics, such as general walk-in clinics or sexual health clinics.

Research

This study, although rigorous in its approach, was completed with a small number of participants recruited from a single clinic. Within critical theory, this is not a limitation, because individual subjective realities are accepted. However, in order to increase the transferability of this research to other settings, a larger study should be completed to confirm these findings in multiple settings, such as tertiary care, multiple cities, and different

types of clinics.

This study only examined the experiences of gay male youth within the therapeutic relationship. However, the therapeutic relationship does not only involve the patient, but the nurse/health care workers as well (McKlindon & Barnsteiner, 1999). Therefore, it is important to discuss these findings with the nurses/health care workers who interact with gay male youth in their practice, and gather their perception on their interactions with this population. For instance, in early phases of data analysis of this research, multiple types of stigma were identified (see Appendix E). However, without also interviewing nurses, it could not be identified if the stigma present was indeed accidental or intended. Therefore, it would be of particular importance to examine nurses' perceptions of their feelings towards gay male youth. Previous studies on nurses attitudes towards those living with HIV/AIDS found that stigma against this population was actually an extension of stigma against homosexuals, intravenous drug users (Surlis & Hyde, 2001), or fear of 'catching' HIV (Brown, Trujillo & Macintyre, 2003). Since these studies are more than ten years old, new research is needed to determine if the current stigma experienced by the participants in this study is still stemming from a place of fear or judgments on the part of the health care worker.

Clinical Practice

Fear of stigmatization was a type of stigma that the participants experienced before they entered into an interaction with health care workers. It was based on the assumption they would be stigmatized. In clinical practice, a patient should never enter into a health care environment where they expect to be stigmatized. Evidently, if a patient was never stigmatized in a health care setting, then they would never experience the fear of

stigmatization because their previous experiences, i.e., historically constructed realities, would never lead to this expectation. However, if this expectation does exist, then clinicians must examine how they could make the patient feel comfortable within the health care environment.

The participants provided many characteristics of staff that made them feel comfortable at the gay men's sexual health clinic, such being friendly, knowledgeable, un-intrusive, and non-judgmental. This comfort led them to trust the staff at the clinic. However, the participants also described instances where they did not feel comfortable within a health care environment, particularly when they had to 'come out' to health care workers in settings that were not specifically orientated towards gay men. In these situations, the participants described feeling stigmatized due to the health care worker 'reacting' to their sexual identity. This 'reaction', which was described as non-verbal by one participant, could be diminished by maintaining a neutral expression, which was labeled as a positive communication technique by the participants.

The stigma felt by the participants from health care workers that was interpreted as perceived could be eliminated from the therapeutic relationship by the health care worker simply become aware that these activities were considered stigmatizing by this population. For example, the participants described feeling stigmatized when too much emphasis was placed on a negative outcome, such as contracting HIV. However, emphasizing hope and using constructive criticism were found to be protecting factors against stigma.

In addition, the participants described experiencing stigma when emphasis was placed on contracting HIV/STIs. One participant even described how this emphasis was placed before his sexual health history was taken. Therefore, he felt the stigma as a judgment of his

sexual identity, not his sexual activity. The participants universally described the importance of being non-judgmental; however, judgment was clearly felt when this risk was emphasized. The concept of risk itself is a subjective term that is the product of the cultural and social environment in which it exists (O'Byrne, 2008). Therefore, by emphasizing the risk for HIV, the nurse/health care worker was declaring HIV risky. By placing the emphasis on this risk before the health history is taken, the nursing was indicating that being gay is risky, and therefore placing homosexuality under the political and cultural umbrella of risk. This is stigmatizing indeed.

Overall, clinicians need to be aware that the activities that they engage in to provide care, such as safer sex teaching or emphasizing risk factors, might be perceived as stigmatizing within this population. In order to combat this stigma, nurses need to utilize therapeutic communication techniques, remain neutral, possess up-to-date knowledge of gay health issues, including STIs/HIV, and be as non-judgmental and un-intrusive as possible when working with gay male youth.

Education

The importance of disseminating the results of this study into the nursing curriculum cannot be overemphasized. In this study, the participants described both positive and negative experiences that they had with both health care workers and health care environments. By incorporating the points emphasized by the participants, nursing students can begin to reflect about them in their own practice. Therefore, stigma within the therapeutic relationship may be avoided with this population due to adequate training of nursing students on this population.

One point emphasized by the participants was the importance of being knowledgeable,

particularly in regards to gay issues. This breath of knowledge is what enabled the participant to trust nurses. For example, one participant described how this knowledge combined with passion and caring, enabled him to trust nurses. Other participants described how the nursing code of ethics, such as confidentiality, enabled that trust to develop. In addition, another participant described the importance of having a university degree as the basis of trust. Nursing education already focuses on developing nursing knowledge, as well as teaching the importance of adhering to the code of ethics. However, adding content on gay issues, such as STIs/HIV and gay culture, could increase the trust in nurses with this population.

