LEADING CHANGE: GENERATING CULTURAL RESPONSIVENESS AND COMPETENCE IN NURSING

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ABSTRACT

Culturally responsive teachings prepare students to support social justice, diversity, equity, and inclusion (DEI) in and beyond the classroom. Rising reports of culturally insensitive care and the reported challenges that nurses experience when caring for culturally diverse patients warrant the advancement of the intercultural readiness of nursing students. The study investigated the cultural content taught, encompassing LGBTQ+ health education, at the School of Nursing at a historically black college and university (HBCU) in the Southeastern United States. The participant selection involved purposeful sampling of various stakeholders engaged in interviews and focus groups, including faculty, nursing students, and nurse managers with diverse cultural backgrounds. The participants' narratives captured different viewpoints and experiences, informing the research. A critical perspectives framework guided this study. The inquiry revealed the disparities for LGBTQ+ people, identified significant gaps in LGBTQ+ health education and patient care, and a deficit approach to cultural responsiveness within the curriculum. The participant responses from the data lent themselves to curriculum reform. Applying recommendations from the findings of this study can lead the change for the school of nursing to generate and cultivate cultural responsiveness for students to become more culturally competent.

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DEDICATION

To my dearly departed parents, who instilled in me that I am capable.

And to the late Ruth Ashley, a woman of God, family, optimist, educator, advocate, mentor, and friend, who, still at the age of ninety-two, exemplified education and so eloquently demonstrated that learning is lifelong.

To God be the Glory!

I can do all things through Christ who strengthens me.

(Philippians 4:13, NKJV)

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CHAPTER ONE: INTRODUCTION

Introduction

With rising reports of culturally insensitive care and the reported challenges that nurses experience when caring for culturally diverse patients, advancing the intercultural readiness of nursing students is a necessity (O'Brien et al., 2021). Culturally responsive teachings prepare students to support social justice in and beyond the classroom and seek to strengthen the learner's ability to recognize and respond in an inclusive way to diverse perspectives (Day & Beard, 2019). More specifically, *cultural relevance* and *culturally relevant teaching* are terms created by Gloria Ladson-Billings (1995), who says that it is "a pedagogy that empowers students intellectually, socially, emotionally, and politically by using cultural referents to impart knowledge, skills, and attitudes" (Ladson-Billings, 1995; Will, 2022). Nursing theorist Dr. Josepha Campinha-Bacote (2007) defines cultural competence as "the ongoing process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of the client (family, individual, or community)" (p. 12). Successively, cultural competence is a dynamic process that requires ongoing development of cultural awareness, knowledge, sensitivity, and skills (Cai, 2016).

Based on the above focus, a task force of the Expert Panel for Global Nursing and Health of the American Academy of Nursing (AAN), along with members of the Transcultural Nursing Society developed the *Standards of Practice for Culturally Competent Nursing Care.* The AAN requires that nursing schools implement these standards. Nursing schools encompass these standards into one commonly required course titled *Transcultural Nursing. Transcultural Nursing* presumably addresses both culturally responsive and competence standards, yet it is outdated and not inclusive of current needs.

The overall goal of *Transcultural Nursing* is to develop nursing actions that promote cultural competence and foster culturally responsive teachings to achieve positive patient outcomes (Campesino, 2008; Day & Beard, 2019; Prosen, 2015; Tosun, 2021). The current course content focuses on ethnic and racial demographics, grounded in stories and perspectives developed in the 1990s. This outdated focus is in and of itself problematic because it potentially racializes and stereotypes people from different origins, perpetuating the intentionally designed educational practices and enactments that strip non-Western/non-White people of their cultures (Au et al., 2017).

One glaring omission from this curriculum is a focus on LGBTQ+ communities. Following in the footsteps of deculturizing racial and ethnic groups, LGBTQ+ (lesbian, gay, bisexual, transgender, and queer/questioning) people incessantly experience discrimination (Coleman & Vella, 2021; Dorsen & Niernberg, 2021). Despite increasing social tolerance of sexual minorities in the United States, the LGBTQ+ community continues to experience bias, discrimination, and homophobia in the health care system and at large (Englund et al., 2020). To be sure, many normative and dominant discourses shape society's interpretation of LGBTQ+ as an illness. Yet, the LGBTQ+ population is a heterogeneous group with a unique culture and like any other cultural group deserves culturally competent care. This population faces health disparities related to stigma, discrimination, and denial of civil and human rights (Eickhoff, 2021; Healthy People 2020; Kates et al., 2018). Recent events, including state and local laws, prohibit those who identify as LGBTQ+ from receiving health care treatments. An absence of LGBTQ+ conversations in nursing schools emphasizes that nurses are not prepared to treat this population. Dorsen and Niernberg (2021) explain that "Providing care for LGBTQ+ patients requires an inclusive and educated approach from nursing professionals" (Dorsen & Niernberg,

2021). Currently, nursing professionals are lacking education and competency to create an inclusive healthcare environment to meet the needs of LGBTQ+ populations.

In short, *Transcultural Nursing*, in its current state, is inadequate in preparing nurses to become culturally responsive and competent in present day. The course is not only out of date but also missing a critical group, LGBTQ+ individuals. Curriculum specialists also know that *one-stop* cultural training is not an appropriate approach cultivating culturally responsive and competent professionals (Blanchet Garneau, 2016; Brown et al., 2021). The research on inter- or transcultural nursing education and cultural competence indicates that the relationship between nurse educators' cultural competence levels and culturally responsive teachings is not meeting the healthcare needs of the present day culturally diverse population (Haller, 2018; O'Brien et al., 2021). LGBTQ+ population-specific information is not only missing from the nursing curriculum but also missing from the medical education curricula for physicians, physician assistants (PAs), and nurse practitioners (NPs) (GLAAD, 2022; GLMA, 2021; National LGBTQIA+ Health Education Center, 2019). The norm in many healthcare institutions is still to privilege the Western heteronormative perspective and facilitate practices that openly dismiss or subliminally suppress alternative voices (Day, 2019). The GLMA Board of Directors adopted a position statement recognizing that "A culturally competent, interdisciplinary, collaborative healthcare team is needed to combat LGBTQ+ health disparities" (GLMA, 2021, p. 2). This statement underscores that culturally competent healthcare professionals of all disciplines and all levels of practice play a vital role in caring for LGBTQ+ patients.

Alternatively, all courses in the nursing program must infuse cultural relevancy and competence. Responding to and understanding how best to care for LGBTQ+ individuals is situated in a complex reality. To illustrate this complex reality, I offer insight into the barriers of

LGBTQ+ individuals, including *Access to Care, Lack of Gender Acceptance, Financial Burdens, and Stigmatization.*

Access to Care

Historically and presently, LGBTQ+ individuals experience limited access to healthcare (Cicero et al., 2019; Gridley and Kothary, 2016; Fredriksen-Goldsen et al., 2013; Institute of Medicine IOM, 2011; James et al., 2016; Sherman et al., 2021; Ward et al., 2014). In the United States, only 200 LGBTQ+-specific healthcare centers provide affirming and competent care to lesbian, gay, bisexual, transgender and queer patients (GLAAD, 2022). Thirteen states have no LGBTQ+-specific healthcare centers, indicating that LGBTQ+ people who live in those 13 states or in rural areas across the nation have little to no access to LGBTQ+-specific care (GLAAD, 2022). This is important since approximately 13% of lesbian, gay and bisexual individuals in the U.S. report that LGBTQ-centered clinics are their source of care (GLAAD, 2022). GLAAD (2022) further reports that a separate study found nearly 40% of transgender people stated having been to an LGBTQ clinic in the previous five years. Not all of these locations provide services like mental health or have pharmacies, limiting the kinds of treatment accessible to LGBTQ+ individuals seeking a place that understands them (GLAAD, 2022). Even once affirming care is identified, LGBTQ+ individuals may need to travel great distances and across state lines to receive care (Hostetter et al., 2022).

It is of concern that access for LGBTQ+ patients is waning. Healthcare for LGBTQ+ patients is front-page news since numerous states have enacted laws constricting access to care, particularly for transgender youth (Coleman & Vella, 2021). Many states will be reviewing LGBTQ+ health care (see https://freedomforallamericans.org/legislative-tracker/medical-care-bans/). In the news, we see a denial of healthcare for LGBTQ+ patients. Namely, Texas and

Oklahoma are examples of states outlawing transgender care. With such laws, there is less emphasis on preparing healthcare workers with knowledge of LGBTQ+ individuals. Yet, healthcare workers take an oath to serve and care for all humanity. We need to understand and respect personal gender identity and expression. Understanding gender identity is one aspect that needs to be part of a curriculum for nursing.

To rectify this situation for all humanity, recently, the U.S. Department of Health and Human Services (HHS) announced a proposed rule implementing Section 1557 of the Affordable Care Act (ACA) that prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities. The Office for Civil Rights (OCR) enforces Section 1557 of the Affordable Care Act (Section 1557) (https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html). The proposed rule affirms protections against discrimination based on sex, including sexual orientation and gender identity.

In the meantime, access becomes a real barrier that nurses need to realize and understand. The American Association of Nurse Practitioners (AANP) and the American Nurses Association (ANA) are among many professional healthcare organizations that have issued statements of diversity, equity, and inclusion, recognizing the importance of addressing and understanding LGBTQ+ health needs. Yet, nursing education in the United States remains largely heteronormative concerning the pedagogical framework that informs nursing students. Lim et al., (2014) define heteronormativity as the incorrect assumption that all individuals are, by default, heterosexual (Englund et al., 2020, Lim et al., 2014). Hence, the relevance of cultural education directly contributes to future nursing competence, nursing student, and patient outcomes (O'Brien, 2021; Tosun, 2021).

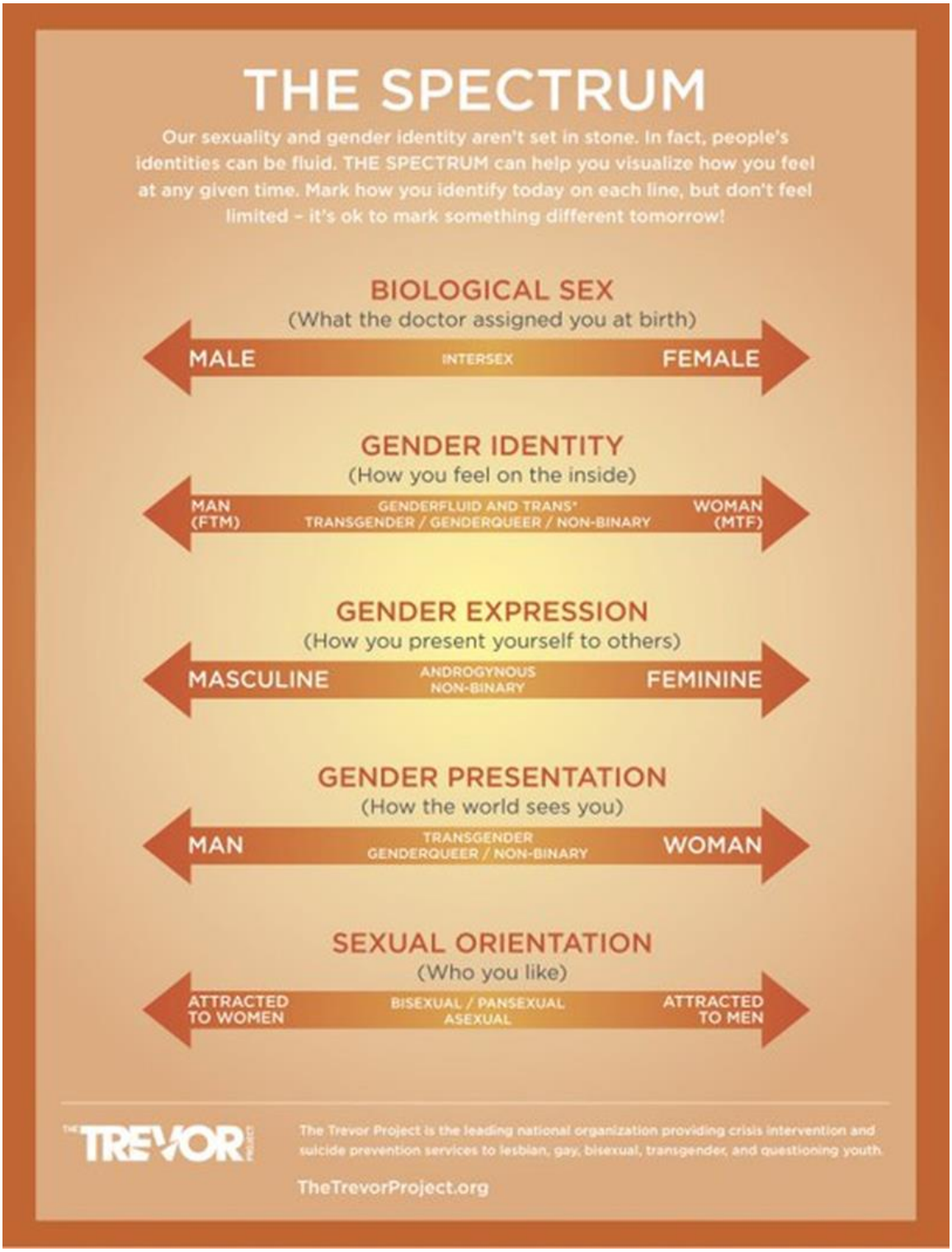
Lack of Gender Acceptance

Nursing is a holistic profession. As nurses, we aim to care for the whole person. Unfortunately, social norms do not embrace that persons go beyond the male/female binary, denying social acceptance for those who identify otherwise. Intolerance and misunderstandings create complex societal strains that we, as nurses, need to understand. While not congruent with biological sex assigned at birth, LGBTQ+ individuals base their gender on personal experience and innermost concept of self (GLAAD, 2022). These identifiers include masculine, feminine, a blend of both, another gender(s), or none, to name a few. To these individuals, gender is a spectrum or an umbrella term, and there are as many gender definitions as there needs to be for every person to have a label that lets them feel true to themselves. There are three distinct and independent pieces of who we are – gender identity, sexual orientation, and gender expression. Each component depends on the other to form a complete identity (see Table 1, Leventry, 2021).

GLSEN (2022) and the Safe Zone Project (2022) define these components as follows: Gender identity is defined as how a person identifies and sees themself. Everyone gets to decide their gender identity for themselves. A person may identify as a girl or a boy. If a person does not feel like a boy or a girl, they might identify as agender, genderqueer, nonbinary or just as a person (GLSEN, 2022; Safe Zone Project, 2022).

Table 1

Sexuality and Gender Identity Spectrum



Gender expression, also referred to as “gender presentation,” is the external display of one’s gender, through a combination of clothing, grooming, demeanor, social behavior, and other factors, generally made sense of on scales of masculinity and femininity (The Safe Zone Project, 2022).

Sexual orientation refers to the kind of sexual, romantic, emotional/spiritual attraction one can feel for others, usually based on the gender relationship between the person and the people they are attracted to, often confused with sexual preference (The Safe Zone Project, 2022).

Sex refers to the biological differences between males and females, such as the genitalia and genetic differences. Sex assignment usually happens at birth based on anatomical and physiological markers (Newman, 2021). Not every individual physically or vocally fits the conventional image of male or female. These societal norms must be challenged, as assumptions of gender identity can be offensive and close-minded. It can also lead to pronoun assumptions based on how certain individuals dress, what their voices sound like, or how they might have been referred to in the past (GLAAD, 2022; GLSEN, 2021; Nolasco, 2021). Gender, in some circles, is becoming acceptable to self-identify, while other entities maintain traditional male/female categorizations based on their assigned sex at birth (Renner, Täuber, & Nieder, 2022).

