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## Cultural Competence of Nurse Practitioners: Providing Care for Gay and Lesbian Clients

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CULTURAL COMPETENCE OF NURSE PRACTITIONERS:  
PROVIDING CARE FOR GAY AND LESBIAN CLIENTS

By

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## ABSTRACT

### **Cultural Competence of Nurse Practitioners: Providing Care for Gay and Lesbian Clients**

by Paul Steven Smith

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Nurse practitioners provide care to an increasing number of diverse individuals who are faced with specific healthcare needs, as well as health disparities. This care encompasses those individuals who identify as lesbian, gay, bisexual, or transgender (LGBT). These individuals may have experienced delivery of healthcare by providers who lacked the necessary knowledge and/or skills needed to adequately address the needs of this specific client population. Many in the LGBT population have faced prejudice, bias, or homophobia from healthcare providers that became a barrier to accessing healthcare. In order to avoid potential barriers, nurse practitioners who function increasingly as primary care providers, must attain knowledge and skills to provide culturally competent care. Nursing programs have a responsibility to provide education within the curricula that addresses the specific healthcare needs of LGBT individuals, as well as identify health disparities faced by this population. The inclusion of LGBT nursing education, using various teaching strategies, may assist the nurse practitioner in developing cultural competence as it relates to caring for LGBT clients.

Bias and prejudice against LGBT individuals have been identified among registered nurses (RN) and nursing students. This concern relates directly to nurse practitioners, who began their careers as a nursing student and then as an RN. The small body of literature available on nurse practitioners caring for LGBT clients indicates a lack of education in their graduate programs that specifically addressed the healthcare and the health of LGBT persons. The lack of

knowledge and the potential scarcity of experiences with LGBT individuals have likely contributed to healthcare providers' inability to provide culturally competent care. Limited literature exists on the sensitive issue of nurse practitioner beliefs and behaviors with LGBT individuals. Beliefs guide and inform behaviors, which directly impact client care.

In order to assess the current beliefs and behaviors of nurse practitioners in providing culturally competent care for lesbian and gay clients, an exploratory survey was conducted. Additionally, their perceptions of the cultural competence education received in general, and specific to the care of lesbian and gay individuals was examined. The Gay Affirmative Practice (GAP) Scale was used as well as demographic information and open-ended questions in a statewide survey of currently licensed nurse practitioners. The study was informed by Josepha Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services*. Descriptive and inferential statistics were used to analyze results. Data were analyzed using established statistical methods for correlational studies, primarily by Pearson product-moment correlation coefficients (Pearson's  $r$ ), and analysis of variance (ANOVA) for between-groups statistical analysis.

The findings of this study revealed that the participants' reported level of cultural competency nursing education specific to gay and lesbian clients in both their pre-licensure and graduate nursing education programs influenced beliefs and behaviors when providing care to this population. Additionally, significant differences were found in regard to types of nurse practitioners, sexual orientation, and religious affiliation when comparing practice beliefs, practice behaviors, and total GAP scores. The insights gained from this study have the potential to inform the development of pedagogical practices that could enhance nursing education regarding cultural competence, with a focus on LGBT health.

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## DEDICATION

I dedicate my dissertation work to the memory of my wonderful mother, father, sister and brother. Although they are no longer physically with me to celebrate in this accomplishment, I feel their presence each and every day and I would not be where I am today if it were not for their love and support through the years. You are all truly missed.



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## **CHAPTER ONE**

### **INTRODUCTION**

Nurses and nurse practitioners are expected to provide culturally competent care for all of their clients. Culturally competent care is defined as client care that is sensitive to diversity in the client population, and understanding of the impact of cultural factors such as language, communication styles, beliefs, attitudes, and behaviors on health and healthcare (Agency for Healthcare Research and Quality, 2012). Understanding the motivation, purpose, and goals in becoming culturally competent by the provider is necessary and requires self-evaluation, skill development, and increasing knowledge regarding culturally diverse groups and individuals that belong to them (Kersey-Matusiak, 2012). One such subculture is that of the lesbian, gay, bisexual and transgender (LGBT) community. Approximately 3.5% of the adults in the United States (U.S.) identify as lesbian, gay, or bisexual, and approximately 0.3% of adults are transgendered – that is, approximately 9 million Americans who self-identify as LGBT (Gates, 2011). Unfortunately, many in the LGBT community may not seek needed healthcare because they fear prejudice or discrimination; or if they do seek healthcare and experience an uncomfortable encounter, they may stop seeking medical care (Dayer-Berenson, 2011; Hutchinson, Thompson, & Cederbaum, 2006; McManus, 2008; Mayer et al., 2008).

At the request of the National Institutes of Health (NIH), the Institute of Medicine (IOM, 2011b) convened a consensus committee to discuss the state of knowledge regarding LGBT health, and to prioritize areas in need of research. The committee outlined a research agenda to improve LGBT health research efforts, and presented six additional recommendations intended to advance understanding of LGBT healthcare needs (IOM, 2011b). The purpose was to convey the lack of understanding regarding LGBT individuals and their healthcare needs, and the national priority to address this deficit of knowledge.

In addition, a current goal of Healthy People 2020 is to improve the health, safety, and well-being of LGBT individuals (U.S. Department of Health and Human Services, 2011). The Joint Commission has published literature for hospitals that instructs practitioners how to provide a more welcoming, safe, and inclusive environment that will improve healthcare for LGBT individuals and their families (Pelletier & Tschurtz, 2012). It is clear that nurses and nurse practitioners, who are the most visible presence during health care encounters, must receive adequate academic and clinical training in order to deliver culturally competent care to this population (Lim, Brown, & Jones, 2013). Although the focus of this study was on the ability of nurse practitioners to provide culturally competent care, literature that focused on nurses was integrated due to the limited amount of published literature on nurse practitioners providing culturally competent care for LGBT clients.

Nursing practice, education, research and public policy were four priority areas Keepnews (2011) identified as having the capability of increasing visibility of LGBT health issues in nursing. Keepnews also suggested the importance of creating an organization for nurses who are part of the LGBT community as one way to focus the energies of nurses who feel that the profession should address LGBT issues and health in a more visible and consistent manner. On August 5, 2014, the Gay and Lesbian Medical Association (GLMA) announced the creation of the GLMA Nursing Section as a focal point for advocacy on LGBT nursing issues (GLMA, n.d.).

### **Problem Statement**

Advanced-practice nurse practitioners (APRNs) represent 8% of the total nurse workforce in the U.S. (Naylor & Kurtzman, 2015). According to the American Association of Nurse Practitioners (2014), more than 205,000 APRNs are licensed in the U.S.; approximately

15,000 of them completed their academic programs in 2012–2013. Of the practicing APRNs, some 70–80% practice in primary care settings (Naylor & Kurtzman). With an undersupply of primary care physicians, and health care reform that will result in an increase in demand for health services, nurse practitioners are available to fill many of the gaps in primary care at a lower cost, and without diminishing quality of care (Bauer, 2010).

APRNs provide annual care to more than 3 million American families at some 1,100 new retail clinics that are primarily staffed by APRNs (Aiken, 2011). An individual seeking medical care or medical treatment now has more choices in regard to primary care. Aiken states that more than 16 million people are receiving care provided by APRNs, and projects that APRNs will continue to fill roles related to primary care, prevention, and care coordination with continued health care reform.

With the aforementioned demand for primary care, nurse practitioners have gained ground and traction with the general public and are providing primary care in large and small private and public practices as well as in schools and clinics (Fairman, Rowe, Hassmiller, & Shalala, 2011; Naylor & Kurtzman, 2010). Studies have indicated that primary care services provided by nurse practitioners are as safe and effective as services rendered by physicians and that nurse practitioners, when compared to physicians, provided longer consultations and more information to clients (Laurant et al., 2005). In addition to care by APRNs being as safe and effective as that provided by physicians, there is also a reduced overall cost of producing care (Bauer, 2010). Additionally, the IOM (2011a) called for an expansion of the scope of practice in regard to nurse practitioners and primary care. With this increase in client population, as well as a call for an increased presence within primary care, nurse practitioners will provide care to a more diverse client population, including those from the LGBT community.



Given the diversity of the client population, nurse practitioners will provide care to LGBT individuals; therefore, it is highly critical that they are knowledgeable regarding the care of LGBT clients. In addition to being knowledgeable about LGBT clients, nurse practitioners should also strive to be inclusive and equitable in their provision of care to all groups in the community. The cultural competence necessary for nurse practitioners to provide inclusive and equitable care is imperative to maximize the potential for optimal LGBT health care outcomes.

### **Background and Significance**

#### **Importance of Generalized Cultural Competence in Nurses/Nurse Practitioners**

Generalized cultural competence is an approach in understanding individual differences and in identifying how these differences affect the treatment and outcomes of diverse clients (Horevitz, Lawson, & Chow, 2013). An analysis of the core components of nine of the most frequently cited cultural competence theoretical frameworks allowed for an identification of four main themes (Jirwe, Gerrish, & Emami, 2006). The four themes were identified as: (a) an awareness of the diversity that exists among human beings, including self and others; (b) an ability to provide care for individuals; (c) non-judgmental openness, including the ability to overcome prejudices; and (d) the understanding that cultural competence is a continuous process (Jirwe et al.). Cultural competence in nurses and nurse practitioners develops over time. This means that learning about the cognitive, affective, and skilled components of cultural competence education is an ongoing process (Cross et al., 2008). From a constructivist viewpoint, culture is not a list of features and characteristics for a person to memorize; rather, it is a complex interaction that needs to be fully examined and engaged (Gray & Thomas, 2006).

## **Barriers in LGBT Health Care**

McCormack (2007) identified several barriers that impair or diminish the care of LGBT individuals. Such barriers included, but were not limited to, provider homophobia, lack of access to health insurance, exclusion of significant others in the plan of care, and reluctance to access care because of past negative encounters (McCormack, 2007). Developing nurse practitioners' cultural competence could diminish some of these barriers, or ameliorate conditions that give rise to these barriers. The first approach pertains to the fact that most clients who receive care, regardless of sexual orientation, may experience a sense of vulnerability and uncertainty when interacting with nurse practitioners or any other health care provider. This is due to the need to discuss intimate parts of their lives (Flemmer, Dekker, & Doutrich, 2014). Nurse practitioners can take steps to ensure that the clinical environment is safe; thus allaying their LGBT clients' apprehension. The ability of a nurse practitioner to create a safe space in which to provide care can foster provider-client trust, and facilitate collaboration toward mutual goals (Flemmer et al., 2014). Nurse practitioners must tailor interventions for the LGBT client that addresses the health disparities and the health care issues that these clients experience (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013).

## **LGBT Cultural Competence in the Nursing Curriculum**

The second approach to reducing LGBT clients' health care barriers – ensuring that the designs of interventions are optimal for LGBT clients – underscores the importance of nurse practitioners' LGBT cultural competence. This stresses the importance of educating nurse practitioners about LGBT health concerns and disparities with respect to other populations. However, despite the need for LGBT cultural competence in clinician education, research has found that discussion of the health needs of LGBT clients in health care providers' curricula is

lacking (Brennan, Barnsteiner, de Leon Siantz, Cotter, & Everett, 2012; Chinn, 2013; Eliason, Dibble, & DeJoseph, 2010; IOM, 2011b; Lim, Johnson, & Eliason, 2015; Obedin-Maliver et al., 2011; Røndahl, 2009). Moreover, this deficiency has given rise to a number of barriers in the health care provided to this population. Integration of LGBT education within curricula is crucial in providing skills and knowledge that develop student abilities to provide culturally appropriate, high-quality care (IOM, 2011b).

Many nursing curricula do not offer content regarding personal relationships and sexuality, and LGBT issues are rarely discussed (Røndahl, 2009). Due to the paucity of research regarding nurse practitioner education and LGBT health, previous research with nursing students (pre-licensure) was reviewed, since all nurse practitioners were also educated within pre-licensure schools of nursing. As a step toward rectifying deficiencies in clinicians' awareness of LGBT health care issues, Røndahl developed the Knowledge about Homo- and Bisexual and Transgender Persons Questionnaire (KHBT). The KHBT was based on the Knowledge about Homosexuality Questionnaire (KHQ) developed by Harris, Nightengale, and Owens in 1995. Røndahl administered the KHBT instrument to 71 nursing students and 53 medical students. With regard to essential knowledge for providing competent care to LGBT persons, Røndahl found that 82% of nursing and medical students lacked basic knowledge. It was presumed, in the study, that if the students had received adequate education regarding both personal relationships and sexuality, fewer students might have failed.

Even though the study recruited nursing students who were in their last semester of the nursing program, which could have influenced the results, the study, nevertheless, illuminated the need for LGBT education. The knowledge deficiencies among both nursing and medical students, pointed toward a need for including more LGBT content in the curriculum of both

educational programs, as a means to increase knowledge and to develop the ability of students to provide culturally competent care for LGBT individuals (Röndahl, 2009).

### **Biases that Impact LGBT Health Care**

One important bias-related factor that could be a barrier to providing culturally competent care to LGBT individuals is the practitioner's own homophobia or homonegativity (McCormack, 2007). Therefore, cultural competence includes not only being able to provide quality care to diverse individuals, but also being able to reflect on any possible biases that the provider may consciously or unconsciously entertain, including prejudice and stereotyping that may be a contributing factor to disparities in health (Mayer et al., 2008; Rutledge, Scott, Garzon, & Karlowicz, 2004). A provider's cultural competence has the potential to not only improve the care provided to clients but also to facilitate the elimination of health disparities (Betancourt, Green, Carillo, & Ananeh-Firempong II, 2003). However, homophobia and homonegativity are two important barriers to culturally competent care.

Homophobia is defined as “the fear of feelings of love and affection for members of one's own sex and the hatred of those feelings in others” (Tate & Longo, 2004, p. 28). Homophobia is a learned behavior that can be intentional or unintentional as well as subtle or overt (Irwin, 2007; Tate & Longo, 2004). Internalized homophobia is when people who are homosexual or bisexual have hatred toward themselves because of their sexual orientation (Tate & Longo).

Morrison and Morrison (2011) have proposed that homonegativity, the second barrier, “refers to negative affect, cognitions, and behaviors directed toward individuals who are perceived – correctly or incorrectly – to be gay or lesbian” (p. 2573). Negative attitudes toward homosexuality have been related to a number of issues that affect members of the LGBT

community, including negative mental health outcomes, social oppression, isolation, sexual health concerns, delayed treatment or lack of regular health care, and fear during health care interactions due to stigmatization and discrimination (David & Knight, 2008; Gandy, McCarter, & Portwood, 2013; Maticka-Tyndale, 2008; Maurer-Starks, Clemons, & Whalen, 2008; Nakamura & Zea, 2010). A nurse practitioners' homonegativity could thus adversely affect a client's psychological and physiological health. In fact, McCusker and Galupo (2011) addressed homonegativity as a contributing factor to men not seeking psychological services when suffering from depression because some may view depression as unmanly or an indication of weakness.

Although it is important to address homonegativity and homophobia, there is also a need to acknowledge that for some providers, feelings and attitudes may not be as extreme as homonegativity and/or homophobia. Some nurse practitioners may exhibit some degree of bias or prejudice that is not indicative of homophobia or homonegativity in working with LGBT clients, and some nurse practitioners may not possess any bias or prejudice. Benkert, Tanner, Guthrie, Oakley, and Pohl (2005) examined student nurse practitioner cultural competence regarding attitudes, behaviors, and service delivery elements. They found that 20% of the 122 respondents reported that they were "not at all comfortable" or "sort of comfortable" with those with different sexual orientation (Benkert et al). Within nursing education, both pre-licensure and graduate, it is important to expose students to individuals of differing sexual orientation in order to produce a nurse practitioner who is comfortable providing care for gay and lesbian clients. This lack of education and exposure has a potential to affect decisions on whom nurse practitioners will care for, or how they interact with those clients who they do see in practice.

A nurse practitioner who provides culturally competent care to gay and lesbian clients could help alleviate negative feelings such as personal homonegativity or internalized homophobia. Personal homonegativity refers to the client's internalization of social stigma based on sexual orientation, which may have a direct impact on sexual risk taking (Masters, Beadnell, Morrison, Hoppe, & Wells, 2013). Some gay men and lesbian women experience difficulty accepting their own sexuality resulting in self-hatred or shame about their sexual orientation (Kort, 2008; Tate & Longo, 2004). A client may wish to discuss the associated difficulties with his or her health care provider in an environment the client feels is safe, and where the health care provider is able to offer appropriate support and resources.

The expectation is for nurse practitioners to provide culturally competent care to LGBT individuals. In a grounded theory study, Johnson and Nemeth (2014) interviewed nine women who identified as lesbian or bisexual. One of the themes that emerged from the interviews was the "moment of truth" – when a woman disclosed her sexual orientation to the provider. The disclosure of sexual orientation was a pivotal point in the health care experience when the provider's response to this disclosure indicated the provider's ability to provide high-quality, culturally competent care as perceived by the participant. The researchers found that the women wanted their providers to "have knowledge about same-sex relationships, sexuality, sexual health, and other topics specific to lesbian and bisexual women" (p. 637).

In order to provide culturally competent care, nurse practitioners should become familiar with the differences between the LGBT culture and the mainstream heterosexual culture (McManus, 2008). One identified difference is the historical stigmatization of LGBT people that provides the source for health disparities based on sexual orientation and gender identity (IOM, 2011b). Familiarization with the differences is one step in assisting the nurse practitioner in

ascertaining whether he or she is providing culturally competent care to LGBT individuals. This discovery may start with a self-reflection by the nurse practitioner in order to assess whether he or she is providing culturally competent care for the gay and lesbian client.

### **Gay Affirmative Practice**

Davies (2003) defined gay affirmative practice (GAP) as an affirmation “of a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity” (p. 25). Crisp and McCave (2007) further identify GAP as “a culturally sensitive model for working with gay, lesbian, and bisexual adults” (p. 403). Gay affirmative therapy emerged as an attempt to rectify discriminatory practices by psychotherapists, and aimed to achieve this rectification by having providers use a framework of affirmation of lesbian, gay, and bisexual individuals (Langdrige, 2007).

There are six fundamental principles of GAP according to Appleby and Anastas (1998) (as cited in Crisp, 2006b):

1. Do not assume that a client is heterosexual.
2. Believe that homophobia in the client and society is the problem, rather than the sexual orientation.
3. Accept an identity as a gay, lesbian, or bisexual person as a positive outcome of the helping process.
4. Work with clients to decrease internalized homophobia to achieve a positive identity as a gay or lesbian person.
5. Be knowledgeable about different theories of the coming out process for gays and lesbians.
6. Deal with one’s own homophobia and heterosexual bias.

Nurse practitioners who employ GAP allow for open dialog and disclosure with LGBT clients; this can improve the care they provide. Gay affirmative practice supports cultural competency practices, as well as increasing the consciousness of both the client and the practitioner (Crisp, Wayland, & Gordon, 2010). Gay affirmative practice also encourages the provider to “directly challenge negative self-attributions and encouragingly affirm positive self-attributions about a person’s sexual identity” (Langdrige, 2007, p. 37). The model of GAP embraces the strengths of clients and encourages practitioners to: (a) support their clients’ self-determination; (b) view their client’s gay, lesbian, or bisexual identity as healthy, not pathological; and (c) assist their clients in “questioning and challenging oppressive structures in their lives” (Crisp et al., 2010, p. 9). The ultimate goal of GAP is for the practitioner to become an ally and an advocate for LGBT persons (Hunter & Hickerson, 2003).

In order to assure optimal health outcomes for gay and lesbian clients, nurse practitioners must provide care that is culturally competent. Not all gay and lesbian clients are receiving care that is culturally competent, which may dissuade them from accessing health care services or from seeking out care from a provider, such as nurse practitioner (Mayer et al., 2008). This deficiency of culturally competent care, as previously stated, can potentially be attributed to the insufficiency of education regarding LGBT persons and their health needs. With a significant number of Americans identifying as LGBT, as well as identified health disparities among this population, it is imperative that nurse practitioners are able to meet the needs of this client population. Barriers to care, health disparities, and other needs have been identified in relation to gay and lesbian clients, yet there is a lack of literature examining the beliefs of nurse practitioners regarding working with LGBT patients, and the behaviors that these practitioners exhibit.



### **Focus on Gay and Lesbian Clients**

In researching the ability of nurse practitioners to provide care that is culturally competent, as well as gay affirmative, the focus was on gay and lesbian clients. The decision to focus on gay and lesbian clients, and to exclude bisexual and transgendered clients, was based on the information from the IOM reporting that, collectively, members of each identifiable group have their own unique health concerns and issues and suggesting that these concerns and differences be researched separately (IOM, 2011b). Furthermore, researching the entire LGBT population as a monolithic aggregate would have obscured important between-group differences.

### **Purpose of the Study**

This study had two purposes. The first was to explore the cultural competence of nurse practitioners by examining their practice beliefs and behaviors (gay affirmative practice) as they relate to working with gay and lesbian clients. Conducting research in this area was an important first step in determining the practice beliefs and behaviors of nurse practitioners regarding caring for gay and lesbian clients, and if they were providing care that was both culturally competent and gay affirmative. The second study purpose was to determine whether nurse practitioner beliefs and behaviors toward gay and lesbian clients were related to the amount of reported generalized cultural competence nursing education they received and the cultural competence they received specific to the care of gay and lesbian clients. The study utilized the GAP Scale score, and the reported amount of nursing education in general cultural competency, and in cultural competency specific to caring for gay and lesbian individuals, in order to fulfill both purposes of the study. Examining the perceived education of nurse practitioners was a starting point for potentially designing not only curricular interventions for academic programs but also continuing education programs for nurse practitioners already in practice.

## **Research Questions**

The following research questions were used to guide this study:

1. Is there a relationship between the self-reported beliefs of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients?
2. Is there a relationship between self-reported behaviors of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients?
3. Is there a significant difference between demographic categories of nurse practitioners (e.g., age, ethnicity, religious affiliation, type of nurse practitioner) and their self-reported beliefs and behaviors toward gay and lesbian clients?

## **Theoretical and Operational Definitions**

Variables are operationalized in a study by developing both conceptual and operational definitions (Burns & Grove, 2011). A conceptual definition is the abstract or theoretical meaning of a concept (Polit, 2010; Polit & Beck, 2014). An operational definition identifies the exact set of operations or procedures that are used to collect the needed information and to measure the concept within the research (Polit, 2010; Polit & Beck, 2014). Operational definitions are developed in order for a variable to be measured or manipulated in a concrete situation, and these definitions need to be independent of time and setting in order to utilize them at different times and in different settings (Burns & Grove, 2011). The information obtained from studying a variable will often increase the understanding of the theoretical concept that the variable represents (Burns & Grove, 2011).

The following terms are used in discussing the study:

### **Belief**

The definition of belief is the conviction of the truth of some statement or the reality of some being or phenomenon – especially when that truth is based on the examination of evidence; a feeling of being sure that someone or something exists or that something is true (Belief, n.d.). As a conceptual definition, belief can be identified as a mental representation of an attitude that is positively focused towards something being true. This belief can be seen in the way a client is cared for or beliefs about the way a client should be treated. For the purpose of this study, the operational definition of belief was in terms of nurse practitioners' belief about treatment with gay and lesbian clients. Belief was measured using 15 items of the GAP Scale.

### **Behavior**

The definition of behavior is the manner of conducting oneself; the way in which something functions or operates (Behavior, n.d.). As a conceptual definition, behavior is actions of a person towards another person or a group. For the purpose of this study, the operational definition of behavior was the actions taken by the nurse practitioner when caring for gay and lesbian clients. Behavior was measured using 15 items of the GAP Scale.

### **Cultural Competence**

For the purpose of this study, Campinha-Bacote's (1999) conceptual definition of cultural competence was used, which states that cultural competence is "the process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family or community)" (p. 203). According to Garneau and Pepin (2015), this definition of cultural competence is the most cited in the scientific literature. For the purpose of this study, the total score of the 30-item GAP Scale was used to measure cultural

competence of nurse practitioners with gay and lesbian clients. The GAP Scale has been used in other disciplines as a measurement of cultural competency and cultural sensitivity of providers toward gay and lesbian clients (Crisp & McCave, 2007; Van Den Bergh & Crisp, 2004).

### **Assumptions**

Assumptions are principles that are accepted as being true based on logic or reason (Polit & Beck, 2014). According to Burns and Grove (2011), universally accepted truths, prior research, theories, as well as nursing practice, are all sources of assumptions. Early identification of assumptions by the researcher should be considered a strength, as this identification can “influence the development and implementation of the research process” (Burns & Grove, 2011, p. 48).

In this study, the following assumptions underlie the discussion:

1. Cultural competence affects the care received by gay and lesbian clients.
2. Although most, if not all, nursing curricula include content on overall cultural competence, cultural competence as it relates to LGBT clients is often not addressed.
3. Nurse practitioners work with clients who are gay or lesbian.
4. Gay and lesbian clients seek health care from nurse practitioners as primary providers.
5. Nurse practitioners have a desire to provide culturally competent care to gay and lesbian clients.
6. The nurse practitioners who serve as participants in the study will respond honestly to the questions on the GAP Scale.

## **Chapter One Summary**

This chapter has offered background information regarding the unique health characteristics and health care issues of gay and lesbian clients and the importance of nurse practitioners to provide culturally competent care to them. There was discussion that bias and prejudice, as well as homophobia and homonegativity, may be present in some providers and how this can affect the ability to provide culturally competent care to gay and lesbian clients.

Nurse practitioners are positioned to provide primary care for LGBT clients, as the landscape of health care has changed. Nurse practitioners have the ability, by providing culturally competent care to LGBT individuals, to provide the health care needs of this patient population as well as to address the health disparities faced by this group.

Unique health characteristics and health care deficiencies directly affect gay and lesbian clients' health and wellness and result in disparities between these populations and other populations. National professional bodies, as well as the small amount of existing literature, indicate that LGBT individuals may not be receiving care that is culturally competent, which could perpetuate the health disparities identified within this client population. The importance of nursing education regarding cultural competence was highlighted. Chapter Two will present a review of the literature as well as the theoretical framework that guided the study.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

Chapter Two includes the review of the pertinent literature informing the conceptualization and operationalization of this study on nurse practitioners' cultural competence toward gay and lesbian clients and nurse practitioners' perceived nursing education specific to gay and lesbian persons. The chapter will begin by describing the process of conducting the search for applicable literature followed by a review of the current state of the science related to health disparities, GAP, barriers to care, positive strides in LGBT care, nursing education, and the importance of cultural competence among nurse practitioners and nurses. Lastly, the chapter will provide an overview of the theoretical framework for this study; Dr. Josepha Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services*.

#### Review of the Literature

##### Process for the Literature Search

An initial search was conducted using the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database and the Public/Publisher MEDLINE (PubMed) database. The following search parameters were used for both databases: (a) English language; (b) academic journals; (c) published in 2000 or later, allowing for a fifteen year time period; and (d) full text search within the articles for the identified search terms. In addition, the PubMed search was limited to human subjects. The results, using various search term combinations, are identified in Table 1. The results of the search demonstrate a gap in the research specific to cultural competence of nurse practitioners in providing care for gay and lesbian clients, as no articles were located.