One point that the majority of the participants emphasized was the importance of treating gay individuals as normal, regular people, and treating HIV/STI testing as routine, normal practice. This is likely a challenging concept for health care workers who do not interact with gay individuals exclusively, as they do at the gay men's sexual health clinic. Nursing students should be taught the importance of remaining neutral when interacting with this population, and avoiding judgement no matter what the nurses' personal views. This is, in fact, consistent with the nursing code of ethics, which emphasizes treating all patients' in an ethical way.

The principles of therapeutic communication, a concept taught within the existing nursing curriculum, was also emphasized by the participants as important. Although not labelled as therapeutic communication, the principles, such as providing constructive criticism, using a two-way working relationship, maintaining a neutral expression, and only asking pertinent questions, were discussed extensively. These concepts are extensively taught and practiced within the nursing curriculum, but may not be taught in specific relation

to the gay population.

Finally, the participants discussed the importance of using distraction. Although initially this could be dismissed as a non-essential nursing skill, when re-examined in the context described by the participants, it can be seen as an essential component of nurse-patient interaction within this context and worthy of instruction within the nursing curriculum. The participants described distraction in the context of the rapid HIV test, where the participant must wait for two minutes to find out the results, which was described as a very stressful time. By distracting the participant during these two minutes, the nurse helps relax the patient, and reinforce that they are professional yet approachable, another positive characteristic mentioned by the participants.

Chapter Six-Conclusion

When examining stigma within the therapeutic relationship, this research aimed to provide the perspective of gay male youth who interact with health care workers/nurses, particularly at a gay men's sexual health clinic. By exploring the experiences of these youth from a critical theory perspective, this research provided new light to the interactions between health care workers and this unique population.

For instance, this study showed that stigma still exists in some interactions between nurses and gay male youth. The way in which stigma is perceived within an interaction is unique to the two individuals, the health care worker and patient, who are involved. The gay male youth who were interviewed perceived this stigma in many ways, such as judgement or embarrassment, and at different times, such as during the interaction or before it occurred. Interactions that were perceived as particularly stigmatizing when health care workers/nurses emphasized the specific probability of contracting HIV for gay men, as well as the link between promiscuity, HIV, and gay men. In addition, the participants reported more experiences of stigma when they had to 'come out' to a health care worker. However, no two participants described their experiences the same way. Therefore, stigma was considered a unique, individualized, internally constructed perception, which is consistent with the constructed and subjective ontological and epistemological underpinnings of critical theory in which this research is situated.

This study also demonstrated that these participants had overall positive experiences accessing health care, particularly within the context of the STI/HIV testing they received at the gay men's sexual health clinic where they perceived the staff as knowledgeable, un-intrusive, and friendly, and non-judgmental.

However, in a somewhat paradoxical fashion, therefore, the gay men's sexual health clinic, first, diminishes stigma and stigmatization, and, thereby, increases STI/HIV testing among a group of gay male youth who epidemiological surveillance data indicate are particularly affected by HIV, while, second, the very existence of such a clinic specifically for men who have sex with men simultaneously propagates the association between gay males and HIV that most of the participants stated they found stigmatizing in other clinical settings. This reinforces the idea that stigma is a personal experience that is independent of action and locale. Indeed, the association between homosexuality and STIs/HIV was reported as being stigmatizing in some situations, while the construction of an entire clinic on the premise that gay men require such testing was not considered stigmatizing.

These conclusions, by no means, however, indicate that such gay men's sexual health clinics should be closed. Individuals, who wish to access services, particularly if they have a heightened probability to exposure to health issues, should feel comfortable accessing such health clinics. One must, nevertheless, be mindful to fully analyze such clinical services, and acknowledge that while such service provision might be helpful on the one hand, it is, on the other hand, a method by which social rules can be enforced and maintained. It is, simultaneously, important to recognize the difference between offering services and imposing them. For the participants in this study, the gay men's sexual health clinic offered a comfortable, and stigma-free locale to undergo STI/HIV testing. It is important to remember that overall, their experiences at the clinic were perceived as positive. However, as noted in the above recommendations, the existence of these clinics does not change the homophobia present in society or other health care institutions. Therefore, their usefulness should be

questioned because while they exist, there is no incentive for the rest of the health care system to become spaces of inclusion for gay men.

In summary, in specific reference to those individuals interviewed for this study, the major findings of this thesis are:

1. Stigma is an internalized feeling that is unique to each individual (theme one)
2. Stigma may be felt as perceived or a fear of stigmatization (theme one)
3. The experience of stigma is a perception on the part of the individual (theme one)
4. The participants had a overall positive attitude towards the health care system in Canada and felt comfortable utilizing it, particularly the gay men's sexual health clinic (theme two)
5. Overall, the interactions between the interview participants and health care workers were perceived as positive and stigma-free (theme three)
6. Nurses were considered trustworthy by the participants (theme three)

Consequently, the findings of this exploratory study indicate that the participants overall, felt that they are being treated fairly and well by the health care system and health care workers/nurses. However, in therapeutic interactions where stigma does occur, it manifests as a negative perception within the individual who is experiencing it. Further research needs to explore if nurses/health care workers also feel this perception of stigma when they interact with members of this population.