Self-identification is not always available within institutional systems. Many systems are lagging the inclusion of pronouns and gender identity information. Despite this, various healthcare facilities, organizations, and government databases are updating their demographic identifiers to be respectful and inclusive of LGBTQ+ people. One example is the U.S. Census Bureau. For the first time in 2021, their population survey included sexual orientation and gender identity (File & Marshall, 2021). Another notable government database, the Health, United

States – Data Finder, which belongs to the Centers for Disease Control and Prevention (CDC), is not providing inclusive identifiers. The national Prevention Information Network (NPIN), in conjunction with the CDC (NPIN/CDC.gov, 2021), affirms addressing the diverse needs and life contexts of those who are marginalized because of race, ethnicity, and socioeconomic status (SES), sexual orientation, age, or gender. Although these organizations expect anyone providing services, care, and treatment programs to demonstrate cultural competence, their database illustrates non-compliance. Sexual orientation and gender identity are missing from the data. This becomes problematic in collecting accurate data since sex is not the same as gender, for instance, identifying suicide rates only by sex, as illustrated in Table B (see page 12). Data from other bases confirms that the LGBTQ+ community experiences higher suicide rates than heterosexual adults (GLAAD, 2022; Ramchand et al., 2021).

Overstreet et al. (2021) assert that often healthcare providers do not intentionally or maliciously misgender patients or make them feel alienated. The problem is rooted in broader systemic issues; nurses and other healthcare professionals have been socialized or taught to believe that being transgender or gender non-conforming (GNC) is wrong, so they might not want to treat or support trans- and GNC patients (Overstreet et al., 2021). Furthermore, the healthcare system can disproportionately harm LGBTQ+ patients due to biases, stigmatization, and outdated policies (GLAAD, 2022; GLMA, 2021; GLSEN,2021; Overstreet et al., 2021).

It will be difficult to legislate social thought, yet we can expand our knowledge to understand the reasons why people choose to self-gender-identify. Nurses need to become aware of the non-binary ways individuals identify their gender, many of which lie outside the heteronormative male/female binary. As professionals, we need to understand that we all use pronouns. Pronouns convey gender information. Cisgender people rarely think about pronouns

because their gendered pronouns align with their assigned sex at birth. (GLAAD, 2022). For LGBTQ+ patients, the social transition may involve asking others to refer to them with new and different pronouns to reflect their true gender identity. Many LGBTQ+ people have faced harassment, embarrassment, or discrimination when seeking routine healthcare. “Simply respect the pronouns people ask you to use and use them as requested, just as you would strive to pronounce someone's name correctly” (GLAAD, 2022).

Financial Burdens

When employees reveal that they identify as LGBTQ+, they run the risk of losing their jobs. Hence, many LGTBQ+ individuals find themselves in financial hardship. This in itself contributes to healthcare iniquities.

One example is the U.S. Supreme Court's holding in Bostock v. Clayton County (ANA Community, 2022). Bostock, who is the plaintiff and who sexually orients as gay, worked for Clayton County, Georgia (“Clayton County”) as a child welfare services coordinator. Bostock participates in a gay recreational softball league. Bostock alleges that powerful individuals in Clayton County publicly criticized his participation in the softball league and his sexual orientation. Clayton County subsequently terminated Bostock, stating that his conduct was “unbecoming of a county employee” (Franicevic & Ko, 2019).

The argument of discrimination stems from the language based on Title VII of the Civil Rights Act from 1964. Clayton County contends that the Court should interpret Title VII based on the public’s understanding when it was first enacted in 1964 rather than rely on a present-day interpretation. Consequently, Clayton County argues that at the time of Title VII’s enactment in 1964, sex was commonly understood as the trait of being male or female and did not refer to sexual orientation based on present-day interpretation (Franicevic & Ko, 2019).

> Clayton County asserts that the meaning of sex in 1964 has retained the same meaning that it has today. Moreover, Clayton County rejects Bostock's argument that sexual-orientation discrimination depends on an employee's sex and is thus prohibited by Title VII because sex and sexual orientation are distinct terms and are not commonly conflated with one another. Furthermore, since sex is listed alongside other traits and characteristics in Title VII—race, color, religion, and national origin—rather than behaviors, Clayton County maintains that Title VII only prohibits discrimination on the basis of a sex-based trait—being male or female—rather than sexuality. (Franicevic & Ko, 2019)

This ruling by HHS and the Bostock v. Clayton County case illustrates the continued bias and discrimination against those who are not heteronormative. In this case, among many others, such discrimination affects a person's livelihood, health, and wellness. Because of discrimination, as illustrated above, many LGBTQ+ individuals lose their employment. Without a job, individuals most often also lose their health benefits. As uninsured and stigmatized patients enter our spaces, we must understand that the lack of coverage is not necessarily a personal choice. Instead, societal norms and stigmas prohibit equitable access to health care support.

Stigmatization

Stigmatization exists on many levels surrounding the LGBTQ+ community at structural (e.g., societal norms, laws, and policies), interpersonal (e.g., everyday interactions), and individual (e.g., beliefs and behaviors) levels. There is a long history of stigmatization associated with the LGBTQ+ community. In the 1980s and 90s, the media strongly associated HIV and AIDS with being homosexual. This framing further solidified societal definitions of gender and reinforced the myth that homosexualism is a curable disease. Many years later, we find ourselves in a similar scenario. Monkeypox (MPV) is disproportionately affecting LGBTQ+ people,

particularly gay and bisexual men and people living with HIV (GLAAD, 2022). The media again perpetuates and associates the disease as pervasive in this community, perpetuating the idea that non-normative gender identification is a disorder.

There is a misconception that sex is biologically determined while gender identity is a choice. This incorrect assumption contributed to insurance companies denying coverage for certain surgeries and hormonal treatments for people who felt their sex was inconsistent with their gender (Skoufalos, 2018). Dr. Nicoletta Skoufalos (2018), a renowned psychologist, posits that healthcare professionals must understand the differences between sex, gender, and sexual orientation and not make assumptions about these three when meeting a new patient. She affirms that people simply choosing a gender that is not consistent with their biological sex is a faulty argument:

> However, there is now ample research demonstrating a biologic basis for how people feel about their gender identity, and there is evidence supporting the reality that having a different sex than what you feel your gender is can result in extreme dysphoria and can significantly impact one's mental health and quality of life. (Skoufalos, 2018)

Researchers associate the stigmatization of the LGBTQ+ community with a propensity for non-related emotional hardships such as suicide, cancer, mental illness, and violence. Rejection of identity is particularly hard on young people. LGBTQ+ youth are not inherently prone to suicide risk because of their sexual orientation or gender identity but are at higher risk because of how they are mistreated and stigmatized in society. Data from the Trevor Project shows that addressing youth by their correct pronouns had half the rate of attempted suicide compared to those who did not have their pronouns respected (GLAAD, 2022; Trevor Project [2022 National Survey on LGBTQ Youth Mental Health]).

Table 2

Excel and PowerPoint: https://www.cdc.gov/nchs/hus/contents2019.htm#Figure-005

Death rates for suicide, by sex: 2008–2018

Year	Total	SE	Male	SE	Female	SE
			Age-adjusted deaths per 100,000 population\1			
2008	11.6	0.06	19.0	0.11	4.8	0.06
2009	11.8	0.06	19.2	0.11	4.9	0.06
2010	12.1	0.06	19.8	0.12	5.0	0.06
2011	12.3	0.06	20.0	0.12	5.2	0.06
2012	12.6	0.06	20.4	0.12	5.4	0.06
2013	12.6	0.06	20.3	0.11	5.5	0.06
2014	13.0	0.06	20.7	0.12	5.8	0.06
2015	13.3	0.06	21.1	0.12	6.0	0.06
2016	13.5	0.06	21.4	0.12	6.0	0.06
2017	14.0	0.07	22.4	0.12	6.1	0.06
2018	14.2	0.07	22.8	0.12	6.2	0.06

Table 2 demonstrates that LGBTQ+ health statistics are lacking, and for more precise data, government databases should include gender identity. A study by Ramchand et al. (2021) at the National Institute of Mental Health (NIMH) supports that suicide risk varies considerably depending on the intersectionality between sexual identity, gender, age, and race/ethnicity. The lead author and senior advisor on epidemiology and suicide prevention at NIMH, Rajeev Ramchand (2021), declares “This study demonstrates the importance of asking about sexual identity in national data collection efforts, and it highlights the pressing need for suicide prevention services that address the specific experiences and needs of lesbian, gay, and bisexual adults of different genders, ages, and race and ethnic groups,” (Ramchand et al., 2021).

Intersectionality, defined by Crenshaw (1991), refers to the multiple identities that depict individuals. These include race; ethnicity; gender; gender identity and expression; sexual orientation; socioeconomic status; education; employment; insurance status; illness and wellness beliefs and experiences; existing and past illnesses and comorbidities; experiences with stigma, hate, racism, and discrimination; genetics; epigenetics; religion and other beliefs; ethics; politics; relationship status; language; communication style; culture; and geography (Rice, 2019). An

example of intersectionality in the LGBTQ+ community is a transgender African American woman with low socioeconomic status and health literacy. She is underinsured and HIV-positive. She lives in the rural South in a stressed relationship with an unsupportive partner alienated from family. These aspects of identity intersect and inadvertently affect this person's life, health, and well-being.

These realities result in transgender people, especially trans women and trans people of color, experiencing extremely high levels of minority stress that result in poor mental and physical health. The American Medical Association reports that transgender people face an "epidemic of violence." Transgender people face barriers in accessing healthcare, including anti-trans bias and lack of care by providers. (GLAAD, 2022; Ramchand et al., 2021; Skoufalos, 2018). Once nurses understand their own biases and learn more about LGBTQ+ individuals, they can take steps to provide affirming healthcare spaces for people in these communities (Overstreet et al., 2021).

Gender-nonconforming and transgender individuals are targets of social and economic marginalization, harassment, and violence (Cherry, 2020; Stotzer, 2017). Public statements from LGBTQ+ people substantiate that constant worry of judgment and non-acceptance when out in public can lead to heightened anxiety. No one likes rejection. Unfortunately, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) people experience much rejection and oppression, leading to depression, other mental illnesses, and suicide (Nolasco, 2021). According to the U.S. Trans Survey, 40% of transgender respondents reported attempting suicide, compared to 4.6% of the general population GLAAD, 2022).

In this way, stigmatization leads to implicit biases among the healthcare workforce, substantially obstructing the quality of care, affecting patient/provider interactions, patient

outcomes, treatment decisions, and patient treatment adherence (Brown et al., 2021; Hall et al., 2015). As we can see, stigmatization has a lasting negative impact on health, which expresses itself structurally—among other things—in barriers to accessing health care (Renner, 2022).

Statement of the Problem

As I have argued above, LGBTQ+ people have been denied access to healthcare, endured a lack of gender acceptance, financial burdens, and stigmatization. These inequities arise mainly from misconceptions and discrimination, which nurses must understand to provide the correct care. In this way, we can better prepare our nurses to care for this population while at the same time building empathy and comprehending patient experiences. Moreover, nursing programs must rethink the nature of our "one size fits all" Transcultural Nursing course. We must consider including LGBTQ+ instruction across the curriculum. Becoming aware of that complexity includes gaining a more profound sense of the interrelationships of society and identity.

Statement of Purpose

The purpose of my study is to investigate the cultural content taught at the School of Nursing at a historically black college and university (HBCU) located in a large city in the Southeastern United States, which is my home institution. I am interested in reviewing what exists in our curriculum and what our community envisions in terms of change. As argued above, the convergence of healthcare needs for today's diverse patient population is necessary for our nursing students. We must define in what ways to address cultural competence and how to cultivate culturally responsive care for LGBTQ+ individuals. As a result, my study aims to address curriculum reform to generate cultural responsiveness and competence in the School of Nursing, focusing on patient care of members of the LGBTQ+ community.

Research Question

The following research question guides this research study:

R1: Concerning LGBTQ+ healthcare preparation, what are we teaching [in our School of Nursing] and what can we do to improve our nursing curriculum?

Significance of Study

The Cumulative Index to Nursing and Allied Health Literature (CINAHL), an esteemed databank for nursing and allied health information, only houses 33 articles on *culturally responsive teaching* from 2003 to 2022. Furthermore, the database only produced 55 papers from 2004 to 2022 about *LGBTQ education* related to baccalaureate undergraduate nursing programs and registered nurses' education. Increasing knowledge and awareness about this topic can minimize inefficient patient care or inadequate professional performance. A 2018 survey revealed that 80% of clinicians believe it is inappropriate to discuss a patient's sexuality and to inquire about a patient's sexual orientation or gender identity (GLMA, 2021). Sexuality is an aspect of culture and is considered an imperative aspect of holistic care. Research shows that it is often not considered, as it should be, in health services (Verrastro et al., 2020). Nurses are essential in providing an affirming space for LGBTQ+ patients since many patients confide in nurses (Overstreet et al., 2021). Nurse educators have a central role in cultivating intercultural inclusivity. Therefore, higher-education institutions should provide thorough training for their students to achieve cultural competence (Markey et al., 2021; Verrastro et al., 2020).

Conclusion

Cultural competence integrates and transforms knowledge about individuals and groups to increase and improve the quality of care, thereby producing better outcomes. Therefore, teaching culturally relevant content in the schools of nursing is of the essence. Disparities in

receiving quality care extend beyond race and gender to other segments of underrepresented populations. Anyone providing services, care, and treatment programs must demonstrate cultural competence (NPIN/CDC.gov, 2021).

Conversely, cultural knowledge, sensitivity, and awareness do not include the concept of instituting change. Although they imply understanding cultural similarities and differences, they do not include action or structural change. Cultural competence is a developmental process directed toward creating an environment that is more inclusive and has space to challenge the dominant status quo (Dugan et al., 2017). Individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum (NPIN/CDC.gov, 2021). Consequently, the nursing faculty is responsible for students to receive evidence-based, culturally appropriate education in caring for populations experiencing health disparities.

Incorporating LGBTQ+ population-specific information into the curriculum increases awareness, understanding, empathy, and skills critical for effective nursing practice and enhances the ability of future nurses to engage in therapeutic professional relationships when caring for LGBTQ+ individuals (McNeil & Elertson, 2018).

Definition of Context, Terms, and Abbreviations

Cultural Competence: Awareness, Sensitivity, Relevance, and Responsiveness

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function

effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (NPIN/CDC.gov, 2021)

DEI

Diversity. A broad range of individual, population, and social characteristics, including but not limited to age; sex; race; ethnicity; sexual orientation; gender identity; family structures; geographic locations; national origin; immigrants and refugees; language; physical, functional, and learning abilities; religious beliefs; and socioeconomic status (AACN, 2021).

Equity. The ability to recognize differences in the resources or knowledge needed to allow individuals to fully participate in society, unhampered by artificial barriers, stereotypes or prejudices, with the goal of overcoming obstacles to ensure fairness (AACN, 2021).

Inclusion. Environmental and organizational cultures in which nurses with diverse characteristics thrive. Inclusive environments require intentionality and embrace differences, not merely tolerate them. Everyone works to ensure the perspectives and experiences of others are invited, welcomed, acknowledged, and respected in inclusive environments (AACN, 2021).

GLAAD. Formerly Gay and Lesbian Alliance Against Defamation, organization created in 1985 that is devoted to countering discrimination against lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals in the media and promoting understanding, acceptance, and equality (Farr, 2019).

GNC. Gender Non-Conforming is a term used to refer to people who do not conform to the stereotypical or social expectations of their gender or birth sex. People whose gender expression differs from conventional expectations of masculinity and femininity. Note that many cisgender people have gender expressions that are gender non-conforming. Simply having a non-conforming gender expression does not make someone trans or nonbinary (GLAAD, 2022).