Table 1

*Search results from CINAHL and PUBMED*

<b>Search Term Combinations</b>	<b>CINAHL</b>	<b>PUBMED</b>
<b><i>Nurse Practitioner AND:</i></b>		
<i>LGBT AND Cultural Competence</i>	0 results	0 results
<i>LGBT</i>	3 results	0 results
<i>Gay</i>	18 results	0 results
<i>Lesbian</i>	11 results	0 results
<i>Homosexual</i>	2 results	0 results
<i>Cultural Competence</i>	50 results	7 results
<b><i>Nurse AND:</i></b>		
<i>LGBT AND Cultural Competence</i>	4 results	0 results
<i>LGBT</i>	21 results	4 results
<i>Gay</i>	138 results	58 results
<i>Lesbian</i>	97 results	54 results
<i>Homosexual</i>	55 results	16 results
<i>Cultural Competence</i>	750 results	164 results
<b><i>Nursing AND:</i></b>		
<i>LGBT AND Cultural Competence</i>	16 results	2 results
<i>LGBT</i>	119 results	10 results
<i>Gay</i>	823 results	124 results
<i>Lesbian</i>	515 results	124 results
<i>Homosexual</i>	434 results	29 results
<i>Cultural Competence</i>	2,415 results	427 results

## **Dearth of Research**

Overall, research to address the health of the LGBT population is lacking. Snyder (2011) conducted a medical literature search for the years 1950–2007, using terms and MEDLINE keywords that are commonly used to describe LGBT persons (e.g., gay, homosexual, lesbian, LGBT, queer). Snyder manually reviewed the initial 22,537 results to ensure that the publication pertained to sexual minority persons. After all exclusions, 21,728 papers were included for further analysis. These identified publications were then individually categorized into 30 major topic areas of publication as well as categorized by general publication type, with a large percentage of overlap into two categories or publication types. The vast majority of publications were descriptive articles; demonstrating the lack of research in general related to the LGBT population. The most commonly associated topics of publications identified regarding LGBT individuals included: human immunodeficiency virus (HIV)/ acquired immune deficiency

syndrome (AIDS)/AIDS-related opportunistic infections; adolescent health; substance abuse; race and ethnicity; identified risk behaviors; homosexuality as a deviant, immoral behavior or as a psychiatric illness; and healthcare provider interactions with LGBT clients.

Snyder (2011) found that a large percentage (31.78%) of the examined 21,728 publications focused on HIV, AIDS, and sexually transmitted diseases (STDs). Snyder identified that an increase in the number of publications addressing what would be eventually termed AIDS, began in 1981, which coincides with the first identified cases in the U.S. During the early years of AIDS, there was an association of the disease with gay men; as the common press described AIDS as gay-related immune deficiency (GRID). There was an identified stigmatization associated with AIDS as well (Snyder). The impact of these initial beliefs, as well as a narrow understanding, attributed to the increase in the medical literature pertaining to LGBT persons and HIV/AIDS. Snyder did identify that over the last two decades, medical literature had evolved to be inclusive of heterosexual patients within publications focused on HIV/AIDS.

Snyder (2010) further conferred that of the 30 identified topics, 10 of the topic areas were demonstrating significant growth among publications on LGBT persons and LGBT health. The top 10 topics were identified as: adolescents; tobacco, alcohol, and substance abuse; racial and ethnic minorities; “risk” behaviors; hepatitis; non-HIV-related neoplasms and cancer screenings; aging and end-of-life topics; “coming out”; health needs assessment; and personal happiness and relationship satisfaction. Furthermore, three topics demonstrated a significant decline in their representation in the medical literature, including: homosexuality as a deviant behavior and/or mental illness, the use of diagnostic tools to uncover homosexuality, and treatment of homosexuality. This decline demonstrated that homosexuality was no longer viewed as a condition in need of treatment within the medical literature (Snyder).



The health needs of the LGBT community have also been inadequately described within research specific to nursing. Eliason et al. (2010) conducted a review of the nursing literature published between 2005 and 2009 related to LGBT health within the 10 top nursing journals based on the 5-year impact factor. The 5-year impact factor is based on the average number of times articles from a specific journal have been cited within the past 5 years. Key terms that were applicable to sexuality and gender were used for the CINAHL literature search and the number of hits that occurred within any field, within the title only, and within the abstract was identified (Eliason et al.). The most common hits within any field; were gay (2123), lesbian (1051), and bisexual (898). When reviewing hits within the title, which might be indicative of the focus of the article, Eliason et al. found the three most common hits were gay (1332), lesbian (652), and bisexual (451). Hits for gay men in the title and within any field, were double the number of hits for lesbians. There were fewer hits for bisexuals and even less for transgender (327 in any field and 230 in the title), when compared to gay men and lesbians.

Out of almost 5,000 journal articles published between 2005 and 2009 within the top 10 nursing journals, Eliason et al. (2010) identified 8 articles (0.16%) that primarily focused on LGBT health issues. Of the 8 identified articles; 6 were qualitative studies, 6 appeared in one specific journal (Journal of Advanced Nursing), and none were from U.S. researchers.

In addition to the 8 articles with a primary focus on LGBT issues, there were 19 articles identified by conducting key word searches that mentioned, but did not focus, on LGBT issues (Eliason et al., 2010). These articles demonstrated that LGBT literature exists; however, much of it is descriptive and little focused on developing providers to adequately provide care to this population.

Only three of the top 10 nursing journals identified in Table 2 contained articles regarding LGBT health issues and five of the top-10 impact journals had “a complete silence on LGBT issues” (Eliason et al., 2010, p. 212). An important aspect regarding silence in the nursing literature is that it can lessen the visibility and importance of LGBT people, families, and communities and propagate health disparities (Eliason et al.). A replication study of the review of the literature from 2009 to 2015 is needed, in order to ascertain the current state of the evidence regarding LGBT health issues.

Table 2  
*Top 10 Nursing Journals by Impact Score Identified by Eliason, Dibble, and DeJoseph (2010)*

<b>Journal Name</b>	<b>Impact Score</b>
<i>Birth</i>	2.933
<i>European Journal of Oncology Nursing</i>	2.482
<i>Journal of Advanced Nursing</i>	2.324
<i>Nursing Research</i>	2.259
<i>International Journal of Nursing Studies</i>	2.251
<i>Cancer Nursing</i>	2.248
<i>American Journal of Critical Care</i>	2.065
<i>Journal of Clinical Nursing</i>	1.922
<i>Journal of Nursing Scholarship</i>	1.692
<i>Heart and Lung</i>	1.658

### **Literature Specific to Nurse Practitioners and LGBT**

No literature was retrieved using the PubMed database regarding nurse practitioners and specific LGBT terms (LGBT, lesbian, gay, homosexual). The CINAHL database identified a total of 34 hits regarding nurse practitioners and the selected LGBT terms (LGBT, lesbian, gay, homosexual). Publications specific to providing care to LGBT persons or the health issues/concerns of LGBT persons were identified. Reviews, practice alerts, and studies authored by a researcher with the last name ‘Gay’ were excluded. Three publications overlapped into more than one of the search categories. Table 3 identifies the final culmination of seven articles retrieved from the literature search that will be discussed in detail within the literature review.

Table 3

*Articles for Review Regarding Nurse Practitioners and LGBT*

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**Author(s), Year, Title, and Journal Title**

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Barnes, H. (2012). Health needs of lesbians. *Primary Health Care*.

Blackwell, C. W. (2014). Vaccination guidelines for gay and bisexual men. *The Nurse Practitioner*.

Chaplic, K. C., & Allen, P. J. (2013). Best Practices to Identify Gay, Lesbian, Bisexual, or Questioning Youth In Primary Care. *Pediatric Nursing*.

Gee, R. (2006). Primary care health issues among men who have sex with men. *Journal Of The American Academy Of Nurse Practitioners*.

Parr, M. M. (2013). Homeless sexual minority youth: An overview for the nurse practitioner. *The Internet Journal of Advanced Nursing Practice*.

Ridner, S., Frost, K., & LaJoie, A. (2006). Health information and risk behaviors among lesbian, gay, and bisexual college students. *Journal Of The American Academy Of Nurse Practitioners*.

Waterman, L., & Voss, J., (2015). HPV, cervical cancer risks, and barriers to care for lesbian women. *The Nurse Practitioner*.

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**Health needs of lesbians.** Barnes' (2012) informational article addressed the importance of improving education and staff training on LGB health needs for primary health care professionals. Barnes specifically provided an overview of the health needs of lesbians not being addressed by primary care providers. A need existed for primary providers to increase their awareness of health needs of lesbians in order to ensure that this population was not disadvantaged (Barnes).

Barnes (2012) focused on four primary topics: health promotion, cervical cancer, sexual health, and mental health. Disparities of lesbians were identified including, but not limited to: provider homophobia causing delays in seeking treatment; higher smoking rates and alcohol consumption; greater body mass indexes which may lead to cardiovascular disease; increased risk for breast cancer; and higher rates of self-harm, depression, and suicidal thoughts (Barnes).

Barnes identified ways in which health care provisions can be made for this population. The five implications for practice were identified as:

- Ensure targeted health promotion: breast and cervical screening and appropriate sexual and mental health assessments and referrals.
- Improve LGB focused education for health care practitioners, including free preregistration training.
- Women who have sex with women require health education about sexually transmitted infections and cervical cancer risks. Provide lesbian-specific leaflets and information in general practitioner practices and other health areas.
- Primary care services should advertise confidentiality policies as ‘lesbian friendly’. Recording patients’ sexual orientation can prevent the need for patients to repeatedly come out.
- Use gender-neutral language, do not assume heterosexuality. (Barnes, 2012, p. 30)

Nurse practitioners, as primary providers, need to be aware of the specific needs of lesbian clients in order to provide culturally competent care. Knowledge and skills are necessary in order to meet these identified needs.

Waterman and Voss (2015) conducted a literature search in order to identify Pap testing rates among lesbians as well as to identify reasons for lack of recognition of cervical cancer risks. A relevant literature search was conducted using PubMed, CINAHL, and dissertations between 2000 and 2013 using search terms and combinations of: human papillomavirus (HPV), lesbian, women who have sex with women (WSW), Pap, cervical cancer, preventive, disparities, and screening (Waterman & Voss). Nineteen manuscripts were identified and reviewed with a final count of 10 key studies. All studies were cross-sectional, non-experimental designs.

Waterman and Voss extracted data on current Pap screen rates and the percentages of women who reported never having had a Pap test. Lesbians reported having a Pap within the previous 3 years at a rate of 48% to 81% ( $M = 60.5\%$ ) in the U.S., of 57% in the United Kingdom, and of 78% in Australia. The mean between all studies for a Pap test within the previous 3 years was 68.1%. According to Waterman and Voss, this is lower than the reported rates of heterosexual women. Findings also demonstrated that: (a) many lesbians do not seek gynecologic care; (b) lesbians perceived themselves to have a lower prevalence and risk for contracting HPV, sex between two women is inherently safe; and (c) there is a lack of health care provider knowledge regarding screening practices for WSW. When caring for a lesbian client, providers must understand that there may be a lack of trust toward the provider. Providers must not assume clients are heterosexual and must be sensitive when providing care (Waterman & Voss).

**Vaccination guidelines for gay and bisexual men.** Blackwell (2014) identified that gay and bisexual men have unique health needs that can present challenges for primary care providers. Nurse practitioners working in primary care settings should understand the role sexual orientation could play in promoting health. Blackwell identified gay and bisexual men as having an increased risk for acquiring sexually transmitted infections, hepatitis A, hepatitis B, and HPV. Because some conditions are vaccine-preventable, Blackwell recommended that for higher-risk adults, such as gay and bisexual men, the need to receive HPV, hepatitis A, and hepatitis B vaccinations.

Blackwell (2014) stressed the importance of not assuming a client is heterosexual and to take direct approaches when inquiring about sexual relationships. Recommendations were made in order to convey the recommended vaccinations to the gay and bisexual male community that

included: use of social media, information videos, and providing vaccinations at social events targeted to the gay community (Blackwell).

Additionally the informational article presented the importance of nurse practitioners maintaining open, nonjudgmental communication with clients in order to accurately obtain sexual history (Blackwell, 2014). Like Barnes (2012), Blackwell emphasized unique health needs and identified that nurse practitioners must have adequate knowledge in order to meet the needs of the clients.

**Best practices for youth in primary care.** Chaplic and Allen (2013) conducted a review of the literature in order to identify the best practices of primary care providers when working with gay, lesbian, bisexual, or questioning youth. The literature review identified youth at higher risk for many at-risk behaviors when compared to heterosexual youth. Increased risks were: (a) behaviors that contribute to violence; (b) behaviors related to attempted suicide; (c) tobacco, alcohol and drug use; (d) sexual behaviors; and (e) weight management (Chaplic & Allen).

According to Chaplic and Allen (2013), knowing the youth's sexuality is important in order to address the unique health needs of this population. Nurse practitioners can promote an environment that is both confidential and supportive for these youth by providing care that is culturally competent. Four key actions were identified, based on the review of the literature, for sexual history taking in adolescents.

- Providers should initiate open, honest, nonjudgmental discussions about sexuality as well as provide rationale on why this honest history is important.
- Providers should stress the importance and the right of confidentiality, including when it may need to be broken.

- Providers must increase their knowledge and comfort level in providing care to gay, lesbian, bisexual and questioning youth. When taking a sexual history, the provider should inquire about sexual orientation, sexual attraction, and romantic or sexual activity.
- Providers should inquire about same-sex attraction, romantic relationships, and sexual activity, as this is more important than disclosure of sexual orientation. This is due to sexual orientation being unstable during adolescence. (Chaplic & Allen, 2013, p. 101)

**Health issues among men who have sex with men.** Gee (2006) conducted an extensive literature review of research articles, journals, clinical practice guidelines, books, and public health department Internet Web sites. The purpose of the literature review was to examine health care that is appropriate for men who have sex with men (MSM). The term MSM encompasses gay and bisexual males, and includes those males who have sexual relations with men, but do not identify as gay or bisexual.

Gee (2006) identified the importance of nurse practitioners' awareness when addressing MSM, as there are unique health needs and risks associated. Areas of focus identified from the review of the literature: anal carcinoma, sexually transmitted diseases, high-risk sexual practices, depression, and substance abuse (Gee). There was an identified need for nurse practitioners to provide care that included health promotion, disease prevention, risk reduction, and patient education as well as a greater awareness of health issues, such as health screenings with the anal Pap smear and the high risk for substance abuse problems (Gee). Appropriate health care for MSM included social, emotional, and mental health factors. In order to address the unique health needs of MSM, nurse practitioners must have skills and knowledge about this population as well as the factors that influence these disparities.

**Homeless sexual minority youth.** Parr (2013) conducted a systematic literature review to ascertain the state of the evidence related to the health and health needs of homeless youth who identified as LGBT as well as to provide a theory-based model of care. A systematic review was conducted using CINAHL, MEDLINE, and PubMed databases in order to identify pertinent research articles (Parr, 2013). There were 531 articles written in English between 2002 and 2012 that contained the keywords “intervention,” “homeless,” “sexual minority,” “youth,” and “health”. Most articles were found to be quantitative, exploratory, and descriptive in design.

Key findings from the literature review included data concerning family acceptance and manner of homelessness; substance use, mental health and sexual behaviors; and the experience of discrimination, stigma and victimization. Parr (2013) identified that sexual minority youth (SMY) face a multitude of challenges in achieving and maintaining health and safety. When adding the homelessness to this already difficult situation, the SMY are at a greater risk for negative health outcomes and barriers when accessing care. Parr also identified that there was a lack of evidence-based research useful to nurse practitioners despite the amount of attention and calls to address disparities among this population.

Parr (2014) posited that nurse practitioners are well suited to address the health needs of the homeless SMY as they have advanced training and a history of caring for vulnerable populations. There is a need for nurse practitioners to become knowledgeable not only about homeless SMY, but also about LGBT youth as a vulnerable population with which they may have increased encounters in primary practice.

**Health information and risk behaviors among LGB college students.** Ridner, Frost, and LaJoie (2005) conducted a study in order to describe the differences in alcohol use, marijuana use, and smoking behaviors of LGBT and heterosexual college students. The purpose



was to determine if there were differences among the groups in order to identify strategies and interventions to minimize health risk and eliminate health disparities for this particular group. A sample of 3,000 full-time college students aged 18–24 years were randomly selected to receive an email inviting them to participate. A total of 810 (27%) surveys were returned with 772 (25.7%) comprising the final sample. Responses indicated that 731 identified as heterosexual (94.7%) and 41 (5.3%) as LGB. In order to compare LGB males and females to heterosexual males and females, a group was comprised of lesbian and bisexual women ( $n = 21$ ) and a group was comprised of gay and bisexual men ( $n = 20$ ). Bisexuals were added to the lesbian and gay groups because of the small numbers who reported being exclusively gay or lesbian (Ridner et al.).

Comparisons of LGB and heterosexual students indicated that LGB students were more likely to be smokers compared to the heterosexual students,  $\chi^2(1, N = 772) = 8.0, p < .01$ , and current alcohol users,  $\chi^2(1, N = 772) = 4.5, p = .03$ , when compared to their heterosexual peers (Ridner et al., 2005). Marijuana use among LGB students was higher (22%) than among heterosexual students (12%), although the findings were not statistically significant. Although fewer LGB students when compared to heterosexual students received health education related to tobacco prevention and alcohol and drug prevention, the finding was not significant.

Gay/bisexual males were similar to heterosexual males in terms of rates of smoking, drinking, and marijuana use. In contrast, there were major differences between lesbian/bisexual females and heterosexual females. Lesbian/bisexual women were 4.9 times more likely to smoke, 10.7 times more likely to drink, and 4.9 times more likely to use marijuana than heterosexual women (Ridner et al., 2005).

Limitations to this study included self-reporting of behavior, as students may not have been forthcoming in the truth regarding smoking, drinking, and using marijuana. This cross-sectional study does not allow for a deeper insight into changes in health risk behaviors and factors that would attribute to these changes. A longitudinal study may provide more information. Another limitation was the small number of LGB students who responded and the fact that gay males and lesbians were combined with bisexual males and females in order to have meaningful sized groups. This limitation and size decreased the generalizability of the findings.

This study is applicable to nurse practitioners as primary providers as preventive services can be anticipated when working with LGB clients. Ridner et al. (2005) also identified the importance of nurse practitioners' awareness of the health disparities that are present among LGB clients in order to assist in eliminating the disparity.

Among all seven publications, the commonality was the importance of providers being prepared to provide care for LGB individuals. As nurse practitioners are being identified as primary providers, there is a need for increased knowledge regarding the unique health issues and disparities among the LGB community.

### **Gap in the Literature**

The insufficient amount of literature and research regarding nurse practitioners and gay and lesbian clients, identifies a gap that needs to be addressed in the literature. Given that this particular group has been identified as playing a pivotal role in the future of health care as primary providers, there is a need to understand their beliefs and behaviors in caring for gay and lesbian clients. There is also a need to identify the perceptions of their education in preparing them to care for these clients.

## **Expounded Literature Review**

An expounded literature review was completed that focused not only on the health concerns of LGBT individuals but also on cultural competence and nursing education. Nursing education focused on both pre-licensure nursing programs (associate and baccalaureate) and graduate nursing programs (masters and doctoral). Before continuing the educational process towards a graduate degree, all nurse practitioners were first educated as registered nurses, thus the inclusion of education in pre-licensure programs was appropriate. The review did not limit the provider of care to nurse practitioners, but included registered nurses without advanced degrees as well as other health care providers.

Literature used for this study was inclusive of bisexual and transgendered individuals even though the study is addressing nurse practitioners' beliefs and behaviors specifically with gay and lesbian clients. This is in part because much of the scientific literature includes all lesbian, gay, bisexual persons under the umbrella term of LGBT despite the fact that each group is distinct and has its own specific health-related concerns and needs (IOM, 2011b). There is literature related to individuals that do not identify as lesbian, gay, or bisexual, although they engage in same-sex sexual activities, such as MSM and WSW.

## **Health Disparities**

Gay and lesbian persons experience many identified health disparities. Despite the increase in the number of facilities identified as leaders in providing health care equality to the LGBT community, research has shown that disparities still exist. Nurse practitioners have a unique role as nurses with advanced education in providing primary care services for the LGBT community. Understanding the health disparities faced by gay males and by lesbians is a necessary step for nurse practitioners in order to provide knowledgeable care.

Sexual minorities living in high-prejudice communities have been found to have a decreased life expectancy of approximately 12 years (Hatzenbuehler et al., 2014). Studies have also found that there are higher rates of excessive drinking among lesbian and bisexual women when compared to heterosexual women (Conron, Mimiaga, & Landers, 2010; Fredriksen-Goldsen & Muraco, 2010; Fredriksen-Goldsen et al., 2013; Ridner et al., 2006). In addition, there are higher rates of obesity among lesbians than among heterosexual women (Barnes, 2012; Conron et al., 2010; Boehmer, Bowen, & Bauer, 2007; Fredriksen-Goldsen et al., 2013). Suicide, homicide/violence, and cardiovascular diseases were found to be substantially elevated among sexual minorities who live in high-prejudice communities (Hatzenbuehler et al., 2014).

Healthy People 2020 acknowledged that LGBT individuals also experience health disparities related to cancer, physical and emotional violence, obesity, substance abuse, higher rates of mental health issues, and HIV and other sexually transmitted diseases (U.S. Department of Health and Human Services, 2011). Prior literature reviewed and discussed has also identified specific health disparities seen among lesbians, gays, bisexuals, homeless SMY, adolescents, and MSM (Barnes, 2012; Blackwell, 2014; Chaplic & Allen, 2013; Gee, 2006; Parr, 2013; Ridner et al., 2006; Waterman & Voss, 2015).

LGBT individuals are at risk for physical and emotional violence, which can take many forms. One of the most extreme manifestations of societal prejudice against gay and lesbian individuals is that of a hate crime (Cramer, Wakeman, Chandler, Mohr, & Griffin, 2013). According to the Federal Bureau of Investigation's (FBI) 2013 Hate Crime Statistics Report, the top three bias categories among the 5,922 single-biased hate crimes reported were race (48.5%), sexual orientation (20.8%), and religion (17.4%). Of the reported 1,402 hate crime offenses based on sexual orientation, 60.6% were classified as anti-gay (male) bias (FBI, 2013).

Individuals who are sexual orientation minorities were found to have a higher risk for post traumatic stress disorder (PTSD) compared with heterosexuals when having experienced multiple types of violence (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010). Sexual orientation minorities were also twice as likely as the heterosexual reference group to be initially exposed to violence (Roberts et al.). These identified frequent experiences of violence and victimization have long-lasting effects on LGBT individuals and the community, such as social isolation and increased rates of risk-taking behaviors (especially substance abuse).

D'Augelli and Grossman (2001) identified that lifetime occurrences of victimization due to sexual orientation amongst sexual minority older adults affects mental health as the individual ages. Physical victimization also is higher among adolescents with same-sex romantic attractions or who self-identify as gay than with their heterosexual counterparts (Friedman, Koeske, Silvestre, Korr, & Sites, 2006) and homophobic attitudes towards gay males correlates with homophobic aggression towards classmates who were perceived as gay (Murdock & Bolch, 2005; Prati, 2012).

Health care providers need to be aware of the high percentage of sexual minority clients who may have been victims of violence as well as the histories of abuse, neglect, or violent victimization of adolescents who identify as lesbian, gay, or bisexual (Roberts et al., 2010). Nurse practitioners who possess this knowledge are better positioned to understand the importance of follow-up care in order to assist the client in coping with a history of victimization. Nurse practitioners also should be knowledgeable regarding services and interventions for those who have been victimized and have an understanding of how these experiences can be a barrier for gay and lesbian clients.

More studies are beginning to examine the health disparities of older lesbians and gay males. Fredriksen-Goldsen et al. (2013) analyzed data from the 2003–2010 Washington State Behavioral Risk Factor Surveillance System ( $n = 96,992$ ) on health outcomes, chronic conditions, access to care, behaviors, and screening gender and sexual orientation with adjusted logistic regressions. Results demonstrated that LGB older adults (older than 50 years of age) had higher risk of disability, poor mental health, smoking, and excessive drinking when compared to older heterosexuals (Fredriksen-Goldsen et al.). Older lesbians and bisexual women had a higher risk of cardiovascular disease and obesity, and gay and bisexual men had higher risk of poor physical health and living alone than did heterosexuals (Fredrickesen-Goldsen et al.). Lastly, older lesbians reported a higher rate of excessive drinking than bisexual women; bisexual men reported a higher rate of diabetes and a lower rate of being tested for HIV than did gay men.

The literature demonstrates that aging LGBT individuals face unique disparities. Older LGBT individuals may rely on friends and caregivers rather than family for their needs (IOM, 2011b). Lim and Bernstein (2012) conducted a literature review and presented issues faced by aging LGBT individuals in order to promote awareness in nursing education.

### **Gay Affirmative Practice**

This section of the literature review will identify studies that have used the GAP Scale as a tool to measure GAP of various providers. Gay affirmative practice is considered a culturally sensitive model for working with gay and lesbian clients (Crisp & McCave, 2007). The reliability and validity of the tool will be discussed in Chapter Three. A literature search identified eight scholarly and peer reviewed sources that used the GAP Scale as a measure of gay affirmative practice on the practice domains of beliefs and behaviors. The GAP Scale consists of 30-items, 15-items measuring practice beliefs and 15-items measuring practice behaviors, using

a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) for beliefs and 1 (*never*) to 5 (*always*) for behaviors; with a possible range of scores from 30 to 150. A higher total score reflects a greater degree of affirmative practice with gay and lesbian clients. The entirety of the GAP Scale was used in five studies (Crisp, 2005; Crisp, 2006a; Crisp, 2006b; Greenberg, Pievsky, & McGrath, 2015; Mullins, 2012), and three studies used only the items measuring provider beliefs in caring for gay and lesbian clients (Chapman, Watkins, Zappia, Nicol, & Shields, 2011; Gandy et al., 2013; Nicol, Chapman, Watkins, Young, & Shields, 2013).

The participants in the samples varied and consisted of the following: religious mental health professionals (Greenberg et al., 2015); mental health service providers (Gandy et al., 2013); nursing and medical students (Chapman et al., 2011); health professionals described as nursing, allied health or medical professionals (Nicol et al., 2013); social workers and psychologists (Crisp, 2005; Crisp, 2006a); and social workers (Crisp, 2006b; Mullins, 2012). The same dataset and respondents were used for the studies regarding social workers and psychologists, and social workers alone (Crisp, 2005; Crisp, 2006a; Crisp, 2006b).

The GAP Scale can be helpful because it can be used as a rapid assessment instrument by a variety of professionals to evaluate the degree to which a person practices affirmatively with gay and lesbian clients. The GAP Scale has also been found to be significantly and positively correlated to other measures of attitudes toward gay and lesbian clients (Crisp, 2006a).

Additionally, the scale can be used to measure the effectiveness of educational interventions with a test-retest design (Crisp, 2006a).

Two relevant studies using the GAP Scale as a measurement tool are described in detail below. The other studies focused on social workers, psychologists, medical and nursing students, mental health providers for LGBT youth, and religious psychotherapists. The findings

of the studies were that participants were considered gay affirmative within their identified practice area. The scope of limitations for the studies included low sample size and low response rates which did not allow for generalizability to the target population. Another limitation was that several of the studies involved professionals who were members of professional organizations that have demonstrated strong support of gay and lesbian issues. Lastly, the majority of the samples were homogenous being Caucasian and heterosexual.

**GAP study with medical social workers.** Mullins (2012) explored the levels of beliefs about practice and practice behaviors of social work practitioners in a medical setting using the GAP Scale. A stratified random sample of 600 medical social workers was drawn from a national mailing list. The participants were administered a 50 item questionnaire that contained 20 demographic variables and the 30-item GAP Scale (Mullins).

Of the 600 invited participants, 127 (21%) completed the online survey (Mullins, 2012). The average age of respondents was 47.32 years, and the participants were largely female (81.9%), White (90.7%), married (67.7%), and heterosexual (89%). The average score on the practice belief domain was 64.7, and the average score on the practice behavior domain was 51.33 (highest possible score in each domain = 75). A significant moderate, positive correlation was found to exist between beliefs and behaviors ( $r = 0.551, p < .01$ ) according to Mullins (2012).