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Appendix A: **Information Letters**

Title of Study: A grounded theory exploration of gay male youths' perceptions of stigma in the therapeutic relationship at gay/HIV clinics

Inclusion Criteria: In order to participate, you must be a male between the ages of 20 and 29, have had sexual contact with another male, and have had contact with nurses within the previous two years.

Exclusion Criteria: You may not participate if you are female, are HIV positive, or if you do not speak English.

Researcher:

Jessica Watts RN
Masters student
University of Ottawa
Faculty of Health Science
School of Nursing

Supervisor:

Patrick O'Byrne, RN, PhD
Assistant Professor
University of Ottawa
Faculty of Health Science
School of Nursing

Research Objectives: To explore stigma within the nurse-patient relationship from the perspective of gay male youth who attend STI clinics. In addition, this research will aim to explore the impact of stigma on the health-care seeking behaviours and attitudes towards the health-care system of gay male youth.

Contribution of Participants/Participation: Should you accept to participate in this research, you will need to allow a maximum of one hour to complete an interview. This interview will take place while you are waiting to be seen at the clinic and will take place in a private room. Alternately, you can choose to do the interview in a private office at the University of Ottawa at a different time. If this option is more convenient for you, please contact the researcher by email. Basic personal information (age, education, and income) will be collected so this research may be applied to other clinic settings. The interview

will be recorded in order to reduce error in data collection. At any time, you may withdraw from this research by requesting to stop the interview.

Anticipated Benefits to Research and Participation: By agreeing to take part in this research, you are promoting the improvement of knowledge in a part of nursing that is not well understood. This research aims to fill a



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infirmières

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Faculty of Health
Sciences
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gap in nursing knowledge by better understanding the behaviours from nurses that gay male youth find stigmatizing or offensive.

Risks Associated with Participation: The researcher is aware that discussing the topic of stigma in relation to sexual identity is intrusive in nature. As such, certain questions may bring on strong emotions. If you experience any strong emotions, the researcher will provide you with a list of counseling services and helplines available in Ottawa if you wish to speak with someone.

Confidentiality and Anonymity: The privacy (confidentiality and anonymity) of each participant will be respected in this research. All interviews will be conducted using a pseudonym (fake name) to prevent identification. There will be no identifying link between the consent forms and the data from each interview. Direct quotations will be used when this research is communicated to the public (presentations at conferences and scientific articles). However, pseudonyms will be used and there will be no identifying links between these quotes and the participants.

Conservation of Information and Communication of Research Results: The data from the interviews will be kept in a locked cabinet in the research supervisors office at the University of Ottawa for five years. The final stage of the research process will involve communicating the results of the research in the form of a scientific article or at a conference. By agreeing to participate in this research, you accept that the results that are obtained from analyzing the interviews will be used for scientific or teaching purposes. There will be no identifying information used at any time in this process.

Voluntary Participation: You do not have to participate in this research and are under no obligation to do so. If you do want to participate, you may withdraw at any time, or refuse to answer questions. If you wish to withdraw, all information gathered until you withdraw will not be used in the research and will be destroyed. There are no consequences if you choose not to participate or withdrawal from the study. Your care at the clinic will not be affected whether or not you choose to participate.

Compensation: Participants will be given a \$10 Tim Hortons gift certificate as a thank you for their time.

Additional Questions or Comments: The researcher is more than willing to answer any questions you may have about the research study. If you have any concerns regarding the ethical nature of this research, please feel free to contact the Protocol Officer for Ethics in Research at the University of Ottawa, Tabaret Hall, 550 Cumberland St., room 154, Ottawa, ON, K1N 6N5, 613.562.5387, ethics@uottawa.ca or the Secretariat at the Ottawa Public Health Research Ethics Board, 100 Constellation Crescent, 7th floor, Ottawa, ON, K2B 2J1, Oph.ethics@ottawa.ca, Tel: (613) 580-6477 ext. 16543, Fax: (613) 580-9601.

Lettre d'information

Titre de l'étude: une exploration de la théorie ancrée perceptions des jeunes hommes homosexuels » de la stigmatisation dans la relation thérapeutique au gay / VIH cliniques

Critères d'inclusion: Pour participer, vous devez être un homme, âgés de 20 et 29, ont eu un contact sexuel avec un autre mâle, et ont eu des contacts avec des infirmières dans les deux années perméables.

Critères d'exclusion: Vous ne pouvez pas participer si vous êtes une femme, sont positifs au VIH, ou si vous ne parlez pas anglais. S'il vous plaît noter que l'interview sera menée en anglais.

Chercheur:

Jessica Watts RN
étudiante à la maîtrise
Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

Superviseur:

Patrick O'Byrne, IA, Ph.D.
professeur adjoint
Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

Objectives de recherche: Pour explorer la stigmatisation au sein de la relation infirmière-patient du point de vue des jeunes hommes gais qui fréquentent les cliniques IST. En outre, cette recherche aura pour objectif d'explorer l'impact de la stigmatisation sur la santé cherchent comportements et les attitudes envers le système de soins de santé des jeunes hommes homosexuels.

