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Social Representations of Sexual Orientation and Gender Identity Among Nurses in Portugal

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Abstract

Introduction A number of studies in different countries have highlighted discrimination of sexual and gender minorities in healthcare environments. Although Portugal has made considerable progress in the acquisition of rights for LGBT people, there are still gaps in the training of health professionals. Among these, nurses are at the forefront of many of the close interactions with patients. This article aims to ascertain the social representations of sexual orientation and gender identity among nurses in Portugal from a sociological perspective.

Methods A quantitative survey of Portuguese nurses was conducted in an online questionnaire. The data were collected between May and July 2020, and the participants were recruited through the Portuguese Nurses Association. The universe of the study consisted of 75,928 nurses, from which a sample of 899 was obtained.

Results The results showed that Portuguese nurses tended to have a positive social attitude towards non-normative sexual orientations and gender identities, which they perceived as a natural expression of human diversity. This attitude was stronger among the younger, politically left-leaning participants without a religion, and close to LGBT people. The vast majority recognized that they lacked adequate training in LGBT issues and a significant part expressed the need to bridge that gap, mainly with regard to gender identity.

Conclusions and Policy Implications This study provides insights into the insufficient inclusion of LGBT matters in nursing courses, and the need for ongoing, and specialized training. Knowledge and cultural competencies in the care of LGBT people should be guaranteed and made universal for nursing and other health professionals in order to reverse the reduction in their access to healthcare and ensure respect for the human right to health for LGBT people.

Keywords Nurses · Healthcare · Sexual orientation · Gender identity · Social representations · Social attitudes

Introduction

This article focuses on the social representations of sexual orientation and gender identity among nurses in Portugal. The discrimination and inequality experienced by sexual and gender minorities in healthcare environments have been highlighted by many studies across the globe (Cunha et al., 2017; Duffy, 2011; FRA, 2014; Gessner et al., 2020; ILGA Portugal, 2014; Lerner et al., 2021; Macedo, 2018; Moleiro & Pinto, 2009; Puckett et al., 2018; Rondahl et al., 2004).

In Portugal, a survey of the lesbian, gay, and bisexual population concluded that the vast majority of respondents had not revealed their sexual orientation in a healthcare setting and, even so, 17% reported discrimination in this environment (ILGA Portugal, 2014). Sixteen percent of trans people said they felt discriminated against in health services (FRA, 2014).

The effect of anticipating discrimination and of prior experiences of stigmatization in health services inhibits LGBT people (lesbian, gay, bisexual, and transgender) from revealing their sexual and gender identity (Frankowski & Clark, 2009; Rosati et al., 2021) or even from accessing the healthcare they need (Gessner et al., 2020; Lerner et al., 2021). For trans people in particular, the relation between experiencing discrimination and avoiding or delaying recourse to healthcare was found to be significant (Lee et al., 2022).

Furthermore, realizing that health professionals lack knowledge on LGBT issues (Puckett et al., 2018) and

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anticipating a confrontation with that lack of knowledge, and therefore having to inform and raise health professionals' awareness on these issues, contribute to keeping LGBT patients away (Lerner et al., 2021).

A growing body of research has demonstrated the need for sexual and gender minority-specific healthcare and specialized training for providers (Stromberg et al., 2021). In fact, the training of health professionals fails to address the needs of LGBT people (Baiocco et al., 2021; Macedo, 2018; Parameshwaran et al., 2017; Stotzer et al., 2013). Training in cultural competence has proved to be a suitable strategy for reducing the barriers in access to care encountered by LGBT people, while also improving the quality of the services provided to them (Hanssmann et al., 2008).

Among the different health professionals, nurses, due to the nature of their work, are responsible for a large part of the interactions with patients and are in close contact with them. Less favorable attitudes towards the LGBT population also apply to them. Dorsen (2012) conducted a literature review on nurses' attitudes towards LGBT patients, concluding that all the studies examined showed some evidence of negative attitudes. Such attitudes have implications for LGBT people's experiences with nursing services. Based on a review of 16 studies published in English language journals, Nhamo-Murire and Macleod (2018) found that several LGB participants had experienced exclusion and oppressive social norms in nursing healthcare.

Recent studies in different countries have shown a favorable evolution in these attitudes, although it is not common to all nursing professionals (Çakır et al., 2020; Della Pelle et al., 2018; Lin et al., 2019). A study on Italian nurses showed them to have a moderately positive attitude towards lesbian and gay patients (Della Pelle et al., 2018). A study in Turkey found that most of the nurses were not professionally homophobic, although their personal homophobia scores were high (Çakır et al., 2020). In Taiwan, research concluded that nurses' intention to care for gay and lesbian patients and knowledge regarding homosexuality significantly increased from 2005 to 2017 (Lin et al., 2019).

In Portugal, Brás (2008) and Cunha et al. (2017) found that nurses were not well trained in sexuality in general. As far as homosexuality was concerned, 49% of nursing students stated they had received no scientific training on the topic (Gato & Fontaine, 2012).

In addition to or as a consequence of the lack of training, 26% of health professionals displayed inadequate practices and homophobic behavior (Cunha et al., 2017). Nursing is based on cisheteronormativity and nurses express discomfort when having to care for LGB and trans and gender-diverse people (Dias, 2015). The same results were described by Moleiro and Pinto (2009), where nurses were perceived as potentially homophobic and prone to prejudice in their professional practice.

Studies regarding trans people in different countries also show the existence of prejudice and lack of information among nurses, which result in unequal, poorer healthcare (Paradiso & Lally, 2018; Puckett et al., 2018; Rotzinger, 2018).

LGBT Rights and Health in Portugal

Portugal has made considerable progress in the acquisition of rights for sexual and gender minorities, especially since the beginning of this century (Andrade & Saleiro, 2021; Cascais, 2006; Hines & Santos, 2018; Santos, 2013; Vale de Almeida, 2010). In 2010, it became the eighth country worldwide to approve same-sex marriage (Law no. 9/2010 of 31 May), and in 2018, the sixth to enact a law on the self-determination of gender identity and expression (Law no. 38/2018 of 7 August). This progress, particularly in terms of legislation, explains its third place in the Rainbow Europe Index 2021, a ranking of 49 countries organized by ILGA Europe, which reviews the legal framework and public policies for LGBT and intersex[1] people in these countries (ILGA Europe, 2021).

In this context of significant progress, the area of health has been one of the most resistant to change. A more detailed analysis of the Rainbow Index shows that a substantial part of the existing gaps in Portugal falls within this area. In the section "equality and non-discrimination," the only missing areas for sexual orientation and gender identity are "health" and "conversion therapy ban." A proposed ban on clinical practices aimed at changing sexual orientation or gender identity has only very recently been placed on the political agenda and has yet to be approved and implemented. Also, blood donation without discrimination on the grounds of sexual orientation and gender identity was only approved by the Portuguese Parliament in late 2021.