Mullins (2012) conducted a discriminant analysis on the mean scores of the practice belief domain and found that region, number of workshops attended with content on lesbian and/or gay issues, having friends who are lesbian and/or gay, and frequency of contact with lesbian and/or gay clients had an impact on the scores. Group differences within the variables with the practice belief scores were tested using an analysis of variance (ANOVA). One of the



statistically significant differences was found for regions between the following groups: Midwest Region and South Region, and the South and West regions (Mullins). Scores on the practice behaviors domain were affected by population density, number of workshops attended with content on lesbian and/or gay issues, having friends who are lesbian and/or gay, and frequency of contact with lesbian and/or gay clients according to the discriminant analysis (Mullins, 2012).

This study found that beliefs have a significant impact on practice behaviors but are not the only factor (Mullins, 2012). Mullins also stated that the research added to the body of knowledge regarding formal education of social workers in that it provides programs that assist future social workers in working with diverse populations.

Although Mullins (2012) did not address any limitations with the study, it is important to note that limitations are present. Although the study used various geographical regions, there was still a small response rate that may impact the generalizability of the study findings to the population of social workers in medical practice. Social workers work in a profession that adheres to practices of diversity and many respondents may have answered questions based on what they felt was warranted from their profession, and not necessarily on their own beliefs and behaviors. Self-administered studies have the ability for a respondent to not be forthcoming or truthful in his or her reply, thus skewing the data and findings.

**GAP study with health professionals.** Nicol et al. (2013) conducted a descriptive comparative study of health staff using a cross-sectional survey. The purpose of the study was to determine health professionals' knowledge, attitudes, and beliefs in working with LGBT patients seeking health care for their children in a pediatric tertiary hospital setting in Australia (Nicol et al.).

A total of 746 eligible health professionals were recruited. Inclusion criteria included: (a) being a nursing (registered or enrolled), allied health or medical professional; (b) being permanently or temporarily employed full time or part time; and (c) being an employee in participating in patient and outpatient departments (Nicol et al., 2013). Those departments with direct family contact were included. Allied health was defined as staff identifying with the disciplines of physiotherapy, speech pathology, occupational therapy, pharmacy, psychology, social work and audiology (Nicol et al.).

The researchers in liaison with department managers used the roster schedule in order to identify current staff for the survey. Of the 646 identified staff who met the eligibility requirements, 412 were nursing, 134 were medical, and 100 were allied health staff members (Nicol et al., 2013). The survey included basic sociodemographic data and assessed whether staff members had ever cared for a child from an LGBT family. In addition, there were three published scales administered within the questionnaire. The scales included were the Knowledge about Homosexuality Scale (measuring the accuracy of the staffs' knowledge related to homosexuality), the Attitudes Toward Lesbians and Gay Men (ATLG) scale (measuring the staffs' attitudes towards lesbian and gay men), and 15 items from the GAP Scale (measuring the staffs' consistency among beliefs with GAP).

Questionnaires were returned by a total of 212 participants (32.8% response rate), which including 142 (67.3%) nurses, 31 (14.6%) doctors, and 38 (17.9%) allied health professionals and other staff (Nicol et al., 2013). Age was not identified to have any statistical significance on the measures of the three tools.

Of the 19 knowledge statements from the Knowledge About Homosexuality Scale, 25.0% of the nurses, 54.8% of the doctors, and 42.1% of the allied health or other health

professionals identified 17 (90%) or more statements correctly (Nicol et al., 2013). This low percentage of nurses correlates with the low percentage of nursing students identified by Chapman et al's. (2011) study when compared to medical students' knowledge using the Knowledge about Homosexuality Scale.

The knowledge scores were significantly associated with professional group, gender, Caucasian race, political voting behavior, presence of religious beliefs, the frequency of attendance at religious services, the frequency of praying and having a friend who is openly LGBT (Nicol et al., 2013). The greatest differences identified between knowledge scores were those found among race and attendance at religious services, with non Caucasian respondents and those who attended religious services at least weekly having the lowest scores (mean scores of < 70% of items correct). Regarding attitudes toward lesbians and gay men, the most negative attitudes were found among respondents who reported attending religious services at least weekly, and those who reported not having a friend who is openly LGBT (Nicol et al., 2013).

Fourteen percent of nurses, 3.2% of doctors and 7.9% of allied and other health professionals achieved maximum scores on the belief domain of the GAP Scale. Although nurses scored lower in knowledge, they scored higher in beliefs regarding affirmative practice. There was a weak positive correlation identified between knowledge scores and GAP scores ( $r = 0.22, p = 0.001$ ) and a moderate negative correlation between attitude and knowledge scores ( $r = -0.40, p < 0.001$ ), indicating that increased knowledge is associated with more positive attitudes.

Limitations include the use of a convenience sample from one agency that may not allow for generalizability among all health providers. Also a limitation was the fact that the

researchers did not adjust for multiple comparisons, which may demonstrate some associations that have been identified by chance (Nicol et al., 2013).

### **Barriers to Care**

**Discrimination.** In the spring and summer of 2009, Lambda Legal conducted a survey of LGBT people and people living with HIV in regard to discrimination (Lambda Legal, 2010). With the assistance of over 100 organizations in 35 states, the survey was distributed to LGBT people and people living with HIV nationwide. Participants included 25 national organizations and 75 local, state and regional organizations. Thirteen groups were specifically people of color organizations and 12 specifically focused on people living with HIV. The survey was administered using various methods, including email requests sent to members and supporters; posting survey links on organizational websites and social networking sites; and distributing and collecting paper surveys (Lambda Legal). The survey was presented in both English and Spanish and used convenience sampling and snowball sampling in order to increase the percent of response (Lambda Legal).

There was no data that identified the specific number of individuals who received the invitation to participate in the survey, which did not allow for a calculation of the return rate. A total of 4,916 valid responses were considered valid and were used for the final analysis (Lambda Legal, 2010).

The demographics of the respondents were that over half identified as gay ( $n = 2,727$ ), with just fewer than 30% identifying as lesbian ( $n = 1,453$ ). Bisexuals accounted for 11.2% of the respondents. The majority identified as White ( $n = 4,241$ ; 86%) and employed fulltime (56.9%). Regarding gender: 55.7% were all male, 52.8% were non-transgendered male, 37.8% were all female, and 32.9% were non-transgendered female. Regarding age: 9.5% were 18–24

years of age, 41.6% were 25–44 years of age, 23.9% were 45–54 years of age, 18.1% were 55–64 years of age, and 6.9% were age 65 and above. There were 17.6% who stated they had never had an HIV test, 68.8% who stated their last HIV test was negative, and 13.6% who identified as having HIV or AIDS (Lambda Legal, 2010).

According to the survey findings, more than half of the participants reported experiencing at least one of the following types of health care discrimination: being refused needed care, health care professionals refusing to touch them or using excessive precautions, using harsh or abusive language, blaming the LGBT individuals for their health status, or being physically rough or abusive (Lambda Legal, 2010). The survey explored fears and concerns of LGBT individuals as well as those living with HIV, displayed on Table 4 as percentages. On all six items, transgender individuals and individuals living with HIV had higher percentages than LGB individuals.

Table 4  
*Fears and Concerns About Accessing Health Care Percentages*

<b>Question</b>	<b>LGB</b>	<b>Transgender</b>	<b>Living with HIV</b>
I will be refused medical service because I am...	9.1	51.9	20.0
Medical personnel will treat me differently because I am...	28.5	73.0	35.5
Not enough health professionals adequately trained to care for people who are...	49.0	89.4	48.0
Not enough support groups for people who are...	24.3	50.5	31.0
Not enough substance abuse treatment for people who are...	28.8	58.8	31.1
Community fear/dislike of people who are...is a problem.	52.4	85.7	66.1

*Note.* Adapted from "When health care isn't caring" by Lambda Legal, 2010. p.12.

Key recommendations were made in order to address the disparities and discrimination identified based on the survey results. One recommendation was to require that all health profession students and health professionals undergo significant cultural competency training

about sexual orientation, gender identity and expression and HIV status (Lambda Legal, 2010). This recommendation is appropriate, as one of the fears and concerns with a high percentage was regarding lack of health professionals being adequately trained to care for LGBT persons and those individuals living with HIV (Lambda Legal).

**Disclosure of sexual identity to providers.** Neville and Henrickson (2006) conducted a national survey in New Zealand in order to explore perceptions regarding the disclosure of a lesbian, gay or bisexual identity to primary health care providers. There was a call for partnership between LGB individuals as a cultural group, and providers, in order to understand and address specific needs (Neville & Henrickson). The survey instrument had a total of 133 items with specific questions regarding health and well being that was developed by an interdisciplinary research team in close consultation with a community advisory group comprised of LGB community leaders and members (Neville & Henrickson). The questionnaire was available both electronically and as a hard copy.

Participants were recruited through both mainstream and gay-targeted media due in part to New Zealand's combination of dense urban areas and sparsely populated rural areas. Websites and weblinks, print media, radio and television were all used to assist in the recruitment of participants. The community advisory group contacts distributed the study and a link to the uniform resource locator (URL) of the website. The target group were men and women in New Zealand who experienced sexual attraction for those people of the same sex or who engaged in sexual activity with people of the same sex, regardless of how they self-identified (Neville & Henrickson, 2006). The introductory ethics statement for recruitment identified that the participant must be 16 years of age or older.

A total of 2,269 unduplicated responses were received from a combination of the website (83.6%) and the paper surveys (16.4%) (Neville & Henrickson, 2006). The sample was comprised of 45.2% female, 54.5% male, 0.2% transgendered or intersexed, and 0.4% that did not respond to the question on gender. Other results from the demographic data represented that 51.1% had an undergraduate or postgraduate degree, 45.0% identified as having a relationship with a same-sex partner and living together, and 71.5% described their overall health as 'excellent' or 'good' (Neville & Henrickson).

With regard to provider assumptions about sexual identity, women (83.2%,  $n = 842$ ) were statistically significantly more likely than men (65.8%,  $n = 804$ ;  $p < 0.001$ ) to report that their health care provider 'usually' or 'always' presumed them to be heterosexual. Regarding age, 76.2% of those under the age of 40 ( $n = 894$ ) and 70.9% of those 40 and older ( $n = 734$ ) stated that their health care providers 'always' or 'usually' presumed that they were heterosexual.

More women (11.4%,  $n = 84$ ) than men (6.1%,  $n = 50$ ;  $p < 0.001$ ) reported that health care providers were uncomfortable with disclosure of sexual identity, although the number was quite small in both cases. Age, as a demographic variable, was statistically significant as more of the participants aged 40 years and older (85.1%,  $n = 678$ ) than those under 40 (77.8%,  $n = 574$ ), indicated that their health care provider was completely comfortable with the disclosure

One of the study limitations was the recruitment of participants. The participants, who elected to become involved with the study, may have been comfortable with their sexuality and felt the need to be heard and counted, according to Neville and Henrickson (2009). Although many efforts were made to reach out to various sectors of LGBT communities throughout New Zealand, it is likely that those who participated were connected to a wider network of LGBs as well. Another identified limitation was the use of gay media as a recruitment strategy.

Unfortunately, persons who may have been eligible for the study may have been excluded, because they did not view gay themed media. Another limitation was that the study was conducted in New Zealand, which may not adequately capture the population of those in the U.S. or may lack generalizability to those in other countries.

Neville and Henrickson (2009) identified four key discussion areas identified upon the conclusion of their study. The first discussion was LGB individuals felt that health care professionals' attitudes toward sexual identity were important, and influence the quality of care offered and received. Secondly, integral to the delivery of quality and appropriate health services, are health care providers allowing opportunities for LGB clients to disclose their sexual identity. Thirdly, despite additional training and an increased public profile, health care workers still largely assume that clients are heterosexual until proven otherwise. Lastly, heteronormativity and homophobia need to be addressed in nursing curricula as well as an appropriate theoretical and practical preparation for students in order to ensure that LGB clients receive culturally competent care (Neville & Hendrickson, 2009).

**Past negative experiences with providers.** There is also a demonstrated lack of accessing health care by many gay or lesbian individuals because of past negative experiences with homophobic providers (Dayer-Berenson, 2011; Hutchinson et al., 2006). Providers should strive to create an environment that is both welcoming and safe for diverse clients, which includes not making assumptions of heterosexuality and of sexual practices, as these may lead to inadequate care (Hutchinson et al., 2006).

**Homophobia.** Prati (2012) used social cognitive theory to investigate self-reported homophobic aggressive behaviors in school. The 863 participants were from 49 classes within 10 Italian public high schools, grades 9–13. Prati found that when there was a class-level



homophobic attitude toward gay males, this mediated the relationship between student observations of peer homophobic aggression and self-reported engagement in homophobic aggression towards schoolmates. Understanding the impact of homophobic bullying is necessary in order to address the potential consequences of this behavior, such as issues surrounding mental health (e.g., depression, anxiety, decreased self-esteem) and educational attainment (e.g., school failure, dropout).

In a study that systematically reviewed instruments measuring homophobia, Costa, Bandeira, and Nardi (2013) stated that the development of homophobia scales had been concentrated in the U.S. This concentration may suggest “that the notion of homophobia and the contemporary political movement around it came from the U.S.” (Costa et al., 2013, p. 1329).

Röndahl, Innala, and Carlsson (2004) conducted a study to explore the emotions of both nursing staff and nursing students toward homosexual patients in Sweden. All members of the nursing staff (48 nurses and 37 nursing assistants) were recruited for the first phase of the study. Inclusion criterion was that staff had to work directly with patients. A total of 57 (67%) staff responded and the majority of the sample were female (90%) and over the age of 36 (62%).

Nursing students ( $n = 155$ ) in semesters two and six of a program in central Sweden and nursing assistant students ( $n = 113$ ) in semesters four and six of an upper secondary program in central Sweden were recruited to participate. A total of 165 students (62%) responded with a majority being female (86%). The mean age of the nursing students was 27 years and 18 years for the nursing assistant students. There were 32 students (11.9%) who were of non-Swedish background, none from the U.S. (Röndahl et al., 2004).

Participants were asked to complete a survey that included a demographic datasheet, Affect Adjective Checklist (AAC), and Nursing Behavior Questionnaire (NBQ). The AAC

measures emotional aspects of homophobia. After reading a specific scenario involving a man who fell in love with his male friend, participants rated adjectives (such as compassionate, angry, and embarrassed) on a four-point scale from 'very much' to 'not at all' based on their emotional response (Röndahl et al., 2004). The NBQ is a four-statement tool constructed by the researcher for the study. Findings from the AAC included three emotional components: homophobic anger, homophobic guilt, and delight (Röndahl et al., 2004). Significant differences were found between groups in that nursing assistant students expressed more 'anger' and 'guilt' than the other groups. Student groups expressed more 'delight' than the nursing staff. Groups with cultural backgrounds different than Swedish, expressed higher scores for both 'homophobic anger' and 'homophobic guilt'. Findings from the NBQ found that of the practicing nurses and nursing assistants, 36% stated they would choose to refrain from nursing homosexual patients if the possibility existed. The corresponding figure for the students was 9%. Practicing nurses have influence over students and those with strong condemning attitudes may attempt to transfer their views to students (Röndahl et al., 2004).

One of the limitations of the study was the lack of testing for reliability and validity for the NBQ. Another limitation is that the tool asked questions about homosexual patients and HIV-infected patients, which may have influenced how the respondent answered. Respondents may have seen the two groups as interrelated, which may have biased their response.

As direct providers of care, nurse practitioners need to be aware of the potential impact of homophobia on all gay and lesbian clients. Gay and lesbian clients may hesitate to seek care and/or may be reluctant to reveal their sexual identity if they have experienced a homophobic encounter with a health care provider (Röndahl et al., 2004). As discussed, homophobia can have a negative impact on a person whether it is from an external source or whether it is internal

(Irwin, 2007; Kort, 2008; Tate & Longo, 2004). Being able to engage in dialog with gay and lesbian clients regarding their experiences with homophobia will allow nurse practitioners the ability to provide a safe environment and to foster a relationship of trust.

### **Positive Strides in LGBT Health**

The Healthcare Equality Index (HEI) was created in 2007 as a resource for all healthcare facilities across the country to assess and improve their policies and practices related to the LGBT community. The HEI identifies the Four Core Criteria as the policies and practices that are foundational to equitable and inclusive LGBT care. These Four Core Criteria are: patient non-discrimination policies, visitation policies, employment non-discrimination policies, and training in LGBT patient-centered care (HRC, 2014). The fourth core calls for key facility employees to receive expert training in LGBT patient-centered care. This criterion recognizes the fact that training is critical for policies to be successful and for truly LGBT – welcoming care to occur.

The Human Rights Campaign (HRC) Foundation independently assessed hundreds of U.S. facilities in addition to those who voluntarily participated leading to a total of 1,504 healthcare facilities evaluated in the 2014 HEI (HRC, 2014). Of the 1,504 U.S. healthcare facilities, 427 earned the coveted designation as a “Leader in LGBT Healthcare Equality” in 2014; representing a 101% increase over the number of designated facilities in 2013 (HRC, 2014).

### **LGBT Nursing Education**

**The identified need to integrate LGBT into curriculum.** Current nursing student attitudes toward LGBT individuals supports the need for LGBT content within nursing curricula, both undergraduate and graduate. Integrating various teaching–learning strategies such as an

online cultural self-assessment, case scenarios, and cultural assessment of clinical agencies can be helpful in moving nurse practitioner students along the continuum of becoming culturally competent practitioners (Cross, Brennan, Cotter, & Watts, 2008). The American Association of Colleges of Nursing (AACN, 2008) identified the inclusion of cultural competency in nursing education as a means to educate future nurses in providing care that is patient-centered as well as the importance of addressing and eliminating disparities faced by those from diverse and vulnerable populations (AACN, 2008). The National Organization of Nurse Practitioner Faculties (NONPF, 2014) also addressed the relevance of cultural competency as a legislative and regulatory issue within the competency of health delivery systems. Integration of LGBT content could assist future nurses and nurse practitioners in moving towards cultural competency in working with LGBT clients (Eliason et al., 2010). Educational strategies regarding LGBT health could readily be integrated into curriculum that could increase knowledge and skills, as well as allow for exposure and experiences related to LGBT content and persons. These educational strategies could include didactic content, case studies, LGBT panels, group discussions, simulation experiences, key informant interviews, and use of standardized patients.

There is often a limited amount of information or education within nursing curricula that addresses LGBT concepts, experiences, and needs that are related to health and illness (Brennan et al., 2012; Chinn, 2013; Eliason et al., 2010; Røndahl, 2009). Lim et al. (2015) stated that among baccalaureate nursing programs, there was an estimated median time of 2.12 hours devoted to teaching LGBT health.

Lim et al. (2013) identified that nursing curriculum needs to be reviewed for gaps in LGBT-related topics. Suggestions for ways to implement content were given that would allow for promotion of LGBT health. Recommended educational strategies included simulation, case

studies, nursing care plans, course development, independent study, elective courses, clinical affiliations, and assignments (Lim et al.). Nurses are direct caregivers and play a pivotal role in eliminating health disparities among the LGBT population. The essential first step toward achieving this goal is education and training (Lim et al.).

Brennan et al. (2012) identified that attitudes, knowledge, and skills in nursing education were necessary in order for a student to develop as a culturally competent provider. Pedagogical strategies were identified that could be useful in assisting students in understanding the complexities of care for the LGBT community. Some of the strategies included: panel discussions in order to create sensitivity and empathy; group projects aimed at reducing heterosexism among students; reflective activities where students write both positive and negative associations with various terms; and literature, film and music that evoke discussion (Brennan et al., 2012).

Carabez, Pellegrini, Mankovitz, Eliason, and Dariotis (2015a) found that among practicing nurses in the San Francisco Bay area, 80% stated that they had not received education or training on LGBT issues. Carabez et al. (2015b) conducted a study in the San Francisco Bay Area where 119 nursing students enrolled in a community/public health nursing theory course in a large urban university were given an assignment to interview two nurses regarding caring for LGBT patients. The nursing students recruited key informants ( $n = 268$ ) through convenience sampling who had to meet the inclusion criteria of being a registered nurse, residing in the San Francisco Bay Area, being age 18 or older, and willing to discuss health care needs of LGBT clients based on their professional experience.

Interviews were conducted face-to-face and audio recorded. A 16-item scripted interview was based on the HEI with a primary focus on training and comfort level working with LGBT

clients. The interviews were analyzed using content analysis in order to identify initial themes. The three themes were identified as: organizational training, comfort level, and revelations sparked by the interviews.

Of the 268 key informants, 46% had 10 or more years of nursing experience and nearly 80% mostly worked with adults and provided direct patient care (71%). When asked if their organization offered training regarding LGBT patient care 212 (79.1%) said no and when asked how prepared/comfortable nurses are working with LGBT clients, 189 (70.5%) said that nurses in general were comfortable in providing care to LGBT clients (Carabez et al.). Given this high percentage, it appears that the process of being interviewed may have alerted many nurses to their lack of knowledge related to LGBT health because after the interviews, a number of them, 55 (20%), voluntarily stated that they wanted training or wished that more was available (Carabez et al.).

Studies have also demonstrated that nursing students had inadequate knowledge regarding LGBT health concerns (Cornelius & Carrick, 2015; Røndahl, 2009; Røndahl et al., 2006). However, Carabez et al. (2015b) found that the majority (74%) of nursing students enrolled in a public health class reported that an assignment with specific focus on LGBT health increased their awareness of LGBT issues. The assignment consisted of diverse teaching strategies: readings, a 2-hour presentation on LGBT health issues, and an assignment to conduct a scripted interview with two nurse key informants, based on the HEI. Integrating LGBT content within curriculum can increase awareness of health issues and potentially impact the health disparities faced by the LGBT community as well as increase the knowledge of the provider.

**Barriers to nursing education.** Although cultural competence has been taught to nursing students for many years, the emphasis has commonly been placed on cultural or ethnic

beliefs, values, and practices, rather than issues of race, gender, class or sexual orientation (Abrums & Leppa, 2001). The lack of inclusion of sexual orientation within cultural competency education or the pure lack of LGBT content in curriculum is a barrier to nursing education.

**Faculty.** One barrier that has been identified is faculty who are unprepared to teach content regarding LGBT health due to a lack of knowledge and skills. Sirota (2013) conducted a descriptive study to explore the attitudes of 1,282 nurse educators toward homosexuality. Recruitment emails were sent to those faculty who appeared on the public website for the Commission on Collegiate Nursing Education accredited colleges in the U.S. ( $n = 6,766$ ). The email contained a link to the study materials, including the 20-item ATLG scale. The majority of the respondents were: female (90.3%), White (90.7%), born in the U.S. (95.0%), over the age of 51 (68.7%), and heterosexual (89.3%). Various religions were represented in the sample as well as various levels of education.

Sirota (2013) found that most participants (78.6%) felt that teaching nursing students about homosexuality was important to extremely important, but 71.9% also indicated that they were 'not at all prepared' (56.6%) to 'somewhat prepared' (15.3%) to teach the content. The conclusions made by Sirota were that nurse educators had a favorable attitude toward homosexuality. The mean scores on the ATLG scale were impacted by various demographic and occupational factors (age, sexual orientation, gender, religion degree of religious observance, degree of spirituality, geographic location of employment, length of time of employment in nursing education, and opinion about the importance of teaching nursing students about homosexuality).

One of the implications for practice identified by Sirota (2013) was that “nurse educators must gain comfort, cultural competence, and a strong knowledge and skills base to proficiently teach content about sexual minorities and to work with LGB patients and students” (p. 225). Educational content should be developed that allows for students to develop attitudes towards homosexuality that translate into culturally competent care for these vulnerable populations.

Lim et al. (2015) used a survey to assess the knowledge of faculty in baccalaureate nursing programs and their readiness to teach about LGBT health. The survey was sent to a nonprobability purposive sample of nursing school administrative leaders ( $n = 739$ ) who were asked to share the link with faculty. All faculty were included and eligible to participate and programs were represented that were both online and traditional.

The researchers developed a 23-question survey with a focus on faculty opinion about LGBT health knowledge and experience teaching LGBT health topics, as well as readiness to integrate content into curriculum (Lim et al., 2015). Four content experts in LGBT health reviewed the questionnaire for content validity.

The survey consisted of both Likert scale items as well as open-ended questions that allowed for analysis of qualitative data. A total of 721 schools were included in the study and a total of 1,231 faculty members participated. Response rate was not calculated, as there was not a way to confirm how many faculty received the survey link.

The majority of respondents were female (90%), White (88%), heterosexual (78%), employed full-time (86%), and highest level of education was a master’s degree (50%). The majority of the faculty had more than 5 years of teaching experience (67%); with 24% having between 5-10 years and 43% having more than 10 years (Lim et al., 2015). The average age of respondents was 50.6 years.



Findings included that about 50% of respondents identified both a lack of knowledge and awareness with regard to LGBT health issues. Of the 1,231 faculty surveyed; 45% of heterosexual male faculty, 17% of heterosexual female faculty, 10% of lesbian/bisexual female faculty, and 8% of gay/bisexual male faculty reported that LGBT health topics were unimportant. Twenty-eight percent of heterosexual female faculty, 14% of heterosexual male faculty, 14% of lesbian/bisexual faculty, and 13% of gay/bisexual male faculty stated that they were uncomfortable addressing LGBT health topics. Lastly, 55% of heterosexual male faculty, 46% of heterosexual female faculty, 23% of lesbian/bisexual faculty, and 15% of gay/bisexual male faculty stated that they lacked knowledge of LGBT health (Lim et al.).

Limitations were identified as bias associated with nonprobability sampling methods, lack or reliability testing for the survey, inclusion of only baccalaureate nursing programs, and faculty who did not respond to the survey. Another limitation was that the survey link was not directly sent to nursing faculty, which may have impacted the sample participants.

***Homophobia among nursing students and faculty.*** Dinkel, Patzel, McGuire, Rolfs, and Purcell (2007) conducted a descriptive study with a convenience sample of 126 nursing students and 15 faculty members in a baccalaureate nursing program at a midwestern university to assess the level of homophobia among faculty and nursing students. Students from all four semesters were represented in the total of 126 nursing student.

The participants completed a demographic questionnaire that included age range, position in the School of Nursing, sexual orientation/identity, familiarity with LGBT persons, previous participation in diversity class/workshop and the impact of religious beliefs on acceptance or non-acceptance of LGBT (Dinkel et al., 2007). In addition to the demographic questionnaire,

two tools measuring homophobia were used for the study: the Index of Attitudes Toward Homosexuals (IAH) and the Homophobic Behavior of Students Scale (HBSS).

The IAH is a measure of homophobic attitudes originally developed by Ricketts and Hudson and consists of 25 items using a Likert scale and has a reported Cronbach's  $\alpha$  of .90 and a Standard Error of Measurement (*SEM*) = 4.43 (Dinkel et al., 2007). Scores range from 0–100 and scores above 50 indicate the presence of homophobic attitudes. The HBSS measures students' behavioral responses in classroom or social settings toward gays and lesbians and was developed by Van de Ven, Bornhodt and Bailey. The HBSS is a 10 item Likert scale with scores ranging from 0–100 with the higher scores indicating more negative behavioral intentions towards homosexuals. Reliability of the HBSS instrument, with a Cronbach's  $\alpha$  of .81, was reported (Dinkel et al.). Measurement tools, consent to participate and demographics tool were distributed to students in person and to faculty via their work e-mail addresses (Dinkel et al.).

The majority of the students were in the 19–30 year old age range (76%), identified as heterosexual (96%), and stated that they had a friend, acquaintance, co-worker, or family member who identified as LGBT (81%). Only 34% of the students participated in a class or a workshop that addressed diversity in sexual orientation (Dinkel et al., 2007). Regarding whether religious beliefs influenced the students in an accepting way towards LGBT person, 21% were greatly influenced, 34% somewhat influenced, 35% not at all influenced, and 10% reported that the question was not applicable to them (Dinkel et al.). Conversely, when students were asked if religious beliefs influenced them in a non-accepting way towards LGBT, 11% were greatly influenced, 27% somewhat influenced, 50% not at all influenced, and 12% reported the question as not applicable to them.