Contribution des participants / participation: Si vous acceptez de participer à cette recherche, vous aurez besoin pour permettre à un maximum d'une heure pour compléter une entrevue. Cette entrevue aura lieu alors que vous êtes en attente d'être vus à la clinique et aura lieu dans une salle privée. Alternativement, vous pouvez choisir de faire l'entrevue dans un bureau privé à l'Université d'Ottawa à une époque différente. Si cette option est plus pratique pour vous, s'il vous plaît contacter le chercheur par email. Base de renseignements personnels (âge, éducation et revenu) seront collectées.

L'entrevue sera enregistrée afin de réduire les erreurs dans la collecte des données. A tout moment, vous pouvez retirer de cette recherche en demandant d'arrêter l'interview.

Avantages prévus à la recherche et Participation: En acceptant de prendre part à cette recherche, vous faites la promotion de l'amélioration des connaissances dans un cadre de soins infirmiers qui n'est pas bien comprise.



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infirmières

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Faculty of Health
Sciences

School of Nursing

613 562-5473
613 562-5443

451 Smyth
Ottawa ON K1H 8M5 Canada

www.uOttawa.ca

Cette recherche vise à combler une lacune dans les connaissances en soins infirmiers en mieux comprendre les comportements des infirmières que les jeunes gais jeunes hommes à trouver la stigmatisation ou offensant.

Risques liés à la participation: Le chercheur est conscient que d'aborder le sujet de la stigmatisation liée à l'identité sexuelle est intrusive dans la nature. En tant que tel, certaines questions peuvent porter sur des émotions fortes. Si vous rencontrez des émotions fortes, le chercheur va vous fournir une liste des services de conseil et services d'assistance téléphonique disponible à Ottawa si vous désirez parler à quelqu'un.

Confidentialité et anonymat: La vie privée (confidentialité et l'anonymat) de chaque patient seront respectées dans cette recherche. Toutes les entrevues seront menées en utilisant un pseudonyme (faux nom) pour empêcher l'identification. Il n'y aura pas de lien entre l'identification des formulaires de consentement et les données de chaque entrevue. Les citations directes sera utilisé lors de cette recherche est communiquée au public (présentations lors de conférences et d'articles scientifiques). Toutefois, les pseudonymes seront utilisés et il n'y aura pas d'identifier des liens entre ces citations et les participants.

Conservation de l'information et la communication des résultats de recherche: Les données des entrevues seront conservés dans une armoire verrouillée dans le bureau de recherche des superviseurs à l'Université d'Ottawa pendant cinq ans. L'étape finale du processus de recherche consistera à communiquer les résultats de la recherche sous la forme d'un article scientifique ou de conférence. En acceptant de participer à cette recherche, vous acceptez que les résultats qui sont obtenus à partir de l'analyse des entretiens seront utilisés à des fins scientifiques. Il n'y aura pas d'informations d'identification utilisées à tout moment dans ce processus

Participation volontaire: Vous n'avez pas à participer à cette recherche et ne sont pas tenus de le faire. Si vous ne voulez pas participer, vous pouvez retirer à tout moment, ou de refuser de répondre aux questions. Si vous souhaitez retirer, tous les renseignements recueillis jusqu'à ce que vous retirez ne seront pas utilisés dans la recherche et seront détruits. Il n'ya aucune conséquence si vous choisissez de ne pas participer ou de retrait de l'étude. Vos soins à la clinique ne sera pas affectée si vous choisissez d'y participer.

Rémunération: La participation sera remis un certificat de 10 \$ cadeaux Tim Hortons en guise de remerciement pour leur temps.

Autres questions ou commentaires: Le chercheur est plus que disposée à répondre à toutes questions que vous pourriez avoir sur l'étude de recherche. Si vous avez des préoccupations concernant le caractère éthique de cette recherche, s'il vous plaît n'hésitez pas à contacter le fonctionnaire du protocole pour l'éthique dans la recherche à l'Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, salle 154, Ottawa, ON, K1N 6N5, 613.562.5387, ethics@uottawa.ca, ou le secrétariat du comité d'éthique de la recherche de santé publique Ottawa, 100 croissant Constellation, 7ième étage, Ottawa, Ontario, K2B 2J1, Oph.ethics@ottawa.ca. Tel : (613) 580-6477 ext. 16543, Fax : (613) 580-9601

Appendix B:
Self-Administered Questionnaire

**A Grounded Theory Exploration of Gay
Male Youths' Perceptions of Stigma in the
Therapeutic Relationship at Gay/HIV
Clinics**

Self-Administered Questionnaire

**Jessica Watts RN
Masters student
University of Ottawa
Faculty of Health Science
School of Nursing
451 Smyth Rd.
Ottawa, ON
K1H 5E8**



1) What year were you born? _____

2) What is your sexual orientation?

- a) Heterosexual/straight
- b) Homosexual/gay
- c) Bisexual
- d) Unsure/other

3) What is highest level of diploma or degree you have attained?