GLMA. Health Professionals Advancing LGBTQ Equality (GLMA) is the world's largest and oldest membership association of LGBTQ healthcare professionals and allies (GLMA, 2021).

GLSEN. The leading national education organization focused on ensuring safe and affirming schools for all students. Pronounced 'glisten,' formerly the Gay, Lesbian & Straight Education Network. GLSEN envisions a world in which every child learns to respect and accept all people, regardless of sexual orientation, gender identity or gender expression (GLSEN, 2016).

LGBTQ+. The acronym is used to represent a diverse range of sexualities and gender-identities, referring to anyone who is transgender and/or same/similar gender attracted (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning). The "plus" (+) is important and should not be overlooked. The purpose of the acronym is to represent the tremendous diversity of people who are same/similar gender attracted and transgender. The addition of the plus is better able to fully capture that diversity (Cherry, K., 2020).

The Safe Zone Project (SZP) is a free online resource providing curricula, activities, and other resources for educators facilitating Safe Zone trainings (sexuality, gender, and LGBTQ+ education sessions), and learners who are hoping to explore these concepts on their own (https://thesafezoneproject.com/about/, n.d.).

The Trevor Project is an American nonprofit organization founded in 1998. It focuses on suicide prevention efforts among lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth (The Trevor Project.org, n.d.).

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

This chapter examines the information on this topic and serves two purposes. First, I review the literature according to dialogue about cultural responsiveness and cultural competence within the nursing curriculum and its effects on healthcare. Second, I describe my theoretical framework that will guide my inquiry as outlined in Chapter Three. These dialogues vary from field to field (nursing, healthcare, LGBTQ+ community), illustrating classic works that inform the disciplines, exhibit current research, and disclose contemporary findings.

Nursing adopts a humanistic and holistic approach that embraces compassion, honesty, kindness, and altruism in the delivery of healthcare, considering the cultural needs of patients, need for equal access to health care, respect for cultural background, beliefs, and safety needs (Prosen, 2015; Tosun, 2021). The convergence of healthcare needs for today's diverse patient population is necessary for our nursing students. We must define in what ways to address cultural competence and how to cultivate culturally responsive care for LGBTQ+ individuals.

The American Association of Colleges of Nursing (AACN), National League for Nursing (NLN), and the Institute of Medicine (IOM) support the development of a culturally competent nursing workforce (Curtis et al., 2016). My literature review further explores the culturally responsive teachings and the integration of LGBTQ+ health content in the schools of nursing and how faculty addresses cultural competence in the nursing curriculum. I am using a critical lens as my framework in this process.

Literature Review

In Chapter One, I explained the significance of this study and the sparse research on this topic that exists within traditional databases. Hence, I accessed diverse field data to perform a comprehensive investigation. What follows is a description of each with its emerging subsets.

My review is organized according to the two main foci of my dissertation, *cultural responsiveness* and *cultural competence* in nursing. Below these headings, I am listing the themes which subsequently emerged through my inquiry to offer further insight by specifically addressing *Transcultural Nursing Education, Barriers to LGBTQ+ Education, Culturally Relevant Education, Culturally Competent Healthcare Professionals,* and *Cultivating Culturally Responsive Care for LGBTQ+ Patients.*

Cultural Responsiveness

Transcultural Nursing Education.

Incorporating culture into nursing care and the nursing curriculum has been a part of the professional development of nurses since the 1950s (Leininger, 2000). Transcultural nursing focuses on global cultures, cultural caring, health, and nursing phenomena with the goal to provide culturally congruent nursing care (Registered Nursing.org, 2022). “Transcultural nursing has been the major breakthrough for nursing education, research, and practice in the twentieth century, and it offers even greater potential as an imperative for health care in the third millennium” (Leininger, 2000, p. 69). With the ever-increasing multicultural population in the United States, transcultural nursing is an essential aspect of healthcare today and poses a significant challenge to nurses providing individualized and holistic care to their patients (Maier-Lorentz, 2008).

Leininger and Maier-Lorentz (2008) both underscore the dynamic process of cultural teachings and its effects on healthcare. Nursing schools address cultural health aspects during one commonly required course titled *Transcultural Nursing.* Transcultural Nursing presumably addresses both culturally responsive and competence standards. Yet, O'Brien et al. (2021) point out the risks of cultural competence diminishing overtime, including a lack of consensus within the literature as to how this should be structured and organized, thus suggesting the need to re-examine ways of developing the intercultural readiness of nursing students in caring for culturally diverse patients (O'Brien et al., 2021). The overall goal of transcultural nursing is to use cultural knowledge to develop nursing actions that will promote cultural competence and foster culturally responsive teachings to achieve positive patient outcomes (Campesino, 2008; Day & Beard, 2019; Prosen, 2015; Tosun, 2021).

Transcultural Nursing is based on the premise that culturally diverse factors such as religion, politics, economics, worldview, environment, cultural values, history, language, gender, and others influence patient care. Consequently, these factors need to be addressed in the nursing curriculum for culturally competent care. The transcultural nursing practice standards highlight the following:

> Professional nurses need specific knowledge about the major groups of culturally diverse individuals, families, and communities they serve, including, but not limited to: specific cultural practices regarding health, definitions of, and beliefs about, health and illness; biological variations, cross-cultural worldviews; acculturation, and life experiences, such as refugee and immigration status, as well as a history of oppression, violence, and trauma suffered. (Expert Panel on Global Nursing & Health, 2010, p. 6)

LGBTQ+ patients are represented in all intersections of these groups. Hence, their health needs must be included into the nursing curriculum (ACI, 2022; GLAAD, 2022; Mejia et al., 2018).

Barriers to LGBTQ+ Education.

Eickhoff (2021) reports that a gap analysis of LGBTQ+ specific content currently being taught in American Association of Colleges of Nursing (AACN) member schools and schools of nursing accredited through the Commission on Collegiate Nursing Education (CCNE) was conducted with the aim to provide an overview of the quantity and quality of LGBTQ+ health education. The study included both baccalaureate and graduate nursing programs and indicated that nursing faculty and students recognize the importance of educating nurses about the health needs of the LGBTQ+ population, yet content is not always consistently or comprehensively provided to students, largely because of lack of time and lack of faculty competence in LGBTQ+ health needs (Eickhoff, 2021). Previous conversations with faculty from the School of Nursing at my institution, support that "lack of time" and viewing cultural teachings from a "dominant culture" perspective exclude LGBTQ+ content. Eickhoff (2021) and Tosun (2021) also agree that education content, training methods, and cultural content vary amongst nursing faculty and are not standard in the literature, perpetuating dominant ideologies and personal bias.

Regrettably, the healthcare industry and medical communities are still affected by societal homophobia, biphobia, and transphobia, affecting the quality of healthcare that LGBTQ+ people receive (GLAAD, 2022). Thus, LGBTQ+ education is nonexistent in many areas of the nursing curriculum and in the clinical setting. It is challenging to facilitate critical sociocultural dialogue where stereotypes, biases, and privileges are exposed (Dugan et al., 2017, p. 2). Education for nursing students [nurses and other health care workers] is key to addressing these barriers (Eickhoff, 2021). Nursing faculty generate and disseminate cultural knowledge

selectively, either perpetuating cultural content taught from the twentieth century and not updating the curriculum to reflect current healthcare needs or foregoing culturally relevant subject matter because of personal ideology (ACI, 2022; Dugan et al., 2017; IGI Global.com, 2022).

A preliminary examination of the nursing curriculum at my organization revealed that no textbook, including *Teaching Cultural Competence in Nursing and Health Care* by Jeffreys (2016), formally addresses LGBTQ+ health needs. A review of a survey from May 2022 assessing the knowledge and understanding nursing faculty possess regarding the LGBTQ+ community and incorporating LGBTQ+ health education into the nursing curriculum shows that most faculty are either disengaged, uncomfortable, or knowledge deficient.

Culturally Relevant Education.

Nurse educators are responsible for students to receive evidence-based, culturally relevant education in caring for people experiencing health disparities. Therefore, faculty must advance their own cultural knowledge and skills to improve patient care (Gonzalo, 2021; Leininger, 2000; Prosen, 2015; Nahas, 2000). Currently, nursing students are missing out on cultural relevance, as defined by Billings (1994), in their curriculum. Cultural teachings are selective, and cultural responsiveness is ill-defined by faculty. Cultural responsiveness means being respectful and open to everyone's backgrounds, beliefs, values, customs, knowledge, lifestyle, and social behaviors. Culture is relevant in providing culturally appropriate care and support (ACI, 2022). "Evidence shows that when there is a lack of cultural responsiveness, health outcomes are much poorer. Improving cultural responsiveness cannot only remove barriers to accessing healthcare but may also reduce inequitable health outcomes for marginalized and vulnerable groups" (ACI, 2022; see also GLAAD, 2022).

Providing culturally congruent care means that nurses are expected to be familiar with a wide variety of cultures, their corresponding values, health beliefs and health problems (Markey et al., 2021; Prosen, 2015; Registered Nursing.Org, 2022). Thus, nursing faculty must convey a willingness to address diversity, equity, and inclusivity to combat differences in healthcare that can influence the care of patients from different cultures, race, ethnicity, gender, and sexuality (Deering, 2022; NPIN/CDC.gov, 2021). An inclusive culture allows diverse individuals to be part of those dynamics and collectively implements the processes associated with shared decision-making, eliminates structural barriers to universal engagement, and celebrates differences (Bleich et al., 2015; Brown et al., 2021). Fostering diversity and meaningful inclusion of diverse perspectives in the nursing curriculum (lecture, labs, and clinical learning environments) are important steps toward building a stronger nursing workforce and improving patient outcomes (Brown et al., 2021; Day & Beard, 2019).

In addition, patients of the LGBTQ+ community not only experience health disparities because of a lack of support at home, school, and other social spaces, but health needs are unmet due to providers' lack of acceptance, knowledge, or understanding (Alpert et al., 2017; Eickhoff, 2021, GLAAD, 2022; Safer et al., 2016). Eickhoff (2021) emphasizes "Although discrimination in health care generally has improved, barriers to culturally congruent care remain" (Eickhoff, 2021, p. 552). By engaging in culturally responsive teaching, nurse educators prepare a nursing workforce that contributes to a safer and more effective health care system (Blanchet, 2016; Day & Beard, 2019).

The American Association of Colleges of Nursing (AACN) is the national voice for academic nursing. AACN works to establish quality standards for nursing education; assists schools in implementing those standards; influences the nursing profession to improve health

care; and promotes public support for professional nursing education, research, and practice (AACN, 2022). AACN's position statement on *Diversity, Equity, and Inclusion in Academic Nursing* recognizes the impact of shifting U.S. population demographics, and persistent health inequities on academic nursing:

Therefore, AACN and its member schools commit to accelerating diversity, inclusion, and equity initiatives to prepare the current and future nursing workforce to be reflective of the society it serves while simultaneously fulfilling societal expectations and needs (Relf, 2016; Danek & Borraya, 2012). Healthcare reform has revitalized efforts to examine how our nation's health system should evolve to meet the needs of all persons while being representative of the population served (Danek & Borrayo, 2012). Health inequities, including diminished life expectancy and poor health outcomes, vary based on race, ethnicity, culture, sexual orientation, gender identity, age, and socioeconomic status. To improve the quality of nursing education, ameliorate health inequities, and advance leadership in the profession and society at large, the values and principles of diversity, inclusion, and equity must remain mission central. These values and principles should be a part of the ongoing dialogue of AACN-member nursing schools, which are responsible for defining their particular educational missions and then engaging in the work to make those visions become a reality. (AACN, 2017)

AACN (2017) amplifies the need for ongoing dialogue of AACN-member nursing schools, which are responsible for defining their particular educational missions. Dugan et al. (2017) correspond that leading change can be difficult and uncomfortable, and it is challenging to facilitate critical sociocultural dialogue where stereotypes, biases, and privileges are exposed (Dugan et al., 2017).

Cultural Competence

Culturally Competent Healthcare Professionals.

Cultural competence involves systems, agencies and providers having the ability to respond to the unique needs of populations whose cultures are different from the "dominant" culture and to function effectively within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cuellar et al., 2008; Day & Beard, 2019; NPIN/CDC.gov, 2021; Prosen, 2015). Scholars and healthcare professionals agree that cultural competence is a dynamic process that requires the ongoing development of cultural awareness, knowledge, sensitivity, and skills (Markey et al., 2021; Cai, 2016). Nursing faculties need to employ a curriculum that supports culturally competent care and guides students to provide care that promotes social justice, particularly for the underrepresented members of society, such as the LGBTQ+ community.

One aspect of cultural competence in healthcare is openly discussing sexuality and sexual health (SSH). Though SSH are essential aspects of care that have evolved since a 1975 World Health Organization (WHO) report on SSH, nurses still consider discussing the subject with patients a challenge (Åling et al., 2021). Thus, culturally competent educators need to facilitate discourse that supports DEI and addresses all aspects of care.

Nurse educators must understand that health risk factors are elevated in lesbian, gay, bisexual, and transgender (LGBT) patients and are perpetuated by a lack of cultural competency (Nowaskie & Sewell, 2021). Furthermore, cultural competence extends beyond acute care into tertiary care settings. Skilled nursing facilities and nursing homes are tertiary care centers. Junior et al. (2021) assert that nursing homes are configured as spaces that are not very inclusive, where LGBTQ+ elders' demands are not considered due to the cis- heteronormativity in force in these

places. Fostering cultural competence through training and awareness of health professionals on the LGBTQ+ theme is a tool that can make such spaces more inclusive for this population (Health Research & Educational Trust, 2013; Junior et al., 2021).

The American Hospital Association's position statement on *Cultural Competence* affirms that hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. Yet, institutional culture can foster a single, dominant western medical perspective and ideology. The presence of a hierarchy, in which status and authority mute differing perspectives and do not challenge those in higher positions, compromises patient safety and care (Brown et al., 2014; D'Agostino et al., 2017; Day & Beard, 2019; Maxfield et al., 2005; Moorman, 2007). This phenomenon starts in the classroom, transitions into acute care, encompassing physicians over other health professionals, and professionals over patients and family members (Day & Beard, 2019; Foronda et al., 2016; Hannawa et al., 2018).

AACN recognizes DEI as critical to nursing education and fundamental to developing a nursing workforce able to provide high quality, culturally appropriate, and congruent health care in partnership with individuals, families, communities, and populations (AACN, 2017). GLAAD (2022) points out that the key to LGBTQ+ health is not a theoretical difference in biology or behavior between LGBTQ+ people and cisgender, straight people, but in the many challenges and stigmas that make LGBTQ+ people vulnerable to illness (GLAAD, 2022).

Cultivating Culturally Responsive Care for LGBTQ+ Patients.

Many of my reviewed articles contain similar data about critical constructs that are missing in the care to achieve cultural competence. Unless cultivated in the schools of nursing, nurses will not be able to deliver care that is culturally congruent with the populations served.

With the scarcity of LGBTQ+ content in nursing education and curricula, faculty are unable to provide nurses with the baseline knowledge to care for and interact with LGBTQ+ people (Traister, 2020).

LGBTQ+ content must be incorporated into the classroom and clinical education for nursing students, such as ingrained in simulations, case studies, nursing care plans, test questions, and elective courses (Lim & Borski, 2015). Other common recommendations for universities and nursing schools include hiring diverse faculty who are openly LGBTQ+ to bring multicultural perspectives and education into the classroom and clinical setting (Lim & Borski, 2015; Traister, 2020). Kamen et al. (2019) make the following recommendations for [student] nurses in caring for LGBTQ+ patients and their families: provide safe clinical encounters, by inquiring and responding professionally to patients' identities and identifiers, include chosen support people, provide care relevant to patients' gender identities, and address treatments' effects on sexuality (Kamen et al., 2019). When familiar with identity terms, nurses can interact more knowledgeably and sensitively with members of the LGBTQ+ community (Dorsen & Niernberg, 2021; Kamen et al., 2019).