The majority of the faculty members were older than 40 years of age (93%), heterosexual (87%), had a friend, acquaintance, co-worker, or family member who identified as LGBT (100%), and had participated in a class or workshop that addressed diversity in sexual orientation (64%). When faculty members were asked if religious beliefs have influenced them in an accepting way toward individuals who identify as LGBT, 36% were greatly influenced, 14% somewhat influenced, and 50% not at all influenced. When asked if religious beliefs have influenced them in a non-accepting way toward LGBT, 8% were somewhat influenced while 92% stated that they were not at all negatively influenced (Dinkel et al., 2007).

The overall level of homophobia for the sample was low, as demonstrated by a mean of 34.90 for the IAH and 23.49 for the HBSS (excluding faculty due to the nature of the measure). Dinkel et al. (2007) posited that the scores could have been reflective of tolerance and acceptance of those individuals who were not heterosexual. The scores may have also been representative of students and faculty taking a neutral position on the subject, as this position may be the safest and require the least from the health care provider (Dinkel et al.). Lastly, the scores may have represented heterosexism among the participants according to Dinkel et al.

Within the sample, there were two students and two faculty who identified as lesbian and two of the researchers were also lesbian (Dinkel et al., 2007). The knowledge that there were faculty members and students, who identified as lesbian, may have created an environment of acceptance, thus impacting the results of the study.

One limitation of the study was the small sample size that does not allow for generalizability but also limits statistical analysis. Secondly, two of the researchers were faculty members within the school of nursing, which may have influenced students to participate regardless of their views of LGBT. Lastly, different procedures were used in administering the

tools by lead faculty. Some of the faculty offered participation in the study before class while others offered participation after class, which may have had an impact on whether students participated.

***Heteronormativity in healthcare education programs.*** Røndahl (2011) conducted a descriptive study using semi-structured group interviews with nursing and medical students in Sweden in order to evaluate students' perceptions of their education in regard to sexual orientation. The participants included five nursing students and three medical students who were in semesters 2–6 of their program. Interviews were conducted by groups of nursing students and medical students, with an interview guide that was based on a qualitative interview method. An analysis of the data and were presented in a descriptive summary (Røndahl, 2011).

The theme of heteronormativity was consistent throughout all of the interviews (Røndahl, 2011). There were no specific teachings identified about LGBT people and the only time homosexuality was mentioned was in connection with sexually transmitted diseases (Røndahl). The students identified LGBT persons as a silent minority and felt that content regarding LGBT individuals could easily integrate into the curriculum in various methods. Students also described faculty and administrators as passive in regard to LGBT knowledge and also stated that they often felt excluded from theoretical as well as clinical training, as situations were not relevant to them (Røndahl).

Limitations to the study were a threat to credibility by using open interviews. Also the recruitment of students from the schools gay student organization may allow for biased opinions because the students are gay or lesbian.

**Comfort and bias.** Eliason and Raheim (2000) conducted a study of 196 Caucasian, undergraduate students in a nursing prerequisite course in a major Midwestern university. The

sample consisted of 173 women and 23 men with ages ranging from 18 to 43 ( $M = 21$ ). All respondents to the survey indicated that they were heterosexual. Eliason and Raheim stated that many White undergraduate students entering the health care profession often lacked exposure or education to people from cultures other than their own.

An instrument was developed that included demographic information, questions about exposure to people from 14 culturally diverse groups, and level of comfort with people from each group (Eliason & Raheim, 2000). If a student identified that he or she was uncomfortable with one of the culturally diverse groups, an open-ended item asked why. The instrument contained 48 items and underwent pilot testing with a sample of 25 students who completed the instrument at 2-week intervals that showed a test-retest correlation of .94. Eliason and Raheim stated that their primary focus was to study the attitudes about African American, lesbian, gay and bisexual people. Other groups were added not only to partially mask the primary research questions but also to gather preliminary data regarding the relationships between contact and attitudes for other social groups.

The instrument asked the students to identify how much experience they had working or socializing with people from each group (none, a little, some, or a lot), and also how comfortable they would be working with clients from each group (not at all, somewhat uncomfortable, somewhat comfortable, very comfortable). An open-ended question was then asked to indicate any reasons why the student would not feel comfortable working with people from a specific group (Eliason & Raheim, 2000).

Students identified little or no experience with individuals who were: HIV-positive (97%), bisexual (96%), blind (93%), lesbian (92%), homeless (91%), Native American (89%), and gay males (87%). The top four groups that students reported being uncomfortable working

with were: lesbians (44%), bisexuals (43%), HIV-positive people (42%), and gay men (35%; Eliason & Raheim, 2000). A literature review examining attitudes of nursing students towards caring for people with HIV/AIDS found that homophobia and stigma played a role in the reluctance to provide care (Pickles, King, & Belan, 2009).

Correlational coefficients (Pearson  $r$ ) were computed for experience and comfort levels and there was a high degree of relationship between experience and level of comfort for all but two of the groups; Native Americans and homeless persons. If students had previous experience with a group, they were more likely to experience comfort in working with members of the group (Eliason & Raheim, 2000).

Written comments were analyzed for patterns to identify why there were feelings of discomfort among students. Four themes emerged as to what caused the discomfort, which were identified as:

1. Lack of knowledge, skills, or exposure.
2. Disapproval or negative attitudes towards group members.
3. Feeling threatened by group members.
4. Feelings of guilt, sympathy, or pity toward group members (Eliason & Raheim, 2000).

When analyzing the comments, respondents most often attributed their lack of comfort with lack of knowledge, skill, or exposure to people within that group. The only exception noted was in response to those who were HIV-positive, which respondents identified being uncomfortable because of a fear of contracting the virus. The three groups regarding sexual identity (gay men, lesbians, bisexuals) had the largest number of responses indicating that the uncomfortable feelings by students were due to disapproval or negative attitudes.

Eliason and Raheim (2000) discussed how students seemed less inhibited about expressing negative attitudes about lesbian, gay, and bisexual people. Because comments were made that had affective underpinnings regarding LGB people (“gross,” “disgusting,” “immoral”), education needs to address more than just knowledge deficits. Eliason and Raheim stated that students might feel a higher amount of stress regarding LGB people because the difference is often invisible and members of the group may not be as identifiable.

Strong and Folse (2015) conducted a study to address educational needs of undergraduate nursing students and to determine whether the knowledge, attitudes and cultural competence toward LGBT patients could be improved. A convenience sample of 88 nursing students attending an undergraduate university in the Midwest was used for the study. Complete responses from 58 students were included in the data analysis and partials sets of responses were excluded from the analysis. The study used three measurement tools: (a) a modified ATLG scale; (b) the Lesbian, Gay, Bisexual, and Transgender Healthcare (LGBT Healthcare) Scale; and (c) the Lesbian, Gay, Bisexual, and Transgender Knowledge (LGBT Knowledge) Scale. The modified ATLG was used to assess the attitudes of students regarding the LGBT population. The original ATLG Scale was expanded to use questions regarding bisexuals and transgendered individuals. The original ATLG has been found to be reliable with a Cronbach’s alpha > 0.85 (Strong & Folse, 2015). The LGBT Healthcare Scale is a 6-item Likert scale that allows for written elaboration and the final three items were added by the research team and were specific to perceptions of competence, cultural sensitivity skills, and nursing curricula (Strong & Folse). The LGBT Knowledge Questionnaire is 15-item true or false questionnaire where two items were taken from a previously developed instrument, the Knowledge About Homosexuality Scale, and the research team added 13 items after a review of the literature (Strong & Folse).

This study focused on an educational intervention to improve the knowledge and attitudes of baccalaureate nursing students with a focus on terminology, health disparities, and culturally sensitive communication and used a pre and post-test design (Strong & Folse, 2015). The educational intervention was organized as PowerPoint slides. Content validity was obtained by having the intervention piloted by an expert panel of seven members of the university's Pride Alliance, which is an organization for those who identify as part of the LGBT community or an ally of the community (Strong & Folse). The feedback provided from the panel of experts resulted in a 40 to 45 minute educational intervention on relevant definitions, LGBT health disparities, cultural competence, and transgender-specific health care (Strong & Folse).

The sample included students from all four years of the nursing program (6.9% first year, 10.3% second year, 34.5 third year, and 48.3% fourth year). All students identified as heterosexual. Gender was not asked on the demographic questionnaire and was intentionally excluded per Strong and Folse (2015) stating the small number of male nursing students as the rationale. The majority of the students identified with a religion (82.8%), reported that they had a friend who identified as LGBT (79.3%), and had an acquaintance who identified as LGBT (55.2%). Friends and family (89.7%) were identified as being the most influential regarding attitudes about the LGBT community followed by positive or negative experiences with the LGBT community (56.9%) and the attitudes of the media (27.6%; Strong & Folse, 2015).

Strong and Folse (2015) found that changes in attitudes towards LGBT individuals were significantly improved after the intervention. Knowledge was improved as well as demonstrated by an increase in the mean score of the LGBT Knowledge questionnaire after the intervention. The participants indicated that the nursing curriculum inadequately addressed LGBT patient care (Strong & Folse).



There are several identified limitations within the study. The study used two measurement tools developed by the research team that demonstrated suboptimal reliability; the LGBT Healthcare Scale ( $\alpha = 0.54$ ) and the LGBT Knowledge Questionnaire ( $\alpha = 0.54$ ). Other limitations included the small sample size, which did not allow for generalizability to undergraduate nursing students, and the homogeneity of the sample. Not including gender on the demographic information is a limitation because although the number may be small in comparison to female nursing students, there is importance in analyzing whether there are differences based on gender regarding attitudes and knowledge of the LGBT community. Lastly, presenting the educational intervention during scheduled class time was a limitation as this limited the amount of content that could be included due to time constraints.

The study's finding regarding the insufficiency of addressing LGBT patient care in nursing curriculum, demonstrates the importance of incorporating content regarding LGBT health care into nursing curriculum. Strong and Folse (2015) focused their study on undergraduate nursing students. There is also worth in addressing the perceptions of nurse practitioners on their education regarding LGBT patient care. The data may give supporting evidence to inform nursing programs what information regarding LGBT health care is important for inclusion and what information may be able to improve the ability of providers to deliver culturally competent care to LGBT clients.

### **Importance of Cultural Competence in Nurses/Nurse Practitioners**

Rutledge et al. (2004) used Campinha-Bacote's model as a framework to integrate cultural content into standardized patient encounters for nurse practitioner students. Three different formats were used with the standardized patient: a group training interview, a group physical assessment, and a one-on-one interaction.

Rutledge et al. (2004) identified a number of benefits for nurse practitioner students using a standardized patient program including: consistency of clinical encounters, feedback to faculty and student, decreasing student anxiety, and videotaping of encounters. With these additional experiences, Rutledge et al. posited that students would gain awareness and knowledge regarding cultural competence and would become more comfortable with various cultural groups, thus increasing the student's desire, as future providers, to appropriately care for diverse clients.

Campbell-Heider et al. (2006) described the development, implementation and evaluation of a new family nurse practitioner curriculum designed to educate students to be culturally competent. A Cultural Quiz (25 true or false statements) was used to measure cultural knowledge, the Xenophilia scale (35-item scale) measured tolerance or openness to persons from other cultures, and the Cross-Cultural World-Mindedness (26-item tool) measured value orientation toward viewing the world as a singular system. Increased cultural competency specifically related to an increase in cultural knowledge was identified (Campbell-Heider et al.).

During a focus group conducted post-program, students stated that their cultural competence increased over the two years of education (Campbell-Heider et al., 2006). One key finding was the need for immersion experiences to assist nurse practitioner students in changing negative attitudes regarding unfamiliar groups.

Ndiwane et al. (2004) also identified the importance of immersion of nurse practitioner students into various cultures in order to become culturally competent providers. Curricular changes focused on cultural competence, as APRNs were identified as being primary providers of care for those who are medically underserved and/or ethnically diverse (Ndiwane et al.).

Using Campinha-Bacote's cultural competence model as a framework for the changes in the curriculum, an emphasis was placed on the cultural encounters in order to provide nurse

practitioners with the opportunities to learn and appreciate the uniqueness of clients from different cultures (Campinha-Bacote, 2002b; Campinha-Bacote, 2007; Ndiwane et al., 2004). Snyder (2011) stated by achieving greater cultural competency in interacting with LGBT clients, health care providers have the ability to assist in breaking down existing barriers that currently limit delivery of the “highest quality health care to LGBT individuals” (p. 186).

Examples of curricular changes were: the addition of two hours of didactic presentation of cultural components into five of the graduate courses, the integration of case scenarios based on Campinha-Bacote’s cultural competence model, the introduction of the Inventory to Assess the Process of Cultural Competency (IAPCC) as an instrument, and the integration of techniques for conducting cultural assessments and collecting cultural data during health assessments (Ndiwane et al.). Enhancing nurse practitioners’ cultural competency skills is necessary to meet the needs of a more diverse population. Ndiwane et al. (2004) emphasized, “cultural desire requires self-motivation and a commitment to care for all patients regardless of cultural beliefs and values” (p. 121). Nurse educators need to work with students to ensure that they possess the necessary cultural awareness, knowledge and skills to provide culturally competent care. Education is most successful when clinical, didactic, and administrative settings all work toward the goal of cultural competence for students and future providers (Calvillo et al., 2009).

### **Theoretical Framework of the Study**

#### **The Process of Cultural Competence in the Delivery of Healthcare Services**

Cultural competency has several frameworks that guide the path towards becoming culturally competent yet there are no specific major transcultural nursing theories that specifically include homosexuality as a determinant (McManus, 2008). Researchers have noted that the use of cultural competence models can facilitate understanding of health disparities and

how to address them (Shen, 2015). Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services* not only serves as a model and framework for cultural competence, but also as a model for service care delivery (Campinha-Bacote, 2002b). The model focuses specifically on the ability of the health care provider to strive to achieve the ability to effectively work within the cultural context of the client (Campinha-Bacote, 2002b).

In a review of six cultural competency models, Brathwaite (2003) states that Campinha-Bacote's model is "comprehensive in content, has a high level of abstraction, conceptual clarity, and logical congruence as well as demonstrates clinical utility" (p. 4). Brathwaite (2003) further stated that nurse educators could use Campinha-Bacote's model to instruct nurses how to deliver care that is culturally competent by integrating all of the model's constructs in an education program.

The review of the literature has shown that in order to address the health needs of the gay and lesbian client, practitioners must be culturally competent to the LGBT culture. LGBT adults have voiced concerns about the lack of providers who have adequate knowledge about LGBT health (IOM, 2011b). Gay and lesbian clients need care that is both high quality and culturally competent administered by providers who know and understand them. Cultural competency will allow for the nurse practitioner to adequately provide care to a population that faces many identified disparities, discrimination, and stigma.

Campinha-Bacote (2003) emphasized the importance of moving beyond knowing the values, beliefs, practices, and customs of diverse groups in order to address cultural diversity. Cultural diversity is broad and includes "religious affiliations, language, physical size, gender, sexual orientation, age, disability (both physical and mental), political orientation, socioeconomic status, occupational status and geographical location" (Campinha-Bacote, 2003,

p. 1). The inclusion of sexual orientation identifies that this is an important aspect of cultural competence.

### **Theoretical Model Defined**

Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services* was used as the theoretical framework for this study. The framework of Campinha-Bacote's model is an ongoing process that involves five constructs. These constructs are identified as: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002b; Campinha-Bacote, 2007). Integration of the five aspects of the model enables the provider to address any need that the patient has in regard to his or her culture.

**Cultural awareness.** The first aspect of the cultural competence model is cultural awareness. According to Campinha-Bacote (2001), cultural awareness is a process which will involve a health care provider to examine "one's own prejudices and biases" in regard to other cultures and the provider must also explore his or her own background (p. 8). This is important when caring for anyone who is not from a provider's own background and shows that the provider is performing a self-assessment in order to care for a patient. Specific to nurse practitioners, McManus (2008) stated there should be an awareness of how a person's attitudes may have a direct impact on the clinical judgment in providing care. A question that one could ask of themselves in regard to cultural awareness is, "Are you aware of your personal biases and prejudices towards cultures different than your own?" (Campinha-Bacote, 2002a, p. 187).

**Cultural knowledge.** Cultural knowledge is the second part of the model and according to Campinha-Bacote (2001); this is where the provider seeks to have an understanding of the patient's worldview, which is the value and meaning that the patient places on his or her life

events. Within the context of cultural knowledge, health care professionals must address disease incidence and prevalence as well as health disparities (Campinha-Bacote, 2007).

**Cultural skill.** Thirdly, Campinha-Bacote (2002b), describes cultural skill as “the ability to collect relevant cultural data regarding the client’s presenting problems as well as accurately performing a culturally based physical assessment” (p. 182). The data that is obtained by conducting a cultural assessment will allow health care providers the ability to formulate a treatment plan that is both mutually acceptable and culturally relevant (Campinha-Bacote, 2007).

**Cultural encounters.** The fourth piece of the model is in addressing cultural encounters. This is the experience that the provider will gain from repeated exposure to those of different cultures. Campinha-Bacote (2002b) stresses the fact that being exposed to a specific culture three or four times does not make the provider an expert on that specific ethnic group. A question that a provider could ask in regard to cultural encounters is, “How many face-to-face encounters have you had with patients from diverse cultural backgrounds?” (Campinha-Bacote, 2002a, p. 187). Seeking out encounters is pivotal in moving the health care provider towards cultural competence. Campinha-Bacote’s theoretical framework of cultural competency stresses the importance of cultural encounters and exposure to culturally diverse groups, such as face-to-face interactions, in order for the health professional to modify beliefs and avoid stereotyping (Dayer-Berenson, 2011).

**Cultural desire.** The final aspect of the model is cultural desire, which states that the provider should be willing to become engaged in learning about different cultures and ethnic groups. This is a large step in a provider becoming culturally aware and according to Campinha-Bacote (2001) this is where the words and actions of the provider must “be congruent with his or her true inner feelings” (p. 10). This desire has to be something that comes from the provider

and shows a sincere connection with the client. Desire is an important aspect of having a practice that is gay affirmative as well as an integral part of the process of cultural competency, as desire truly demonstrates the provider's motivation to work with gay and lesbian clients because he or she wants to and not because there is a feeling of being mandated to (Campinha-Bacote, 2002a; Crisp, 2006b).

### **Assumptions of the Model**

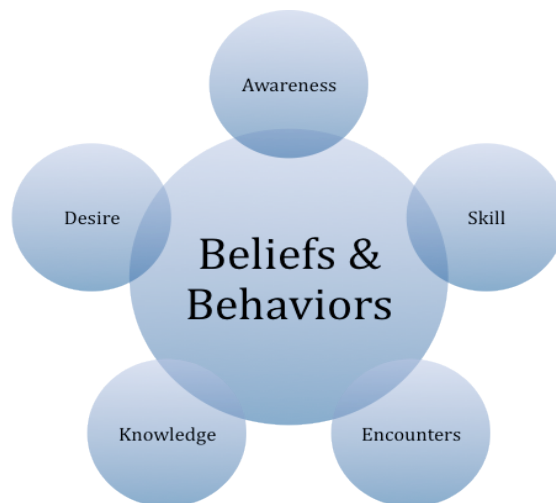
1. Cultural competence is a process, not an event; a journey, not a destination; dynamic, not static; and involves the paradox of knowing (the more you think you know; the more you really do not know; the more you think you do not know; the more you really know).
2. The process of cultural competence consists of five inter-related constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
3. The spiritual and pivotal construct of cultural competence is cultural desire.
4. There is more variation within cultural groups as well as across cultural groups (intra-cultural variation).
5. Cultural competence is an essential component in rendering effective and culturally responsive care to all clients.
6. All encounters are cultural and sacred encounters. (Campinha-Bacote, 2007).

### **Use of Theory as a Framework**

In order to provide safe and competent care, not only do nurse practitioners need to strive to become culturally competent in caring for members of the LGBT community but also to have a knowledge of health disparities within the community.

Figure 1 is a diagram created of the five constructs of Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services*. The diagram also illustrates the two domains measured by the GAP Scale (beliefs and behaviors) as central words. The figure also represents how the continuous application of the process of moving towards cultural competency impacts the beliefs and behaviors of the practitioner and is central in becoming culturally competent. The belief and behavior domains can be understood within the context of the *Process of Cultural Competence in the Delivery of Healthcare Services*.

*Figure 1*



Regarding awareness, Campinha-Bacote (2002b; 2007) emphasized the recognition of one's own biases and prejudices. Regarding GAP, the sixth identified fundamental principle is to deal with one's own homophobia and heterosexual bias (Crisp, 2006b). This statement identifies the rationale in Figure 1 of the circle of 'awareness' being part of the circle of 'beliefs & behaviors'.

Campinha-Bacote (2002b; 2007) stressed the importance of desire as the provider's motivation to engage in the process of the other four constructs (skill, knowledge, awareness, encounters). Caring and love are identified as central to the construct of cultural desire (Campinha-Bacote, 2007) and can be correlated to the tenet of 'affirming' within GAP, as a



declaration or pledge. This demonstrates how the theoretical model has implications in assisting nurse practitioners to provide care that is culturally competent as well as gay affirming in order to address the health disparities faced by LGBT persons. Table 5 demonstrates how selected items from the GAP Scale are affiliated with the different constructs of Josepha-Bacote's model.

Table 5  
*Selected GAP Scale Statements and correlation with Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services*

<b>GAP Scale Statement</b>	<b>GAP Domain</b>	<b>Process of Cultural Competence in the Delivery of Healthcare Services associated concepts</b>
Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	Belief	Skill Desire
Practitioners should make an effort to learn about diversity within the gay/lesbian community.	Belief	Encounters Awareness Knowledge Skill Desire
Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	Belief	Knowledge Desire
I provide interventions that facilitate the safety of gay/lesbian clients.	Behavior	Encounter Skill Desire
I am open-minded when tailoring treatment for gay/lesbian clients.	Behavior	Encounter Skill Desire
I respond to a client's sexual orientation when it is relevant to treatment.	Behavior	Knowledge Skill
I educate myself about gay/lesbian concerns.	Behavior	Awareness Desire

## Chapter Two Summary

This chapter discussed the process of the literature for the purpose of this study as well as an explanation of the scarcity of the research regarding the cultural competence of nurse practitioners in caring for gay and lesbian clients. Articles associated with LGBT terms and nurse practitioners were identified and discussed. In addition, this chapter focused on a review of current literature related to LGBT health disparities, gay affirmative practice, barriers to care, positive strides in LGBT care, nursing education, and the importance of cultural competence of

nurse practitioners and nurses. Lastly, Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services* was identified as the theoretical foundation for this research study. A connection between Campinha-Bacote's theory and GAP, as measured by the GAP Scale, was identified and explained for the purpose of the study.

There is a growing body of evidence available on addressing the knowledge of both nursing students and nursing faculty regarding LGBT health that has occurred within the last few years. Much of the available literature is descriptive and anecdotal in nature, and of the few studies that do exist, major limitations have been noted. There is an identified paucity of research as it pertains to nurse practitioners and caring for LGBT clients in a culturally competent manner.

Overall, this literature review revealed the following:

- Gay affirmative practice is measureable using the GAP Scale.
- It is important for health care providers to provide culturally competent care to gay and lesbian clients.
- The LGBT community faces many health disparities and barriers to care.
- Nursing education is a way to increase exposure to students in assisting them in becoming more knowledgeable regarding LGBT health.
- The literature supports more integration of LGBT health into nursing curricula.
- There is a lack of knowledge among nursing students regarding LGBT health.
- A serious gap in the literature is noted regarding nurse practitioners and care of LGBT patients.

As nurse practitioners are increasingly providing primary care services, there is an urgent need to discover more about the practice beliefs and behaviors of these practitioners when

providing care to gay and lesbian clients. This ability for nurse practitioners to provide culturally competent care to this particular patient population has not been researched and is absent in the literature. An integral part of providing culturally competent care is knowledge regarding the patient population. The literature has demonstrated a need for further integration of LGBT content into nursing curriculum in order to provide nurse practitioners with this identified knowledge in order to provide culturally competent care.

## **CHAPTER THREE**

### **METHODOLOGY**

Chapter Three presents an overview of the methodology for this research study. The purpose, research design, variables, sample and setting, procedures, instrumentation, validity and reliability of the instrument, data analysis, and ethical considerations used in the study will be discussed, as well as the limitations.

#### **Purpose and Description of the Research Design**

The main purpose of this study was to examine nurse practitioners' self-reported beliefs and behaviors in relation to the provision of care for gay and lesbian clients. The study also explored nurse practitioners' perceptions of whether or not they felt they were prepared by their nursing education to provide generalized cultural competence, as well as cultural competence specific to gay and lesbian individuals.

In order to address the targeted research questions, an exploratory survey research design was implemented. The study included a convenience sample of nurse practitioners in a Northwestern state of the U.S. Data were analyzed utilizing descriptive and inferential statistics in order to determine the relationships and differences between nurse practitioners' level of culturally responsive education and their GAP scores. The design of the study allowed for description and examination of the variables without any manipulation (Burns & Grove, 2011).

#### **Research Questions**

As noted in Chapter One, the study sought to answer the following three research questions:

1. Is there a relationship between the self-reported beliefs of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients?
2. Is there a relationship between self-reported behaviors of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients?
3. Is there a significant difference between demographic categories of nurse practitioners (e.g., age, ethnicity, religious affiliation, type of nurse practitioner) and their self-reported beliefs and behaviors toward gay and lesbian clients?

### **Research Variables**

Table 6 presents the study variables, descriptions, and associated measures. The outcome variables (i.e., dependent variables) were self-reported beliefs and behaviors that pertained to providing care for gay and lesbian clients. These beliefs and behaviors were assessed using the GAP Scale. The independent variables were the nurse practitioners' reported perception of the extent of their nursing education regarding culturally competent care in general, and the nurse practitioners' reported perception of the extent of their nursing education regarding culturally competent care for gay and lesbian clients in particular. Other identified independent variables that were compared were identified within the demographic categories and included age, gender, sexual orientation, ethnicity, personally knowing a lesbian female or gay male, educational level, type of nurse practitioner, whether currently practicing, and religious affiliation.

Table 6  
*Description of Study Variables*

<b>Study Variable</b>	<b>Description</b>	<b>Associated Measure</b>
Demographic variables <i>[Independent variables]</i>	Age, gender, sexual orientation, ethnicity, personally knowing a lesbian female or gay male, educational level, type of nurse practitioner, whether currently practicing, and religious affiliation	Student investigator designed demographic questionnaire (See Appendix A)
Nursing education regarding providing culturally competent care <i>[Independent variable]</i>	Self-reported Likert scale items measuring education to provide culturally competent care.	Student investigator designed 5-point Likert scale items (see Appendix A)
Nursing education regarding providing cultural competent care to gay and lesbian clients <i>[Independent variable]</i>	Self-reported Likert scale items measuring education to provide culturally competent care specifically to gay and lesbian clients	Student investigator designed 5-point Likert scale items (see Appendix A)
Beliefs regarding care for lesbian and gay individuals <i>[Dependent variable]</i>	Likert scale questionnaire with 15 items. Assesses beliefs in providing care for lesbian and gay individuals.	Gay Affirmative Practice scale (GAP) (see Appendix B)
Behaviors regarding care for lesbian and gay individuals <i>[Dependent variable]</i>	Likert scale questionnaire with 15 items. Assesses behaviors in providing care for lesbian and gay individuals.	Gay Affirmative Practice scale (GAP) (see Appendix B)

### **Participants and Setting**

The study used a convenience sample of nurse practitioners who were licensed in one Northwestern state in the U.S. The sample included certified nurse practitioners within the state but did not include other APRNs such as Clinical Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNA), and Certified Nurse-Midwives (CNM). The decision to exclude these APRNs was based on the fact that they are unlikely to be the first direct contact of the patient seeking primary care. A list of nurse practitioners was obtained through the State Board

of Nursing (SBON), which maintains records for approximately 3,000 licensed nurse practitioners. The mailing list was publically available for a small fee. According to the SBON of this state, the mailing list included information regarding active licenses, licensee first and last name, license type, license number, license expiration, and license issue dates, as well as U.S. mailing addresses and email addresses.