- a) No Diploma
- b) High School Diploma
- c) College Diploma (general or professional)
- d) Bachelor Degree
- e) Master's Degree
- f) Doctoral Degree
- g) Other, please specify _____

5) What was your income last year? (before taxes)

- a) Less than \$10,000
- b) \$10,000 - \$19,000
- c) \$20,000 - \$29,000
- d) \$30,000 - \$39,000
- e) \$40,000 - \$49,000
- f) \$50,000 - \$59,000
- g) \$60,000 - \$69,000
- h) \$70,000 - \$79,000
- i) \$80,000 - \$89,000
- j) \$90,000 - \$99,000
- k) More than \$100,000

6) Ethnic origin:

- a) Caucasian
- b) African Canadian
- c) Latin
- d) Asian
- e) Aboriginal (First Nations, Inuit, Metis)
- ✕① Other, please specify _____

Appendix C: Consent Form

Title of Study: A grounded theory exploration of gay male youths' perceptions of stigma in the therapeutic relationship at gay/HIV clinics



Université d'Ottawa
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de la santé
École des sciences
infirmières
University of Ottawa
Faculty of Health
Sciences
School of Nursing

Researcher:

Jessica Watts RN
Masters student
University of Ottawa
Faculty of Health Science
School of Nursing

Supervisor:

Patrick O'Byrne, RN, PhD
Assistant Professor
University of Ottawa
Faculty of Health Science
School of Nursing

Invitation to Participate: You are invited to participate in the above research study conducted by Jessica Watts RN and supervised by Dr. Patrick O'Byrne.

Purpose of the Study: To explore stigma within the nurse-patient relationship from the perspective of gay male youth who attend STI clinics. In addition, this research will aim to explore the impact of stigma on the health-care seeking behaviours and attitudes towards the health-care system of gay male youth.

Contribution of Participants/Participation: Should you accept to participate in this research, you will need to allow a maximum of one hour to complete an interview. This interview will take place while you are waiting to be seen at the clinic and will take place in a private room. Alternately, arrangements can be made to do the interview at a different time at the University of Ottawa. Basic personal information (age, education, and income) will be collected so this research may be applied to other clinic settings. The interview will be recorded in order to reduce error in data collection. At any time, you may withdraw from this research by requesting to stop the interview.

Anticipated Benefits to Research and Participation: By agreeing to participate in this research, you are promoting the improvement of knowledge in a part of nursing that is not well understood. This research aims to fill a gap in nursing knowledge by better understanding the behaviours from nurses that gay male youth find stigmatizing or offensive.

Risks Associated with Participation: The researcher is aware that discussing the topic of stigma in relation to sexual identity is intrusive in nature. As such, certain questions may bring on strong emotions. If you experience any strong emotions, the researcher will provide you with a list of counseling services and helplines available in Ottawa if you wish to speak with someone.

Confidentiality and Anonymity: The privacy (confidentiality and anonymity) of each participant will be respected in this research. All interviews will be conducted using a pseudonym (fake name) to prevent identification. There will be no identifying link between the consent forms and the data from each interview. Direct quotations will be used when this research is communicated to the public (presentations at conferences and scientific articles). However, pseudonyms will be used and there will be no identifying links between these quotes and the participants.

Conservation of Information and Communication of Research Results: The data from the interviews will be kept in a locked cabinet in the research supervisors office at the University of Ottawa for five years. The final stage of the research process will involve communicating the results of the research in the form of a scientific article or at a conference. By agreeing to participate in this research, you accept that the results that are obtained from analyzing the interviews will be used for scientific or teaching purposes. There will be no identifying information used at any time in this process.

Voluntary Participation: You do not have to participate in this research and are under no obligation to do so. If you do want to participate, you may withdraw at any time, or refuse to answer questions. If you wish to withdraw, all information gathered until you withdraw will not be used in the research and will be destroyed. There are no consequences if you choose not to participate or withdrawal from the study. Your care at the clinic will not be affected whether or not you choose to participate.

Compensation: Participants will be given a \$10 Tim Hortons gift certificate as a thank you for their time.

Acceptance: I, _____, agree to participate in the above research study conducted by Jessica Watts, RN, and supervised by Dr. Patrick O'Byrne from the University of Ottawa, Faculty of Health Science, School of Nursing.

Additional Questions or Comments: The researcher is more than willing to answer any questions you may have about the research study. If you have any concerns regarding the ethical nature of this research, please feel free to contact the Protocol Officer for Ethics in Research at the University of Ottawa, Tabaret Hall, 550 Cumberland St., room 154, Ottawa, ON, K1N 6N5, 613.562.5387, ethics@uottawa.ca or the Secretariat at the Ottawa Public Health Research Ethics Board, 100 Constellation Crescent, 7th floor, Ottawa, ON, K2B 2J1, Oph.ethics@ottawa.ca, Tel: (613) 580-6477 ext 16543, Fax: (613) 580-9601.

This study has been explained to me. I have read and understood this consent form, and I have no additional questions. There are two copies of this form, one of which is mine to keep.