Regarding trans-specific healthcare, although self-determination of gender has been officially recognized for legal changes (name and reference to sex on identity cards), bodily self-determination is not yet a reality (Davy, 2011), since a mental health diagnosis is still required before accessing the body transformations that the individuals themselves want. Depathologization is therefore another of the missing areas in the Index. Article 11 of Law no. 38/2018 of 7 August establishes that the State must ensure that those who wish have access to referral services within the National Health System, and ordered the Directorate-General for Health to develop a model for the intervention of health professionals in the field of gender identity and

[1] Although nurses' representations of intersex people are not covered in this study, the acronym LGBTI is used in this article when referring to documents that also include them.

expression. As a follow-up to the law, a Health Strategy for LGBTI People was published for the first time in 2019 (DGS, 2019). The strategy recognizes the invisibility of this population in health planning and actions, avoidance by professionals, professionals' limited scientific and technical knowledge, and the fact that LGBTI people avoid contact with professionals due to previous adverse reactions to some of their identity characteristics. The strategy highlights an increase in mental health problems (depression, substance abuse, and suicide) among LGBTI people, the risk of violence based on homophobia and transphobia, and specific aspects of LGBTI healthcare (DGS, 2019: 7–10). It also outlines a strategy for promoting trans people's health, which includes a model of intervention, legal framework, professional training, involvement of civil society, and promotion of health literacy in LGBTI issues. Finally, it underlines the importance of training as a key element in developing best practices in the provision of care to LGBTI people.

According to the strategy paper, responsibility for training in the health of LGBTI people falls first and foremost on schools of medicine, nursing, health psychology, and others in the field of health sciences (DGS, 2019: 20). The paper anticipates "the development of a training plan that simultaneously covers the training of professionals, who become a special reference in these fields at each health institution, and gradual capacity building of as many professionals as possible (medicine, nursing, and psychology, among others) to receive and assist LGBTI people." It also said, "training should be based on the standards to be produced" (DGS, 2019: 21). However, these standards have not yet been drafted and the training of professionals, including nursing staff, continues to be an identified gap. So far, sexuality and gender in the curricula of Portuguese nursing courses have been included in the training on women's health, which is limited to reproductive health and therefore leaves out non-reproductive, non-normative sexualities and gender identities as a whole (Gomes, 2020).

The Present Study

Evidence on the experience of sexual and gender minorities in healthcare environments and the landscape of LGBT rights in Portugal, particularly in the field of health, make it possible to frame the context in which interactions between nurses and LGBT people unfold. With this starting point in mind, the purpose of the study was to ascertain the social representations of sexual orientation and gender identity among nurses in Portugal from a sociological perspective, to identify training levels and needs in terms of sexual orientation and gender identity, as reported by nurses; and to hear the self-perceptions of nurses on their own competencies in the care of LGBT people.

Methods

Procedures

In order to meet the study objectives, a questionnaire was used for a quantitative research survey of Portuguese nurses. The questionnaire was specifically designed for this study, based on existing research literature and new indicators developed by the authors. The questionnaire was pre-tested on a panel of 24 registered nurses in March 2020. The nurses were asked to assess whether the items were understandable and clear. In general, they expressed overall agreement with the questionnaire's content and clarity and only a few adjustments were made, particularly in the terminology.

The study was approved by the Ethics Committee of Iscte-University Institute of Lisbon. Participants were recruited and data were collected in an online survey on the Qualtrics platform between May and July 2020. Respondents were recruited through a link to the survey in the newsletter of the Portuguese Nurses Association (Ordem dos Enfermeiros), which is the body responsible for issuing professional nursing licenses in Portugal. Participation was voluntary. All participants were informed of the study objectives, were guaranteed anonymity, and gave their consent at the beginning of the online survey, which was a requirement for completing the questionnaire.

Sample and Setting

The study universe consists of 75,928 nurses with a professional license issued by the Portuguese Nurses Association and active registration in Portugal, out of which 62,438 (82%) are women and 13,490 (18%) are men (Ordem dos Enfermeiros, 2020). A non-probability sample of 899 valid responses was obtained.

Measures

The questionnaire was designed to address three dimensions: (i) attitudes towards gender and sexual diversity, (ii) knowledge and academic training in gender and sexual diversity, and (iii) competencies in gender and sexual diversity (Table 1). Sociodemographic data were also collected (Table 2).

Data Analysis

Indicators for the first dimension—attitudes towards gender and sexual diversity—were measured in a question with a set of eleven statements on gender and sexual diversity. The

Table 1 Dimensions and indicators

Concept	Dimensions	Indicators
Social representations of nurses on gender and sexual diversity	Attitudes on gender and sexual diversity	Sexual relations between two men being wrong
		Sexual relations between two women being wrong
		Sexual relations with both men and women being wrong
		Identifying with a gender different from the one assigned at birth being wrong
		Male homosexuality as a "natural" sexual orientation
		Female homosexuality as a "natural" sexual orientation
		Bisexuality as a "natural" sexual orientation
		Trans as a "natural" gender identity
		LGBT discrimination in healthcare environments
		Sexual orientation and "conversion therapy"
		Gender identity and "conversion therapy"
	Knowledge and academic training on gender and sexual diversity	Perceptions of adequacy of the training about sexual orientation
		Perceptions of adequacy of the training about gender identity
		Training needs about sexual orientation
		Training needs about gender identity
	Cultural competencies on gender and sexual diversity	Professional contact with lesbians and gays
		Professional contact with bisexual people
		Professional contact with trans people
		Preference not to care for LGBT people
		Refusal to care for LGBT people
		Self-assessment of competencies to care for LGBT people
		Nurse colleagues' competencies to care for LGB people
		Nurse colleagues' competencies to care for trans people

participants were asked to indicate their agreement with each statement on a 4-point Likert scale. A principal component analysis (PCA) with oblique rotation (direct oblimin) was conducted in order to reduce dimensionality and increase the interpretability of the data by providing an understanding of the attitudes and representations underlying each statement. Keiser-Meyer-Olkin checked the adequacy of the sampling for the analysis (KMO = 0.81, above the commonly recommended 0.6) and Bartlett's test of sphericity was significant ($X^2(45) = 4237.040$; $p < 0.05$), thereby confirming the suitability of the analysis.