Several articles pointed out that an awareness exists in nursing about a deficit in cultural competence. Hence, nursing students and faculty were recruited from baccalaureate and masters' programs to complete the Cultural Awareness Scale (CAS) which measures four dimensions of cultural awareness and sensitivity. Other studies examined transcultural self-efficacy of nursing students, using the Transcultural Self-Efficacy Tool to measure outcomes (Singleton, 2017; Stiles et al., 2018). Findings and recommendations are similar. Pre-tests confirmed a knowledge deficit, and post-test scores showed increased awareness and knowledge after receiving culturally relevant education. Weston et al. (2020) conclude that offering experiential learning

sessions that focus on culturally prevalent health conditions and including case-based scenarios with reflective roundtable discussion could provide a combined student- faculty enhancement of cultural understanding of community needs, which would also serve the LGBTQ+ community (Weston et al., 2020).

Besides quantitative studies, other literature shows the use of interviews with nurse educators exploring their perceptions about implementing culturally sensitive and inclusive nursing education (CSINE). Sommers' and Bonnel's (2020) results from an associate degree nursing program indicate that learning about CSINE is an ongoing and necessary process for nurse educators (Sommers & Bonnel, 2020).

Kirby et al. (2021) recommend the implementation of an academic systems change to improve undergraduate nursing students and educator intercultural knowledge and competencies since many organizations have diversity and inclusion guidelines and initiatives for healthcare providers to consider in determining culturally competent care:

1. Assess student's mindset at the beginning and the end of an undergraduate nursing course by using the Intercultural Development Inventory®, a 50-item cross-cultural, theory-based assessment tool in a pre- and post-test design.
2. Ensure diversity and inclusion content was provided to faculty through a continuing education program.
3. Review all undergraduate courses for diversity and inclusion content and perform curricular blueprinting.

Kirby at el. (2021) conclude that continual changes, assessment, and evaluation need to occur since there is minimal literature specific to nursing which describes how to change or implement the topic of culturally responsive care in a school of nursing (Kirby et al., 2021).

Another way to foster cultural competence is described by Ozkara et al. (2019) applying a multidimensional education strategy by including Transgender Standardized Patient Simulation (TSPS) into the nursing curriculum to improve students' knowledge, skills, attitudes, and confidence in providing culturally sensitive care to a transgender patient (Ozkara et al., 2019). James and Al-Kofahy (2021) endorse academic community engagement (ACE), which is a pedagogy used to teach course concepts through service and journaling. Their results support the use of ACE as a reliable teaching strategy in nursing education to improve engagement, cultural sensitivity, humility, and altruism (James & Al-Kofahy, 2021).

Alexander-Ruff and Kinion (2019) suggest a similar approach promoting culturally conscious care. Nursing students of a senior cohort participated in a 1-week cultural immersion service-learning (CISL) experience. Implementing CISL experiences into the undergraduate curriculum may help nursing students recognize societal privilege and improve cultural consciousness (Alexander-Ruff & Kinion, 2019). Both cultural immersion experiences took place among indigenous communities. However, this experience can be easily adopted for LGBTQ+ communities, assisting nurse educators to develop partnerships with Safe Zone and other LGBTQ+ organizations, which make CISL experiences possible (Alexander-Ruff & Kinion, 2019; James & Al-Kofahy, 2021).

O’Brien et al. (2021) reinforce that nurse educators need to urgently examine ways of improving the intercultural readiness of new nursing graduates. The authors highlight the engagement of students in activities that augment their understanding of cultural care, including a variety of integrated approaches to give opportunities for cross-cultural experiences. O’Brien et al. (2021) agree that cultural competence should be paramount for students and nurse educators in all learning and teaching approaches (O’Brien et al., 2021).

Critical Perspectives and Framework

Next, I describe the framework used in this inquiry. Day and Beard (2019) indicate that culturally responsive teachings prepare students to support social justice in and beyond the classroom and aim to strengthen the learner's ability to recognize and respond in an inclusive way to diverse perspectives (Day & Beard, 2019). Therefore, applying a critical framework is fitting. Here, I am also providing subheadings to emphasize the diverse applications of Critical Theory (CT).

Dugan et al. (2017) recommend using critical perspectives to describe, deconstruct and reconstruct leadership concepts in education and their implications on society. A critical perspective is an approach that assesses the domination problem, questions power, and exploitation, and strives for a just society (IGI Global.com, 2022). To support the use of critical perspectives, I am applying Critical Theory (CT), drawing from some of its subsets to investigate the issues of cultural responsiveness and cultural competence education in the schools of nursing relating to the LGBTQ+ health disparities encompassing intersectionality, diversity, equity, and inclusion.

Critical Theory

Critical Theory (CT) as defined by Mejia et al. (2018) recognizes the complexity of social processes and has continued to grow and contribute to the bases for inquiry in other fields such as sociology, education, pedagogy, andragogy, and other areas, including feminism, law, and social sciences. These theories illustrate studying context, gender, culture, society, and other factors through a critical lens to achieve equity (Mejia et al., 2018).

Nursing faculty are in leadership roles and exercise academic freedom. Such power and control in the classroom can lead to dominant ideology, implicit, and intrinsic biases, affecting

diversity, inclusion, and equity of content taught. Fawcett (2015) explains that the mission of the professional discipline of nursing is to not only generate and disseminate knowledge but also to use that knowledge in service to human beings. Nursing knowledge provides the understanding and perspective for practicing nurses to care for people and to suspend judgments of their behavior (UMB.edu, 2022). Fawcett (2015) clarifies "The nurses' job is to take care of people who are suffering horrible things. It doesn't matter who they are, only that they are suffering" (UMB.edu, 2022). Situating practice into a conceptional model does not excuse or condemn a patient's behavior but promotes cultural responsiveness and healing (UMB.edu, 2022).

As indicated by Day and Beard (2019), culturally responsive teachings prepare students to support social justice in and beyond the classroom. National and international nursing organizations also endorse this concept. Yet, nursing faculty and leadership in the United States have widely failed to integrate culturally relevant evidence-based research and education into pre-licensure and advanced degree nursing curricula (Day & Beard, 2019; Sherman et al., 2021).

Intersectionality.

Intersectionality is another crucial factor contributing to cultural relevance and responsiveness. Our identities are not static; we are not only our race or our gender identity, or our sexual orientation; instead, our identities are also fluid. Intersectionality, as defined by Crenshaw (1991) and explained by Ramchand et al. (2021) as it pertains to the LGBTQ+ community and their health needs, can be further supported through the application of [LatCrit & Chicana] Cultural Theory. LatCrit scholars, particularly Anzaldua (1987), assert that racism, sexism, and classism are amidst other layers of subordination based on immigration status, sexuality, culture, language, phenotype, accent, and surname. Dugan et al. (2017) posit that one aspect of the dominant ideology in the United States is the sense that being White, male,

cisgender, and heterosexual are ideals (Dugan et al., 2017, p. 83). The mainstream [dominant, heterosexual] American culture may not see including LGBTQ+ health education in the curriculum as significant and appropriate. Consequently, it is imperative that the nursing profession understands the importance of cultural differences by valuing, incorporating, and examining their own health-related values and beliefs and those of their health care organizations. Only then can they support the principle of respect for persons and the ideal of transcultural care (Battle, 2012; Bjarnason et al., 2009; Prosen, 2015).

Critical Pedagogy.

Moreover, Critical Pedagogy (CP), as defined by Henry Giroux (2007), insists that issues of social justice and democracy are not distinct from acts of teaching and learning (Giroux, 2007). "Education for nurses and other health care workers is key to addressing these barriers; however, little we know about the status of LGBTQ health education in nursing schools" (Eickhoff, 2021, p. 552). Bassey (2016) declares that teachers who practice culturally responsive teaching understand that education is not apolitical and, as a result, they help students to understand their roles as change agents in society (Bassey, 2016).

Conclusion

Brown et al. (2021) assert that higher education has the responsibility to teach concepts of diversity and inclusion [LGBTQ+ content] as well as cultural competence, guided by explicit learning outcomes or course objectives in syllabi (Brown et al., 2021). The effects of a diverse and inclusive education also have workplace implications (Blanchet, 2016; Brown et al., 2021; Danek & Borraya, 2012; Day & Beard, 2019; Hall et al., 2015; AACN, 2017; Relf, 2016). Implicit biases among the healthcare workforce can substantially obstruct the quality of care, especially as they affect patient-provider interactions, patient outcomes, treatment decisions, and

patient treatment adherence (Blanchet, 2016; Brown et al., 2021; Danek & Borraya, 2012; Day & Beard, 2019; Hall et al., 2015; AACN, 2017; Relf, 2016).

The literature demonstrates disparities for LGBTQ+ people, significant gaps in understanding between LGBTQ+ patients and providers, and a deficit approach to cultural responsiveness in the schools of nursing. “Giving sufficient attention to any and all special populations with unique needs is certainly a challenge that must be surmounted, but the LGBTQ+ population should not be neglected when balancing demands on the curriculum” (Eickhoff, 2021, p. 556). This lack of data will have ongoing and compounding effects on LGBTQ+ people, including the study and impact of other diseases and epidemics (GLAAD, 2022).

In summary, my literature review reveals that a lack of cultural competence and adequate LGBTQ+ education exists in healthcare, which is problematic for the execution of culturally congruent care and patient outcomes (Alpert et al., 2017; Dorsen & Van Devanter, 2016; Eickhoff, 2019; Stewart & O’Reilly, 2017).

CHAPTER THREE: METHODOLOGY

Introduction

In the previous chapter, I provided the literature review that illustrates that LGBTQ+ education is lacking from the nursing curriculum and cultural competence is compromised. This chapter outlines the rationale and specific methodological approaches for my study. The first section outlines my qualitative methodology. The next section describes my research design. The final section includes the approach I will use for my data analysis.

Qualitative Methodology

As a reminder, this study is in support of gaining insight into my research question, which is as follows:

R1: Concerning LGBTQ+ healthcare preparation, what are we teaching [in our School of Nursing] and what can we do to improve our nursing curriculum?

To examine this question, I use a qualitative approach. Qualitative research, as defined by Bhandari (2021), involves collecting and analyzing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences. It can be used to gather in-depth insights into a problem or generate new ideas for research (Bhandari, 2021).

To refine my methodology in answering my research question, I am explicitly conducting critical *Participatory Action Research (PAR)* to address this educational deficit. Thus, let me further define this type of inquiry. As I explained in Chapter Two, I use a critical lens and critical framework in this study.

Participatory Action Research

In education, PAR stems from the ideas of critical pedagogy. Fals Borda (1991), one of the founders of PAR, expresses a profound distrust of conventional academia and great

confidence in relevant knowledge in the fields of counterhegemonic education on issues ranging from violence to criminality, racial or sexual discrimination, educational justice, healthcare, and the environment (Borda & Rahman, 1991).

Participatory action research (PAR) is an approach to action research emphasizing participation and action by members of communities affected by that research. In this situation, I am a nurse practicing at the bedside caring for LGBTQ+ patients, and I am faculty at the school of nursing where I am conducting my research. Merriam and Tisdell (2016) explain PAR as follows:

> In almost all PAR studies, researchers are either insiders of the communities where they are conducting such studies or are specifically asked by a community to help them engage in a PAR study. In critical PAR studies, participants are "profoundly" interested in their practices "and in whether the conditions under which they practice are appropriate." (Merriam & Tisdell, 2016, p. 57)

Moreover, critical PAR studies can affect and transform everyone involved from an individual and societal perspective. Kemmis et al. (2014) posit that when participants are asked questions in interviews and through other means of inquiry about their experiences related to gender, race, class, or sexual orientation, "the very act of talking about issues changes their consciousness about these things and hence invites change" (Kemmis et al., 2014; Merriam & Tisdell, 2016, p. 63).

To support my intent of PAR, let me summarize how critical research focuses on context and worldview. Action research addresses a specific problem in a practice-based setting, i.e., classroom and hospital. The goal of the study, as defined by Merriam and Tisdell (2016), is to critique, challenge, transform, and analyze power relations, anticipating that people will act

because of the study (Merriam & Tisdell, 2016). Patton (2015) describes it best that critical research aims to critique existing conditions and, through that critique, brings about change (Patton, 2015).

Educational scholars often employ various types of critical research, which I described. I also bring in a perspective from the design research field called Human Centered Design (HCD).

The Human-Centered Design (HCD) model helped me frame a preliminary inquiry on this subject, collecting anecdotal evidence, ultimately leading to the affirmation of my dissertation topic. Two key concepts of the HCD toolkit are empathy and immersion. Since nursing adopts a humanistic and holistic approach that embraces compassion, honesty, kindness,

and altruism, immersing myself in the lives of LGBTQ+ individuals has helped me to empathize and understand their despair. Therefore, including LGBTQ+ education across the curriculum can better prepare our nurses to care for this population while at the same time building empathy for what these patients experience.

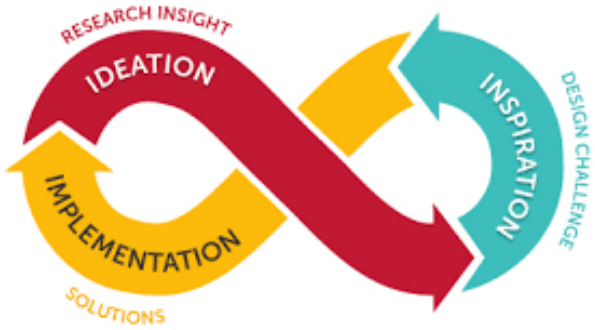
Human Centered Design

HCD is a generative and collaborative process responding to human needs. Human-centered designers adopt an iterative approach to solving problems. Involving the partners they are designing for and obtaining their feedback is a critical part of how a solution evolves (IDEO.org, 2015).

HCD consists of three fluid phases (Inspiration, Implementation, and Ideation) that devise a methodological approach to facilitate change, as shown in Figure 1.

Figure 1

The HCD Model



During the inspiration phase, HCD starts with the designer asking crucial questions. The following are mine:

- *What is the problem I am trying to solve?*

  Including LGBTQ+ health education into the nursing curriculum.

- *Why is it important?*

a. The LGBTQ+ community is a prevalent yet vulnerable population

b. LGBTQ+ individuals exist on every demographic level (students, patients, colleagues, family, friends…)

c. Nursing students need to be well-informed to engage with LGBTQ+ patients. Their health needs are complex.

- *Where is the current disconnect?*

a. No formal training has occurred on campus for faculty, staff, and students since the grant-funded development of the Safe Zone office in 2015

b. The Training and Professional Development Department workshops and online training on Integrity, Inclusion & Diversity (e.g., bias, harassment, bullying) do not include LGBTQ+ modules

c. Academic freedom to include choice of textbooks makes LGBTQ+ health education optional
d. The dominant [heterosexual] culture may not see this education as important
e. Faculty have intrinsic bias and discomfort with openly discussing LGBTQ+ health issues
f. Faculty have limited to no training, and expertise in caring for LGBTQ+ patients. The majority of faculty have never taken care of a transgender patient.