Participants signature:

Date:

Researchers signature:

Date:

Appendix D: **Interview Guide**



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Before the interview:

- sign consent and go over info sheet, ask if they have any questions, choose pseudonym
- verbal assurance that all information will be kept confidential and that the interview will be recorded to ensure accuracy and to enhance the quality of the data
- inform participant that I will challenge them, play devil's advocate, in order to make sure I fully understand
- when I start the recording, state interview #, date, pseudonym

1. Why did you choose to participate in this research?
2. What kind of contact have you had with the health care system in the past two years (clinic, hospital, etc.). Why did you seek services?
3. Did you have any health concerns that you did not seek care for? Why?
4. How do you feel about the nurses and other health care workers you have come into contact with? Do you feel comfortable discussing sexual health topics with them? Why or why not?
5. Do you feel that nurses or health care workers treat you in a respectful manner when discussing sexual issues? Why or why not?
6. How specifically do nurses behave when discussing sexual health issues with you?
7. How comfortable are you with these nurses? Do you feel accepted by them? Why or why not?
8. Do you trust nurses? Why or why not?
9. Do you feel that nurses treat you fairly? Why or why not?
10. How do you feel about the health care system as a whole?

Questions added after initial interviews:

11. Do nurses/health care workers give you constructive criticism or are they rude/mean to you?

12. How do nurses earn your trust?

13. Do you feel nurses/health care workers treat you like a normal person or an abnormal person? Why?

14. Do you feel embarrassed when you talk to nurses/health care workers about sexual health issues? Why?

15. Do nurses/health care workers put you down/make you feel bad for your sexual activities?

16. Can you tell me a bit about the first time you ever had to 'come out' to a nurse/health care worker.

Appendix E:
Data Analysis Step One

Theme	1	2	3	4	5	6	7	8
stigma exists about the Gay community	5-14 727-729	6-9		480-483				
stigma affects a lot of gay men	5-14			480-483				
People at GMSHC are friendly	33-34		151-153		78-79	55-65		323-335 579-583
People at GMSHC are professional but approachable	33-34 40-48 97-100		198-201 375-379			115-138		
People at GMSHC use distraction	40-42		186-192		455-477			323-335
People at GMSHC are trustworthy	40-48			450-466		169-171		180-192
People at GMSHC are knowledgeable	55-60 76-82		157-159 198-201	480-490	83-86 695-698		346-366	
People at GMSHC have the appropriate nursing skills	76-82							
Other HCW are professional	101-103	450-452	141-142					
Other HCW provide comfort, calming/give hope	101-103 228-248	43-46					89-95	424-427 487-520 579-605
stigma from mean, older, conservative doctor	104-113 179 “Grumpy old man”				155-184 201-228		226-291 311-317 567-570	
authoritarian	117-128				514-519			
disclosure leads to judgement which leads to shame	117-128		275-309 492-502					
constructive vs. destructive criticism	117-135	276-284	320-330	187-221	538-563	94-113		
Other HCW use	136-137		72-75		455-477			

distraction								
Distant nurse/HCW, no communication	138-155	197-206						334-337 356-415
Disclosure leads to grumpy/abrasive doctor which leads to feeling uncomfortable	183-189				155-184			
No communication leads to feeling like a machine	198-220						113-135	334-337 356-415
Other HCW are knowledgeable	228-248	42-46			567-573			529-536
Other HCW build trust	228-248						36-46	
HCW utilize a two-way working relationship with the patient	228-248	48-53			83-86 429-453		214-222 617-635	487-520
Break in trust by refusing services	248-263			157-185 187-221 231-243				80-97
No hassle for services at GMSHC	262-263						368-384	
Knowledge, passion, and caring, experience leads to trust	340-348 357-368 414-422		235-244 348-364	121-152 520-543 597-599	577-588	149-167 395-420	67-80 104-108 392-399 427-457 622-635	
Normalization by HCW/GMSHC	357-368 465-466		366-379	68-85 89-104 372-384 415-437 609-620	640-654	273-282 treated as 'special'	465-468	514-520 "didn't react" 604-610
Feeling judged and uncomfortable	426-438	142-150			155-184 269-321		165-212	128-148 302-309
Feel like no stigma from most HCW, overall good experiences	437-438 582-585	37-40	235-244 588-598	289-290				
embarrassed about	457-466			450-468 609-636		284-322		417-459

discussing sexual health issues								
Lack of normalization leads to embarrassment/stigma	461-470			450-468 609-636				256-276
Being unfamiliar with Gay lifestyle leads to embarrassment	472-494							
Lack of knowledge leads to embarrassment (have to explain more)	496-511			55-66				
Neutral expression equals no judgement	528-531		194-201					278-302
Feel need to not “flaunt your gay life”	551-565							
Treated “fairly and well” by the HC system	567-572	286-298	409-414	545-550	611-619	207-234	459-472	
Nurses/HCW seem stressed/overworked	600-607	240-243, 450-452 300-306			254-255	261-262		
Gay HCW/GMSHC normalize and are relatable	645-663 697-703			480-510	376-391		633-653	191-213
Relatability leads to trust	657-663 697-703	261-274						
Gay HCW have more knowledge of gay issues	657-663							
Education on gay issues is distancing/stigmatizing	671-673							556-572
HCW having gay friends equals normalization	677-685							
“it’s normal, that’s also our	742			480-483				