Initial eigenvalues indicated that two factors met Kaiser's criterion of 1 and explained 56.18% of the variance. The scree plot showed inflections retaining three or four factors. Solutions for three and four factors were examined and, in the end, a three-factor solution was adopted, which explains 70% of the total variance. The decision was based on the theoretical and analytical consistency of the three-factor solution. The item "LGBT discrimination in healthcare environments" was eliminated, as it did not contribute to a simple factor structure.

The final solution suggests that attitudes towards gender and sexual diversity are based on three factors. Composite scores were generated based on the mean of the items with the highest loadings in each factor. The scale for each item was inverted to facilitate interpretation, and, as a result, the scores ranged from 1 to 4, with 4 being the highest level of agreement. Cronbach's alpha was used to examine internal consistency, which showed good reliability in all scores (factor 1 $\alpha = 0.893$; factor 2 $\alpha = 0.924$; factor 3 $\alpha = 0.769$).

The indicators included in the second dimension—knowledge and academic training in gender and sexual diversity—were measured in two groups of indicators. The first concerned perceptions of the adequacy of training received at nursing school. The participants were asked if they felt they had received adequate training on (a)

Table 2 Sociodemographic characteristics

	N	%
Gender		
Female	688	80.8
Male	163	19.2
Age		
20–29	168	19.7
30–39	332	39.0
40–49	183	21.5
50–67	168	19.7
Religiousness		
Religious	644	75.7
Non-religious	207	24.3
Political stance		
Left	328	40.8
Center	306	38.1
Right	169	21.0
Sexual orientation		
Heterosexual	717	85.5
Straight woman	634	74.4
Straight man	83	9.7
LGB	122	14.5
Gay	66	7.8
Lesbian	25	2.9
Bisexual woman	21	2.5
Bisexual man	4	0.5
Other	5	0.6
Prefers not to answer	13	1.5
Closeness to LGB people		
Yes	672	80.2
No	166	19.8
Closeness to trans people		
Yes	82	9.8
No	756	90.2

homosexuality and bisexuality and (b) gender identity and trans/transsexuality in yes or no questions. The second was related to the need for further professional training on these matters. The participants were asked to identify these needs in their present jobs—regarding (a) sexual orientation and (b) gender identity—in yes or no questions.

The indicators included in the third dimension—cultural competencies in gender and sexual diversity—were measured in three groups of questions. The first, on professional contacts with LGBT individuals, asked the participants whether they had cared for (a) homosexual people, (b) bisexual people, and (c) trans people in their work, with yes or no answers. A composite score was generated from the count of each positive answer in order to access the global levels of experience with LGBT patients and test for variation. The score ranged from 0 to 3, where 3 meant nursing experience with all of the three subgroups. Cronbach's alpha was used to assess internal consistency and showed moderate reliability (score for nursing experience $\alpha = 0.599$).

In the second group of questions, the participants were asked to indicate their agreement, on a 4-point Likert scale, with two statements on (a) their possible preference for not caring for LGBT patients and (b) their possible preference for refusing to care for LGBT patients. A composite score was generated based on the means of these items in order to shed light on the different layers of agreement and disagreement with a possible refusal of care. Cronbach's alpha was used to assess internal consistency and showed good reliability (score for refusal of care $\alpha = 0.759$).

Finally, in a self-assessment of their competencies, the participants were asked to indicate their agreement, on a 4-point Likert scale, with a statement on their competencies to care for LGBT people. They were also asked to self-assess their competencies in providing nursing care to (a) homosexual and bisexual patients and (b) trans patients, compared to their peers, with possible answers "Higher/The same/Lower than most nurses I work with."

A bivariate analysis was conducted for variation according to the main independent variables of the study (gender, age, sexual orientation, religion, political leaning, closeness to LGB and trans people), running *t*-tests of mean differences, one-way ANOVA, and chi-square tests of independence. Results were significant at 0.05.

The data were analyzed with SPSS (Statistical Package for Social Sciences, IBM SPSS Statistics version 24.0).

Results

The sample followed the same distribution as the universe of practicing nurses in Portugal, both in terms of gender—with a strong predominance of women—and age—with more than half up to 40 years old. Similar to Portuguese society as a whole, the population was mainly catholic (Teixeira, 2019) and politically positioned towards the center and left (Heyne & Lobo, 2021). The total population of the sample was predominantly heterosexual (84.1%), although the number of LGB participants was considerable (14.3%). The male population, in particular, was balanced between heterosexual and homosexual orientation. No participant identified with a gender "other" than male or female. Where closeness to LGBT people was concerned, the vast majority had LGB friends or family members (80%), although only approximately 10% had trans family or friends. Table 2 shows the main characteristics of the sample.

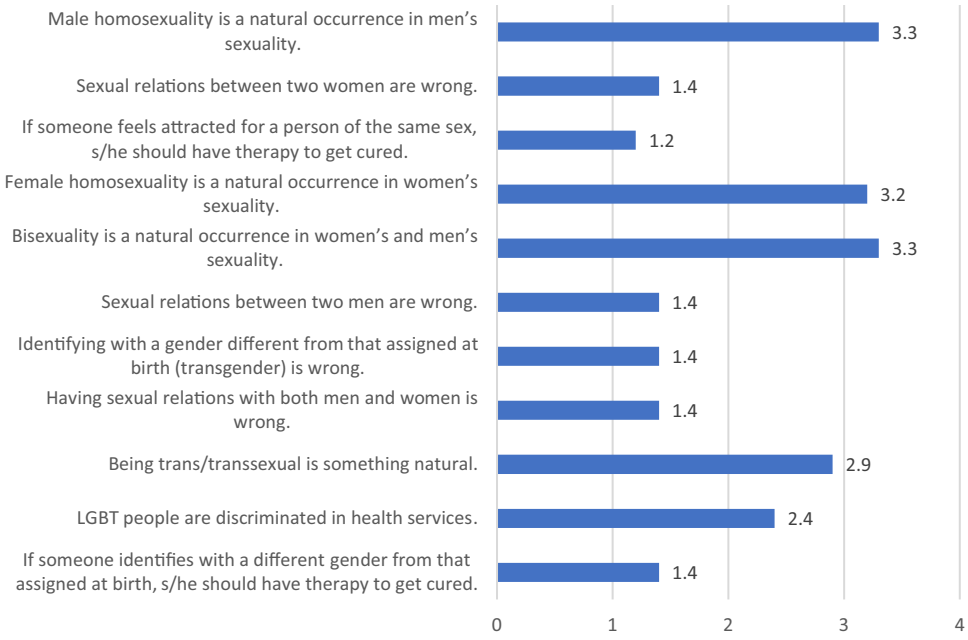

Fig. 1 Attitudes towards gender and sexual diversity (scale ranging from 1 *completely disagree* to 4 *completely agree*—means)

Attitudes Towards Gender and Sexual Diversity

Considering the individual items on attitudes towards gender and sexual diversity, overall the answers tended to reflect favorable attitudes (Fig. 1). The highest level of agreement was the view that male homosexuality is a natural occurrence in men, while the lowest was the view that those who identify with a gender different from the one assigned at birth need therapy. In general, having a homosexual orientation, especially among men, was considered more "natural" than having a gender identity that falls outside the expected gender binary of male or female. Accordingly, it was also considered more likely to be "cured."