For the purpose of this study, all licensed nurse practitioners in this Northwestern state that were listed on the SBON mailing list were recruited. The lack of information available regarding nurse practitioners as providers of care for lesbian and gay clients was a key factor in the decision to recruit all practicing nurse practitioners in the state, rather than a smaller sample. This was to help assure the greatest representation of the group.

The inclusion criteria of the sample were nurse practitioners currently licensed to practice in this Northwestern state and whose e-mail addresses were active. Nurse practitioners who no longer held an active license with the SBON for this Northwestern state were excluded from study participation as were nurse practitioners who did not have an email address listed on the information obtained from the SBON. Lastly, APRNs such as CNSs, CRNAs, and CNMs were excluded.

The participants completed a demographic questionnaire containing 15 researcher-developed questions (see Appendix A). Four Likert scale items regarding education were included in order to ascertain respondent perceptions of their nursing education as the education related to cultural competence in general, and to gay and lesbian cultural competence in particular. To gain additional understanding about nurse practitioner perceptions of their educational preparation, four open-ended questions were also asked as well as providing participants the ability to provide additional comments after completing the survey (see

Appendix A). The questionnaire was distributed along with the GAP Scale measurement tool (see Appendix B). Prior permission was obtained from the author for use of the GAP Scale in this study, using either written or electronic format, without any changes to the original questions (see Appendix C).

### **Procedures of the Study**

A timeline outlining the steps of data collection for the study was created (see Appendix D). No portion of the study commenced until university Institutional Review Board approval had been granted (see Appendix E).

### **Recruitment**

For the purpose of this study, the decision was made to utilize an email invitation to participate in the study as there was less cost and the collected data would be readily available, as well as easily exported to statistical software for analysis (McPeake, Bateson, & O'Neill, 2014). To begin the recruitment process, the email addresses obtained from the SBON were entered into Qualtrics. Qualtrics is an online survey software that allows for the creation and distribution of electronic surveys, and is made available to university students, staff, and faculty at no charge through a university-wide site license. Qualtrics can be used to capture survey results from a publicly-available survey, or from users who are specifically given access to a survey. After entering the potential participant's email addresses into Qualtrics, a recruitment email was sent to all practicing nurse practitioners in the state containing a description of the study (see Appendix F).

The email described the purpose of the study and invited recipients to participate in the survey. This invitation directed interested recipients to access (via a hyperlink) the online consent form at the Qualtrics website (see Appendix G). By clicking on the "I agree to



participate in this study” button at the bottom of the page, informed consent was implied. Once nurse practitioners had indicated that they were willing to participate and had given informed consent, they were automatically directed to complete the demographic, GAP Scale, Likert scale, and open-ended questions.

There was no consensus on the best day to send an electronic survey, however based on external research on the topic of optimal invite timing, Quinn (2009) identified that sending surveys on Tuesdays, Wednesdays, or Thursdays provided the best results. In a study of response patterns for emailed survey instruments that identified an overall response rate of 31.25%, Shinn, Baker, and Briers (2007) found that Wednesday had the highest response rate at 43.59% followed by Tuesday with a 37.5% response rate. Based upon four survey examples, Quinn (2009) identified that sending surveys between 10am and 11am, and 3pm to 4pm warranted the highest response rates. Based on these findings, the survey email for this study, and subsequent reminder emails, were sent on Wednesdays at 3:00 p.m. Pacific Time.

The Qualtrics features were set to prevent duplicate responses when reminder emails were sent to study participants. Once data had been obtained from completed surveys, the information obtained from Qualtrics was directly imported to the Statistical Package for the Social Sciences (SPSS) version 21.0 and were kept on the student investigator’s password-protected computer.

Nulty (2008) identified a range of response rates (23% to 43%) from eight online surveys; taken together, the overall average response rate was 33%. Using the identified average of 33% as a benchmark, the goal was to obtain a 33%, or higher, return rate. After the identified data collection time (see Appendix D), the response rate was identified based on the number of surveys that were originally sent, and those that were returned as completed.

Kittleson (1997) identified a 25% to 30% response rate for electronic surveys without a follow-up reminder, and suggested that sending a reminder may double the survey response rate. Numerous reminder notices may not significantly affect response rates, and, in fact, a slight decrease in responses has been observed among those receiving the largest number of reminders (Cook, Heath, & Thompson, 2000). McPeake et al. (2014) have found value in sending two reminder emails as their own survey demonstrated a 42% response rate after the initial survey was sent electronically, a 16% response after the first reminder, and a 4% response after the second reminder for an overall response rate of 62%. Reporting the current response rate as well as setting goals with the participants has the potential to motivate participation in the survey (McPeake et al.). On the days when a reminder email was sent to potential participants, the original intent was to include the current number of responses to the survey, the percentage of returns, as well as the stated goal of a 33% response rate. Although reminder emails (see Appendix H) were sent to potential participants as planned, there was an inability to include the current number of responses, the percentage of returns, and the stated response rate goal in the reminder emails.

### **Data Collection**

The initial data collection period for the study was identified as six weeks. Once the initial survey had been sent, a follow-up first reminder was sent to the participants who had not completed the initial survey after two weeks. After the next two week period (weeks 3 and 4), the response rate was calculated, and a second (final) reminder was emailed in an effort to increase the number of participants who had completed the survey four weeks after the initial survey was distributed (see Appendix D). At the end of the six-week period, a minimum of 350 participants was achieved; however, there was not a 33% return rate. The data collection was

extended for an additional two weeks, and weekly reminders were sent with the goal of further increasing response rate. The optimal goals were to obtain a minimum of 350 participants and a response rate of 33%. This minimum number of participants was stated because given an estimated population of 3,000, a confidence level of 95%, and a margin of error of 5%, there would need to be a total of 341 participants to conduct the various statistical tests and to draw specific conclusions. However, if the number of responses had been less than 341 participants, data would have been analyzed and findings would have been presented based on the number of respondents. After the two-week extension the data collection ceased, even though there was not a 33% response rate achieved. The data collection process utilized a detailed and thorough protocol to administer the survey and the tool. Features of the study design were incorporated to ensure sound Internet data collection including how respondents would access the tool, safeguards to maintain confidentiality, the order of the information that was given, and how the information would be permanently removed (Waltz, Strickland, & Lenz, 2010).

### **Instrumentation**

**GAP Scale.** Gay Affirmative Practice was assessed using the GAP measurement tool, which was developed by Dr. Catherine Crisp for her 2002 dissertation and first published in 2006 (Crisp, 2002; Crisp, 2006a). The GAP Scale is a 30-item scale designed to “assess practitioner’s beliefs and behaviors in practice with gay and lesbian individuals” (Crisp, 2006a, p. 115). The final version of the instrument consists of two item domains identified as (a) beliefs about working with gay and lesbian clients, and (b) behaviors used when working with gay and lesbian clients with each domain consisting of 15-items (Crisp, 2006a). All 30-items of the tool use a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) for the belief domain and 1 (*never*) to 5 (*always*) for the behavior domain; with a total possible range of scores from 30

to 150. A higher total score reflects a greater degree of affirmative practice with gay and lesbian clients. According to Crisp (2005), in general, GAP scores of 90–150 are “more affirming,” and scores of 30–89 are “less affirming.” Crisp (2005) has also ranked GAP scores of 120–150 as “most affirming,” 90–119 as “2nd most affirming,” 60–89 as “2nd least affirming,” and 30–59 as “least affirmative” (p. 58).

**Validity and reliability of the instrument.** The GAP measurement tool has high reliability, with an overall Cronbach’s alpha of .95 for the entire 30-item tool upon initial use (Crisp, 2006a). The Cronbach’s alpha for the belief domain is reported to be .93 and for the behavior domain to be .94 (Crisp, 2006a). The instrument’s initial validity was ascertained via several methods, including a confirmatory factor analysis that found loading of all items on the intended domain at .60 or higher; this finding substantiates the instrument’s factorial validity (Crisp, 2006a). In addition, the scale has a  $SEM = 1.91$  for the belief domain, and a  $SEM = 2.71$  for the behavior domain (Crisp, 2006b). The GAP Scale is presented as a highly reliable and valid instrument based on the psychometric properties of the first validation of the tool (Crisp, 2006a). This study attempted to further validate this tool as a measure of gay affirmative practice, which demonstrates the concepts of cultural competence.

### **Data Analysis**

The collected data was exported from Qualtrics to SPSS using the student investigator’s personal computer, which was password protected in a locked office. Data were analyzed using both descriptive and inferential statistics. Descriptive statistics were obtained from the data in order to describe and summarize the collected data as well as describe the population of nurse practitioners being studied. Frequency distributions, measures of central tendency (mean, median, and mode), averages, and percentages were calculated. Correlational statistics and

correlational analyses were conducted to determine the relationships between and among variables as well as the direction and magnitude of the relationship between variables (Burns & Grove, 2011; Polit, 2010).

A correlational analysis was conducted in order to identify the direction and magnitude of the relationships between perceived cultural competence education and GAP scores (beliefs, behaviors, and total score) as well as perceived cultural competence education regarding lesbian and gay issues and GAP scores (beliefs, behaviors, and total score). The GAP scores, and the self-reported cultural competence education variables were measured using a Likert scale, which was considered an interval scale. Given that the variables were measured on an interval, the correlation index that was used was the Pearson product-moment correlation coefficient (Pearson's  $r$ ) (Polit, 2010).

A one-way, between-groups ANOVA was conducted to analyze the different categories of nurse practitioners as an independent variable. One categorical independent variable (type of nurse practitioner) had three different levels that correlated with the types of nurse practitioners, and three continuous dependent variables (beliefs, behaviors, and total GAP score). This required a  $3 \times 3$  (Type  $\times$  Beliefs, Behaviors, and total GAP) one-way between groups ANOVA. In order to identify any significant explanation for the findings, ANOVAs were used to analyze and identify the differences in the belief scores, behavior scores, and total GAP scores and participant demographic information. Additionally, one-way between-groups ANOVAs were conducted on all variables having more than two groups. For variables having two groups, independent-samples  $t$ -tests were conducted on the data.

A content analysis was performed on the four, open-ended questions to determine any possible themes regarding nursing education. The focus was on whether the comments

supported one of the quantitative questions within the study or if the comments were addressing or discussing a different focus area. Additionally, demographics were compared of those who participated in the study.

### **Ethical Considerations**

Prior to study recruitment, Institutional Review Board (IRB) approval was obtained from the University of Nevada, Las Vegas. Ethical considerations were employed in order to maintain participant privacy. None of the questions that participants were asked elicited information that resulted in the revelation of participant identity. The informed consent clearly demonstrated that participants had the ability to skip any question they did not wish to answer or to quit the study at any time by simply clicking out of the survey. Individual consent forms were obtained electronically from the participants via Qualtrics prior to their completion of the questionnaire. The consent did not require a signature; therefore, no names were obtained. Clicking on the box at the end of the consent form and advancing to the next screen constituted consent. Participant engagement with all survey tools was secure, and was provided by means of Qualtrics. All Internet Protocol (IP) address capabilities were disabled. Qualtrics was set to administer the questionnaire in a manner to insure that all responses were anonymous, and that participant email addresses were not identifiable.

### **Study Limitations**

The study had several potential limitations that needed to be considered. The first limitation was the potential bias that may occur from the fact that the sample was obtained from a nonprobability sampling method. There may have been the possibility that nurse practitioners who did not value the importance of gay and/or lesbian health may not have completed the questionnaire or that nurse practitioners who already were involved or who have a passion for

gay and/or lesbian health may have been more likely to complete the questionnaire. This could have impacted not only the type of responses but also the number of responses. With any survey, there is a potential limitation in regard to response rate. Although there were more than 3,000 nurse practitioners identified within the Northwestern state, the number of those who decided to participate could not be controlled. Frequent reminders were sent to participants with the goal of increasing the response rate.

Another limitation was that the participants were limited to one specific state, which represented one particular geographical region of the U.S. Additionally, this regional limitation did not allow for generalizability of the findings to all nurse practitioners in the U.S. The use of a convenience sample within one state might be a limitation as well, however, this topic lacks research and the information obtained from the study will be a potential catalyst for future studies.

Although the GAP Scale has proven validity and reliability, the measurement tool has limited use in nursing and has not been used in previous research with a focus on nurse practitioners. However, there was a benefit in the fact that the GAP Scale does specifically measure the GAP of nurse practitioners whereas measurement tools for cultural competence are not inclusive of LGBT health and diversity.

Finally, self-reporting on a questionnaire was a limitation. Because of the topic of gay and lesbian clients, nurse practitioners might have answered the questions the way in which they felt the profession of nursing would have wanted and not what they truly believed or how they truly behaved in regard to gay and lesbian clients. This limitation could not be overcome, as the study was designed with a survey that requires self-reporting.

### **Chapter Three Summary**

In summary, the study explored the beliefs and behaviors of nurse practitioners in a Northwestern state of the U.S. regarding caring for gay and lesbian clients, and the relationships between GAP scores and perceptions of educational preparedness regarding cultural competence in general and cultural competence in providing care for gay and lesbian clients. The GAP score data revealed how one state's nurse practitioners score in self-reported perceptions of beliefs and behaviors might identify needs for additional or modified education in nursing programs. The GAP score data was also used to ascertain whether the self-reported amount of education about general cultural competency and gay and lesbian cultural competency were correlated with beliefs and behaviors regarding provision of care for gay and lesbian clients.

This chapter presented the methodology, sample population, instrumentation, data collection procedure, and statistical analyses procedures that were utilized for the study as well as limitations of the study. Findings from the study will be discussed in Chapter Four.



## **CHAPTER FOUR**

### **RESULTS**

This chapter presents the results of this study which was conducted to: 1) determine the relationship between the self-reported beliefs of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients; 2) determine the relationship between self-reported behaviors of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients; and 3) identify the effect of demographics of nurse practitioners on both beliefs and behaviors of the Gay Affirmative Practice (GAP) scale. The demographic characteristics of the sample are described followed by the study findings from the GAP Scale and researcher-developed open-ended questions.

#### **Presentation of Descriptive Characteristics of Participants**

A recruitment email was sent to 2,366 nurse practitioners practicing in a Northwestern state whose email addresses were purchased from a publically available list from the Board of Nursing in that state. Initially, 56 surveys bounced back as "undeliverable", decreasing the available pool of potential participants to 2,310 nurse practitioners. Of that number, 1,419 opened the email that contained the request for participation. Although 629 participants started the survey, only 520 were identified as completing the survey per Qualtrics. Upon reviewing the data, it was noted that several participants did not answer the last question, which asked the participant to click a button to submit the survey. However, that question followed a final open-ended question asking participants to identify any final comments. Accounting for the 585 participants who had completed the survey up to that point resulted in a 25.32% response rate.

Further data mining resulted in 15 additional responses being deleted as incomplete. The final sample used for the study included 560 nurse practitioners ( $N = 560$ ) and a total response rate of 24.24%.

Table 7 depicts the summary of the frequency distributions for gender, age range, ethnicity, acquaintance of a gay or lesbian individual, religious affiliation, sexual orientation, and current practice. Percentages reported within all tables are based on valid percent, taking into account those individuals who did not respond to a particular question.

Table 7  
*Nurse Practitioner Characteristics of the Sample (N = 560)*

Characteristic	<i>n</i>	%
<b>Gender</b>		
Male	60	10.7
Female	497	88.8
Other	1	0.2
Prefer not to answer	2	0.4
<b>Age Range</b>		
< 25 years of age	1	0.2
26 – 35 years of age	82	14.7
36 – 45 years of age	125	22.4
46 – 55 years of age	130	23.3
56 – 65 years of age	190	34.1
> 65 years of age	30	5.4
<b>Ethnicity/Race</b>		
American Indian or Alaska Native	5	0.9
Asian	11	2.0
Black or African American	4	0.7
Hispanic or Latino	16	2.9
Native Hawaiian or Other Pacific Islander	1	0.2
White	512	91.6
Prefer not to answer	10	1.8
<b>Acquainted with someone who identifies as a gay male or lesbian</b>		
Yes	556	99.6
No	2	0.4
<b>Religious Affiliation</b>		
Yes	277	49.5
No	268	47.9
Prefer not to answer	15	2.7
<b>Sexual Orientation</b>		
Heterosexual	466	83.2
Homosexual	41	7.3
Bisexual	33	5.9
Prefer not to answer	20	3.6
<b>Currently Practicing as nurse practitioner</b>		
Yes	541	96.6
No	19	3.4

*Note.*  $N = 560$ . *n* varied due to missing data

The sample demographics of the participants ( $N = 560$ ) revealed that the majority of respondents were female (88.8%), were heterosexual (83.2%), were over the age of 46 (62.8%), and were White (91.6%). Additionally, there was a near even divide in regard to religious affiliation, with 49.5% of participants identifying as having a religious affiliation and 47.9% identifying as not having a religious affiliation.

Table 8 identifies the highest educational degree obtained in nursing by the participant, as well as all of the degrees in nursing education received. A master's degree in nursing was the highest degree obtained by the majority (79.3%) of the participants, followed by a doctoral degree (14.1%). A small percentage (6.6%) stated their highest degree as "other", which included post-master certificates as well as degrees other than nursing. With regard to degrees received in nursing, the vast majority of participants held a master's degree (94.6%), nearly 25% had begun with an associate degree and less than 15% held terminal degrees (DNP, PhD).

Table 8  
*Educational Levels of Nurse Practitioners (N = 560)*

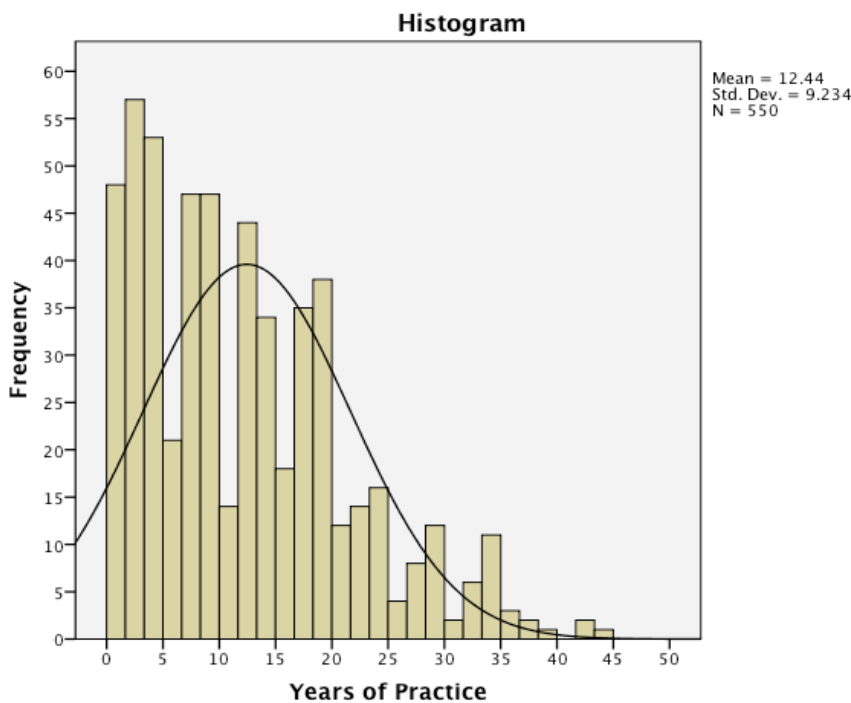
Characteristic	<i>n</i>	%
Highest Degree Obtained		
Masters in Nursing (MSN, MN)	444	79.3
Doctorate in Nursing (PhD, DNP)	79	14.1
Other	37	6.6
All Degrees Received by Nurse Practitioners		
Associate Degree in Nursing (ADN)	136	24.3
Bachelor of Science in Nursing (BSN)	435	77.7
Master's Degree in Nursing (MSN, MN, MS)	530	94.6
Doctoral Degree in Nursing (PhD, DNP)	77	13.8
Other	121	21.6

*Note.*  $N = 260$ .  $N$  varied due to missing data

Nurse practitioners were asked to identify years of practice. The mean years of practice for participants who answered the question ( $N = 550$ ) was 12.44 years ( $SD = 9.234$ ) with a range from 0.1 to 45 years of practice (see Figure 2). The mode was 1 year of practice ( $n = 33$ ; 6.0%), and there were a total of 46 participants (8.2%) who reported having one year or less of practice

experience. Data obtained regarding years of practice were reviewed to identify the years that represented 5% or more of the participants. The following were identified as comprising 5% or more of the sample: 1 year of practice (6.0%), 3 years of practice (5.5%), 5 years of practice (5.5%), and 10 years of practice (5.6%). There were 28.7% of the respondents who reported 5 years or less as the years of practice. Almost half (49.6%) of the participants identified their years of practice as 10 or less. A graph including a histogram of years of practice is presented in Figure 2.

Figure 2  
*Histogram of Identified Years of Practice as a Nurse Practitioner*



As shown in Table 9, participants identified their specialty area of practice. Over 75% of nurse practitioners indicated they practiced as adult nurse practitioners, a category which included adult, nurse midwife, family, geriatric, and women’s health. Nineteen respondents indicated "other" as area of practice but did not specify which area beyond that.

Table 9  
*Areas of Practice Identified by Nurse Practitioners (N = 559)*

	<i>n</i>	%
Adult nurse practitioner (Adult, Nurse Midwife, Family, Geriatric, Women's Health)	427	76.4
Psychiatric/Mental Health nurse practitioner	86	15.4
Neonatal or Pediatric nurse practitioner	27	4.8
Other	19	3.4

### **Analysis of Data**

The data were managed and analyzed using the Statistical Package for the Social Sciences (SPSS) version 21.0. The data were exported directly from Qualtrics into SPSS and included information from the demographic data form, the GAP Scale, and the open-ended questions. Data were screened for accuracy, and frequency distributions on all variables were conducted to determine if there were incorrect data or outliers. Data were analyzed using descriptive statistics, Pearson product-moment correlation coefficient, independent-samples *t*-test, and one-way, between group ANOVAs.

### **Reported Nursing Education**

Participants were asked to self-report the perceived amount of nursing education in their pre-licensure and graduate nursing programs regarding generalized culturally competent care and culturally competent care specific to gay and lesbian clients. A total of four Likert-type scale questions were asked in order to collect the data regarding cultural competence education. Table 10 shows how participants responded to questions regarding nursing education.

Table 10  
*Degree/Extent of Preparation that Nurse Practitioners Reported from their Nursing Programs*

Nursing Program Type and Cultural Competence	1 None	2 Little	3 Somewhat	4 Much	5 A Great Deal
<b>Pre-licensure programs (e.g., ADN and/or BSN)</b>					
Nursing education to provide culturally competent care	15 2.7%	63 11.3%	199 35.7%	166 29.7%	115 20.6%
Nursing education to provide culturally competent care to gay and lesbian clients	99 17.7%	179 32.1%	183 32.8%	66 11.8%	31 5.6%
<b>Nurse practitioner programs (e.g., MSN and/or DNP)</b>					
Nursing education to provide culturally competent care	10 1.8%	45 8.0%	179 32%	201 35.9%	125 22.3%
Nursing education to provide culturally competent care to gay and lesbian clients	43 7.7%	138 24.6%	175 31.3%	139 24.8%	65 11.6%

*Note.* *n* presented followed by percentage

For pre-licensure nursing programs, such as ADN and BSN programs, the 558 respondents had a higher mean ( $M = 3.54$ ,  $SD = 1.02$ ) when reporting the nursing education they received regarding providing culturally competent care than the nursing education they received regarding providing culturally competent care to gay and lesbian clients ( $M = 2.55$ ,  $SD = 1.08$ ). For nurse practitioner programs, such as MSN and DNP programs, the 560 respondents had a higher mean ( $M = 3.69$ ,  $SD = 0.96$ ) when reporting the nursing education they received regarding providing culturally competent care than the nursing education they received regarding providing culturally competent care to gay and lesbian clients ( $M = 3.08$ ,  $SD = 1.12$ ).

### **GAP Scale**

The GAP Scale consists of 15 questions measuring beliefs and 15 questions measuring behaviors when providing care for gay and lesbian clients. The questions are Likert-style with responses ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) for beliefs and 1 (*never*) to 5 (*always*) for behaviors. The possible range of scores for both beliefs and behaviors is 15 to 75. The total GAP Scale score has a possible range of 30 to 150, with a higher total score reflecting a

greater degree of affirmative practice with gay and lesbian clients. The GAP measurement tool has good internal consistency, with an overall Cronbach alpha of .95 for the entire 30-item tool, a Cronbach alpha of .93 for the belief domain, and a Cronbach alpha of .94 for the behavior domain (Crisp, 2006a). Cronbach alpha values were obtained for the current study using SPSS to check the reliability of the scale. In the current study, the Cronbach alpha coefficient for the total 30-item GAP Scale was .95. A Cronbach alpha of .95 was identified for the belief domain, and a Cronbach alpha of .92 for the behavior domain.

Table 11 demonstrates the descriptive statistics of GAP Scores obtained from the participants in the study. If a response to a question within either beliefs or behaviors was missing, the participant's score was excluded from the analysis. Of the 560 total participants, there were 17 data sets missing a response regarding beliefs ( $N = 543$ ), 18 missing a response regarding behaviors ( $N = 542$ ), and 35 missing from the overall GAP score ( $N = 525$ ).

Table 11  
*Descriptive Statistics of GAP Scores*

Measurement	<i>n</i>	Range of Scores	<i>M (SD)</i>	Skewness (Standard Error 0.11)	Kurtosis (Standard Error 0.21)
Beliefs	542	15 – 75	66.74 (9.46)	-2.30	8.75
Behaviors	543	25 – 75	58.87 (9.88)	-0.58	0.39
Total GAP Score	525	57 – 150	125.58 (16.80)	-0.91	1.02

### Research Questions

A bivariate product-moment correlation analysis (Pearson's  $r$ ) was conducted using the identified variables of: (a) beliefs, (b) behaviors, (c) total GAP score, (d) pre-licensure cultural competency nursing education, (e) pre-licensure cultural competency nursing education specific to gay and lesbian clients, (f) nurse practitioner cultural competency nursing education, and (g)

nurse practitioner cultural competency nursing education specific to gay and lesbian clients (see Table 12). The information from the table will be used to report the statistical analysis for the research questions.

Table 12  
Correlation (Pearson *r*) Matrix Among Study Variables

	Pre-licensure programs (e.g., ADN and/or BSN)		Nurse practitioner programs (e.g., MSN and/or DNP)	
	Nursing education to provide culturally competent care	Nursing education to provide culturally competent care to gay and lesbian clients	Nursing education to provide culturally competent care	Nursing education to provide culturally competent care to gay and lesbian clients
Beliefs	-.085*	-.006 <sup>ns</sup>	.005 <sup>ns</sup>	.042 <sup>ns</sup>
Behaviors	.014 <sup>ns</sup>	.142**	.068 <sup>ns</sup>	.185**
GAP Scale Total	-.043 <sup>ns</sup>	.077 <sup>ns</sup>	.041 <sup>ns</sup>	.130**

ns = not significant ( $p > .05$ ), \*\*  $p < 0.01$ , two-tailed, \*  $p < 0.05$ , two-tailed.

### Research Question 1

The first research question was to determine the relationship between the self-reported beliefs of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients. There was no significant relationship between beliefs and pre-licensure cultural competency nursing education specific to gay and lesbian clients ( $r = -.006, p = .894$ ), nurse practitioner cultural competency nursing education ( $r = .005, p = .910$ ), and nurse practitioner cultural competency nursing education specific to gay and lesbian clients ( $r = .042, p = .323$ ). The correlation between beliefs and pre-licensure cultural competency nursing education was significant ( $r = -.085, p = .049$ ). There was a small, negative correlation between the two variables, with lower levels of perceived cultural competence nursing education associated with



higher belief scores on the GAP Scale. The coefficient of determination for the correlation was  $r^2 = .007$ . When converted, the percentage of variance for the correlation was less than 1%.