norm too that we get judged” (referring to stigma)								
Nurses who seem like a friend, makes jokes, are more relatable, comfortable	765-773	450-452	375-379		251-253			
Stigma from HIV non-disclosure laws		6-9						
Increase in HIV in youth		13-16						
HCW are doing their jobs	147-151	37-40						
HCW are caring		37-40					414-421	
Feel comfortable utilizing the HC system	282-291 457-470	65-76		287-296 739-742	235-238	25-35	155-163	
Diversity among HCW at GMSHC (straight and gay) is a positive thing		83-110						
comfortable talking about sex if relevant to care	379-412 549-565	112-122 440-448	262-273		393-400 656-659	45-53 284-294	305-317	
Nurses overall are gay culturally sensitive		131-133		514-518				
Emphasis on increased risk of HIV/illness for gay men equals stigma (promiscuity)		155-171 387-401	275-309	645-696				32-37 93-126** 221-229 466-470 540-554
Intense facial expression equals stigma		169-176						221-236
Nurse/HCW not aware of judging, judging through care		178-185					293-303	128-148
HCW at GMSHC seem		223-236	238-244			67-70		

to enjoy their jobs								
Nurses seen as regular people		248-251			571-578			
Feel accepted by nurses		253-259				145-158	401-410	
Feel nurses are trustworthy	638-663	261-269	272-273 391-407	38-46	580-586	169-171	427-457	
Comfortable talking about sex in general		379-385	568-580			45-53		
Lack of knowledge/exp experience leads to stigma		387-410					165-212 293-303	48-78 356-415
Nurse acting overly serious/emphasizing bleak outcome leads to stigma		412-438						591-610
Other HCW are friendly			72-75					529-536
People at GMSHC don't judge you			157-159		691-693	81-92	368-384	
Perceived stigma from going to gay clinic			176-178 535-562					
Not emphasizing why visiting clinic leads to comfort			213-214					529-536
fear of "coming out" to HCW			275-293					
"coming out" to HCW leads to emphasis on sexual activity which leads to feeling uncomfortable (perceived stigma)			275-309					205-225
perceived stigma from HCW leads to closed communication			451-465 473-485 507-508	68-85 89-96 289-325				238-245
Perceived lack of knowledge				109-134			272-281	93-148 256-263

equals perceived stigma								
written communication of embarrassing details equals comfort				324-368				
Comfort with clinic equals increased trust				372-395		338-343		
Nurses are desensitized				415-437	565-573			
Overall, society is becoming more gay friendly	727-729			573-575				
Nurses/HCW are unprofessional					105-107 269-321			
Clinic layout					98-128 bad 132-135 good			
embarrassment leads to decreased trust					269-321			
Perceiving female HCW as more caring leads to increased communication					358-372			
Using guilt/scare tactics leads to feeling judged which leads to decreased communication					486-512 517-536			
nurses teaching safer sex is belittling					538-563			
Nurses code of ethics (confidentiality/ professionalism) leads to increase in trust			262-273		590-611	169-205	75-87 547-562	
HCW ask only pertinent questions and are non-	657-663			38-46		72-79		

judgmental								
HCW empathize				372-395		81-92		
Trust nurses/HCW until given reason not to				287-296		169-191		
Support from gay friends make 'coming out' at clinic easier						329-371		
Trust nurses/HCW because lying is a waste of time			445-449				47-52	
"I don't care if you think I'm gay ... that won't make me either promiscuous or HIV positive"							286-291	
Preventative HC is important							493-504	
HCW embarrassed about discussing sexual health issues					155-184		528-551	308-317
Projecting uncomfortableness onto HCW				68-117			571-575 good quote	
comfortable "coming out"							577-606	
best clinic experiences at GMSHC	582-585 638-641							29-31 424-427
Nurses/HCW "try their best"	342-348							308-314
when not enough teaching is done, feel like being treated unfairly (leads to unnecessary worry)								342-354 356-415
perceived stigma leads to emotional				607-636				431-470

embarrassment								
emotional vs. physical embarrassment							622- 629	431-470 good quote

Most common complaints about the health care system: wait times, rushed staff, more emphasis on preventative care

Appendix F: **Reflexive Journal Context**

As part of the data collection process, a reflexive journal was kept before, during, and after the research process ended in order to increase the rigor of this study and include the researchers' perspective, as described above. Although a thorough journal was kept, noting the participants demeanor, non-verbal cues, researchers' perceptions/first impressions, and researchers' behaviour, only the points that were analyzed as being related to the data will be discussed here. First of all, the question proposed to the participants regarding their feelings on 'coming out' to health care workers was formulated only in later interviews, based on the results of early interview data. This is regretful as this particular question revealed many interview themes and was a very useful starting question to ask other more specific questions. Second, the researcher reflected in the journal before the interview process started that she felt that many nurses stigmatize without realizing it. This point materialized during the analysis stage of the study and was interpreted as perceived stigma. Thirdly, John was noted as being rather nervous during the interview process. He was perceived to be not as 'out' as the other participants. He had not told his family he was having sex with men and he wouldn't tell his family physician. Fourthly, following the initial interview, the researcher reflected that normalization, or making the sexual health interaction routine, would become an important point during the interview process, and indeed, it was a point mentioned by many participants. These points, in keeping with the critical theory paradigm and grounded theory lens, add context to the research by acknowledging the researchers' point-of-view.