In my preliminary inquiry through anecdotal data collection, applying the concepts of HCD, such as *Conversation Starters,* are the beginning of creating change. "Conversation Starters are a great way to get a reaction and begin a dialogue" (IDEO.org, 2015, p.45). I shared my concern openly with the Dean and faculty through *inspiring stories* and revealing the *secondary research* data on *why* LGBTQ+ health education is vital to increase awareness, understanding, and empathy. Using diverse *interview* strategies to create a dialogue with faculty can uncover the deep motivations and assumptions that underpin a person's behavior. The *group interview* with students hears everyone's voice, gets diverse opinions, and is strategic about group makeup (IDEO.org, 2015, p. 37, 42).

HCD is the catalyst for my methodology, and PAR is the formal process. Next, I will demonstrate the steps of my participant selection and present additional research methods for this study.

Research Design

I describe below my process for my sustained inquiry. This section discusses the various components of the research design.

Participant Selection

My organization is one of only three HBCUs in the United States with an LGBTQ+ student organization and a Safe Zone resource center (Lenning, 2017). Yet, there are no partnerships or outreach between The School of Nursing and Safe Zone.

The School of Nursing employs 36 faculty members and has an enrollment of approximately 302 students in its undergraduate program. Students and faculty complete clinical hours at the surrounding area hospitals and clinics.

In this study**,** participant selection involves the process of purposeful sampling. Merriam and Tisdell (2016) consider purposeful sampling based on the assumption that the primary investigator (PI) wants to discover, understand, and gain insight. Hence, the PI must select a sample from which we can learn the most (Merriam & Tisdell, 2016). This type of sampling also considers the various stakeholders.

Step 1: My participant selection includes nurse faculty teaching the *transcultural* nursing course, *fundamentals* in nursing, and *expanded adult health* nursing. These are the main courses where LGBTQ+ health surfaces, though nurse educators should include LGBTQ+ health disparities throughout the undergraduate curriculum.

- Faculty will be asked for their voluntary participation in a structured audio-recorded interview in a private setting specific to their cultural teachings and knowledge in preparing nursing students to care for today's culturally diverse patient population emphasizing LGBTQ+ content.

Step 2: My second group of participants are nursing students from the junior and senior cohorts. These students have already progressed through the majority of the nursing curriculum. Hence, I

want to get their perspectives about cultural competence, and their preparedness of caring for LGBTQ+ patients.

- Students will be asked for their voluntary participation in an audio-recorded focus group interview, consisting of four to six participants per group. The sessions will be in a private setting. Questions will focus on students' perceptions of preparedness of knowledge, comfort, and cultural competence in caring for culturally diverse patients with health disparities, particularly regarding LGBTQ+ health needs.

Step 3: Facilitation of recruitment and consent. Student recruitment takes place in person through a general announcement in the classroom before the beginning of class in one of their courses where I have no direct association. I will use an IRB-approved verbal recruitment script (Appendix B) to facilitate this process. As the primary investigator (PI), I have submitted my application for research to the Internal Review Board (IRB) at the University of North Carolina Wilmington (UNCW), following IRB policies. My data collection methods met Internal Review Board (IRB) approval and qualified for an exemption.

- The PI obtains verbal consent in person and presents the subjects a hard copy according to a customized Human Subjects Informed Consent Alternate Format Bullet Statement, also describing the use of audiotaping without gathering personal information.
- Data will be electronically recorded, stored, and protected through encryption. Upon completion of the project, the PI will permanently delete all transcribed recordings. The PI will secure access to study data by a username and password to meet the universities' password guidelines. The PI will only enter and review study data accessible over a network connection from within a secure network. The PI's computer storing and

accessing study data will have an updated version of anti-virus/anti-spyware software installed.

Step 4: I will gather information via secondary data collection from two different North Carolina hospitals. The purpose of extracting this information is to find out to what extent these organizations incorporate cultural diversity into their daily operations and their position on DEI serving the LGBTQ+ community.

Step 5: Secondary data collection from nurse managers will focus on patient demographics, including gender identity and use of pronouns. I will invite the nurse managers of the mentioned hospital departments to informally share their observations and perspectives on caring for LGBTQ+ patients in their respective units.

The timeline table provides an overview of the culminating project.

Table 3

Timeline

Phase	**Description**	**Dates**	**Method/Data Collection**
I	**Faculty & Student Recruitment**	**August/September 2022**	**In Person**
II	**Faculty & Student Interviews**	**September 2022**	**Personal Interview & Focus Groups**
III	**Secondary Data**	**August/September 2022**	**Access government data bases and hospital data**
IV	**Data Analysis**	**October 2022**	**Coding. Interpretation & Write-Up**
V	**Results**	**October 2022**	**Share Results**

Data Analysis

In this final section I present the method that will guide my data analysis. In keeping consistent with my critical framework, I am using discourse analysis to analyze my findings.

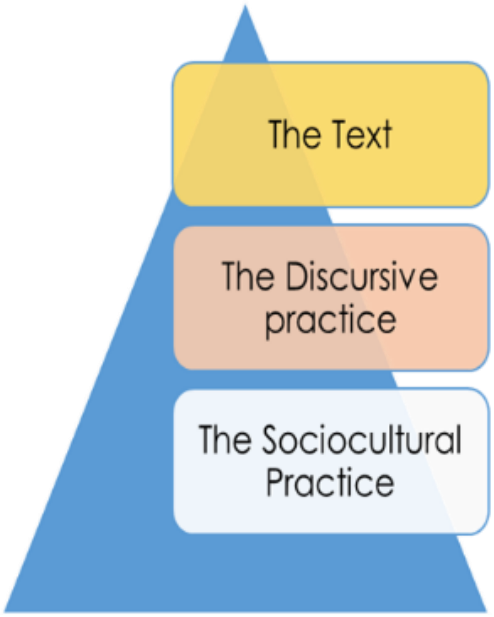
Critical Discourse Analysis

Critical Discourse Analysis (CDA) is my investigative method of examining the nursing curriculum. CDA is an interdisciplinary approach for critically describing, interpreting, and explaining spoken or written language related to its social context. CDA contextualizes the relations between discourse, power, and ideology.

I focus on hermeneutics (text interpretation and the relation to human actions) by applying Fairclough's triangulation (see Figure 2). *Triangulation* involves different types of data and theories to establish the significance of the sites of engagement and mediated actions. Clear triangulation procedures are essential in drawing inferences about observations and producing interpretations (Meyer, 2001).

Figure 2

The Fairclough Model



Fairclough's Three Levels of Analysis

The Text: Omitting cultural [LGBTQ+] health education from the text.

The Discursive Practice: Creating stigmas, cultural stereotypes, and prejudices. Using deficit expressions for vulnerable populations.

The Sociocultural Practice: Perpetuating dominant ideology and the status quo. Heterosexuality is the norm.

Conclusion

This chapter outlined my methodological approaches, processes, rationales, and theoretical perspectives guiding this study. The next chapter gives an in-depth description of the dialogues and their research context.

Definition of Terms

Anecdotal Evidence. Evidence based only on personal observation, experiences, and reports, collected in a casual or non-systematic manner (yourdictionary.com).

Focus Groups. A focus group brings together a group of participants to answer questions on a topic of interest in a moderated setting. Focus groups can provide more nuanced and unfiltered feedback than individual interviews (George, 2022).

Interview. Structured. Structured interviews have predetermined questions in a set order. Asking set questions in a set order allows to easily compare responses between participants while keeping other factors constant. This can mitigate biases and lead to higher reliability and validity (George, 2022).

Secondary Data Collection. Existing datasets that have already been collected from sources such as government agencies or research organizations (Bhandari, 2021).

CHAPTER FOUR: FINDINGS

Introduction

This chapter introduces the participants and presents the findings from faculty interviews, student focus groups, and hospital data. I am taking an analytical and narrative approach in presenting the participants' thoughts and perspectives individually to offer insight into their dialogues and research context investigating cultural responsiveness and competence specific to LGBTQ+ healthcare and education

The presentation of my data centers on faculty and student narratives. Hospital [secondary] data is provided to give more details about the micro, meso, or macro context of the current state of LGBTQ+ culture in our system. While it may be traditional to provide an analysis and themes in Chapter Four, I define the narratives with subheadings to distinguish the participants emerging positions within their dialogues. These narratives include faculty, students, and hospital data. My interview questions (Appendix C) are italicized, threaded throughout the narratives and often embedded within the participants' responses. It will be in Chapter Five when I further analyze the data and provide a synthesis of their narratives according to my research topic and question.

Narratives

The major portion of my findings lies in the narratives of faculty and students. *Table 4* assists in setting up the organization of the data. You can see that there are three primary headings: Faculty, Students, and Hospital Data. I would like to note that in accordance with the IRB, all participants are provided with pseudonyms.

Table 4

Participant Outline

Faculty		
Narrative I	Dr. A	Transcultural Nursing Course
Narrative II	Mrs. B	Fundamentals in Nursing Course
Narrative III	Mrs. C	Adult Health Nursing Course
Students		
Narrative IV	Senior Group I	4 Students
Narrative V	Senior Group II	3 Students
Narrative VI	Junior Group I	4 Students
Narrative VII	Junior Group II	3 Students
Hospital Data		
Narrative VIII	DL	Nurse Manger, Novant Health (**D**epartment **L**ead)
Narrative IV	AM	**A**ssistant Nurse **M**anager, Novant Health
Narrative X	CF	Nurse Manager & Clinical Educator, **C**ape **F**ear Valley Health

Let me provide a brief overview of the table for easy of interpretation. Under the first heading of Faculty, I present the narratives of three faculty members: Dr. A, Mrs. B, and Mrs. C. Associatively, I assign Narratives I, II, and III to these participants and the courses they teach. The subsequent narratives follow the ordinal sequence. The second primary heading is Student. The student narratives represent the groups as well as the number of students in these groups. Each group has a name and associated narrative. The third primary heading is Hospital Data. Under hospital data, I include secondary data along with the associated narratives from DL and

AM, nurse managers from Novant Health. CF is a nurse manager and a clinical educator from Cape Fear Valley Health, and I present their combined narrative. Together, these narratives provide a vivid picture of my context and the current state of the curriculum. From my fluid conversations with the participants emerged the big ideas which are accentuated by subheadings. In every section, I present the conversation exemplifying the different participants' viewpoints and experiences and how they came to their current position within this context. What follows are the narratives.

The Faculty

Narrative I: Dr. A

Introduction

Our transcultural nursing course is web-based, only offered to RN-to-BSN students at this university, and not part of the pre-licensure nursing curriculum at this institution. This course is described in the academic catalog to assist the nurse with concepts of culture, belief systems, health, and caring and how these concepts affect the nursing care delivery system.

There are three African American instructors assigned to teach the transcultural nursing course. I recruited all three faculty members to participate. Yet only one faculty member accepted my invitation, Dr. A. She is a full-time assistant professor who has been teaching this course since 2019. Besides teaching the transcultural nursing course, Dr. A also lectures second-semester prelicensure students in the Adult Health I course, instructs pediatric clinicals, and a gerontology course. The participant has been with this university since 2014. Dr. A. is a passionate nurse educator, family nurse practitioner, health disparities activist, student nurse- and patient advocate. Always willing to help and always friendly.

Next, I am providing you with Dr. A's narrative. The conversation contains subheadings to distinguish emerging positions: *Barriers to LGBTQ+ education, cultural competence, lack of gender acceptance, culturally relevant education,* and *cultivating culturally responsive care for LGBTQ+ patients.*

Dr. A and I met via Zoom on a Monday afternoon. Dr. A and her busy self were scrambling to get the camera going. "Mrs. H., it's been a crazy day! I've been in class all morning, and then in meetings. But you know, I love you and appreciate what you're doing so much!" It was in this way that the conversation started. As I furnished the IRB script to obtain her verbal consent before proceeding, Dr. A settled in all seriousness.

Barriers to LGBTQ+ Education

After finding out how long Dr. A has been teaching the transcultural nursing course, I proceeded to inquire if any modifications were made to the course since 2019. She received the course without an explicit hand-off from another faculty member who suddenly became ill and left the institution. Subsequently, the course has been taught primarily the same way for the past three years.

The current assistant professor is collaborating with her other two colleagues in this course. "We are actually looking at some new textbook edition adopting, and some of those gaps that we're seeing." The transcultural course faculty are reviewing the literature and want to make sure that the students are equipped to meet the needs of the population. They are looking to add some additional diversity components. Yet, as far as referencing LGBTQ+ content, the course does not heavily touch on this subject. "We probably get a little bit more into it about the LGBTQ community, but there's not a lot of components, even in some of the textbook pieces,

and identifying reputable resources and points of reference, including those in the course lay out."

How do you define transcultural nursing in your teachings, what is currently your emphasis? Dr. A, "The course starts with a discussion board allowing the students to define how they see transcultural nursing." The participant explains how she then expands her teachings and builds her course components on those student responses. She addresses content through multiple lenses, focusing on ethnicity, spirituality, and cultural patient preferences, integration of complementary alternative practices in terms of their options for treatment choices (e.g., acupuncture or massage for the treatment of management of migraines versus traditional medicines). Students also conduct interviews with someone of their choice from a different culture (i.e.: Russia) to enhance their cultural knowledge. Dr. A:

> There's some other additional integration with cultural competence and an awareness piece. So, I think, looking at diversity, inclusion, and equity, the course is well covered. But I will say, one of the greatest deficits in the course is needing to incorporate more with the LGBTQ+ community. (Dr. A)

Dr. A further elaborates that the students do a self-reflective journal. With that, students have expressed openly their preferences in terms of their sexuality. Through this sharing, she touches on LGBTQ+ content but explains that a course module covering this content does not exist. The professor states there is not enough time to cover these additional topics since the course is taught in an eight-week format. The emphasis is based on cultural confidence, theoretical foundations, religion, ethics, and family. Dr. A informed me that she shared the need to incorporate a specific module about the LGBTQ+ culture with her two transcultural nursing colleagues. She finds it indicated for one because our language and our pronoun usage are

changing. “We really need to be more inclusive and more up-to-date with the times. We are really behind the curveball.”

Cultural Competence

Can you describe the meaning of cultural responsiveness and competence? You already kind of touched on that. So, how do you have the students define that, or are you providing them with a definition? The students submit the meanings through a discussion board and journaling. They provide their definitions and interpretations based on diverse literature, their textbook, websites, and their own cultural experiences. The students are required to do this in the beginning and again at the end of the course to measure the impact of this lecture. Dr. A explains “How has it impacted their definition, has it evolved? Has it expanded, or did it have very little influence?” Most of the students do not think about some of the other pieces such as religion, and they are not as sensitive to the patient’s cultural needs regarding unique populations. Some of the students are not feeling comfortable addressing cultural issues related to gender and sexuality stemming from their upbringing in the South and the Bible belt. “They have not been well prepared.” In this course LGBTQ+ content gets addressed very briefly by illustrating that they may encounter these patients in the hospital and these patients will need appropriate referrals and additional support from the healthcare team.

Do you have a framework or a theorist as a reference in this course who defines cultural responsiveness and competence, are you using anyone in particular? The faculty in this course do not use anyone in particular, and they have not adopted a central framework. Dr. A, “That certainly would be something great for us to look at in this course, so that it will bring some level of consistency.” *Am I understanding correctly that you collaborate with the other two faculty members for more consistency in this course?* Dr. A:

> Yes, ma'am, we do it as a group. Our textbook was significantly outdated, and we wanted to increase the resources for our students. So, after talking, we're able to adopt a newer addition for our coursework. We are really doing them a disservice if we are not up to date in terms of best practice. It's such a diverse group whom we are serving not only culturally and ethnically, but also the demographics are greatly changing. We have to address these things. (Dr. A)

Lack of Gender Acceptance

Do you think that culturally specific content only belongs in the transcultural nursing course, or should it be threaded throughout the curriculum? "We are missing the mark in many areas," Dr. A explained. She concurred that one course alone does not readily prepare students. The pre-licensure students do not have a dedicated *transcultural* nursing course or an *international perspectives of health* course in their program. It is critical to thread this content throughout the curriculum at our school of nursing (SON) to prepare our nurses to meet the needs of the population that they are going to manage.