Following the PCA, three factors were extracted (Table 3). Factor 1, labeled moralization, refers to attitudes that imply a moral judgment of sexual practices and gender identities. Factor 2, naturalization, is the understanding of sexual orientations and gender identities as individuals' natural attributes. Factor 3, pathologization, expresses the idea that gender identities and sexual orientations that are not the norm should be considered a health condition and undergo therapy.

Naturalization showed the highest levels of agreement among nurses ($M = 3.14$, $SD = 0.735$), while moralization ($M = 1.39$, $SD = 0.581$) and pathologization ($M = 1.34$, $SD = 0.521$) showed much lower levels.

Table 3 PCA for attitudes towards gender and sexual diversity

Item	Rotated factor loadings		
	Moralization	Naturalization	Pathologization
Sexual relations between two women are wrong	**.895**	−.041	−.144
Sexual relations between two men are wrong	**.865**	−.084	.025
Having sexual relations with both men and women is wrong	**.746**	.054	.079
Identifying with a gender different from that assigned at birth (transgender) is wrong	**.584**	.024	.253
Female homosexuality is a natural occurrence in women's sexuality	−.011	**.921**	.018
Male homosexuality is a natural occurrence in men's sexuality	−.059	**.891**	.047
Bisexuality is a natural occurrence in women's and men's sexuality	−.053	**.832**	.056
Being trans/transsexual is something natural	.088	**.715**	−.126
If someone identifies with a different gender from that assigned at birth, s/he should have therapy to get cured	−.061	−.035	**.926**
If someone feels attracted for a person of the same sex, s/he should have therapy to get cured	.244	−.017	**.659**
Variance (%)	39.5	21.8	8.8
α	.893	.924	.769

Table 4 Moralizing attitudes among nurses by sociodemographic characteristics

		Mean	*SD*	Statistic	Mean difference
Gender	Feminine	1.3871	.55875	$t(840) = 0.274$	-
	Masculine	1.3735	.62314		
Age	20–29	1.2604	.50159	$F(3) = 8.215$**	20–29 ≠ 50–67**
	30–39	1.3397	.54644		
	40–49	1.4369	.61361		
	50–67	1.5419	.59970		
Sexual orientation	LGB	1.1129	.26151	$t(379{,}675) = 9.813$**	-
	Heterosexual	1.4342	.59916		
Religion	Without religion	1.2178	.38466	$t(560.383) = -6.138$**	-
	With religion	1.4392	.61045		
Political stance	Left	1.2735	.44974	$F(2) = 21.140$**	Left ≠ right**
	Center	1.3985	.53127		
	Right	1.6163	.74687		
Closeness to LGB people	Yes	1.3316	.53170	$t(827) = -5.958$**	
	No	1.6253	.67122		
Closeness to trans people	Yes	1.3323	.64317	$t(95{,}224) = -0.937$	
	No	1.3948	.56489		

**$p < 0.001$

When analyzing variations in the attitudes towards gender and sexual diversity, significant effects were found for age, sexual orientation, religion, political leaning, and closeness to LGB people with regard to moralization, pathologization, and naturalization. Moreover, in naturalization, significant effects were also found for gender and closeness to trans people. This last variable also had effects on the dimension of pathologization.

Regarding moralization, as illustrated in Table 4, a one-way analysis of variance showed a significant effect for age ($F(3) = 8.215$, $p < 0.001$): the youngest nurses, aged 20–29, showed lower scores in terms of moralizing attitudes ($M = 1.27$, $SD = 0.5$) than their older peers aged 50–67 ($M = 1.55$, $SD = 0.6$). The same analysis revealed a significant effect for political leaning ($F(2) = 21.140$, $p < 0.001$): left-leaning nurses reported lower levels of moralization ($M = 1.27$, $SD = 0.45$) than their right-leaning peers ($M = 1.62$, $SD = 0.75$).

A *t*-test analysis of mean differences showed that the levels of agreement with moralizing attitudes were significantly higher for heterosexual respondents ($M = 1.43$, $SD = 0.6$) than for their LGB peers ($M = 1.11$, $SD = 0.26$) ($t(379.675) = 9.813$, $p < 0.001$). Significant mean differences were also found for religion ($t(560.383) = 6.138$, $p < 0.001$), with religious nurses showing higher levels of moralizing attitudes ($M = 1.44$, $SD = 0.61$) than those without a religion ($M = 1.22$, $SD = 0.27$); and closeness to LGB people ($t(827) = -5.958$, $p < 0.001$)—nurses with LGB family or friends showed lower levels of moralization ($M = 1.33$, $SD = 0.53$) than those without ($M = 1.63$, $SD = 0.67$).

As shown in Table 5, similar results were obtained for the pathologization dimension concerning attitudes towards gender and sexual diversity. In the case of age, significant effects ($F(3) = 11.639$, $p < 0.001$) were noted not only in the mean difference between the youngest ($M = 1.2$, $SD = 0.37$) and the oldest nurses ($M = 1.5$, $SD = 0.56$), but also between those aged 30–39 ($M = 1.23$, $SD = 0.46$) and the oldest age group. The effect of political ideology showed the same inclination, with left-leaning nurses reporting lower pathologization ($M = 1.27$, $SD = 0.44$) than their right-leaning peers ($M = 1.5$, $SD = 0.63$).

An analysis of mean differences revealed the significant effect of sexual orientation ($t(373.212) = 8.936$, $p < 0.001$), with heterosexual respondents reporting higher levels of pathologization ($M = 1.36$, $SD = 0.53$) than LGB respondents ($M = 1.10$, $SD = 0.23$). Significant mean differences were also found for religion ($t(535.665) = -7.197$, $p < 0.001$), with religious nurses showing more pathologizing attitudes ($M = 1.39$, $SD = 0.53$) than those without a religion ($M = 1.15$, $SD = 0.35$). There was also significant variation in closeness to LGB and trans people: individuals with LGB family or friends reflected lower pathologizing attitudes than those without ($M = 1.27$, $SD = 0.48$ compared to $M = 1.51$, $SD = 0.57$; $t(820) = -5.003$, $p < 0.001$). Similarly, the participants who were close to trans people reported lower pathologizing attitudes than those who were not ($M = 1.21$, $SD = 0.39$ compared to $M = 1.34$, $SD = 0.52$; $t(820) = -2.183$, $p < 0.001$).