### **Research Question 2**

The second research question was to determine the relationship between self-reported behaviors of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients. There was no significant relationship between behaviors and pre-licensure cultural competency nursing education ( $r = .014, p = .751$ ) and nurse practitioner cultural competency nursing education ( $r = .068, p = .112$ ). The correlation between behaviors and pre-licensure cultural competency nursing education specific to gay and lesbian clients was significant ( $r = .142, p = .001$ ). There was a weak, positive correlation between the two variables, with higher levels of pre-licensure nursing education regarding gay and lesbian clients being associated with higher behavior scores. The coefficient of determination for the correlation was  $r^2 = .02$ . When converted, the percentage of variance for the correlation is 2%.

Additionally, the correlation between behaviors and nurse practitioner cultural competency nursing education specific to gay and lesbian clients was significant ( $r = .185, p < .001$ ). There was a weak, positive correlation between the two variables, with higher levels of nurse practitioner education regarding gay and lesbian clients being associated with higher behavior scores. The coefficient of determination for the correlation was  $r^2 = .034$ , which demonstrates a percentage of variance for the correlation of 3.4%.

### **GAP Scale**

The combined total of beliefs and behaviors is equal to the total GAP score. There was no significant relationship between total GAP score and pre-licensure cultural competency

nursing education ( $r = -.043, p = .321$ ), pre-licensure cultural competency nursing education specific to gay and lesbian clients ( $r = .077, p = .079$ ), and nurse practitioner cultural competency nursing education ( $r = .041, p = .354$ ).

There was a weak, positive correlation between total GAP score and nurse practitioner cultural competency nursing education specific to gay and lesbian clients ( $r = .130, p = .003$ ). Higher levels of nursing education in nurse practitioner programs regarding gay and lesbian clients were associated with higher total GAP scores. The coefficient of determination for the correlation was  $r^2 = .017$ . When converted, the percentage of variance for the correlation was 1.7%.

### **Research Question 3**

The third and last research question was to identify the effect of demographics of nurse practitioners on both beliefs and behaviors of the GAP Scale. Various statistical analyses will be described that are appropriate for each of the independent variables within the study. Additionally, the effect of demographics on total GAP scores will be evaluated and presented.

**Gender.** An independent  $t$ -test was conducted to determine if there was a significant difference in the mean scores for beliefs, behaviors, and total GAP score for male and female nurse practitioners. There was one participant who identified as “other” and two participants who selected not to answer the survey question regarding gender. For all three independent  $t$ -tests, equal variances were assumed within the groups as Levene test for equality of variance was met.

An independent-samples  $t$ -test was conducted to compare the belief scores for males ( $n = 58$ ) and females ( $n = 481$ ). There was no significant difference in scores for males ( $M = 65.67, SD = 8.79$ ) and females ( $M = 66.95, SD = 9.45; t(537) = -0.98, p = .326$ , two-tailed). The

magnitude of the difference in the means (mean difference =  $-1.28$ , 95% *CI*:  $-3.84$  to  $1.28$ ) was very small as indicated by a Cohen's  $d = .141$ .

On average, female participants ( $n = 482$ ) had higher behavior scores ( $M = 59.55$ ,  $SD = 9.87$ ) than males ( $n = 58$ ;  $M = 57.88$ ,  $SD = 10.07$ ); however, there was no significance in the difference in scores  $t(538) = -0.82$ ,  $p = .415$ . The magnitude of the difference in the means (mean difference =  $-1.12$ , 95% *CI*:  $-3.82$  to  $1.58$ ) was very small as indicated by a Cohen's  $d = .112$ .

Additionally an independent-samples  $t$ -test was conducted to compare the total GAP scores for males ( $n = 56$ ;  $M = 123.59$ ,  $SD = 17.49$ ) and females ( $n = 466$ ;  $M = 125.91$ ,  $SD = 16.62$ ). There was no significant difference in total GAP scores for males and females  $t(520) = -0.98$ ,  $p = .326$ , two-tailed. The magnitude of the difference in the means (mean difference =  $-2.32$ , 95% *CI*:  $-6.96$  to  $2.32$ ) was very small as indicated by a Cohen's  $d = .139$ .

**Age.** For the study, participants were asked to select an option indicating a range of age (see Table 7). There was one participant who was categorized as being less than 25 years of age. For the purpose of running an ANOVA, the categories of less than 25 years of age ( $n = 1$ ) and 26 – 35 years of age ( $n = 82$ ) were combined for statistical analysis.

A  $5 \times 3$  one-way between-groups ANOVA was conducted to explore the impact of nurse practitioner age on beliefs and behaviors when providing care to gay and lesbian clients, as well as the total score for the GAP Scale. Table 13 provides a summary of the results.

Table 13  
*Descriptive Statistics of Belief, Behavior, and GAP scores with Respect to Nurse Practitioner Age*

	Belief Scores			Behavior Scores			Total GAP Scores		
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
< 35 years	67.39	8.51	80	58.01	10.20	82	125.46	16.41	79
36 – 45 years	67.53	9.95	119	59.48	9.91	120	126.53	16.86	114
46 – 55 years	65.63	9.67	128	58.52	10.59	127	124.23	17.79	125
56 – 65 years	66.83	9.08	186	58.96	9.08	182	125.81	15.55	178
> 65 years	67.56	9.72	27	60.33	10.85	30	128.81	19.30	27

The homogeneity of variance assumption was met with a Levene Test when exploring the impact of age on belief scores ( $p = .855$ ), behavior scores ( $p = .865$ ), and total GAP scores ( $p = .637$ ). There was no significant effect of age on belief scores,  $F(4, 535) = 0.80, p = .526, \eta^2 = .006$  or behavior scores,  $F(4, 536) = 0.47, p = .757, \eta^2 = .004$ . When exploring the effect of age on the total GAP score, there was no significance found,  $F(4, 518) = 0.55, p = .699, \eta^2 = .004$ .

**Ethnicity.** When asked to identify ethnicity, the majority (91.6%) of participants identified themselves as White. Responses for those who did not identify as white represented a small percentage of the study participants (see Table 7). There were 10 participants who preferred not to answer the question regarding ethnicity, and were not included in the analysis. SPSS was used to collapse the categorical variables into White ( $n = 512$ ) and Non-White ( $n = 37$ ) in order to analyze data using an independent  $t$ -test to determine if there was a significant difference in the mean scores for beliefs, behaviors, and total GAP scores.

An independent-samples  $t$ -test was conducted to compare the belief scores for Whites ( $n = 497$ ) and Non-Whites ( $n = 34$ ). The assumption of equality of variances was met using a Levene test ( $p = .739$ ). There was no significant difference in scores for Whites ( $M = 66.93, SD$

= 9.28) and Non-Whites ( $M = 66.15$ ,  $SD = 8.18$ ;  $t(529) = -0.48$ ,  $p = .739$ , two-tailed). The magnitude of the difference in the means (mean difference =  $-0.78$ , 95%  $CI$ :  $-3.99$  to  $2.43$ ) was very small as indicated by a Cohen's  $d = .089$ .

An independent-samples  $t$ -test was conducted to compare the behavior scores for Whites ( $n = 496$ ) and Non-Whites ( $n = 36$ ). The assumption of equality of variances was met using Levene's test ( $p = .848$ ). There was no significant difference in scores for Whites ( $M = 58.96$ ,  $SD = 9.79$ ) and Non-Whites ( $M = 58.42$ ,  $SD = 10.02$ ;  $t(530) = -0.32$ ,  $p = .75$ , two-tailed). The magnitude of the difference in the means (mean difference =  $-0.54$ , 95%  $CI$ :  $-3.86$  to  $2.79$ ) was very small as indicated by a Cohen's  $d = .054$ .

Lastly, an independent-samples  $t$ -test was conducted to compare the total GAP scores for Whites ( $n = 481$ ) and Non-Whites ( $n = 33$ ). The assumption of equality of variances was met using Levene test ( $p = .846$ ). There was no significant difference in scores for Whites ( $M = 125.84$ ,  $SD = 16.48$ ) and Non-Whites ( $M = 124.61$ ,  $SD = 16.20$ ;  $t(512) = -0.42$ ,  $p = .676$ , two-tailed). The magnitude of the difference in the means (mean difference =  $-1.24$ , 95%  $CI$ :  $7.06$  to  $4.58$ ) was very small as indicated by a Cohen's  $d = .076$ .

**Highest level of education.** Analysis was conducted to compare the mean scores for beliefs and behaviors as well as total GAP scores for those who identified a Masters in Nursing or a Doctorate in Nursing as the highest educational degree obtained. An independent-samples  $t$ -test was conducted to compare the belief scores for Master's prepared nurse practitioners ( $n = 431$ ) and nurse practitioners with a doctoral degree ( $n = 75$ ). The assumption of equality of variances was met using Levene test ( $p = .590$ ). There was no significant difference in scores for Master's prepared nurse practitioners ( $M = 66.50$ ,  $SD = 9.59$ ) and nurse practitioner with a doctoral degree ( $M = 67.76$ ,  $SD = 9.16$ ;  $t(504) = -1.06$ ,  $p = .291$ , two-tailed). The magnitude of

the difference in the means (mean difference =  $-1.26$ , 95% *CI*:  $-3.60$  to  $1.08$ ) was very small as indicated by a Cohen's  $d = .134$ .

An independent-samples  $t$ -test was conducted to compare the behavior scores for Master's prepared nurse practitioners ( $n = 431$ ) and nurse practitioners with a doctoral degree ( $n = 76$ ). The assumption of equality of variances was met using Levene's test ( $p = .823$ ). There was no significant difference in behavior scores for Master's prepared nurse practitioners ( $M = 58.77$ ,  $SD = 9.67$ ) and nurse practitioner with a doctoral degree ( $M = 59.03$ ,  $SD = 10.72$ ;  $t(505) = -.206$ ,  $p = .837$ , two-tailed). The magnitude of the difference in the means (mean difference =  $-0.25$ , 95% *CI*:  $-2.65$  to  $2.15$ ) was very small as indicated by a Cohen's  $d = .025$ .

After meeting the assumption of equality of variance with a Levene's test ( $p = .918$ ), a independent-samples  $t$ -test identified that the difference of total GAP scores,  $-1.48$ , 95% *CI* [ $-5.68$ ,  $2.72$ ] between Master's prepared nurse practitioners ( $n = 418$ ;  $M = 125.25$ ,  $SD = 16.65$ ) and nurse practitioners with a doctoral degree ( $n = 72$ ;  $M = 126.74$ ,  $SD = 17.31$ ) was not significant  $t(505) = -.694$ ,  $p = .488$ . The effect size was small as indicated by Cohen's  $d = .087$ .

**Classification of nurse practitioner.** A 3 x 3 one-way between-groups ANOVA was conducted to explore the impact of self-reported classification of nurse practitioner (Group 1: Adult, Group 2: Psychiatric/Mental Health, and Group 3: Neonatal/Pediatric) on beliefs and behaviors when providing care to gay and lesbian clients, as well as the total score for the GAP Scale. Table 14 provides a summary of the results.

Table 14  
*Descriptive Statistics of Belief, Behavior, and GAP scores with Respect to Nurse Practitioner Classification*

	Belief Scores			Behavior Scores			Total GAP Scores		
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
Adult	66.18	9.95	410	58.19	9.73	416	124.36	16.93	399
Psychiatric/ Mental Health	69.36	5.48	85	63.55	8.96	80	132.81	13.10	79
Neonatal/ Pediatric	66.37	12.19	27	54.93	11.83	27	121.30	20.86	27

The assumption of homogeneity of variances was not met when exploring the impact of nurse practitioner classification on belief scores ( $p = .001$ ). Using the Welch statistic, there is a statistically significant difference among the classification of nurse practitioners,  $F(2, 64.55) = 8.54, p = .001$  on scores for belief. Despite reaching statistical significance, the actual difference in mean scores between the groups was small. The effect size, calculated using eta squared ( $\eta^2$ ) was .015. Post-hoc comparisons using the Games-Howell test indicated that the mean score for beliefs for psychiatric/mental health nurse practitioners was significantly different from adult nurse practitioners. The mean scores of beliefs between adult nurse practitioners and neonatal/pediatric nurse practitioners as well as between psychiatric/mental health nurse practitioners and neonatal/pediatric nurse practitioners were not significant.

The homogeneity of variance assumption was met with a Levene test when exploring the impact of nurse practitioner classification on behavior scores ( $p = .166$ ). There was a statistically significant difference at the  $p < .05$  level in behavior scores for the three classification of nurse practitioner groups:  $F(2, 520) = 12.46, p < .001$ . The difference in means scores between the groups was close to a medium effect,  $\eta^2 = .048$ . Post-hoc comparisons using the Tukey HSD test indicated that the mean score for the behavior score for psychiatric/mental health nurse practitioners was significantly different from adult nurse practitioners and significantly different

from neonatal/pediatric nurse practitioners. The mean scores of practice behaviors between adult nurse practitioners and neonatal/pediatric nurse practitioners were not significant.

The assumption of homogeneity of variances was not met when exploring the impact of nurse practitioner classification on total GAP scores ( $p = .013$ ). Using the Welch statistic, there was a statistically significant difference among the classification of nurse practitioners,  $F(2, 61.17) = 13.01, p < .001$  on the total GAP score. The effect size was small between the groups,  $\eta^2 = .038$ . Post-hoc comparisons using the Games-Howell test indicated that the mean total GAP score for psychiatric/mental health nurse practitioners was significantly different from adult nurse practitioners and from neonatal/pediatric nurse practitioners. The mean total GAP scores between adult nurse practitioners and neonatal/pediatric nurse practitioners were not significant.

**Sexual orientation.** For the study, participants were asked to select an option indicating their sexual orientation as heterosexual, homosexual, or bisexual (see Table 7). Participants were also given a selection choice if they preferred not to answer the question. A 4 x 3 one-way between-groups ANOVA was conducted to explore the impact of nurse practitioner sexual orientation on beliefs and behaviors when providing care to gay and lesbian clients, as well as the total score for the GAP Scale. Table 15 provides a summary of the results.

Table 15  
*Descriptive Statistics of Belief, Behavior, and GAP scores with Respect to Nurse Practitioner Sexual Orientation*

	Belief Scores			Behavior Scores			Total GAP Scores		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>
Heterosexual	66.39	9.80	449	58.05	9.85	452	124.37	16.94	435
Homosexual	69.93	5.39	41	65.18	6.49	40	135.45	9.67	40
Bisexual	70.34	5.42	32	64.94	7.98	31	135.07	10.94	30
Prefer not to answer	62.50	10.64	20	55.35	11.19	20	117.85	20.21	20



The assumption of homogeneity of variances was not met when exploring the impact of sexual orientation on belief scores ( $p = .009$ ). Using the Welch statistic, there is a statistically significant difference among the nurse practitioners on belief scores for the sexual orientation groups,  $F(3, 55.45) = 8.89, p < .001$ . Despite reaching statistical significance, the actual difference in mean scores between the groups was small. The effect size, calculated using eta squared ( $\eta^2$ ) was .026. Post-hoc comparisons using the Games-Howell test indicated that the mean score for beliefs for heterosexual nurse practitioners was significantly lower than both homosexual nurse practitioners and bisexual nurse practitioners. The mean belief score was also significantly lower for the group that preferred not to answer the question than for the homosexual and bisexual group. There were no significant differences between the heterosexual group and the group that selected that they preferred not to answer nor between the homosexual and bisexual groups of nurse practitioners.

The homogeneity of variance assumption was met with a Levene test when exploring the impact of nurse practitioner sexual orientation on behavior scores ( $p = .073$ ). There was a statistically significant difference at the  $p < .05$  level in behavior scores for the four sexual orientation groups:  $F(3, 539) = 11.87, p < .001$ . The difference in means scores between the groups was a medium effect,  $\eta^2 = .066$ . Post-hoc comparisons using the Tukey HSD test indicated that the mean score for behavior for heterosexual nurse practitioners was significantly lower than both homosexual nurse practitioners and bisexual nurse practitioners. The mean behavior score was also significantly lower for the group that preferred not to answer the question than for the homosexual and bisexual group. There were no significant differences between the heterosexual group and the group that selected that they preferred not to answer.

There was also no significant difference between the homosexual and bisexual groups of nurse practitioners.

The assumption of homogeneity of variances was not met when exploring the impact of nurse practitioner sexual orientation on total GAP scores ( $p = .001$ ). Using the Welch statistic, there is a statistically significant difference among the groups regarding sexual orientation of nurse practitioners,  $F(3, 52.85) = 19.75, p < .001$  on the total GAP score. The effect size was medium between the groups,  $\eta^2 = .06$ . Post-hoc comparisons using the Games-Howell test indicated that the mean score for the total GAP score for heterosexual nurse practitioners was significantly lower than both homosexual nurse practitioners and bisexual nurse practitioners. The mean GAP score was also significantly lower for the group that preferred not to answer the question than for the homosexual and bisexual group. There were no significant differences between the heterosexual group and the group that selected that they preferred not to answer nor between the homosexual and bisexual groups of nurse practitioners.

**Religious affiliation.** For the study, participants were asked to select an option indicating whether or not they have a religious affiliation (see Table 7). A 3 x 3 one-way between-groups ANOVA was conducted to explore the impact of nurse practitioner religious affiliation on beliefs and behaviors when providing care to gay and lesbian clients, as well as the total score for the GAP Scale. Table 16 provides a summary of the results.

Table 16  
Descriptive Statistics of Belief, Behavior, and GAP scores with Respect to Nurse Practitioner Religious Affiliation

	Belief Scores			Behavior Scores			Total GAP Scores		
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
Has a religious affiliation	64.49	11.33	268	57.16	9.81	271	121.68	18.33	262
Does not have a religious affiliation	69.18	6.32	259	60.71	9.53	258	129.86	13.73	249
Prefer not to answer	65.07	8.08	15	58.07	12.12	14	122.43	19.12	14

The assumption of homogeneity of variances was not met when exploring the impact of nurse practitioner religious affiliation on belief scores ( $p < .001$ ). Using the Welch statistic, there was a statistically significant difference among the belief scores for nurse practitioners regarding religious affiliation,  $F(2, 37.99) = 18.05, p < .001$ . The actual difference in mean scores between the groups was a medium effect size,  $\eta^2 = .06$ . Post-hoc comparisons using the Games-Howell test indicated that the mean score for beliefs for nurse practitioners who had a religious affiliation was significantly lower than nurse practitioners that did not have a religious affiliation. There were no significant differences between the group who preferred not to answer the question and nurse practitioners that either identified themselves as having a religious affiliation or not having a religious affiliation.

The homogeneity of variance assumption was met with a Levene test when exploring the impact of religious affiliation on behavior scores ( $p = .594$ ). There was a statistically significant difference at the  $p < .05$  level in behavior scores for the religious affiliation groups:  $F(2, 540) = 8.81, p < .001$ . The difference in means scores between the groups was a small effect,  $\eta^2 = .033$ . Post-hoc comparisons using the Tukey HSD test indicated that the mean score for behaviors for nurse practitioners who had a religious affiliation was significantly lower than nurse practitioners that did not have a religious affiliation. There were no significant differences between the group who preferred not to answer the question and nurse practitioners that either identified themselves as having a religious affiliation or not having a religious affiliation.

The assumption of homogeneity of variances was not met when exploring the impact of nurse practitioner religious affiliation on total GAP scores ( $p < .001$ ). Using the Welch statistic, there is a statistically significant difference among the classification of nurse practitioners,  $F(2, 34.94) = 16.46, p < .001$  on the total GAP score. The effect size was medium between the

groups,  $\eta^2 = .06$ . Post-hoc comparisons using the Games-Howell test indicated that the mean of the total GAP score for nurse practitioners who had a religious affiliation was significantly lower than nurse practitioners that did not have a religious affiliation. There were no significant differences between the group who preferred not to answer the question and nurse practitioners that either identified themselves as having a religious affiliation or not having a religious affiliation.

**Years of practice.** The continuous variable of reported years of practice as a nurse practitioner was collapsed in order to explore the effect of years of practice on beliefs, behaviors, and total GAP score. Visual binning in SPSS was used to create equal groups, based on participant response. Regarding years of practice as a nurse practitioner, SPSS created five groups: (a)  $\leq 4$  years, (b) 4.01 to 8 years, (c) 8.01 to 13 years, (d) 13.01 to 20 years, and (e)  $> 20$  years.

A 5 x 3 one-way between-groups ANOVA was conducted to explore the effect of years of practice as a nurse practitioner on beliefs and behaviors when providing care to gay and lesbian clients, as well as the total score for the GAP Scale. Table 17 provides a summary of the results.

Table 17  
*Descriptive Statistics of Belief, Behavior, and GAP scores with Respect to Nurse Practitioner Years of Practice*

	Belief Scores			Behavior Scores			Total GAP Scores		
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
$\leq 4$ years	66.91	8.10	120	57.62	10.45	122	124.45	16.22	116
4.01 to 8 years	67.46	8.71	97	58.68	9.74	98	125.91	16.63	95
8.01 to 13 years	65.30	11.57	101	59.89	9.77	102	124.80	18.15	98
13.01 to 20 years	65.77	10.52	122	58.66	9.50	119	124.66	17.39	116
$> 20$ years	68.48	7.82	92	59.89	9.71	92	128.58	15.71	90

The homogeneity of variance assumption was met with a Levene test when exploring the impact of years of practice on belief scores ( $p = .176$ ), behavior scores ( $p = .952$ ), and total GAP scores ( $p = .878$ ). When exploring the years in practice for nurse practitioners, there was no significant effect on belief scores,  $F(4, 527) = 1.82, p = .123$ , behavior scores,  $F(4, 528) = 1.03, p = .39$ , or total GAP score  $F(4, 510) = 0.99, p = .412$ .

**Current practice.** An independent-samples  $t$ -test was conducted to compare the mean scores for beliefs, behaviors, and total GAP scores for nurse practitioners who are currently practicing and nurse practitioners who are not currently practicing. The assumption of equality of variances was met using Levene test for beliefs ( $p = .388$ ), behaviors ( $p = .293$ ), and total GAP scores ( $p = .222$ ). There was not a significant difference in the belief scores for currently practicing nurse practitioners ( $M = 66.73, SD = 9.54, n = 524$ ) and nurse practitioners who are not currently practicing ( $M = 67.28, SD = 7.23, n = 18$ );  $t(540) = -0.24, p = .808$ . There was no significant difference in the behavior scores for the currently practicing nurse practitioners ( $M = 58.86, SD = 9.94, n = 525$ ) and nurse practitioners who are not currently practicing ( $M = 59.22, SD = 8.39, n = 18$ );  $t(541) = -0.15, p = .878$ . Additionally, there was no significant difference between current practicing nurse practitioners ( $M = 125.56, SD = 16.90, n = 508$ ) and nurse practitioners that are no longer in practice ( $M = 126.24, SD = 13.85, n = 17$ ) for the total GAP score.

**Acquaintance of gay and/or lesbian individual.** The demographic question asked nurse practitioners to identify whether or not they have been acquainted in their lifetime with a person who identifies as a gay male or a lesbian. There were two participants (0.4%) who stated that they had not been acquainted with a gay male or a lesbian. There were 99.6% of participants

who did identify with having a gay or lesbian acquaintance. No statistical analysis was conducted to determine difference in mean score due to the size of the groups.

### **Open-Ended Questions**

Four open-ended questions were asked of participants in order to obtain additional information regarding nursing education experiences. An additional open-ended question was asked at the end of the survey for participants who wanted to provide additional comments. A brief synopsis of the findings will be presented.

**Undergraduate nursing education.** The first two open-ended questions focused on nursing education in undergraduate nursing programs. There were more than 450 participants who submitted a response to both of the questions. The first question asked participants to identify what they felt was the most important thing they learned about caring for gay and lesbian clients in their undergraduate nursing education program. Responses were reviewed to identify recurrent ideas or comments. There were six major recurrent comments that addressed the topics identified below.

1. Little to no education regarding gay and lesbian individuals in undergraduate nursing program. Much of what has been learned has been by both personal and professional experiences.
2. Education regarding homosexuality and homosexuals focused on HIV and AIDS.
3. The importance of communication with gay and lesbian clients, which would include using open-ended questions and being comfortable in addressing a person's sexual orientation.
4. The importance of being nonjudgmental, facing one's own biases, treating "people as people", and providing care with dignity and respect.

5. Participants who identified attending a religious affiliated nursing program stated that gay and lesbian issues were not discussed.
6. Acknowledgement that cultural competency education was integrated in the curriculum, but there were no specific mention of gay and lesbian health issues.

The second open-ended question asked participants to identify what additional information undergraduate nursing program should teach in order to prepare graduates to care for gay and lesbian clients. Many respondents identified that having any information regarding this topic and client population would be better than what they received in their undergraduate nursing education. Table 18 identifies some of the recurrent suggestions made by participants that would be beneficial in preparing graduates to provide care for gay and lesbian clients.

Table 18  
*Recommendations for Undergraduate Nursing Education Regarding Caring for Gay and Lesbian Clients*

Foster open dialogue in the classroom to discuss the topic	Teach effective communication strategies
Address specific health concerns for LGBT individuals and addressing misconceptions	Use case studies and simulation that include gay and lesbian clients
Include specific clinical rotations that will allow for exposure to gay and lesbian clients	Discuss resources for gay and lesbian clients with nursing students
Include guest speakers and/or panel discussions on related health issues/concerns facing the LGBT population	Address psychological aspects of care, including suicide prevention

**Graduate nursing education.** Open-ended questions three and four addressed nursing education in graduate nursing programs and were answered by more than 450 participants. Many of the respondents stated that they had addressed these questions in answering the first two open-ended questions regarding nursing education in undergraduate programs. The third question specifically asked participants to identify what they felt was the most important thing they learned about caring for gay and lesbian clients in their graduate nursing education program. Responses were reviewed to identify recurrent ideas or comments. Seven comments that were most prevalent are presented.

1. Little to no education in graduate programs specific to gay and lesbian clients.
2. A focus was placed upon the specific risk factors and specific health needs for this client population. This included topics such as: intimate partner violence, reproductive health for lesbians, and screening for depression.
3. An emphasis was placed on adolescent health with regard to the “coming out” process, homeless gay and lesbian youth, and depression/suicide.
4. The importance of treating clients with acceptance and the utmost dignity in order to foster a safe practice environment.
5. Having open communication is important, especially being open to having discussions with clients regarding their sexual orientation.
6. Addressing one’s own internalized homophobia or bias.
7. Understanding that many gay and lesbian individuals do not seek treatment due to fear or previous experiences with health care providers.

The fourth open-ended question asked participants to identify what else they felt their graduate nursing program should teach in order to better prepare graduates to care for gay and lesbian clients. Table 19 identifies some of the recurrent suggestions made by participants that would be beneficial in preparing graduates to provide care for gay and lesbian clients.

Table 19  
*Recommendations for Graduate Nursing Education Regarding Caring for Gay and Lesbian Clients*

Focus on the importance of relationships and families within the LGBT population.	Include guest speakers and panel discussions such as gay and/or lesbian individuals who have had experience with health care and providers.
Have specific classes and/or content related to caring for transgendered individuals.	Teach effective communication strategies in order to engage with gay and lesbian clients and foster a safe environment.
Inform students of supportive services for LGBT individuals as well as resources available for clients and providers.	Explore evidence-based practice and research regarding care and health risks for this population.
Teach content that addresses specific health concerns and health risks for the LGBT population.	Inform students of supportive services for LGBT individuals as well as resources available for clients and providers.



**Additional comments.** Lastly, participants were provided an area where they were asked to provide any additional comments. There were 195 participants that provided additional information, with the majority sharing personal experiences or practice experiences, and commenting on the overall study. There were no identifiable recurrent themes among the comments.