Can you tell me where we are at our SON in preparing our students to become culturally competent? Dr. A, "There are a lot of great opportunities here." Preparation starts from the beginning with the *fundamentals in nursing* course and *health assessment*. Cultural concepts such as ethnicity, nationality, pain perception, dietary meal planning and the spiritual components get addressed. LGBTQ+ specific health education still needs to be integrated, such as preferred pronoun usage for instance. "I think, beginning in semester one, when students come into the program, hearing that repetitive language, helping students to understand and apply LGBTQ+ terminology is going to be critical."

Culturally Relevant Education

As I shared the concerns and evidence from my study, where do you position yourself with regard to LGBTQ+ healthcare needs and content taught? Dr. A, "I'm learning a lot about this content area, and I'm also very, very passionate about making sure we're preparing our students in terms of identifying disease processes as well as looking at this special vulnerable population." Dr. A shares that she received a small grant for her research on *Stop the Stigma,* reducing the stigma associated with HIV. Stakeholders from the community were invited to present to our nursing students and the campus community at large. She calls it 'normalizing the conversation' when the audience sees and hears members within their own community share their stories including members from the LGBTQ+ community. Dr. A:

> The key points for the students was the help to normalize the conversation and reduce the stigma. Helping them to get comfortable with managing the needs of patients no matter how they identify. Helping the students understand where that emerged from, why it's relevant and important. Also, we're looking at the LGBTQ+ community. We know that Cumberland County has one of the fastest growing rates within our State. We're in the top-five in terms of the fastest growing out of a hundred counties. That information came up for the students, and also seeing how the LGBTQ+ community is impacted, how minorities are impacted in terms of numbers that are unaffected as well, and also normalizing the conversation of testing. (Dr. A)

Dr. A reiterates that students verbalized feeling uncomfortable having those conversations and that faculty has not exposed or better prepared them. "They don't know what to do. They don't know how to address it. I think it's so needed, not only as the platform for students, but also training faculty of how to lead those conversations." Faculty may be experts to some degree, but

in this area, most of us are nervous. Dr. A suggests that faculty take ownership, admitting they are in uncharted territory and doing their homework to meet the needs of this population.

One of the most difficult segments is the conversation piece. Education needs to be ongoing. Our curriculum lacks the [LGBTQ+] language. We need to prepare our students for one of the fast-growing populations in terms of demographics. Dr. A, "We have to get on board because the train is moving, and we're going to be left if we don't put measures into place." Besides threading LGBTQ+ content throughout the curriculum, the participant recommends establishing course electives that focus on LGBTQ+ health education and incorporating international health perspectives.

Cultivating Culturally Responsive Care for LGBTQ+ Patients

What do you think we can do differently or better at our SON? Dr. A recommends that LGBTQ+ education and generating cultural responsiveness and competence must begin upon admission to the program. For example, in the initial health assessment course, students should learn how to appropriately perform a thorough assessment of a transgender patient in a sensitive manner. They need to learn about gender identity, medication, and diagnostic variables. Many faculty members have never taken care of transgender patients or interacted with patients and their families from the LGBTQ+ community. We need to expand our teachings beyond the textbook and get creative using simulation to help the students prepare and collaborate across the disciplines. Dr. A:

> We need to move beyond of thinking about transcultural nursing in terms of ethnicity and the issue of black and white. People are so far behind in their beliefs to think about this concept only relates to race. It's so much more than that. Our demographics have

> changed with aging and gender identity, not only for adult patients, but the pediatric population. (Dr. A)

Dr. A comments further that we should collaborate with mental health specialists since there has been an emerging number of suicides, depression, and anxiety involving the LGBTQ+ community. In addition, they experience disparities in every aspect of life, not only in healthcare, but with employment and self-esteem. Lastly, the assistant professor raises the question, "How does that make you feel when you are not accepted or respected?" It will require a number of disciplines to collectively join forces within the community to improve LGBTQ+ education and health needs.

Narrative II: Mrs. B

Introduction

Fundamentals in Nursing also known as Concepts Basic to Nursing is one of the primary courses taught in the first semester where students learn the basics of nursing with an emphasis on communication and assessment. The academic catalog describes this course as an introductory clinical course designed to introduce the student to conceptual threads and skills fundamental to the practice of nursing.

The faculty member, Mrs. B., teaching this course is a Caucasian lecturer with three years of experience in nursing education which began at this institution and a nursing background in pediatrics. Mrs. B is also a course and clinical coordinator for the freshman and senior nursing students.

Next, I will present the participant's perspectives and insights to my overarching research question and purpose. The consecutive subheadings distinguishing the emerging positions are as

follows: *Cultural shortcomings, contesting dominant ideologies, getting comfortable with the uncomfortable,* and *denounce bias*.

Mrs. B and I met via Zoom on a sunny Wednesday morning. “Hi, how is it going?” she began before I got my microphone to work. Mrs. B is always casual, eager to get started, and ready for the next adventure. I read my obligatory IRB script and obtained verbal consent so we could dive into the conversation.

Cultural Shortcomings

Are you incorporating culturally specific care content into your lectures? Mrs. B, “I generally show a slide that talks about culturally competent care.” The slide gets shown at the end of the lecture because the content on cultural competence is located at the end in the textbook. When the participant noted that cultural content was introduced not until the end of her course, she came to the realization of incorporating content at the beginning of the course and having a continuation through the weekly lectures would be more beneficial to the students. Subsequently, there is no mention of the LGBTQ+ population within the cultural context at all. Her focus remains on ethnic minorities. The lecturer’s perspectives on teaching about cultural care still reflect the mindset of the 1990s. Mrs. B calls it “checking the boxes.” For example, emphasizing to the students that “Black men are more prevalent to heart attacks” – ☑ “Jehovah’s Witnesses do not get blood” – ☑

Mrs. B further reasons that *we* all fall short of incorporating cultural aspects because *we* all belong to a culture, or a blend of different cultures and have not gone beyond the race and religion component in the schools of nursing.

Contesting Dominant Ideologies

How do you personally define cultural responsiveness and competence, and what does it mean to you? Mrs. B, "Your beliefs are separate from what you are actually teaching." She states that as an educator, she is trying to teach nursing students to be more culturally competent by understanding different patients and cultures. And hopefully to the point where they [the students] walk into a patient's room, no matter their skin color, their background, their sexual orientation, their beliefs, and are comfortable with caring for that patient and knowing what to say. Mrs. B believes it is hard for instructors to get the students to become 100% culturally competent. She hopes to instill that the students will be able to care for a patient by putting their beliefs and opinions aside, even if they disagree with transgenderism, for example. Mrs. B:

> As a nurse, we have to think about the bigger picture. We have to think this is your patient, no matter their culture or identity. It's just like the stigma when we [nurses] get a prisoner. There is the prison culture aspect. Can you say, "I don't want to really treat this patient?" (Mrs. B)

Mrs. B further explains that first-semester students have no idea about the types of patients they will encounter.

Getting Comfortable with the Uncomfortable

Mrs. B gives the students an assignment within the first few weeks of the course proposing different cultures and backgrounds, one being a prisoner, where they write down and discuss their thoughts and beliefs. Mrs. B, "They all want to take care of the perfect patient, the nice patient, the kind patient, the non-aggressive patient. I just know that their world's going to get rocked about what they're going to see." The participant also mentions that she wishes that she had a better script of how to prepare these students instead of saying "Swallow down your

beliefs and care for these patients." Healthcare professionals take an oath to treat and care for every patient. No matter what, they are human beings. When asked about intersectionality and discussing sexuality, she states that it becomes even more complex when caring for a black man or black woman who is also an LGBTQ+ patient. There is a deficiency in communication. As instructors we need to think about how to teach these students to communicate with these patients, so they understand the medical implications for care and treatment.

Do you think that culturally specific content only belongs in the "Transcultural Nursing" course, or should it be threaded throughout the curriculum? While Mrs. B believes that transcultural nursing should be a separate course, she also accentuates that LGBTQ+ health care needs and education should be incorporated into more than one course. Mrs. B, "Students should learn how to communicate with gay men. 'Are you using appropriate protection?' LGBTQ+ patients have risk factors for certain diseases and STDs." She mentions that it would be a very uncomfortable experience for the students and the patient if they did not have any preparation in caring for a patient who is in the process of gender transition. The participant tells the story of a twelve-year-old transgender patient encounter when she was with a student at the hospital. Since they did not talk about this previously, Mrs. B described it as a "very interesting" conversation. A dilemma with pronoun usage and birth name versus their preferred name emerged. The patient's chart had an indicator. Yet, the assumption was made that the patient did not care how to be addressed and that the patient should be called by the name according to their assigned sex at birth. Even though there is an indicator on the chart, the nurse or provider can skip right over this part. Mrs. B suggests we thread these culturally inclusive teachings throughout the curriculum to manage discomfort and reduce bias.

Denounce Bias

In nursing, there is an adage “Discharge teaching starts at admission.” Mrs. B uses this saying to equate it to “cultural responsive teachings should start on day-one of nursing school.” It should be woven into health assessment, pathophysiology, and continued into pediatrics and so on. In her opinion, greater LGBTQ+ content needs to be delivered in the pediatrics course. Mrs. B, “I do think pediatrics is where some of these conversations really start happening. Kids know by the time they're ten and twelve.”

What do you think we can do differently or better at our SON? Making LGBTQ+ health education a standard. Mrs. B, “Making it as natural as teaching our students about drug side effects.” She also questions the legitimacy of the current textbook in her course. Mrs. B refers to a small section in on cultural competence located in the “Female Genitourinary System” chapter of their textbook (Jarvis 2022, p. 731-732). Mrs. B reads me the excerpt:

> Yeah, there's a little paragraph about women who have sex with women including lesbians and bisexual women, and how you need to establish trust with them. It talks about how they might not have insurance, they're at a risk for human papillomavirus (HPV), so you want to make sure you check them for cervical cancer. Oh, here's it is ‘transgender’: “Transgender girls/women are those who had sex assignment as males at birth but who continually identify and live as female. Be aware that transgender women are not cross-dressers or drag queens. Transgender girls may be going through transitions to alter birth sex to their confirming gender.” (Mrs. B)

This is the first time Mrs. B read this section and replies that cultural competence is lacking on her part and from the textbook. The lecturer queries the preconception of these paragraphs. Mrs. B, “This is 2022. *Be aware that transgender women are not cross-dressers and drag queens.* The

author should have not said it like that." She confirms that after looking at this textbook, she would never teach LGBTQ+ content in this manner. Mrs. B asserts that we need to set up LGBTQ+ -specific training at the SON. We need better communication practices for ourselves and for the students. For instance, "if a student came up to me and told me they don't want to take care of a patient because they are a lesbian, I would like to know how to best respond to that student." Mrs. B admits that even as a nursing instructor, getting comfortable with the uncomfortable takes training.

Any other thoughts or perspectives that you would like to share? Mrs. B, "We just need to do a better job." She conveys that this generation is more open to other ways of living and lifestyles. Mrs. B concludes that LGBTQ+ patients are human beings, and all human beings are seeking health care and have needs. We should treat *them* the same because it is not a contagious disease.

Narrative III: Mrs. C

Introduction

Adult Health II also known as the Expanded Adult Health Nursing course is one of the main courses taught in the students' junior year and focuses on theoretical, physiological, and pathological concepts addressing complex and multi-system health needs of adults who are experiencing selected complex health alterations.

Mrs. C, who is the faculty member teaching this course is a multiracial lecturer with three years of experience in nursing education, obtained at this facility, and has a nursing background in cardiovascular critical care. Mrs. C is also a clinical instructor for the senior nursing students.

Next, I will present this participant's narrative organized into these consecutive subheadings distinguishing emerging positions: *Lack of experience, the status quo,*

communicating cultural responsiveness and competence, addressing sexuality, unpreparedness affects patient outcomes, and *generating cultural competence.*

We met via Zoom on a Monday morning, Mrs. C's day off. "I don't mind," she said, "whatever I can do to help." That's Mrs. C's spirit: helpful, soft-spoken, and bashful, yet, engaged, inquiring, and proactive. After getting the IRB formalities settled, our conversation began.

Lack of Experience

Are you incorporating culturally specific care content into your lectures? Mrs. C, "I have not incorporated any LGBTQ+ content. I don't feel like I've had enough experience with that. I do have friends in my personal life who are lesbian or gay, bisexual, and so on." She conveys that most patients are not forthcoming in sharing this information, and therefore neither has much clinical experience. Mrs. C plans to get a new textbook with culturally specific LGBTQ+ objectives and devote a unit lecture to this subject. The new textbook is not yet approved. Thus, her class is still in the old book, not addressing LGBTQ+ health needs. Mrs. C also contributes the knowledge deficit to her inexperience with LGBTQ+ patients. The participant claims that she would benefit from formal training, such as a series of short webinars. Mrs. C confesses that she does not know what is "appropriate" in communicating with an LGBTQ+ patient. Mrs. C is fearful that she would say something interpreted as insensitive or inappropriate.

The Status Quo

What cultural content are you currently addressing? The participant lectures on cultural and socioeconomic disparities based on location, such as food deserts. Mrs. C focuses on *pain perception* of the African American culture versus different cultures. Mrs. C addresses different religions, such as Jehovah's Witnesses (JW) and their belief in refusing blood. The participant

makes it a point to reiterate cultural content from previous courses. Mrs. C, “I try to keep it fresh throughout this course, as it applies to the different content we're covering.” Consequently, the cultural perspectives from the 1990s perpetuate without incorporating the culture of the 21st century.

Communicating Cultural Responsiveness and Competence

How do you define cultural responsiveness and competence? Mrs. C, “I don't have a definition for cultural responsiveness other than how I would interpret it.” The participant describes it as an ability to respond to the ever-changing culture, a melting-pot of cultures in our area. We work with physicians, nurses, and patients from all over the world. This is a military town. We encounter the culture of military personnel and that of the civilian world. We have to be responsive to the ever-changing cultural need, because we cannot remain complacent or stationary in our mindset. We have to learn to respond appropriately to develop competence. “Taking the time to ask questions” is one of her strategies, which she also tries to ingrain into the students. Mrs. C further posits that “you're not going to learn every single thing about every single culture, but you need to be open and respectful, and it's okay to ask questions.” Mrs. C conceives that

> It is okay to ask questions. People feel heard when you ask them. “What are your preferences? What is it that I should know, or you want to tell me about your culture so that I can help meet your needs in a way that you desire.” I think that remaining respectful and asking those questions is key to remaining competent. (Mrs. C)

Mrs. C provides a personal illustration of her cultural background and different adaptions. Her mother is African, and her father is French. She may follow both cultures in various ways, “but you're not going to know unless you ask me.” The participant insists that communication is key

to cultural competence. Yet earlier, Mrs. C revealed that her inexperience with LGBTQ+ patients is keeping her silent.

Addressing Sexuality

Have you thought about intersectionality and sexuality and what that means concerning patient care and patient outcomes? Mrs. C discloses that she is not very good at addressing sexuality with her patients. She is concerned about her patients' dignity and being respectful in that manner. As far as recognizing and asking how a patient identifies, Mrs. C acknowledges a deficit. The participant talks about the perceptions of transgender people, being in the Bible belt, and people superimposing their personal beliefs onto the patient population. Mrs. C, "I want to avoid doing that. I feel like I'm always accepting. I also have to say, I don't remember ever learning anything about it in nursing school." Mrs. C expressed that she would benefit from LGBTQ+-specific training.