Finally, regarding naturalization, significant effects were identified for all independent variables, as shown in Table 6.

Table 5 Pathologizing attitudes among nurses by sociodemographic characteristics

		Mean	*SD*	Statistic	Mean difference
Gender	Feminine	1.3269	.49178	$t(833) = -0.003$	-
	Masculine	1.3270	.55685		
Age	20–29	1.2048	.37365	$F(3) = 11.639$**	20–29 ≠ 50–67**
	30–39	1.2776	.45784		30–39 ≠ 50–67**
	40–49	1.3722	.58882		
	50–67	1.5000	.55661		
Sexual orientation	LGB	1.1042	.23277	$t(373.212) = 8.936$**	-
	Heterosexual	1.3649	.52996		
Religion	Without religion	1.1522	.35153	$t(535.665) = -7.197$**	-
	With religion	1.3854	.53318		
Political stance	Left	1.2615	.43749	$F(2) = 12.415$**	Left ≠ right**
	Center	1.3266	.48567		
	Right	1.5000	.63391		
Closeness to LGB people	Yes	1.2867	.48057	$t(820) = -5.003$**	-
	No	1.5062	.57005		
Closeness to trans people	Yes	1.2125	.38791	$t(820) = -2.183$*	-
	No	1.3423	.51633		

*$p < 0.05$; **$p < 0.001$

Contrary to moralization and pathologization, gender variations were significant in the expression of naturalizing attitudes ($t(221.701) = -2.306$, $p < 0.05$). Although with lower significance and reduced mean difference, men showed more naturalizing attitudes ($M = 3.23$, $SD = 0.82$) than women ($M = 3.12$, $SD = 0.71$).

The effects of the other independent variables on naturalizing attitudes showed the same pattern as moralization and pathologization. Significant effects were found for age ($F(3) = 7.129$, $p < 0.001$): respondents aged 20–29 showed higher levels of naturalization ($M = 3.31$, $SD = 0.68$) than their peers aged 50–67 ($M = 2.99$, $SD = 0.75$). As for political leaning ($F(2) = 17.351$, $p < 0.001$), left-leaning professionals reported higher levels of naturalization ($M = 3.28$, $SD = 0.7$) than their right-leaning peers ($M = 2.88$, $SD = 0.77$).

Significant mean differences were found for sexual orientation; heterosexual respondents reported lower levels of

Table 6 Naturalizing attitudes among nurses by sociodemographic characteristics

		Mean	*SD*	Statistic	Mean difference
Gender	Feminine	3.1182	.71171	$t(221.701) = -2.306$*	-
	Masculine	3.2666	.81712		
Age	20–29	3.3124	.68213	$F(3) = 7.129$**	20–29 ≠ 50–67**
	30–39	3.1998	.72822		
	40–49	3.0458	.73805		
	50–67	2.9905	.75303		
Sexual orientation	LGB	3.6921	.42748	$t(262.747) = -13.546$**	-
	Heterosexual	3.0447	.73672		
Religion	Without religion	3.4244	.64648	$t(831) = 6.372$**	-
	With religion	3.0563	.74003		
Political leaning	Left	3.2793	.69894	$F(2) = 17.351$**	Left ≠ right**
	Center	3.1250	.69984		
	Right	2.8773	.77080		
Closeness to LGB people	Yes	3.2142	.69809	$t(219.182) = 5.904$**	-
	No	3.8101	.78989		
Closeness to trans people	Yes	3.3457	.72350	$t(98.807) = 2.739$*	-
	No	3.1134	.73169		

*$p < 0.05$; **$p < 0.001$

Table 7 Descriptive statistics for knowledge and academic training in gender and sexual diversity

	Yes	No	Do not know/no answer	Never had contact with the topic
Academic training				
Do you think you had adequate training on homosexuality and bisexuality?	13.4	57.5	2.4	26.7
Do you think you had adequate training on gender identity and trans/transsexuality?	11.2	58.0	2.5	28.3
Training needs				
In the exercise of your professional activity, do you feel the need for more training on sexual orientation?	51.1	43.8	5.2	-
In the exercise of your professional activity, do you feel the need for more training on gender identity/trans/transsexuality?	62.0	33.9	4.1	-

naturalizing attitudes ($M = 3.05$, $SD = 0.74$) than their LGB colleagues ($M = 3.69$, $SD = 0.43$) ($t(262.747) = -13.546$, $p < 0.001$). Similarly, religious nurses showed lower levels of naturalization ($M = 3.06$, $SD = 0.74$) than those without a religion ($M = 3.44$, $SD = 0.65$) ($t(831) = 6.372$, $p < 0.001$). Nurses without LGB family or friends showed lower levels of naturalization ($M = 3.81$, $SD = 0.79$) than those with ($M = 3.21$, $SD = 0.7$) ($t(219.182) = 5.904$, $p < 0.001$).

Knowledge and academic training in gender and sexual diversity

The majority of the respondents felt that they had had inadequate training in homosexuality and bisexuality (57.5%) and gender identity and trans/transsexuality (58%) (Table 7). In addition, over one-quarter of the nurses stated they had had no contact with these subjects during their training (26.7% for homo- and bisexuality; 28.3% for gender identity and trans/transsexuality). Consequently, most respondents recognized the need for further training, although the need for training in gender identity scored higher than that for training in homo- and bisexuality (62% and 51.1%, respectively).

A chi-square test of independence showed no significant differences in the acknowledgement of the need for training in sexual orientation, based on age, sexual orientation, religion, political leaning, and closeness to LGB people (Table 8). In contrast, gender proved to have a significant effect ($X^2(4) = 10.954$, $p < 0.05$), with more women (52.5%) than men (46.9%) stating the need for training. It is important to note that the percentage of men expressing a need for training in this subject was the same as those who did not feel any need. Furthermore, a significant variation was also

Table 8 Acknowledgement of training needs in sexual orientation by sociodemographic characteristics