### **Chapter Four Summary**

Chapter Four presented the study results. Demographic information for the 560 study participants was outlined. Next, results from Pearson product correlation for the first two research questions were presented. This information was followed by one-way, between group ANOVAs and *t*-tests to explore the relationship between the demographic information and beliefs, behaviors, and total GAP scores. Lastly, responses to the open-ended questions were explored and discussed. Chapter Five will further explore these study results and their implications.

## **CHAPTER FIVE**

### **DISCUSSION**

This final chapter provides a discussion of the study results. Summaries of the findings for each of the three research questions are presented. Conclusions drawn from the findings are discussed followed by implications for nursing practice. Limitations of the study are addressed. Lastly, recommendations for future research are presented as well as a summary.

#### **Summary of the Study**

The study set out to explore the concept of cultural competency among nurse practitioners when providing care for gay and lesbian clients. The study also sought to identify whether there was a relationship between nurse practitioners' reported level of cultural competence nursing education and the culturally competent care provided for gay and lesbian clients. The available literature on this subject and specifically in the context of nurse practitioner cultural competence with gay and lesbian clients was scant. Estimates imply that there are between 5.2 and 9.5 million adults in the United States who identify as LGBT, with self-identification more common among younger populations (Gates, 2014). Despite advances in equality, such as the national legalization of same-sex marriage (Liptak, 2015), LGBT individuals continue to face health disparities such as increased use of alcohol (Conron et al., 2010; Fredriksen-Goldsen & Muraco, 2010; Fredriksen-Goldsen et al., 2013; Ridner et al., 2006), obesity (Barnes, 2012; Conron et al., 2010; Boehmer et al., 2007; Fredriksen-Goldsen et al., 2013), higher rates of mental health issues (U.S. Department of Health and Human Services, 2011), and physical and emotional violence (Cramer et al., 2013; Hatzenbuehler et al., 2014; U.S. Department of Health and Human Services, 2011). The need for quality health care and the

significant number of individuals identifying as LGBT who will seek primary care made this study important to conduct at this time. The study sought to answer three questions:

1. Is there a relationship between the self-reported beliefs of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients?
2. Is there a relationship between the self-reported behaviors of nurse practitioners toward gay and lesbian clients and reported nursing education related to cultural competence, and cultural competence as it specifically relates to gay and lesbian clients?
3. Is there a significant difference between demographic categories of nurse practitioners (e.g., age, ethnicity, religious affiliation, type of nurse practitioner) and their self-reported beliefs and behaviors toward gay and lesbian clients?

An online, quantitative, exploratory survey design utilizing a convenience sample of nurse practitioners from a Northwestern state was used for the study. Gay Affirmative Practice was assessed using the GAP measurement tool, which is a 30-item scale designed to “assess practitioner’s beliefs and behaviors in practice with gay and lesbian individuals” (Crisp, 2002; Crisp, 2006a, p. 115). Self-reported nursing education related to cultural competence in general and cultural competence as it specifically related to gay and lesbian clients served as independent variables. Self-reported practice beliefs, practice behaviors, and total GAP score, as measured by the GAP Scale, served as dependent variables. Pearson moment correlation (Pearson’s  $r$ ) was used to analyze the data for research questions 1 and 2.

The initial recruitment email was sent to 2,366 nurse practitioners whose email addresses were obtained from the Northwestern state’s Board of Nursing. There were 56 emails returned as undeliverable. Once the survey had closed, 15 of the total 585 responses were deleted for

failure to complete either the entire 30-question GAP Scale or one of the 15-question practice domains (beliefs or behaviors). The final sample included 560 nurse practitioners ( $N = 560$ ) indicative of a 24.24% response rate based on 2,310 eligible participants.

ANOVAs and *t*-tests were used to analyze the data for differences among demographic categories in relation to practice beliefs, practice behaviors, and total GAP scores in order to address the third research question. Demographic categories for the study included gender, age, ethnicity, acquaintance of a gay and/or lesbian individual, highest level of education completed, classification of nurse practitioner, years of practice as a nurse practitioner, currently practicing as a nurse practitioner, sexual orientation, and religious affiliation. Descriptive statistics were used to describe the population.

### **Study Findings and Discussion**

Each of the research questions will be addressed and significant findings from Chapter Four will be presented as well as a discussion of the findings. In order to ascertain information regarding nursing education, participants were asked to identify the degree/extent they felt they were prepared in their nursing programs, both pre-licensure (ADN and/or BSN) and nurse practitioner (MSN and/or DNP), to provide culturally competent care and to provide culturally competent care specific to gay and lesbian clients. The questions used a 5-point Likert-style format ranging from 0 (*none*) to 4 (*a great deal*). The responses were transposed to a range of 1 through 5 when using SPSS in order to run statistical analyses.

Both practice domains, beliefs and behaviors, have a possible range of scores from 15 to 75 based on a 5-point, 15-question Likert-type scale. The scores for the domain of practice beliefs of nurse practitioners ( $n = 542$ ) when caring for gay and lesbian clients ranged from 15 to 75, with a mean score of 66.74. The domain of practice behaviors had a score range of 25 to 75,

with a mean score of 58.87 from the nurse practitioners ( $n = 543$ ). The measurement of the total GAP score is 30 to 150, with higher scores demonstrating more affirming practice with gay and lesbian clients. Study participants ( $n = 525$ ) had a mean total GAP score of 125.58, with scores ranging from 57 – 150. According to Crisp's (2005) classification of GAP scores, the participants would be categorized as "more affirming" (GAP scores of 90–150), and further categorized as "most affirming" (GAP scores of 120–150) when providing care for gay and lesbian clients (p. 58). Since this is the first use of the GAP Scale with nurse practitioners, it is important to see a comparison of selected studies that used the measurement scale.

Gandy et al. (2014) used the GAP Scale to measure the practice beliefs of mental health service providers who ranged from individuals who provided direct care, administrative individuals, and support staff. The mean score for all respondents ( $n = 92$ ) was 61.3 on the beliefs domain. The mean beliefs score of those who identified as direct-care providers ( $n = 32$ ) was 61.28 (Gandy et al.). Both of these are lower than the current study's mean of 66.74 for nurse practitioners.

Crisp (2005) administered the full GAP Scale to both social workers and psychologists and identified a mean score for all respondents ( $n = 477$ ) of 124.20. For social workers ( $n = 257$ ) the GAP Scale mean score was 125.03, and for psychologists ( $n = 220$ ) the mean was 123.17. In comparison, the nurse practitioner participants had a higher total GAP mean score of 125.58.

In a study of 257 social workers, Crisp (2006b) did not report the mean total GAP score for all participants in her findings. However, the mean GAP score was presented for gender and was 124.75 for males ( $n = 44$ ) and 125.82 for females ( $n = 213$ ), with no significant difference regarding gender. When studying social workers ( $n = 127$ ) in a medical setting, Mullins (2012) found an average score of 64.7 on the practice belief domain and 51.33 on the behavior domain.

### **Nurse Practitioner Beliefs and Nursing Education**

In conducting correlations (Pearson's  $r$ ) to address the first research question, there was a significant ( $p = .049$ ) small negative correlation found between reported pre-licensure cultural competence nursing education and practice beliefs. This finding indicated that lower levels of perceived cultural competence nursing education associated with higher belief scores on the GAP Scale. Not much weight was given to these findings due to minimal significance ( $p = .049$ ). There were no other significant findings regarding practice beliefs and reported nursing education.

### **Nurse Practitioner Behaviors and Nursing Education**

When conducting correlations (Pearson's  $r$ ) to address the second research question, there were no significant findings when exploring the relationship between generalized cultural competency nursing education and the domain of behaviors. Regarding cultural competence nursing education that was specific to gay and lesbian clients and the domain of behaviors, there were weak significant positive correlations found for both pre-licensure education ( $p = .001$ ) and graduate (nurse practitioner) education ( $p = < .001$ ). For both pre-licensure and graduate nurse practitioner education, the more reported education received regarding cultural competence for gay and lesbian clients the higher the score for the domain of behaviors.

### **Total GAP Score**

The total GAP score was also explored in relation to self-reported nursing education. The solitary significant finding ( $p = .003$ ) was a weak positive correlation between nurse practitioner cultural competence education specific to gay and lesbians and the total GAP score.

## **Significant Differences among Demographic Categories**

Using ANOVAs and *t*-tests for statistical analyses, each demographic category was explored to identify any significant differences in means of beliefs, behaviors, and total GAP score. One demographic category was whether or not the participant had been acquainted with a person who identified as gay or lesbian. Because there were only two participants stating they had not been acquainted with a gay or lesbian individual, a comparison was not conducted. This was the only demographic category that lacked a large enough number of participants within a specific category to conduct an analysis.

There were six demographic categories that did not have significant differences in mean scores of beliefs, behaviors, and total GAP score. These six categories were: gender, age, ethnicity, highest educational degree, years of practice as a nurse practitioner, and current practice status. Three demographic categories did have significant differences, which were classification of nurse practitioner, sexual orientation, and religious affiliation.

**Classification of nurse practitioner.** With regard to identified classification of nurse practitioners (adult, psychiatric/mental health, neonatal/pediatric), there were significant differences identified. When analyzing the data on practice beliefs, psychiatric/mental health nurse practitioners had significantly higher scores than did the adult nurse practitioners. For both practice behaviors and total GAP scores, psychiatric/mental health nurse practitioners had significantly higher scores than both adult nurse practitioners and neonatal/pediatric nurse practitioners. These results are similar to previous findings with social workers that identified mental health as being their primary area of practice scoring significantly higher on total GAP scores than those who did not work in mental health (Crisp, 2006b).

**Sexual orientation.** With regard to sexual orientation (heterosexual, homosexual, bisexual, prefer not to answer), the significant differences identified were the same for beliefs, behaviors, and total GAP score. Both the heterosexual participants and those who preferred not to answer scored significantly lower than those participants who identified as either homosexual or bisexual. There were no significant findings when comparing the homosexual and bisexual participants nor when comparing the heterosexual and those who preferred not to answer.

Crisp (2006b) also found a significant difference on total GAP scores among social workers when factoring in the demographic of sexual orientation. The social workers that identified as heterosexual scored significantly lower on total GAP score than those who identified within the gay, lesbian, or bisexual group.

**Religious affiliation.** Findings demonstrated that there were significant differences between participants who identified as having a religious affiliation and those who did not. Participants with a religious affiliation scored significantly lower than those without a religious affiliation for beliefs, behaviors, and total GAP score. No differences in scores were found between participants who preferred not to answer the question and participants with or without a religious affiliation.

This finding that nurse practitioners with no religious affiliation scored higher may suggest that nurse practitioners with a religious affiliation are impacted by religious teachings about gay and lesbian issues. This finding supports the literature, as Schlub and Martsolf (1999) found a statistically significant correlation between belief in the Christian religion and increased levels of homophobia among baccalaureate nursing students. Marsh and Brown (2011) found religiosity to be a highly significant predictor of homonegativity. Schlub and Martsolf further posited that the beliefs by many in the Christian community that homosexuality is a sin coupled



with societal fear of gays and lesbians could result in negative influences on the attitudes of nursing students and practicing nurses. While there is a significant difference found within the current study, both those with a religious affiliation and those without a religious affiliation had total GAP Scale mean scores >120, which equates to “most affirming” (GAP scores of 120–150) when providing care for gay and lesbian clients (Crisp, 2005, p. 58).

Although both groups were recognized as having GAP scores demonstrating an affirming practice, some participants identified themselves as having attended a religiously affiliated nursing program and stated they received no education regarding gay and lesbian health. These responses may indicate potential institutional biases and prejudices. The lack of education or content on the needs of specific diverse populations inadequately prepares future nurses and nurse practitioners in providing culturally competent care and may indirectly contribute to disparities and discrimination (Hutchinson et al., 2006).

Nicole et al. (2013), using only the GAP Scale’s beliefs domain, found a significant difference between mean scores of health professionals with regard to attending religious services. Health professionals who identified as attending weekly religious services scored significantly lower on practice beliefs than those who identified attending religious services less than weekly (Nicole et al.). In contrast, Crisp (2006b) did not find religious affiliation as having an association with scores on the GAP Scale, but did find higher scores for those with no religious affiliation on both the Attitudes Towards Lesbian and Gay Men Scale (ATLG) and the Heterosexual Attitudes Toward Homosexuals Scale (HATH) demonstrating more positive attitudes toward gays and lesbians.

## **Conclusions and Implications**

With an overall mean GAP score of 125.58, nurse practitioners participants in the study are considered to be “most affirming” in regard to providing care for gay and lesbian clients and the mean score suggests that nurse practitioners are committed to providing culturally competent care to gay and lesbian clients (Crisp, 2005, p. 58; Crisp, 2006a). The mean score for the GAP Scale equates to a high level of cultural competence in regard to providing care for this particular population. Nurse practitioners are well suited to provide primary care and to address the health needs of all individuals, including those who identify as gay or lesbian. Nurse practitioners are increasingly providing primary care services, and studies have demonstrated that these services are as safe and effective as services provided by physicians, with an overall reduced cost (Bauer, 2010; Fairman et al., 2011; Laurant et al., 2005; Naylor & Kurtzman, 2010). Several narrative responses by nurse practitioners to the study’s open-ended questions identified that much of what they had learned in regard to gay and lesbian individuals was through practice and experience, and not from formal nursing education. This experience-based or experiential learning places the emphasis on the individual’s experiences, and the ability of the individual to reflect upon his or her experience is essential to the process of learning (Andresen, Boud, & Cohen, 1999; Billings & Halstead, 2009). Although the significant relationships between cultural competency toward gay and lesbian clients and nursing education were identified as weak, it warrants exploration and discussion.

Findings demonstrated that higher reported education received regarding cultural competence for gay and lesbian clients in both pre-licensure nursing programs and graduate nursing programs, resulted in higher scores for the domain of practice behaviors. Additionally,

participants who identified receiving higher amounts of graduate level education focused on cultural competence specific to gay and lesbian clients demonstrated higher total GAP scores.

### **Implications for Nursing Education**

The development of nurses and of nurse practitioners begins with nursing education received in both undergraduate and graduate programs. Nursing programs of all educational levels are responsible for not only educating nurses and nurse practitioners about providing culturally competent care but also for including education regarding the care of LGBT individuals (IOM, 2011b). The National League for Nursing (2016) has identified not only a need for nursing education to lead the efforts to increase diversity among faculty and students but also the need to integrate LGBT health care in nursing education curricula. Additionally, the National Student Nurses' Association (2012) passed a resolution in 2010 to support the increase of culturally competent education about LGBT individuals and encouraged nursing programs to incorporate LGBT health inequalities more prominently into nursing education.

The need for inclusion of this population within nursing education was supported by responses from participants when asked what they felt their graduate program should teach in order to better prepare them to care for gay and lesbian clients (Table 20). Study participants also expressed similar comments when asked to identify ways pre-licensure nursing programs could better prepare graduates to care for gay and lesbian clients. There is a need for nursing education to encourage acceptance of differences in society in order to assist students, both pre-licensure and graduate, in developing and enhancing skills in critical thinking (Gray et al., 1996; Maze, 2005). The integration of LGBT health into nursing curricula is necessary to not only educate future health care providers about specific health disparities but also to foster cultural competency (Carabez et al., 2015; Eliason et al., 2010; Sirota, 2013).

Table 20

*Sampling of Responses by Nurse Practitioners in Identifying What Would Better Prepare Graduates of Nurse Practitioner Programs in Providing Care for Gay and Lesbian Clients*

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A lecture from the gay perspective of how they perceive visits to NP or providers including past experiences and challenges.

A course on the subject as part of the nursing program should be essential!

Areas which are most important from the gay and lesbian community for non-gay/lesbian providers to be prepared to address.

Issues specific to gay and lesbian families, how to ask in open ended manner, resources, exploring own biases.

Introduction to the gay/lesbian community and what issues will impact their seeking and receiving health care.

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Previous nursing studies have identified the need for improved knowledge and cultural competence regarding LGBT clients (Chapman et al., 2012). Health care providers who have basic knowledge about LGBT issues were identified as preferred by LGBT patients (Rounds, McGrath, & Walsh, 2013). When a nursing program lacks information regarding a particular patient population, such as LGBT, this can impede the student and future practitioner from becoming culturally competent. Adding supplementary content on sexual orientation to existing nursing school curricula is needed in order to meet the needs of the students and to address the needed education regarding providing care not only for gay and lesbian clients, but also for all LGBT clients.

The recommendations by the participants align with the study's theoretical model, *The Process of Cultural Competence in the Delivery of Healthcare Services*, as these recommendations would allow graduate students the ability to address the constructs of cultural awareness, cultural knowledge, cultural skill, and cultural encounters (Campinha-Bacote, 2002a; Campinha-Bacote, 2002b). The construct of cultural desire would be difficult for schools of nursing to implement, as the student and future health care provider would need to demonstrate his or her own motivation to want to engage in the process of becoming culturally competent when caring for gay and lesbian clients (Campinha-Bacote, 2002a; Campinha-Bacote, 2002b).

Study findings demonstrated that the mean score for practice beliefs of nurse practitioners was higher than the mean score for practice behaviors. This difference may demonstrate that the nurse practitioner has strong beliefs about providing care, but may lack competencies that are necessary to impact practice behaviors and/or lack knowledge and skills needed to practice in an affirming manner. In a previous study, measures of homophobia were moderately correlated with GAP scores demonstrating that there is a relationship between attitudes and practice with gay and lesbian clients (Crisp, 2006b). This could identify that personal bias regarding gay and lesbian clients can impede the ability of a provider to become culturally competent when caring for gay and lesbian clients. Future practitioners should have a safe place where they can discuss their bias in order to acknowledge that it exists, and to have experiences that may affect their bias. One place this can occur is within nursing education, both pre-licensure and graduate.

**Nursing faculty.** An important aspect of the nursing education process is the faculty who teach in the various nursing programs. Although it has been identified that nursing faculty feel that teaching students about homosexuality is very important, it has also been identified that many faculty members do not feel they possess the knowledge and skills necessary to teach this content (Sirota, 2013). Given that a significant relationship with increased content being taught in nursing programs regarding gay and lesbian issues and increased cultural competence in providing care for this population exists, it is important that nursing faculty are adequately prepared to provide the education needed. Nursing programs should provide faculty development training and seminars on an ongoing basis that address LGBT health. This may include designed educational opportunities for nursing faculty as well as inclusion of the topic in conferences that are widely attended by nursing faculty.

**Providing experiences through clinical and simulation.** Nursing programs should provide students with educational experiences that allow for exposure to LGBT individuals and LGBT health topics. Sanchez, Rabatin, Sanchez, Hubbard, and Kalet (2006) found that medical students with increased clinical exposure to LGBT patients not only performed more comprehensive histories, but also had greater knowledge of LGBT health concerns and more positive attitudes toward LGBT patients than students with little or no clinical exposure. Without exposure to LGBT issues, nurses and nurse practitioners may be unable to fully meet the needs of LGBT individuals. Nursing education can improve exposure to LGBT health concerns by providing both clinical and simulation opportunities for students.

Nursing programs should partner with local LGBT organizations in order to provide clinical placements for students. The experience of working with the organization would allow for interactions between students and LGBT individuals. These interactions could be explored in clinical conferences to allow for reflection about working with individuals who may be different than the student. Nursing faculty should provide a safe learning environment where students feel secure in their ability to discuss potential bias or prejudice in order to promote reflection and growth.

Simulated experiences using standardized patients or high-fidelity would be beneficial for nursing students in order to provide learning experiences that have specific learning outcomes related to knowledge of gay and lesbian health as well as disparities. The ability for students to receive feedback and instruction in a controlled environment would allow for opportunities that might not be available in a traditional clinical environment.

**Specific to nurse practitioners.** Nurses entering graduate school in order to become nurse practitioners should receive educational opportunities and experiences that assist them in

becoming reflective and self-regulated learners. Through reflection, nurse practitioner students can evaluate their knowledge, skills and attitudes in providing care for gay and lesbian clients. Advanced case studies can be created and presented in order to facilitate a deeper understanding of the needs of the LGBT community using prior experiences to build upon.

Graduate students attending nurse practitioner programs should have educational opportunities that demonstrate the importance of identifying sexual orientation or gender identity with clients. The ability for clients to feel safe in disclosing sexual orientation/gender identify as well as the acceptance of this identity by providers allows for better health outcomes and fosters trust (Chaplic & Allen, 2013; Durso & Meyer, 2013; Neville & Hendrickson, 2006). Providing nurse practitioner students opportunities to engage in appropriate conversations and to learn how to solicit answers to specific questions using standardized patients can decrease anxiety and increase confidence (Rutledge et al., 2004). With increased comfort in providing care to gay and lesbian clients, nurse practitioner students will be able to provide an environment that is conducive to trust and open communication when providing primary care.

Nurse practitioners need to have an understanding of the unique health needs of gay and lesbian clients in order to provide culturally competent and appropriate health care (Gee, 2006; IOM, 2011b). Some of the study participants stated that they cared for gay and lesbian clients “like everyone else” in response to open-ended questions. This approach to care can prevent nurse practitioners from addressing the health needs or disparities faced by gay and lesbian individuals because the distinct differences are not being evaluated.

### **Implications for Nurse Practitioner Continuing Education**

Once the student has completed his or her graduate degree and is practicing as a nurse practitioner, there must be continuing education available with a focus not only gay and lesbian

clients but also on bisexual and transgendered clients. More educational opportunities for nurse practitioners are warranted that include a specific focus on lesbian and gay issues as there may have been a lack of education received during their nursing education. Providing interactive workshops alone or with other educational interventions have been identified as being likely to improve professional practice among health care providers when compared to didactic lectures (Bellolio & Stead, 2009). Crisp (2006b) found that attending workshops with areas of focus on gay and lesbian issues had a significant positive association with GAP scores.

Nurse practitioners should reflect on whether or not they possess the knowledge and/or skills necessary to provide culturally competent care for this population; understanding that further education may be required (McManus, 2008). Nurse practitioners should inform themselves, by any reliable means, about how gay and lesbian clients, as well as those who identify as bisexual or transgendered, live their lives and about the needs of LGBT clients. Nurse practitioners who fail to obtain the necessary training will create a barrier for LGBT clients to receive culturally competent care. As a culturally competent provider, nurse practitioners should also familiarize themselves with language appropriate for use when working with LGBT clients as well as providing an atmosphere where the client feels comfortable in discussing his or her sexual identity and/or orientation.

There are many resources for practitioners to assist in providing culturally competent care not only to gay and lesbian clients, but also to bisexual and transgendered clients. One example is *Quality Healthcare for Lesbian, Gay, Bisexual & Transgender People*, which is a cultural competence archived webinar series provided by GLMA ([www.glma.org](http://www.glma.org)) that is beneficial for providers. The webinar addresses topics such as understanding the needs of the LGBT



population, providing a safe and welcome practice environment, and clinical skills for providing care for transgender individuals.

In addition to the webinar provided by GLMA, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) identified and reviewed curricula in order to provide resources for practitioners to assist in providing culturally competent care to LGBT clients (U.S. Department of Health and Human Services, 2014). One of the identified trainings focuses on health care communication, and includes LGBT populations in order to improve patient-client communication. Continuing education credits are available for health professionals within organizations such as American Nurses Association, American Medical Association, and American Academy of Physician Assistants, however; the American Association of Nurse Practitioners is not listed as one of the professional associations (U.S. Department of Health and Human Services, 2014).

In order to assist nurse practitioners as well as nurses in providing care that improves health outcomes, states should require continuing education units (CEU) that focus on cultural competence development and care of diverse populations. Within this requirement, there should be a focus on LGBT health and identification of health disparities in order to improve culturally competent care. The inclusion of LGBT health in diversity training and in educational opportunities allows nurse practitioners the ability to increase both their cultural knowledge and cultural skills in order to become culturally competent and is part of the theoretical model (Campinha-Bacote, 2001; Campinha-Bacote, 2002b; Campinha-Bacote, 2007).

### **Limitations**

This study has several identified limitations. First, the generalizability of the findings is limited. The sample itself was not a random sample from the target population of all nurse

practitioners; rather the sample was obtained from a convenience sample of nurse practitioners in one Northwestern state that were willing to participate in an electronic survey. The use of a convenience sample, and the voluntary nature of participation in this study by completing a survey prohibited random sampling. This lack of random sampling limits the extent to which the sample is representative of the target population of nurse practitioners (Burns & Grove, 2011).

Responses to open-ended questions were solicited from nurse practitioners in order to allow participants to elaborate on their nursing education experiences as well as identify what they would like to see incorporated into nursing education programs regarding gay and lesbian clients. Because the information from the responses was obtained from a survey instead of actual interviews, some responses may have lacked depth. Additionally, there was an inability to clarify responses given on the open-ended questions.

All data received was self-reported with the use of an online electronic survey. Participants answered questions regarding their nursing education as well as their practice beliefs and practice behaviors in caring for gay and lesbian clients, none of the responses can be independently verified. Because these responses are self-reported there is a potential for bias among the results. Some of the responses could be based on what the individual feels is the correct answer in regard to the profession of nursing and not reflective of his or her true beliefs. Additionally, nurse practitioners who chose to participate may have felt strongly about the topic and/or may have been motivated by personal interest, whereas those who may not have felt strongly or had a differing view may have chosen not to participate.

## **Recommendations for Future Research**

This study served as a starting point to assess the culturally competent care provided by nurse practitioners to gay and lesbian clients. Based on the limitations of this study as well as the findings, the following recommendations for future research are proposed:

- In order to obtain a potentially more diverse demographic and richer data, a national mixed methods study could be conducted. In addition to the GAP Scale, nurse practitioners that express interest in providing more in-depth information would be contacted by telephone in order obtain qualitative data.
- Conduct a study in order to identify what LGBT individuals are wanting from a health care provider and from health care experiences. This would be important to understand in order to recommend possible educational interventions for health care providers.
- Use the GAP Scale along with a specific cultural competence measurement tool with nurse practitioners or registered nurses in order to correlate the findings from both. This would allow for a correlation between the two measurement tools.
- Conduct a test-retest reliability study using the GAP Scale for nurse practitioners or registered nurses. The GAP Scale could be administered before the implementation of various LGBT focused educational interventions and then re-administered after the interventions in order to evaluate the change in scores. The identification of which educational method is most effective will allow for an improvement in care and practice, as this may assist the practitioner in becoming a more gay affirmative practitioner, thus improving cultural competency for this patient population.

- Further research into characteristics of psychiatric/mental health nurse practitioners and why they have more characteristics of gay affirmative practice in regard to practice beliefs and practice behaviors.

### **Chapter Five Summary**

This final chapter is the conclusion to the research study. A summary of the study, discussion of the findings, implications, limitations, and recommendations for future research were presented. The problem addressed by this study was the need for cultural competence education for nurse practitioners specific to the care of gay and lesbian clients. The study was implemented using a quantitative, exploratory survey design as a primary method for data collection. Data were collected directly from the participants' perspective of their practice with gay and lesbian clients as well as their nursing education experience in order to explore practice beliefs and behaviors and reported nursing education focused on cultural competence.

The theoretical framework proposed that cultural competence is a process that includes five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002a; Campinha-Bacote, 2002b). The theoretical framework also identified a direct relationship between a health care provider's level of cultural competence and his or her ability to "provide culturally responsive health care services" (Campinha-Bacote, 2002b, p. 181). The literature implied that nursing education has the ability to assist future providers in becoming culturally competent.

The findings of this study revealed that the participants' reported level of cultural competency nursing education specific to gay and lesbian clients in both their pre-licensure and graduate nursing education programs, directly influenced beliefs and behaviors when providing care to this population. The insights gained from this study have the potential to inform the

development of pedagogical practices that could enhance nursing education regarding cultural competence, with a focus on LGBT health.