Unpreparedness Affects Patient Outcomes

Mrs. C continues to give examples of her unpreparedness. She does not know any LGBTQ+ terminology, like the interpretation of what it means to be a transgender male or female. Currently, the participant feels uncomfortable teaching about LGBTQ+ health needs because of incorrectness. In further discussion she thinks of an excellent paradigm that can affect patient outcomes. In her lectures she focuses on hypertension and heart disease. Mrs. C:

> This is a man who is in the transition to becoming a woman. How does estrogen affect this man, you know? Is he still at high risk for heart disease; does his risk go down now that he's taking estrogen? Does it increase his vascular elasticity? How does that work? What's the research? What's the data? What do I teach him or her? What do I teach the students? (Mrs. C)

When asked about what she sees done at the bedside, Mrs. C responds that they do not ask questions about pronoun use and sexual identity even though it is integrated into the admission assessment. Often times that part gets skipped because the institution does not make it a requirement.

Do you think that we are preparing our students adequately to care for our diverse patient population? Mrs. C, "Not when it comes to transgender and the LGBTQ+ population. I don't think we hardly touch on it ever." *Do you think that culturally specific content only belongs in the "Transcultural Nursing" course, or should it be threaded throughout the curriculum?* The participant affirms these teachings need threading throughout the curriculum, especially since our SON does not have a prelicensure-specific transcultural nursing course. LGBTQ+ education does not only belong in one course students should get exposed over and over again.

Generating Cultural Competence

Mrs. C emphasizes the importance of continuous LGBTQ+-specific cultural content throughout the curriculum since our SON accommodates a non-traditional student base. *Where should cultural competence start, at the school of nursing or on the job?* Mrs. C, "I think it should definitely start here at the SON." The students must learn to be more accepting and develop professionalism by not being judgmental and putting personal opinions aside. She gives another example of culturally perceived bias at the bedside. Mrs. C states that she has not witnessed open discrimination against LGBTQ+ patients on her unit but has experienced bias from other nurses concerning felons and gang members who were patients. Mrs. C recommends starting culturally specific communication in students' first semester, promoting openness, and establishing trusting relationships. "I think there's definitely room for improvement and a lot to

learn. I try not to discriminate against anyone, but if I don't have the education, it makes me feel like I'm discriminating," Mrs. C explained. Incorporating LGBTQ+ health education would allow us to provide better interdisciplinary care and ensure better patient outcomes.

Mrs. C also suggests faculty training by inviting the director of Safe Zone and other associations and members from the LGBTQ+ community to faculty meetings. The lecturer also believes that sharing annual statistics on these disparities, particularly within our community, would help generate cultural responsiveness and competence.

The Students

My second group of participants are nursing students from the junior (N=32) and senior (N=24) prelicensure cohorts. A total of 14 students consented to participate, seven juniors (Junior Group) and seven seniors (Senior Group). I established four focus groups with random pairing to accommodate the participants' schedules, containing three and four students per cohort (Senior Group I: 4 students, Senior Group II: 3 students; Junior Group I: 4 students, Junior Group II: 3 students). The students' age ranges are twenty-two to fifty-two years. They are different genders, have different cultural backgrounds, diverse ethnicities (African American, Asian, Caucasian, Latino), and nationalities (American, African, Vietnamese). Each focus group was facilitated through an open-ended discussion and was not based on formal (closed-ended) questions. The encounters are illustrated in narrative form, identified through subsequent headings, and emerging positions are further organized through subheadings within each of the accounts.

Narrative IV: Senior Group I

This group consisted of four students, ages 23 to 45 years, with diverse cultural backgrounds, Caucasian and Latino, and identified as heterosexual male and female. We met via

Zoom; the camera was optional for the participants. I proceeded through the IRB script, and all participants remained online. We started in a laid-back atmosphere.

Introduction

Now that you are seniors, can you tell me a little about culturally specific teachings in any particular course or anything that stood out? The four participants agreed that cultural content related to JW and their abhorrence to blood products was thoroughly covered throughout the curriculum along with some other cultural customs including Hispanic mothers and childbirth, and topics related to the Asian patients. Nothing more particular stood out. One of the participants stated "My patient was Jewish. We discussed a kosher diet. No one had asked him about dietary concerns. He was very forthcoming." Another participant encountered a JW patient during her clinical time and found that covered concept beneficial. The participants mentioned discussing religious beliefs (Muslim and JW) as a culturally sensitive topic in *nursing fundamentals.* All participants gave cultural examples encompassing ethnicity, religion, and diet. *I have heard you say thus far that you have received some cultural education throughout your six semesters, mainly focusing on religion and ethnicity. Am I correct in making that statement, or am I missing something?* "No, ma'am, you are correct."

The Status Quo is Affirmed

Do you think that culture only pertains to religion and ethnicity? Or do you think that there are many more aspects of culture? If so, can you give me an example? The participants remained focused on customs and other ritual practices and beliefs depending on geographic origin. The participants declined any further specific cultural preparation to prepare them for the bedside.

Communication Weaknesses

The next discussion point revolved around comfort level and preparedness of addressing patient specific needs. “I suppose, we could always ask them directly!” exclaimed one participant. Another participant inquired if there was a formal way of addressing specific needs with a patient. “I have some knowledge, but I don't feel I have enough, but I will gain it through my experience as I continue to work as a nurse.” The participants share the notion that their communication practices with different patients and meeting patient specific needs will enhance with bedside experience and observing seasoned nurses. These assertions point to weak communication practices. Next, the discussion focused on the cultural aspects of the LGBTQ+ community.

LGBTQ+ Knowledge Deficits

Have you given any thought to this particular culture [LGBTQ+]seeking medical care? “I think, we could be a little bit more sensitive to them, especially when they are filling out forms.” The students vividly deliberated the areas of gender identity, same-sex couples, homosexuality, and pronoun use. One participant shared her encounter with a pediatric (15-year-old) transgender male. “To be honest, I 'm not gonna lie, it took me just a minute. I stumbled when I first walked into the room.” The patient was surrounded by supportive parents, had previous hospital admissions, and led the conversation. “I was able to adapt on the fly if you will. I passed no judgment because it was a patient, period!” She further explained that the nurses on the floor knew but did not disclose this information; instead, they had a conversation about many unique opportunities in patient care, and this was one of them. The nurses remained close by but were seeing how she [nursing student] would react and behave.

Do you think that our SON or any courses that you had, prepared you to care for this particular patient or that culture?

> Honestly, I don't, and that's not to be ugly. I feel it was more focused on religion. I don't believe our courses prepared us for it. We spoke more about cultural sensitivity in terms of personal space, touching, greeting, eye contact, and who is in charge of family chores and the family unit. I don't believe this particular aspect [LGBTQ+] of cultural diversity was addressed.

One of the other participants mentioned that the *Adult Health I* instructor was being an advocate for the LGBTQ+ community on more than one occasion.

> I think it's because, obviously, we're all different, individual people. I think the single biggest thing is to normalize it by just talking about it. So, I would say this instructor definitely helped me normalize it by just talking about it like it ain't nothing but a thing. I think that in itself is something helpful.

Following, the conversation shifted to eliciting student input about creating change in the curriculum, what we can do better or differently to prepare subsequent cohorts.

Preparing the next Cohort

These senior students have completed all course requirements and spent ample clinical time in hospitals, clinics, the health department, and community outreach. They can provide profound insights into their educational experiences and where best to infuse content and facilitate change.

What can we do here at the SON to help prepare you better or differently?

- Making culture more inclusive
- Incorporating LGBTQ+ education into every semester

- LGBTQ+ Community Outreach
- "Meet & Greet" LGBTQ+ social event
- Roundtable discussions
- Creating dialogue and learning how to better communicate
- Have members of the LGBTQ+ community teach us [students]
- Have LGBTQ+ members share their experiences as patients

Final thoughts.

What else would you like to share about this subject, any other thoughts or recommendations?

- Some people [students] may find LGBTQ+ inclusion offensive
- We all have our own beliefs and values
- You may not agree with a person's lifestyle, but they are not coming for you after yours
- Addressing all aspects of DEI will give students exposure and help them work through any biases and determine if nursing is for them
- As nurses, we must give the best care to everyone
- Everyone belongs to different cultures (men, women, military, civilians, etc.), but we are *all* people who need care. We are all just people!

This first focus group meeting concluded after sixty minutes and was very interactive. The subsequent student meetings were conducted in the same format. Next, I will share the perspectives of the second senior focus group.

Narrative V: Senior Group II

This group consisted of three heterosexual participants, an older African American male, a Caucasian female, and an African American female, ages twenties to fifties. Zoom continued to be the preferred way to meet. Again, the setting was casual, the camera optional, and all participants acknowledged the IRB consent.

The discussion was started by iterating the rising reports of culturally insensitive care and the challenges that nurses experience when caring for culturally diverse patients, especially the LGBTQ+ community.

Introduction

What have you encountered so far at the SON within each of your courses, has there been a lot of talk? These participants confirmed receiving information about JW, certain diseases and lab values affecting African Americans differently than other races. They were taught about cultural diets (Kosher). Yet, there was not much teaching on LGBTQ+ health. They did recall attending the forum on HIV "Stopping the Stigma." One of the participants remembered information about pronoun usage. Overall, the conversation was about "be aware of the different cultures that you will encounter," and " this is your patient you're caring for, no matter who they are." According to the participants most of the cultural pieces occurred in their Adult Health I & II courses.

Educational Deficits Affect Patient Care

Have you encountered an LGBTQ+ patient during your clinicals? One participant did. It was a transgender female. As the participant recalled the encounter, she shared that she was lacking the education and terminology. Even now, she was unsure. "She was born a male, but

she went by she." The participant did not perform a head-to-toe assessment nor established medically warranted communication with this patient.

One of the other participants stated that she gained her LGBTQ+ experience through personal encounters with friends from the LGBTQ+ community and being in the military, not the SON. She also brought up some health disparities for the LGBTQ+ population related to gender identity issues known as dysphoria, anxiety, and depression. "We need to know about their medications and how it affects them." The participants pointed out the gaps in education and provider care.

The discussion revolved further around patient assessment and transgender care. One participant commented "I would have never thought to ask a transgender female if she still had a prostate. It's stuff like that that we need to be educated on." Thus, more educational gaps were identified.

Closing The Gap Through Communication

What can we do here at the SON to improve this educational gap? The participants started to share their ideas. "I have a minor in psychology. LGBTQ+ content was covered in some of my psych classes." This participant also noted that being from a different generation and prior military affects the perceptions of LGBTQ+ individuals. "My biggest challenge was how to communicate and engage with these individuals." There was also a general concern about not offending anyone. "It took me a while to be comfortable around them to even want to have a conversation, because I didn't know what to say or how to say it."

Preparedness Starts in The Classroom

The students made the following recommendations:

- Performing skits and roleplay
- Practicing mock LGBTQ+ patient interviews

- Learning about transgender health assessment
- Adding simulation scenarios (e.g., a hypertensive or diabetic LGBTQ+ patient)
- Attending support group meetings for patients with dysphoria
- Learning gender identity terminology
- Getting new textbooks containing LGBTQ+ health education

The participants reached consensus that LGBTQ+ content should be addressed in the same manner as talking about JW specific health content and cultural or religious dietary concerns with a refresher in every semester.

Final thoughts.

What else would you like to share about this subject, any other thoughts or recommendations? The participants discussed that how (e.g., sheltered, conservative, religious) and where (e.g., urban, rural, foreign country) you were raised fosters preconceived notions and bias towards the LGBTQ+ community. “You are a nurse first, but you also need to be an unbiased nurse when caring for your patient.” Another concern was not becoming judgmental towards the patient and questioning their beliefs or bringing up one’s personal beliefs during the patient encounter. “That could either delay their care or change their care altogether.”

The participants also thought that the hospital gender identity and health questionnaire embedded in the electronic medical record should not be an optional inquiry. “You cannot move forward with the assessment until you've asked these questions.” Medical providers have taken an oath. There should be no exception to care. “I think it’s a mindset. It's in their mind to be biased. Are you willing to break that mindset?” They concluded that there needs to be more training and teaching for the medical community.

This meeting was very interactive and gave profound insights. The perspectives from the junior cohort are next.

Narrative VI: Junior Group I

This group consisted of four students. They all identified as heterosexual females, ages 22 to 35, with diverse cultural and ethnic back grounds (African American, Asian, Caucasian). Our encounter was via Zoom, their preferred method. As with the previous Zoom meetings, turning on the camera was optional, and the setting was casual. After listening to and viewing the IRB script, everyone consented, and we started.

Introduction

As a junior, you have experienced quite a bit of clinical time. So far, what have you experienced about cultural diversity and caring for patients who are from a different culture- any thoughts on that? The participants commented that the hospital is located in a diverse city and a military town. One of the students shared her cultural experience when she cared for a Hispanic patient who did not speak English. That was problematic because nobody on the unit spoke Spanish, and the hospital did not have a translator readily available. Thus, her communication skills resorted to illustrations.

Lacking Rapport

When we talk about culture, do you relate culture only to race and ethnicity, or do you think broader when we're talking about culture? The participants commented on religion, diets, and personal preferences such as having family members present during procedures or having mementos at the bedside. “Every semester they [faculty] taught us something about culture and cultural competence, and it’s been helpful. But we never get taught of how to go about talking to a patient about their culture without offending them.” The participants agreed that it would be

beneficial for faculty to include communication practices on how to build rapport with their patients prior to attending clinicals.

Critical Discourse

Many hospitals have issued position statements and included DEI into their admission process to facilitate better communication, care, and meeting patients' needs. Have you had any encounters with LGBTQ+ patients? One of the participants described her situation on the Labor & Delivery Unit when caring for the newborn of a same-sex couple:

> The room was full of people, but you could tell that someone in the room was LGBTQ. I had to give the baby's identification band to the mom and one other person, which would normally be the dad. But in this case, the mom wanted me to give it to this other person, I assume she was lesbian because she looked like a boy. I was scared to ask. I didn't want to offend anybody.

The participants discussed how you [people] were raised and how you grew up determined not to disclose or address sexual identity and orientation.

> We don't want to offend people, because back in the day it was very offensive to call them gay or call them bisexual. It was very offensive to call them out. But nowadays, everybody's going around proud to say that that they're LGBTQ. But people who weren't raised like that, we still don't know how to approach them.

The above statements lend themselves to applying CDA. The language with its particular socio-historical context demonstrates underlying dynamics in interpersonal relations, cultural traces, and institutional influences (Kramer, 2007).

Changing the Mindset

The participants further deliberated cultural aspects that could be presumed offensive when asked about, like religion and race. Hence, they concluded by not asking, nobody would get offended. Yet, they posited as new nurses going into a patient's room "you have no idea what you are walking into. To provide better care to that patient, we need to figure out how to break out of this mindset and just treat people like people." One of the participants was under the [wrong] assumption that she could simply look at her patient's chart to find out what she needed to know about her patient. "One day, I will be confident enough to ask and talk to my patient about their care and figure things out because we learned about it in school."

The participants started to explore learning strategies that could help them to facilitate communication, increase their confidence, and change their mindset.

Getting Comfortable with the Uncomfortable

The students proposed getting more situational examples in their courses. Learning how to speak to an LGBTQ+ patient from a nursing or medical aspect would bring about better interaction and facilitate better care. Another participant shared her experience with two transgender male patients on the adolescent psychiatric unit. She was familiar with pronoun usage and comfortable using her pronouns in the introduction. "Hi, my name is M., my pronouns are she/her. What are yours? By just asking them, you could kind of see them relax, physically like relax in that moment." The participants agreed that these are the type of conversations to have in the classroom to improve student confidence and cultural competence. Participant M. also shared that she completed personal research on this subject to further her knowledge.