		Yes		No		Do not know		Statistic
		N	%	*N*	%	*N*	%	
Gender	Feminine	361	52.5	295	42.9	32	4.7	$X^2(4) = 10.954$*
	Masculine	76	46.9	76	46.9	10	6.2	
Age	20–29	92	54.8	68	40.5	8	4.8	$X^2(6) = 5.596$
	30–39	158	47.4	155	46.5	20	6.0	
	40–49	103	56.3	74	40.4	6	3.3	
	50–67	84	50.0	75	44.6	9	5.4	
Sexual orientation	LGB	67	54.9	51	41.8	4	3.3	$X^2(2) = 1.394$
	Heterosexual	364	50.8	314	43.8	39	5.4	
Religion	Without religion	110	53.1	88	42.5	9	4.3	$X^2(2) = 0.513$
	With religion	327	50.8	283	43.9	34	5.3	
Political stance	Left	175	53.4	142	43.3	11	3.4	$X^2(4) = 5.623$
	Center	155	50.7	135	44.1	16	5.2	
	Right	78	46.2	78	46.2	13	7.7	
Closeness to LGB people	Yes	346	51.5	294	43.8	32	4,8	$X^2(2) = 1.112$
	No	81	48.8	74	44.6	11	6.6	
Closeness to trans people	Yes	49	59.8	33	40.2	0	0.0	$X^2(2) = 6.325$*
	No	378	50.0	335	44.3	43	5.7	

*$p < 0.05$

Table 9 Acknowledgement of training needs in gender identity by sociodemographic characteristics

		Yes		No		Do not know		Statistic
		N	%	*N*	%	*N*	%	
Gender	Feminine	434	63.1	228	33.1	26	3.8	$X^2(4) = 12.448$*
	Masculine	98	60.5	57	35.2	7	4.3	
Age	20–29	120	71.4	44	26.2	4	2.4	$X^2(6) = 10.906$
	30–39	201	60.4	117	35.1	15	4.5	
	40–49	118	64.5	59	32.2	6	3.3	
	50–67	93	55.4	66	39.3	9	5.4	
Sexual orientation	LGB	91	74.6	29	23.8	2	1.6	$X^2(2) = 9.624$*
	Heterosexual	432	60.3	253	35.3	32	4.5	
Religion	Without religion	139	67.1	67	32.4	1	0.5	$X^2(2) = 9.561$*
	With religion	393	60.9	219	34.0	33	5.1	
Political leaning	Left	212	64.6	108	32.9	8	2.4	$X^2(4) = 5.837$
	Center	190	62.1	101	33.0	15	4.9	
	Right	95	56.2	65	38.5	9	5.3	
Closeness to LGB people	Yes	429	63.8	219	32.6	24	3.6	$X^2(2) = 5.413$
	No	91	54.8	65	39.2	10	6.0	
Closeness to trans people	Yes	58	70.7	23	28.0	1	1.2	$X^2(2) = 3.823$
	No	462	61.1	261	34.5	33	4.4	

*$p < 0.05$

found for closeness to trans people ($X^2(2) = 6.325$, $p < 0.05$), as more respondents with trans family or friends indicated a need for training than those without trans family or friends (59.8% compared to 50%).

As shown in Table 9, training needs in gender identity showed more significant variations. Apart from gender ($X^2(4) = 12.448$, $p < 0.05$), with women expressing more training needs than men (63.1% of women, compared to 60.5% of men), differences were also found in sexual orientation ($X^2(2) = 9.624$, $p < 0.05$) and religion ($X^2(2) = 9.561$, $p < 0.05$). LGB nurses indicated higher training needs than their heterosexual peers (74.6% compared to 60.3%), while nurses without a religion expressed more training needs (67.1%) than those with a religion (60.9%).

Cultural Competencies in Gender and Sexual Diversity

Regarding care of LGBT individuals, the vast majority of respondents had been in contact with homosexual people in their work (85%). Experience of nursing care to trans and bisexual patients was, however, less significant (43.9% and 41.6% respectively).

The mean of the composite score for care for all the subgroups was 1.71, with a standard deviation of 1.01, which suggests that, in general, the respondents provided care to at least one of the subgroups.

As for care preferences, if given the choice, 99% marked "no" when faced with the choice not to provide care to LGBT patients, while 99.5% would not refuse to provide care to LGBT patients.

Considering the composite refusal score of these two items, the mean refusal of care for the entire sample was 1.18, with a standard deviation of 0.39. Significant differences were found for age ($F(3.841) = 9.034$, $p < 0.001$), sexual orientation ($t(279.932) = 6.155$, $p < 0.001$), religion ($t(481.295) = -4.319$, $p < 0.001$), and political leaning ($F(2.795) = 6.628$, $p < 0.001$) (Table 10). Regarding age, the preference for not providing care was higher among nurses aged 50–67 ($M = 1.28$, $SD = 0.47$) than among those aged 20–29 ($M = 1.12$, $SD = 0.33$) and 30–39 ($M = 1.12$, $SD = 0.3$). Refusal of care was also significantly higher for right-wing respondents ($M = 1.25$, $SD = 0.44$) than for those who were left-wing oriented ($M = 1.13$, $SD = 0.32$); for heterosexual ($M = 1.2$, $SD = 0.38$) than for LGB ($M = 1.04$, $SD = 0.21$) respondents; for those with a religion ($M = 1.2$, $SD = 0.38$) than for those without ($M = 1.09$, $SD = 0.27$); for nurses without LGB friends or family ($M = 1.1$, $SD = 0.33$) ($M = 1.3$, $SD = 4.5$) than for those with; and for nurses without trans family or friends ($M = 1.2$, $SD = 0.37$) than for those with ($M = 1.1$, $SD = 0.27$).

The vast majority felt confident in their ability to provide care to LGBT patients (95.8%). These results show a significant effect for age ($F(3.813) = 5.697$, $p < 0.001$), with older nurses, aged 50–67, feeling less competent than those aged 40–49 and 20–29, and sexual orientation ($t(803) = -2.410$, $p < 0.05$), with heterosexual nurses feeling less competent than their LGB peers.

Table 10 Refusal of care (intention) to LGBT patients by sociodemographic characteristics

		Mean	*SD*	Statistic	Mean difference
Gender	Feminine	1.1696	.35961	$t(842) = -0.171$	-
	Masculine	1.1750	.35994		
Age	20–29	1.1212	.32737	$F(3.841) = 9.034$**	20–29 ≠ 50–67**
	30–39	1.1242	.29641		30–39 ≠ 50–67**
	40–49	1.2022	.37077		
	50–67	1.2844	.46400		
Sexual orientation	LGB	1.0496	.20822	$t(279.932) = 6.155$**	-
	Heterosexual	1.1955	.38056		
Religion	Without religion	1.0927	.27332	$t(481.295) = -4.319$**	-
	With religion	1.1980	.38325		
Political stance	Left	1.1250	.32186	$F(2.795) = 6.628$**	Left ≠ right**
	Center	1.1871	.35381		
	Right	1.2470	.44114		
Closeness to LGB people	Yes	1.1375	.32796	$t(829) = -5.7822$**	
	No	1.3148	.44544		
Closeness to trans people	Yes	1.1037	.26918	$t(829) = -1.813$*	
	No	1.1796	.36855		

*$p < 0.05$; **$p < 0.001$

Finally, when asked to self-assess their competencies to provide nursing care to LGBT patients when compared to their peers, most respondents considered they had the same ability to care for LGB (78.5%) and trans (79.9%) patients as their coworkers, although approximately one-fifth believed their ability was higher than those of their coworkers. Only a marginal number (around 1%) deemed their competencies lower than their peers.