## APPENDIX A

### Demographic Questionnaire

1. What is your gender?

- Male
- Female
- Other
- Prefer not to answer

2. What is your age?

- ≤25 years of age
- 26–35 years of age
- 36–45 years of age
- 46–55 years of age
- 56–65 years of age
- >65 years of age

3. What is your ethnicity/race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Prefer not to answer

4. In your lifetime, have you been acquainted with a person who identifies as a gay male or a lesbian?

- Yes
- No

5. What is the highest educational degree you have completed?

- Masters in Nursing (MSN, MN)
- Doctorate in Nursing (PhD, DNP)
- Other      Please describe: \_\_\_\_\_

6. Select all of the degrees you have received during your nursing education.

- Associate Degree in Nursing (ADN)
- Bachelor of Science in Nursing (BSN)

- Master's Degree in Nursing (MSN, MN, MS)
- Doctoral Degree in Nursing (PhD, DNP)
- Other Please describe: \_\_\_\_\_

7. In regard to your practice as a nurse practitioner, how would you classify yourself?
- Adult nurse practitioner (Adult, Nurse Midwife, Family, Geriatric, Women's Health)
  - Psychiatric/Mental Health nurse practitioner
  - Neonatal nurse practitioner or Pediatric nurse practitioner
  - Other Please describe: \_\_\_\_\_

8. Are you currently practicing as a nurse practitioner?
- Yes
  - No

9. How long have you practiced as a nurse practitioner?  
\_\_\_\_\_ (years)

10. Do you have a religious affiliation?
- Yes
  - No
  - Prefer not to answer

11. To what degree/extent do you feel you were prepared in your pre-licensure nursing program(s) [Associate Degree (ADN) and/or Baccalaureate Degree (BSN)] to provide culturally competent care?
- 4 = A great deal
  - 3 = Much
  - 2 = Somewhat
  - 1 = Little
  - 0 = None

12. To what degree/extent do you feel you were prepared in your pre-licensure nursing program(s) [Associate Degree (I) and/or Baccalaureate Degree (BSN)] to provide culturally competent care specific to gay and lesbian clients?
- 4 = A great deal
  - 3 = Much
  - 2 = Somewhat
  - 1 = Little
  - 0 = None

13. To what degree/extent do you feel you were prepared in your nurse practitioner program(s) [e.g., MSN and/or DNP] to provide culturally competent care?
- 4 = A great deal
  - 3 = Much
  - 2 = Somewhat
  - 1 = Little
  - 0 = None
14. To what degree/extent do you feel you were prepared in your nurse practitioner program(s) [MSN and/or DNP] to provide culturally competent care specific to gay and lesbian clients?
- 4 = A great deal
  - 3 = Much
  - 2 = Somewhat
  - 1 = Little
  - 0 = None
15. How do you classify your sexual orientation?
- Heterosexual
  - Homosexual
  - Bisexual
  - Prefer not to answer

### **Open-Ended Questions**

16. What was the most important thing you learned about caring for gay and lesbian clients in your undergraduate nursing program?
17. What else do you think your undergraduate program should teach that would better prepare graduates to care for gay and lesbian clients?
18. What was the most important thing you learned about caring for gay and lesbian clients in your graduate nursing program?
19. What else do you think your graduate program should teach that would better prepare graduates to care for gay and lesbian clients?

### **Additional Comments**

20. Please feel free to provide any additional comments here:



APPENDIX B

**Gay Affirmative Practice Scale**

The questionnaire is designed to measure clinicians’ beliefs about treatment with gay and lesbian clients and their behaviors in clinical settings with these clients. There are no right or wrong answers. Please answer every question as honestly as possible.

Please rate how strongly with you agree or disagree with each statement about treatment with gay and lesbian clients on the basis of the following scale:

*Scale of measurement*

**1= Strongly disagree (SD), 2 = Disagree (D), 3 = Neutral (N), 4 = Agree (A), 5 = Strongly agree (SA)**

Items

Item #	Items	1=Strongly disagree	2=Disagree	3=Neutral	4=Agree	5=Strongly Agree
1	In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	Practitioners should make an effort to learn about diversity within the gay/lesbian community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	Practitioners should be knowledgeable about gay/lesbian resources.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	Practitioners should educate themselves about gay/lesbian lifestyles.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	Practitioners should challenge misinformation about gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10	Practitioners should be knowledgeable about issues unique to gay/lesbian couples.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11	Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12	Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13	Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14	Practitioners should help clients reduce shame about homosexual feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15	Discrimination creates problems that gay/lesbian clients may need to address in treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please rate how frequently you engage in each of the behaviors with gay and lesbian clients on the basis of the following scale:

*Scale of measurement*

**1= Never (N), 2= Rarely (R), 3= Sometimes (S), 4= Usually (U) 5= Always (A)**

*Items*

Item #	Items	<b>1=Never</b>	<b>2=Rarely</b>	<b>3=Sometimes</b>	<b>4=Usually</b>	<b>5=Always</b>
16	I help clients reduce shame about homosexual feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17	I help gay/lesbian clients address problems created by societal prejudice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18	I inform clients about gay affirmative resources in the community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19	I acknowledge to clients the impact of living in a homophobic society.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20	I respond to a client's sexual orientation when it is relevant to treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21	I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22	I provide interventions that facilitate the safety of gay/lesbian clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23	I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24	I demonstrate comfort about gay/lesbian issues to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- gay/lesbian clients.
- 25 I help clients identify their internalized homophobia.
- 26 I educate myself about gay/lesbian concerns.
- 27 I am open-minded when tailoring treatment for gay/lesbian clients.
- 28 I create a climate that allows for voluntary self-identification by gay/lesbian clients.
- 29 I discuss sexual orientation in a non-threatening manner with clients.
- 30 I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.

\*Scale used with permission by Catherine Crisp.

## APPENDIX C

### **Permission to use GAP Scale**

Good evening, Paul;

I am writing to confirm that you have my permission to use the Gay Affirmative Practice Scale in your dissertation research for your PhD in nursing at UNLV. You may administer it the scale in any form you choose (hard copy, online, etc) but may not change the questions without additional permission from me.

Best of luck in your research. Please keep in touch and let me know if I can assist you. I look forward to reading your work on completion of your study.

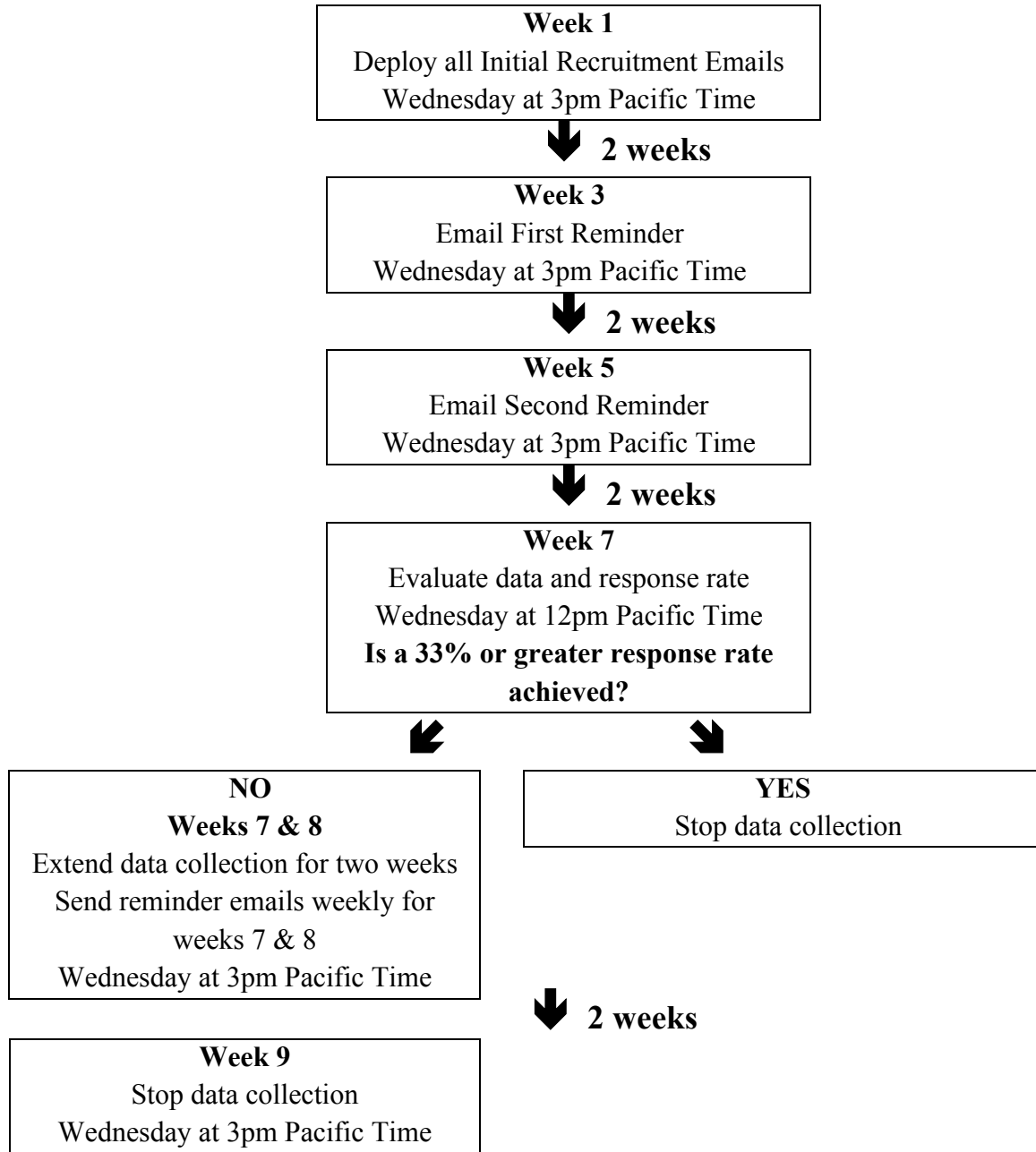
Catherine

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(501) 569-8465 (office) | (501) 569-3184 (fax)

APPENDIX D

**Timeline for Data Collection (to begin following IRB approval)**



APPENDIX E

**IRB Approval**



**UNLV Biomedical IRB - Exempt Review  
Exempt Notice**

**DATE:** October 12, 2015

**TO:** Lori Candela, EdD, MS  
**FROM:** Office of Research Integrity - Human Subjects

**PROTOCOL TITLE:** [819646-1] Cultural competence of nurse practitioners: providing care for gay and lesbian patients

**ACTION:** DETERMINATION OF EXEMPT STATUS  
**EXEMPT DATE:** October 12, 2015  
**REVIEW CATEGORY:** Exemption category # 2

Thank you for your submission of New Project materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

**PLEASE NOTE:**

Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI - HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at [IRB@unlv.edu](mailto:IRB@unlv.edu) or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

Office of Research Integrity - Human Subjects  
4505 Maryland Parkway . Box 451047 . Las Vegas, Nevada 89154-1047  
(702) 895-2794 . FAX: (702) 895-0805 . [IRB@unlv.edu](mailto:IRB@unlv.edu)



**UNLV Biomedical IRB - Administrative Review  
Exempt Notice**

**DATE:** October 13, 2015  
**TO:** Lori Candela, EdD, MS  
**FROM:** Office of Research Integrity - Human Subjects  
**PROTOCOL TITLE:** [819646-2] Cultural Competence of Nurse Practitioners: Providing Care for Gay and Lesbian Clients  
**ACTION:** DETERMINATION OF EXEMPT STATUS  
**EXEMPT DATE:** October 12, 2015  
**REVIEW CATEGORY:** Exemption category # 2

Thank you for your submission of Other materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

**PLEASE NOTE:**

Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI - HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at [IRB@unlv.edu](mailto:IRB@unlv.edu) or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

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(702) 895-2794 . FAX: (702) 895-0805 . [IRB@unlv.edu](mailto:IRB@unlv.edu)

## APPENDIX F

### Recruitment Email

Dear Nurse Practitioner,

My name is Paul Smith and I am a PhD in Nursing student at the University of Nevada, Las Vegas. I would like to invite you to participate in a research study I am conducting to explore cultural competence relating to the care of gay and lesbian clients. Little is known in this area and no research, to date, has examined cultural competence of nurse practitioners specific to the gay and lesbian population. So, your participation is vital to in order to better understand your work. If you decide to participate, you will be asked to complete an online survey. The survey includes questions about basic demographics and beliefs and behaviors when working with gay and lesbian clients. This survey should take approximately 15 minutes to complete and is completely anonymous. You may read the online consent form by clicking the link at the bottom of this page. If you agree to participate, you will automatically be directed to the online survey.

Your practice as a primary care provider is extremely important and the information gained in this study will provide more light on your practice specific to gay and lesbian patients as well as additional educational support you may need to provide better care for them. I truly hope that you will consider participating in my study.

Sincerely,

Paul Smith, MN, RN, CCRN, CNE  
Student Investigator  
PhD nursing student  
University of Nevada, Las Vegas

Lori Candela, EdD, FNP-BC, CNE  
Associate Professor  
Principal Investigator and Committee Chair  
University of Nevada, Las Vegas



APPENDIX G

Consent Form



**INFORMED CONSENT**

Department of Nursing

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**TITLE OF STUDY: Cultural Competence of Nurse Practitioners: Providing Care for Gay and Lesbian Clients**

**INVESTIGATOR(S): Principal Investigator: Lori Candela, EdD, RN, APRN, FNP-BC, CNE; Student Investigator: Paul S. Smith, MN, RN, CCRN, CNE**

For questions or concerns about the study, you may contact **Lori Candela at 702-895-2443 or Paul Smith at 503-593-9841**

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at [IRB@unlv.edu](mailto:IRB@unlv.edu)**.

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**Purpose of the Study**

You are invited to participate in a research study. The purpose of this study is to (a) explore the cultural competence of nurse practitioners by examining their beliefs and behaviors using the Gay Affirmative Practice (GAP) Scale as they relate to working with gay and lesbian clients, and (b) to determine whether the beliefs and behaviors of nurse practitioners who care for LGBT clients are related to the amount of reported cultural competence nursing education they have received.

**Participants**

You are being asked to participate in the study because you fit this criteria: A nurse practitioner currently licensed to practice in the state of Oregon, with an active email address on file with the Oregon State Board of Nursing.

**Procedures**

If you volunteer to participate in this study, you will be asked to do the following: complete a 20 question demographic survey, which includes four open-ended survey questions, and a 30-item Gay Affirmative Practice Scale. The data collection period will remain open for six weeks, with

an additional two weeks added if response rate is less than 33%. Follow-up reminders will be sent every two weeks (at end of week 2 and the end of week 4) during the data collection period. If the data collection is extended for two weeks, follow-up reminders will be sent during week seven and during week eight.

### **Benefits of Participation**

There may be no direct benefits to you as a participant in this study. However, we hope to learn about nurse practitioners' cultural competence and caring for gay and lesbian clients. This would also include information regarding educational preparation in schools of nursing for caring for gay and lesbian clients.

### **Risks of Participation**

There are risks involved in all research studies. This study may include only minimal risks. Some participants may be uncomfortable answering one or more of the questions. However, you may opt to not answer any question you do not wish to.

### **Cost /Compensation**

There will be no financial cost to you to participate in this study. The study will take 15 – 20 minutes of your time. You will not be compensated for your time.

### **Confidentiality**

All information gathered in this study will be kept completely confidential. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for 3 years after completion of the study. After the storage time the information gathered will be destroyed.

### **Voluntary Participation**

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

### **Participant Consent:**

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

By clicking on the "I agree to participate" button below, you consent to participate in this research study. If you do not wish to participate, simply close your web browser.

**[I agree to participate](#)**

***Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.***

## APPENDIX H

### Reminder Email

Dear Nurse Practitioner,

My name is Paul Smith and I am a PhD in Nursing student at the University of Nevada, Las Vegas. I recently invited you to participate in a research study I am conducting to explore cultural competence relating to the care of gay and lesbian clients. As previously stated, little is known in this area and no research, to date, has examined cultural competence of nurse practitioners specific to the gay and lesbian population. So, your participation is vital in order to better understand your work.

I would like to follow-up with you to ask if you would consider participating in my study by completing an online survey. The survey includes questions about basic demographics and beliefs and behaviors when working with gay and lesbian clients. This survey should take approximately 15-20 minutes to complete and is completely anonymous. You may read the online consent form by clicking the link at the bottom of this page. If you agree to participate, you will automatically be directed to the online survey.

Your practice as a primary care provider is extremely important and the information gained in this study will provide more light on your practice specific to gay and lesbian clients as well as additional educational support you may need to provide better care for them. I truly hope that you will consider participating in my study. I would be grateful for your time, and your expertise as a nurse practitioner.

Sincerely,

Paul Smith, MN, RN, CCRN, CNE  
Student Investigator  
University of Nevada, Las Vegas  
Phone: 503-593-9841

Lori Candela, EdD, FNP-BC, CNE  
Associate Professor  
Principal Investigator and Committee Chair  
University of Nevada, Las Vegas  
Phone: 702-895-2443

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## CURRICULUM VITAE

Paul S. Smith, PhD(c), RN, CCRN, CNE

Work Address: Linfield College  
School of Nursing  
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Portland, OR 97210  
(503) 413-7031  
psmith@linfield.edu

### **DEGREE – Institutions:**

PhD	Fall 2013	University of Nevada, Las Vegas Nursing Education (Currently attending – Projected graduation May 2016)	Las Vegas, NV
MN	2007 - 2010	Washington State University Community/Public Health Nurse Educator Certificate	Vancouver, WA
BSN	2005 - 2006	University of Phoenix	Atlanta, GA
ADN	1995 - 1997	Southern Union State Community College	Opelika, AL

### **CERTIFICATION AND LICENSURE**

RN Licensure – Oregon  
RN Licensure – Washington  
RN Licensure – Georgia  
Certificate of Distance Education – Thomas Edison State College June, 2014  
CCRN – American Association of Critical-Care Nurses  
Certified Nurse Educator (CNE) – National League for Nursing Certification  
Basic Life Support (BLS) American Heart Association  
Advanced Cardiac Life Support (ACLS) American Heart Association

### **CLINICAL SPECIALTY**

Adult Health Nursing  
Adult Critical Care with emphasis on neurological conditions

### **ACADEMIC AND CLINICAL EXPERIENCE**

*Assistant Professor of Nursing, Linfield College, Portland, OR (July 2014-present)*

- Teach a variety of courses in both pre-licensure and RN to BSN programs

*Adjunct Nursing Instructor (mentor), Thomas Edison State College, Trenton, NJ (July 2014-present)*

- Adjunct faculty in online RN-BSN program teaching various courses

***Nurse Educator, Chemeketa Community College, Salem, OR (January 2008-June 2014)***

- Provided lecture and clinical instruction for second year nursing students

***Adjunct Nursing Instructor, Linfield College, Portland, OR (September 2010-June 2014)***

- Adjunct faculty in online RN-BSN program teaching various courses

***Clinical Adjunct Nursing Instructor, Linfield College, Portland, OR (September 2007-December 2007)***

- Provided clinical instruction for nursing students in various community settings

***Staff Nurse, Neuro-Surgical Intensive Care Unit, Oregon Health and Sciences University, Portland, OR (April 2007-January 2008)***

- Provided preceptorship and clinical orientation for newly hired staff and graduates
- Focused on medical care of the critically ill patient with a strong emphasis on neuro
- Taught class for new graduates four times a year, with emphasis on case studies, stroke, and neurologically focused disease processes

***Staff Nurse, Medical Intensive Care Unit (20 beds), Crawford Long Hospital, Emory Healthcare, Atlanta, GA (August 2005-March 2007)***

- Provided preceptorship and clinical orientation for newly hired staff and graduates
- Served as member of orientation/education committee
- Focused on medical care of the critically ill patient with a strong emphasis on pulmonary

***New Patient Coordinator, Winship Cancer Institute Call Center, Emory Healthcare, Atlanta, GA (January 2005-August 2005)***

- Coordinated new patient referrals and appointments for all oncology patients
- Triageed calls from oncology patients placed to the call center
- Actively participated in process change in regards to new patient referrals

***Staff Nurse, Interventional Radiology, Emory University Hospital, Atlanta, GA, (August 2000 – May 2003, September 2003 - January 2005)***

- Provided care and education for patients undergoing various types of tests ranging from CT scans to embolizations of cerebral aneurysms
- Proficient in administration of conscious sedation as well as patients on paralytics
- Provided preceptorship and clinical orientation for new staff members
- Served on committee to reorganize orientation manual
- Prepared an Interventional Radiology Nursing Notebook that resides in each Angio Suite
- Promoted to Staff Nurse Level III
- Responsible for nursing schedule for entire radiology nursing staff
- Served as nurse clinician Level IV and interim radiology nursing supervisor
- Taught an “IV Skills” Class to technologists and administered testing and observed IV insertion skills to credential technologists on IV starts.

***Staff Nurse, Neuro/Neurosurgical ICU, Emory University Hospital, Atlanta, GA (January 2000 – August 2000)***

- Critical care nursing practice with expertise developed in neurological and neurosurgical intensive care
- Assessed, planned, implemented and evaluated nursing plans of care for neurological and neurosurgical critically ill patients
- Provided preceptorship and clinical orientation for new clinical staff and for new nursing school graduates

***Staff Nurse, ICU/CCU, West Georgia Health Systems, LaGrange, GA (May 1999 – January 2000)***

- Provided care to various types of intensive care patients, with a strong nursing foundation developed in coronary, pulmonary & surgical intensive care nursing
- Assessed, planned, implemented and evaluated nursing plans of care for critically ill patients
- Developed proficiency in critical care procedures and in intensive care nursing
- Served as Blood Products Administration Chairperson
- Served on Chart Review Committee
- Functioned in charge nurse capacity

***Staff Nurse, Medical / Oncology Unit, West Georgia Health Systems, LaGrange, GA (March 1998 – May 1999)***

- Provided care to oncology patients and to patients with various medical conditions
- Served as chairperson of Restraint Committee
- Functioned in charge nurse capacity
- Certified in chemotherapy infusions

**SCHOLARLY WORK & ACTIVITIES**

*Unpublished graduate thesis at Washington State University defense completed successfully May 2010:*

Smith, P. S. (2010). Cultural Safety in Nursing Education: Increasing Care for LGBT Individuals (Chair: Dr. Renee Hoeksel).

**National League for Nursing Leadership Institute (LEAD program) (2013)**

A year long program where a cohort of peers examines organizational systems and leadership processes focusing on strategic planning, building high performance teams, financial management, and developing a personal career plan to advance in organizational leadership. Throughout the program participants were encouraged to individually grow and the program fostered interactions within the cohort.

**Publications**

**Textbook Contributor**

Burke, K. M., Mohn-Brown, E. L., & Eby, L. (2016). Medical-Surgical Nursing Care (4th ed.) Contributor for *Guidelines for Patient Assessment* (Chapter 5) and *Loss, Grief, and End-of-Life Care* (Chapter 13).

**Manuscript**

**Smith, P. S.,** & Jones, M. (2015). Evaluating an online family assessment activity: A focus on diversity and health promotion. *Nursing Forum*. Advance online publication. doi: 10.1111/nuf.12139

Jones, M., & **Smith, P.** (2014). Population focused nursing: Advocacy for vulnerable populations in an RN-BSN program. *Public Health Nursing*. 31(5), 463-471. doi: 10.1111/phn.12114.

**Reviewer**

Reviewer for *Public Health Nursing* journal.

Elsevier Adaptive Quizzing for the NCLEX-RN Exam (2014). Elsevier. (ISBN: 9780323244954)

### Presentations/Posters

#### **Podium Presentations**

- November 2013      **Smith, P.** & Jasper, S. *Meeting the challenge of reduced clinical placements with a multi-patient unfolding case simulation.* NOADN Conference. Reno, NV.
- March 2013      Jasper, S. & **Smith, P.** *Meeting the challenge of reduced clinical placements with a multi-patient unfolding case simulation.* Drexel University's Simulation in Healthcare: Where No One Has Gone Before. Clearwater Beach, FL.

#### **Poster Presentations**

- April 2016 (accepted)      **Smith, P.** (2016). *Cultural competence of nurse practitioners: Providing care for gay and lesbian clients.* The Western Institute of Nursing (WIN). 49th Annual Communicating Nursing Research Conference. Anaheim, CA.
- September 2015      Volkert, D., & **Smith, P.** (2015). *How the National League for Nursing core values align and support doctoral education.* The National League for Nursing (NLN). 2015 Education Summit. Las Vegas, NV.
- October 2014      de la Cruz, K., & **Smith, P.**, *Smith-de la Cruz Theory of Critical Culture Recognition in Nursing (S-dTCCRN).* The Transcultural Nursing Society. 40th Annual Conference: Living Our Mission in a Changing World. Charleston, SC.
- April 2014      Schneider, B., Suba, R., Miles, S., Myers, S., **Smith, P.**, Volkert, D., & Zeiher, W. *Exploring the development of scholars using word clouds.* Western Institute of Nursing (WIN) 47th Annual Communicating Nursing Research Conference. Seattle, WA.

### HONORS AND AWARDS

- |           |  |
|-----------|--|
| 2015      | Faculty Speaker – Pinning Ceremony, Linfield School of Nursing, Summer 2015  |
| 2014–2016 | Named as Jonas Leadership Scholar – University of Nevada, Las Vegas          |
| 2010      | Award for Outstanding Masters Nursing Student at Washington State University |
| 2006      | Award for “Outstanding Preceptor” for Medical ICU Emory Healthcare           |
| 1997      | Faculty Award for Excellence in Clinical Practice, Leadership & Compassion   |
| 1997      | George E. Sims Jr. Scholarship for Nursing Recipient                         |

### ACADEMIC SERVICE

#### **Linfield College:**

- Lead and Member – NCLEX Taskforce (November 2015 – present)
- Faculty Advisor – Linfield Student Nurses Association (September 2015 – present)
- Member – Search Committee (2014 – present)

#### **Chemeketa Community College:**

- Chair – Informatics Committee (2012 – 2014)
- Member – Nurse Faculty Interview Committee (2010 – 2011)
- Member – Diversity Advisory to the President (2011)
- Program Chair – Second year nursing faculty (2012 – 2014)



## **PROFESSIONAL SERVICE**

National League for Nursing Certification Commission (oversees and supervises NLN Academic Nurse Educator Certification Programs)

Voted onto Board of Commissioners for CNE by national vote:

Term began September 2014 [Three Year Term 2014 – 2017]

National League for Nursing (NLN) Testing Services (2014 - present)

Testing Advisory Committee on Fairness and Equity Issues in Testing

Oregon Action Coalition [educational workgroup] (2014 – present)

Co-lead for workgroup (2016 – present)

Oregon Council of Associate Degree Nursing Programs (OCAP):

Secretary (2010 – 2014)

## **PROFESSIONAL AFFILIATIONS**

### **Professional Organizations**

2016 - Present	Western Institute of Nursing (WIN)
2014 - Present	Gay and Lesbian Medical Association (GLMA)
2005 - Present	American Association of Critical-Care Nurses (AACN)
2006 - Present	Sigma Theta Tau International
2008 - Present	National League for Nursing (NLN)
1997 - 2007	American Nurses' Association

### **Community Activities**

2010 – Present	Multnomah County Health Reserve Corps volunteer
2013 – Present	Oregon Humane Society Volunteer

### **Professional Development (examples of recent activities)**

2015	Jonas Scholar/AACN Conference. Washington DC.
2015	National League for Nursing Educational Summit. Las Vegas, NV
2014	National League for Nursing Educational Summit. Phoenix, AZ
2013	National League for Nursing Educational Summit. Raising the Roof / Advancing the Nation's Health. Washington D.C.
2012	National League for Nursing Educational Summit. Opening Doors to Leadership: Purpose, Power, Passion. Anaheim, CA
2012	Boot Camp for Nurse Educators. Albuquerque, NM
2010	Nurse Educators Conference in the Rockies. Breckenridge, CO
2010	Transforming Clinical Education Post Conference. Portland, OR