Appendix G: **Community Resources**



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www.uOttawa.ca

Distress Centre of Ottawa and Region

Distress Line, 613-238-3311

Offers anonymous, confidential, 24-hr. service

English language service

Tel-Aide Outaouais

Offers anonymous, confidential, 24-hr. service 613-741-6433 or 1-800-567-9699

French language service

Gay, Lesbian, Bi, Trans Youth Line

<http://www.youthline.ca/> or call toll free 1-800-268-9688

confidential, free, and non-judgmental peer support and referrals

Carlington Community and Health Services

900 Merivale road

Ottawa, ON K1Z 5Z8

Phone: 613-722-4000

Offers health and social services including crisis intervention, information and referral, and employment services for all ages.

Centretown Community Resource Centre

420 Cooper street

Ottawa, ON K2P 2N6

Phone: 613-233-4443

Offers health services including a walk-in clinic, anonymous HIV testing, and addictions assessment and referral and social services including counseling, crisis support, and legal advice.

Eastern Ottawa Resource Centre

Beacon Hill Shopping Center

23339 Ogilvie road, 2nd Floor

Ottawa, ON K1J 8M6

Phone: 613-741-6025

E-mail: ita.mccabe@gccr.ca

Hours: 8:30 a.m. to 4:30 p.m. from Monday to Friday

This centre offers counseling, support, advocacy; crisis intervention; workshops and referrals as well as mental health programs and anti-violence programs. Legal services are available on a weekly basis.

Contact the centre for further details.

Hunt Club-Riverside Community Services Centre

3310 McCarthy road

Ottawa, ON K1V 9S1

Phone: 613-247-1600

Offers social services and youth programs.

Lowertown Community Resource Centre

41 Cobourg street

Ottawa, ON K1N 8Z6

Phone: 613-789-3930

Provides social services such as information and referral services, crisis intervention, and counseling.

Nepean, Rideau and Osgoode Community Resource Centre

1642 Merivale road, unit 54

Ottawa, ON K2G 4A1

Phone: 613-596-5626

E-mail: info@nrocr.org

Hours: 8:30 a.m. to 4:30 p.m. from Monday to Friday

This centre offers varied programs and activities for youth, including counseling services, homework help, legal services and youth centered activities and workshops. There is also assistance for young parents and housing information available.

Overbrook-Forbes Community Resource Centre

225 Donald street, unit 120

Ottawa, ON K1K 1N1

Phone: 613-745-0073

Offers social services such as counseling, and information and referral services, as well as youth programs to residents of North-East Ottawa.

Sandy Hill Community Health Centre

221 Nelson street

Ottawa, On K1N 8K7

Phone: 613-798-1500 or 613-789-6309 (social services)

E-mail: info@sandyhill.on.ca

Hours: 9 a.m. to 7:30 p.m. on Mondays and Wednesday; 9 a.m. to 4:30 p.m. on Tuesdays and Thursdays and 8:30 a.m. to 3:30 p.m. on Fridays

This centre offers a medical walk in clinic, social services, counseling as well as computer services and free internet access.

South-East Ottawa Centre for a Healthy Community

600-1355 Bank street

Ottawa, ON K1H 8K7

Phone: 613-737-5115 (General Reception) 613-239-4070 (24hrs)

E-mail: office@seoche.on.ca

Hours: 8:30 a.m. to 4:30 p.m., Mondays, Thursdays and Fridays; 8:30 a.m. to 8 p.m., Tuesdays and Wednesdays

Walk in Clinic: 1 to 4 p.m. from Monday to Friday

This centre offers counseling services, health services, and violence prevention programs. In addition, legal services, school support, some employment services and free internet access is also available.

Vanier Community Resource Centre

282 Dupuis street, 6th floor

Vanier, ON K1L 7H9

Phone: 613-744-2892

Offers social services such as counseling, information and referral services, and crisis intervention.

Western Ottawa Community Resource Centre

2 MacNeil court

Kanata, ON K2L 4H7

Phone: 613-591-3686

E-mail: info@communityresourcecentre.ca

Offers counseling and referral services, youth services, peer support programs as well as various workshops and activities

Adapted from Ottawa Public Health. (2011). *Youth zone: Self help*. Retrieved May, 28, 2011, from http://ottawa.ca/residents/yzj/help/self_help_en.html

Appendix H: **Ethics Approval**

File Number: h06-11-03

Date (mm/dd/yyyy): 09/16/2011



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice **Health Sciences and Science REB**

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Patrick	O'Byrne	Health Sciences / Nursing	Supervisor
Jessica	Watts	Health Sciences / Nursing	Student Researcher

File Number: H06-11-03

Type of Project: Master's Thesis

Title: The intersection of stigma and caring: A quantitative exploration of gay teens at risk for HIV and their perceptions of the impact of stigma on the therapeutic relationship

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
09/16/2011	09/15/2012	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

File Number: h06-11-03

Date (mm/dd/yyyy): 09/16/2011



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.

Signature: _____

Leslie-Anne Barber
 Protocol Officer for Ethics in Research
 For Daniel Lagarec, Chair of the Sciences and Health Sciences REB