When testing for variation in the self-assessment of competencies in caring for homosexual and bisexual patients, significant effects were found for gender, sexual orientation, religion, political leaning, and closeness to LGB and trans people (Table 11).

The gender difference ($X^2(4) = 124.315$, $p < 0.001$) showed that women, more than men, perceived their competencies as being the same or lower than those of their coworkers (81% and 0.4% respectively). On the contrary, men, more than women, felt they had higher skills than their coworkers (33.3%, compared to 19% of women). As for sexual orientation ($X^2(104.669$, $p < 0.001$), most LGB nurses stated they had higher skills than their coworkers (54.9% compared to 14.6% of heterosexuals), while most heterosexuals considered they had the same or lower competencies than their peers (85.3% in relation to 45.1% of LGB). Concerning the effect of religion ($X^2(2) = 18.210$, $p < 0.001$), religious respondents compared themselves less favorably with those without a religion: 17.5% said they had higher competencies than their colleagues (compared to 31.4% of nurses without a religion) and 68.6% said they had the same or lower abilities than their peers (compared to 82.5% of nurses without a religion). Regarding the effect of closeness to LGB people ($X^2(2) = 17.597$, $p < 0.001$), 23.8% of respondents with LGB family or friends stated that they had higher competencies than their colleagues, compared to 9% of those without. Likewise, 39% of the nurses with trans family or friends said that they had higher competencies than their colleagues, compared to 18.9% of those without ($X^2(2) = 18.365$, $p < 0.001$).

The same pattern was identified in competencies in the provision of nursing care to trans patients, although in this case political leaning also had a significant effect on nurses' self-assessment (Table 12). Where gender was concerned ($X^2(4) = 40.146$, $p < 0.001$), men, more than women, tended to consider they had higher competencies than other nurses (26.5% compared to 16.6% of women). On sexual orientation ($X^2(2) = 82.233$, $p < 0.001$), the LGB respondents said they had higher competencies than their heterosexual peers (47.5% compared to 13.2%). As for religion ($X^2(2) = 17.057$, $p < 0.001$), the non-religious participants reported higher competencies than other nurses (27.5% compared to 15.5% of religious respondents). With regard to political orientation ($X^2(4) = 9.502$, $p < 0.05$), left-leaning participants stated they had higher competencies than their peers (22.9%), respondents in the political center (15.7%), and right-leaning respondents (16%). Significant effects were also found for closeness to LGB ($X^2(2) = 12.415$, $p < 0.05$) and trans people ($X^2(2) = 28.979$, $p < 0.001$): respondents with LGB and trans family or friends said they had higher competencies than their coworkers.

Table 11 Self-assessment of competencies in the provision of nursing care to LGB people by sociodemographic characteristics

		Higher than coworkers		Same as coworkers		Lower than coworkers		Statistic
		N	%	*N*	%	*N*	%	
Gender	Feminine	124	19.0	561	81.5	3	0.4	$X^2(4) = 124.315$**
	Masculine	54	33.3	108	66.7	0	0.0	
Age	20–29	39	23.2	128	76.2	1	0.6	$X^2(6) = 5.141$
	30–39	73	21.9	259	77.8	1	0.3	
	40–49	32	17.5	151	82.5	0	0.0	
	50–67	34	20.2	132	78.6	2	1.2	
Sexual orientation	LGB	67	54.9	54	44.3	1	0.8	X^2(104.669**
	Heterosexual	105	14.6	609	84.9	3	0.4	
Religion	Without religion	65	31.4	141	68.1	1	0.5	$X^2(2) = 18.210$**
	With religion	113	17.5	528	82.0	3	0.5	
Political stance	Left	82	25.0	245	74.7	1	0.3	$X^2(4) = 6.968$
	Center	53	17.3	251	82.0	2	0.7	
	Right	34	20.1	135	79.9	0	0,0	
Closeness to LGB people	Yes	160	23.8	509	75.7	3	0.4	$X^2(2) = 17.597$**
	No	15	9.0	150	90.4	1	0.6	
Closeness to trans people	Yes	32	39.0	50	61.0	0	0,0	$X^2(2) = 18.365$**
	No	143	18.9	609	80.6	4	0.5	

**$p < 0.001$

Table 12 Self-assessment of competencies in the provision of nursing care to trans people by sociodemographic characteristics

		Higher than coworkers		Same as coworkers		Lower than coworkers		Statistic
		N	%	*N*	%	*N*	%	
Gender	Feminine	114	16.6	564	82.0	10	1.5	$X^2(4)=40.146$**
	Masculine	43	26.5	217	72.2	2	1.2	
Age	20–29	33	19.6	132	78.6	3	1.8	$X^2(6)=4.545$
	30–39	63	18.9	264	79.3	6	1.8	
	40–49	31	16.9	152	83.1	0	0.0	
	50–67	30	17.9	134	79.8	4	2.4	
Sexual Orientation	LGB	58	47.5	63	51.6	1	0.8	$X^2(2)=82.233$**
	Heterosexual	95	13.2	611	85.2	11	1.5	
Religion	Without religion	57	27.5	145	70.0	5	2.4	$X^2(2)=17.057$**
	With religion	100	15.5	536	83.2	8	1.2	
Political stance	Left	75	22.9	246	75.0	7	2.1	$X^2(4)=9.502$*
	Center	48	15.7	256	83.7	2	2.0	
	Right	27	16.0	140	82.8	2	2.0	
Closeness to LGB people	Yes	139	20.7	522	77.7	11	1.6	$X^2(2)=12.415$*
	No	15	9.0	149	89.8	2	1.2	
Closeness to trans people	Yes	33	40.2	48	58.5	1	1.2	$X^2(2)=28.979$**
	No	121	16.0	623	82.4	12	1.6	

*$p<0.05$; **$p<0.001$

Discussion

Overall, the sample of Portuguese nurses showed attitudes that considered non-traditional gender or sexual identities a natural expression of humanity, following the favorable trend that Portugal has been witnessing in terms of recognizing LGBT rights (Hines & Santos, 2018) and confirming the positive relationship between this acquisition of rights and the attitudes of nursing professionals (as in Rondahl et al., 2004, for Sweden). Being homosexual, mainly male homosexuality, was considered more "natural" than having a trans or gender-diverse identity. Consequently, trans identities were also perceived as more "curable" than homosexuality. This gradation of naturalization connected to being gay, lesbian, or trans may be related to the visibility of these groups in Portuguese society (Saleiro, 2022). The relatively wider perception of non-normative gender identities as something that needs to be cured may be associated with a lack of contact with trans people, as evidenced in the sample, and with the recent removal of trans identities from mental illness manuals (the World Health Organization's International Classification of Diseases and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders) in comparison with sexual orientation. It may also be connected to associating trans identities with gender-affirming healthcare procedures that place them in a clinical setting.

In general, the social representations of gender and sexual diversity among nurses varied according to gender, age, sexual orientation, religion, political orientation, and having LGBT family members or friends. Moralizing and pathologizing attitudes towards gender and sexual diversity, in particular, tended to be stronger among older, heterosexual, religious, and right-leaning nurses, as well as among those with no LGB family or friends. Pathologizing attitudes were also more prevalent among nurses without trans family or friends. Naturalizing attitudes, in turn, were more frequent among men, younger, LGB, non-religious, and left-leaning nurses, as well as among those with LGBT family or friends.

Unlike the population at large (European Commission, 2015) and studies on the representations of LGBT issues among medical students (for example, Lopes et al., 2016), in our study, women did not stand out among nursing professionals as having more favorable, less prejudiced attitudes than men, which is in line with other studies' results for nurses (Della Pelle et al., 2018; Lin et al., 2019). The reason for this is probably that, unlike the medical profession, nursing has traditionally been associated with women and socially represented as a feminized profession. Therefore, men who decide to become nurses can be expected to have an attitude that does not conform to traditional gender norms. While the men in the sample followed the standards of masculinity in aspects such as lower recognition of possible gaps in their training and greater confidence in their work, assessing their ability to provide nursing care to LGBT patients more favorably than their coworker, when it came to attitudes, they did not have a traditional view that morally condemned or pathologized LGBT people, quite on the contrary.

The difference between the younger and older nurses in their representations and attitudes towards non-normative sexual orientations and identities, with younger nurses demonstrating more progressive attitudes no longer aligned with outdated models of moralization and pathologization, followed a trend in society at large (European Commission, 2015).

The more positive representations of diverse sexual orientations and gender identities among LGB nurses, those who were close to LGBT people, those who did not have a religion and were politically left-leaning, were shaped by their personal, family, and friendship experiences, as well as their world view. This was probably also due to their interest in these issues and the information they had on them. While experiencing a non-normative sexual identity understandably shapes more naturalizing, non-pathologizing, or non-moralizing views, closeness to LGBT people has also proved to be an antidote to prejudice (Burke et al., 2015; Çakır & Harmancı Seren, 2020; Lin et al., 2019; Lopes et al., 2016) and to etiology beliefs about homosexuality (Chonody et al., 2016). In contrast, religion is associated with higher levels of homophobia (Della Pelle et al., 2018; Lopes et al., 2016; Whitley, 2009).

Most of the respondents felt they had not received adequate training in gender and sexual diversity, which was in line with the findings of previous studies, where the participants expressed the need for training and a more thorough inclusion of LGBT issues in health curricula (Baiocco et al., 2021; Ziegler et al., 2022). While these results show the existence of gaps in nurses' basic training, they can also be seen as encouraging since the nurses themselves recognized these gaps. Significant differences were only found for gender on training in gender identity, with more men than women saying they had received inadequate training. Considering that men showed the most favorable attitudes, their recognition of the inadequacy of their training may be linked to a greater awareness of these training needs.

In line with the recognition of training needs, most participants in the study acknowledged the need for more training. The women expressed a greater need for training in sexual orientation than the men, who come across as more confident and possibly more informed through other channels. The women, LGB, and non-religious nurses expressed a greater need for training in gender identity than men, heterosexual, and religious nurses, which may be connected to a stronger predisposition towards that training.

This study does not include information on the content or duration of the training received, but rather on the perception of the adequacy of this training. Therefore, it is not possible to draw solid conclusions on the relation between training and attitudes. Further research is thus necessary to allow for a more systematic evaluation of the impact of training on nurses' attitudes towards LGBT patients.

The preference or intention to refuse care was higher among older, heterosexual, religious, and right-leaning nurses, as well as among those who did not have LGBT family or friends. Although this was a minority stance among nurses as a whole, these data are concerning because they show the need for training and binding guidelines in order to reverse these people's personal inclinations and protect the human rights of LGBT individuals.

Finally, although most respondents felt they had the same ability as their peers to provide care to LGBT patients, variations were found according to gender, sexual orientation, religion, and closeness to LGBT people. In terms of providing care to homo- and bisexual people, female, heterosexual, and religious nurses and those without LGBT family or friends compared themselves less favorably with their colleagues. The same pattern was found in the provision of care to trans patients; however, in addition, political leaning also proved to have an effect, with right-leaning nurses assessing themselves less favorably than their colleagues.

Conclusions and Policy Implications

This study, based on a sample of close to 900 nurses, fills a gap in quantitative research on the attitudes and perceptions of these health professionals towards sexual orientation and gender identity. It also throws light on their self-assessment of the training and competencies they have (or lack) in the provision of care to LGBT patients, who are already identified as a vulnerable population in healthcare environments.

The results point to positive social attitudes in general, where non-normative sexual orientations and gender identities are seen as a natural expression of human diversity. However, although these represent a minority, there are still moralizing and pathologizing attitudes towards LGBT people, mainly on the part of older, religious, and right-leaning nurses and those without LGBT family or friends.

This study highlights the absence or insufficiency of LGBT subjects in nursing courses, which most professionals recognize. They also acknowledge the need to fill this gap, mainly with regard to gender identity. This absence makes capacity building in the provision of nursing care to LGBT people depend on the individual initiative of professionals who formally or informally seek that knowledge. Knowledge and cultural competencies in the provision of nursing care to LGBT patients should be ensured and made universal (Dorsen, 2012) in order to reverse the reduction still seen in these individuals' access to healthcare. At the same time, it is necessary to include these subjects in ongoing training for nurses who have completed their degrees and to make specialized courses available to nurses who wish to learn more.

To include LGBT issues in nursing training is to meet their shared interest in receiving and assisting these people in a culturally and clinically competent way. It is essential, alongside the development of other courses in the area of health, to ensure the fulfillment of the human right to health for LGBT people.

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Data Availability The data presented are not publicly available, as this was not included in the informed consent obtained from study participants.

Code Availability Not applicable.

Declarations

Ethics Approval This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of Iscte-Instituto Universitário de Lisboa (26th February 2020/No. 18/2020).

Consent to Participate Informed consent was obtained from all individual participants included in the study.

Conflict of Interests The authors declare no competing interests.

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