The students received basic communication instructions in their first semester, touched on some social justice and healthcare issues, and gained awareness that they would be coming in

contact with people from different cultures such as the LGBTQ+ or non-English speaking patients. They are now in their junior year and still struggle with cultural aspects of patient communication and comfort.

One of the participants from Vietnam provided more detail through her cultural lens about patient communication. “I have only been in this country for five years. Culture and language are a problem for me and lead to misunderstandings.” When asked about her perspectives on caring for LGBTQ+ patients, she feels uncomfortable due to her upbringing. “I think I just need to see more, and I will feel better.” All participants agreed that the lack of LGBTQ+ education added to their discomfort.

Preparation is Key

Any other suggestions or recommendations that you would like to share? Through further interactive dialogue, the participants made the following statements:

- It takes time to build a habit. This is a 2-year program. We need constant exposure to these specific situations.
- We need more cultural inclusion in our courses, not just religion. Our city is a very diverse community. Let’s focus on all the prevalent cultures within our community like LGBTQ+ and the military.
- We need more in-depth training on how to react to other nurses in the field who are not accepting and perpetuate systemic racism or transphobia.
- We need to train our minds to care for all patients with integrity and dignity and not treat them as “others.”

The participants mentioned some of the same deficits and experiences as their peers from the other groups, yet different paradigms emerged addressing cultural responsiveness and competence.

Narrative VII: Junior Group II

The final group of students from the junior cohort was two females (African and Caucasian) and one male (African), identified as cisgender heterosexuals in their late twenties. These participants decided to meet with me in person. We gathered in one of the multi-purpose rooms of the university in the late afternoon, after everyone had left for the day. Our initial round-table dialogue had to begin with the IRB statement. All participants consented, and we moved forward.

Introduction

Tell me what comes to your mind about cultural nursing, how have you been prepared so far? "When we are caring for the patient, you should include them. Depending on their culture, we should respect their beliefs, and we should treat them the way they want to be treated." The discussion started to evolve. The participants recalled cultural components from their first semester in *Fundamentals* and *Health Assessment* courses. The male participant spoke about caring for an obese female, who was also Muslim, and remembered cultural considerations about providing more privacy and a possible apprehension toward male nurses. Other factors brought to the students' attention was JW and an assignment for them [students] to define cultural competence in nursing. They found the assignment helpful because it brought different cultures to the forefront in preparation for their clinicals.

Developing Cultural Responsiveness

So far religion has been a big aspect. Anything else? One of the participants disclosed his encounter with an LGBTQ+ patient without prompting. He was aware of pronoun usage and gender identification from a prior course. “It was perfect, because I understood what I needed to do, how to address the patient. That’s very important, because we get to see that more.”

Another participant shared her encounter with a drug-addicted female prisoner who had given birth:

> It’s not related to LGBTQ, but it was a challenging cultural situation. Some of the nurses on the unit were very disapproving of this situation, but our instructor challenged us to think outside the box. We need to treat her with respect, and we need to do our job.

The conversation led to an intense socio-economic background and intersectionality debate. An excellent point was made by one of the participants stating “When we are in the hospital, we only get to see the patients dressed in a gown. We don’t really get see much about their background.” He further shared two home-visitation experiences from one of his other nursing courses. He described the first home visit as appalling because the house was so dirty, whereas the second home visit was “normal.” The student’s preceptor gave equal treatment and respect to both patients. The participant learned from that experience. Though he was taught in class about giving unconditional care and support to all patients, the experience was an “eye-opener” and helped him to become more passionate about his care.

Generating Cultural Competence through Empathy

The participants started to formulate their ideas to improve their cultural competence. “We need more exposure, to really open our eyes on *everything.*”

- Make home visits part of everyone’s clinical experience

- Have lectures on patient-specific socio-economic and intersectionality issues
- Doing more outreach and volunteering in the community
- Interaction with the LGBTQ+ community
- Advance communication skills with asking the "right" questions and getting us more comfortable with different patients
- Organize a seminar to teach LGBTQ+ content
- Invite patients to share their personal [healthcare] experiences in class
- Teach us how to better advocate for our patients

The participants agreed that applying these principles would make them more comfortable interacting and communicating with patients, lowering their fears and anxiety. "You get to see the other side; and you get to hear the stories, and it's like, oh, my gosh! You know, it just gives you a completely different perspective." Getting involved in patient care outside the hospital through "cultural immersion" helps to relate, confront intrinsic biases, and create empathy.

Bearing the Burden

LGBTQ+ exists everywhere. Tell me about what it is like for this community in your country. "In Ghana it's against the law." The participant shared that the illegality of LGBTQ+ was based on tradition, not religion. She stated that uprisings were happening, and the situation in Ghana was becoming very tense for the LGBTQ+ community, but nobody wants to talk about it. The other student from Kenya also validated that it is not accepted there and talking about it is prohibited. There are underground organizations that exist, and the government is trying to find them. According to the Kenyan participant, "It's considered illegal, and you go to jail. But that doesn't change anything. You can only imagine what that person must be going through. And you don't even have a healthcare community to help you."

Another student talked about an incident when she was still in the military. A soldier died who was married to his same-sex partner, but kept it concealed. The soldier's marital status was disclosed to his parents after his death, and it was a tragic situation to deal with, trying to communicate with the parents. The participant found out later that the mother knew for years, but the father never knew because he was "highly religious." The burden that exists when you must conceal sexual orientation or gender identity and cannot tell anyone is unimaginable.

The participants ended the meeting by reiterating that as nurses, they should not pass judgment, but be accepting, empathetic, and advocate for their patients.

Next, I will share my secondary data along with the narratives from the hospital nurse managers DL, AM, and CF.

Hospital Data

My findings illustrate current aspects of DEI since these organizations have adopted positionality statements on cultural diversity, including gender affirming care. Our students, nurses, and faculty frequent these institutions. The nurse managers from two these two different organizations also shared their observations and perspectives on caring for LGBTQ+ patients in their respective units, imparting anecdotal data.

First, I present an overview of each organization and its position on DEI, followed by the managers' responses.

Novant Health

Novant Health is a four-state (NC, SC, VA, GA) integrated network of physician clinics, outpatient centers and hospitals. Its network consists of more than 1,600 physicians and 29,000 employees at more than 640 locations, including 15 medical centers and hundreds of outpatient facilities and physician clinics. Novant Health serves more than 4 million patients annually.

Novant Health's website has an entire webpage dedicated to LGBTQ affirming care. (Hoppszallern, 2016; Novant Health, 2015, 2022). In addition,

> Novant Health has earned multiple recognitions from the Human Rights Campaign (HRC) Foundation for having more than 10 facilities designated as "Leaders in LGBTQ Healthcare Equality." Facilities are evaluated based on four criteria: patient-centered care, patient services and support, team member policies and patient and community engagement. The HRC Foundation is part of the nation's largest LGBTQ civil rights organization. (Novant Health, 2022)

As I already mentioned, this organization holds a personal interest. I work per diem as a staff nurse in one of their hospitals and recently provided care to a transgender patient. Some of the deliverables in this patient's continuum of care gave me concern, which I discussed with the nurse manager (department lead). Later, I asked him if he would like to contribute to my dissertation through an informal Zoom meeting, me as the PI and him as the participant, disregarding our professional affiliation. He unequivocally accepted.

Next, the department lead nurse manager and assistant nurse manager from my department, an adult critical-and progressive care unit, share their anecdotal insights. First, I introduce the department lead nurse manager with the pseudonym DL.

Narrative VIII: DL Nurse Manager

The nurse manager DL is a married Caucasian heterosexual male with 17 years of diverse nursing experience. We settled into our conversation casually, and I simply asked DL to share his thoughts on how well his department was doing on providing inclusive care.

DL explained that on this unit the staff does a pretty good job of providing inclusive care. All employees receive annual DEI training including LGBTQ+ content. There may be some

deficits in caring for the transgender population because in this facility they do not see as much, but he has noticed an upswing in the transgender patient population. There is a process in place to enter gender specific information pertaining to LGBTQ+ health into the electronic medical record (EMR). Yet, if the patient does not share this information and the staff does not inquire, the data does not get entered. This portion of the health screening is not on the record's front page, nor a requirement, and therefore gets missed or skipped.

Have you noticed any derogatory behavior by staff related to transgender care? DL, "I deal with a lot of complaints, and as former house supervisor that was pretty much my job. This type of situation has not run across my table. I've not had to be pulled into any situations where there was a problem".

Do you think that new graduate nurses are culturally competent and adequately prepared to care for the LGBTQ+ patients? DL, "I think so, mainly because there has been such a push over diversity and inclusion for the last 10 or 20 years. Every new class is probably a little more prepared than the last one".

What are your thoughts on how to best generate cultural responsiveness and competence in nursing? DL, "I think, being empathetic and being able to connect with people outside of what might be your normal comfort. I think of patients as family. Treat them like I want my family to be treated." He further explained, cultural competence and being responsive comes through understanding other people and being exposed to other things. Personal experiences and specialty training on DEI have increased his comfort level. More than 15 years ago, nursing school did not focus on transgender care and sexual identity; it was about religion, the customs of different cultures, and their perception of pain. Instructors converged on holistic and humane aspects, such as treating every patient with respect, no matter their status or origin.

What do you think we can do differently or better, to prepare our nurses to care for our diverse patient population? DL, "Coaching your team, coaching your students on empathy and what *Nursing* represents." Putting aside personal biases, the ultimate goal is patient care regardless of one's lifestyle. Caring takes dedication. Let the preparation begin early on in nursing school, DL explains:

> You don't want to get to the last week of nursing school and have someone ask the question if they have to take care of a transgender patient. If a student is not comfortable doing that, they need to know from the start; maybe nursing is not for them; we just wasted all this time. I think it's crucial to have those conversations as soon as possible. Be upfront. Let everyone know about DEI; it should almost be introductory. You know you're going into health care. You're going to take care of everyone. I think it's important that it starts at the school to let people know the expectation and reality that they're walking into so they're not going into this field with any kind of preconceived notion. Wouldn't it be great to get to a place where we don't even have to have this conversation anymore? Let's all be open. Let's all be honest. Let's all work together, and let's take care of people. (DL)

I appreciated DL's insights. On another occasion, the Assistant Nurse Manger of this department shared his perspectives and personal experiences on this topic, which follows next. His pseudonym is AM.

Narrative IX: AM Assistant Nurse Manager

The assistant nurse manager AM, a Caucasian critical care nurse with 16 years of experience in different states and large hospital settings, is a member of the LGBTQ+ community. He identifies as he/him/his and is married to a man. I coincidentally met up with him

in person on the unit after completing some extra-curricular educational activities. I asked him if he had a little time to spare and would oblige me to share his experiences. AM was already informed about my dissertation topic. We stepped into his office, closed the door, and let the conversation unfold.

When asked about his observations in this department, AM replied, “We see few transgender patients, but there is underreporting and underassessment of LGBTQ+ patients. Bias and stigma are evident in nurses and other healthcare providers.”

As the assistant nurse manager, what are you currently doing to improve conditions for LGBTQ+ patients? AM, “Implementation of zero tolerance. Disciplinary action for personnel making derogatory remarks in public.” AM alluded to a recent incident where hospital staff congregated in the hallway, making callous comments about a transgender patient under their care, and he happened to approach the conversation. Not only was it unprofessional, inappropriate behavior, but the staff was unaware of *who* they were talking to from a cultural position. The discussion resulted in corrective action.

What are your thoughts on cultural competence? AM, “It’s a dynamic process because culture is everchanging. I’m always learning, even being part of the community. Having empathy. I do not know what it is like to be transgender or non-binary, but we should not assume anyone’s identity.”

What are your recommendations and suggestions to improve cultural responsiveness and competence for new nurses and in the hospital setting?

- Providing better annual hospital education besides one competency-based- learning module (CBL) focusing on pronouns

- Holding annual webinars and live forums inviting a member(s) of the LGBTQ+ community focusing on health assessment and treatment regimens, not only for nurses but physicians
- Starting LGBTQ+ education in the School of Nursing
- Having the corporate health system apply a greater emphasis on the care the LGBTQ+ patients. Their position statements and added demographic information "look good on paper" but are not requirements and lack throughput.
- Enforcing a Zero tolerance and taking punitive actions against those who are being discriminatory
- Having empathy and understanding of what it feels like if you had to get up every morning and fake being straight and living under the constant pressure of being scrutinized if you are being honest

Any other comments?

AM, "Having to deny oneself because of others' perceptions leads to more [mental] health issues. LGBTQ+ is not a choice. Being hateful is a choice. Being kind is a choice."

How do you respond to the statement 'Being gay is not natural'? AM, "Define natural for me. Not everything in nature is heterosexual. Being a hater is not natural, it is learned." Pondering on his final comment, I searched the meaning of the word *natural.* "Natural – adjective: existing in or caused by nature, not made or caused by humankind" (search.yahoo.com). The profoundness of these assertations is enlightening.

The following section describes the findings of the local community hospital.

Cape Fear Valley Health

The Cape Fear Valley Health System includes seven medical facilities, as well as several medical offices and clinics spread throughout the Cape Fear region and serves a seven-county region in southeastern North Carolina. Cape Fear Valley Health serves more than 1 million patients annually - each of whom is treated to knowledgeable, personal care (Cape Fear Valley Health, 2022). The organization has a *Mission, Vision, and Values* page and a *Patient Rights & Responsibilities* page embedded on their website defining cultural diversity as "Respecting our community's multicultural diversity in our daily operations and practices" and the patient's right to receive care without regard to "race, color, religion, sex, sexual preference, where you were born or how you pay for your care" (Cape Fear Valley Health, 2020).

This organization is the main hub for our students' clinical experiences. I retired from this hospital in 2018 after spending 21 years at their largest facility. Over the summer our students completed their clinical obstetrics course which I coordinated. I invited the nurse manager and clinical educator on campus for an educational session as part of the students' coursework. During that time, they talked about their patient demographics and shared with the students the patient gender diversities encountered in Labor & Delivery. This assertion prompted me to invite them to participate in my research later.

Narrative X: CF Nurse Manager & Clinical Educator (A Shared Perspective)

The nurse manager and the clinical educator of the Labor & Delivery Unit (L&D) at Cape Fear Valley Medical Center, where most of our nursing students complete their clinical hours, shared their observations in a combined dialogue. Both nurses are Caucasian, heterosexual females with 20 years of experience in obstetric nursing. We met via Zoom for a quick 30-minute dialogue to accommodate her busy manager schedule. "Hi," she said, "I'm sorry that I'm

running a few minutes late. It's busy. I have my clinical educator here in my office with me. You can't see her, just to let you know. We'll contribute together." "No worries, that works," I said and started recording the conversation. Since both nurses were instantly conversing, they are referred to by the combined pseudonym of CF.

How well is gender identity captured in your department? CF responded by explaining the different types of delivery. "If it's a surrogate birth, we know ahead of time," referring to same-sex couples and the requirement of additional legal documents. Most of the time, the patients get asked how the staff can best meet their cultural needs, predominantly religious requests. Typically, the nurses do not ask about the patient's gender identity. "We recognize it when their support person comes to the room, or the patient discloses the information." The patient demographic information is completed at the L&D front desk by the receptionist. CF do not know what questions get asked by the clerk and are not aware of what demographic information gets captured. CF, "Once they come into the unit, this information has already been completed." The L&D nurses do not look back on any demographic information in the patient's EMR.

What is your data on patients from the LGBTQ+ community over the last 12 months? CF perceived serving members from the LGBTQ+ community under twenty patients a year. "But we really don't know because they don't share that information. From that standpoint, it could be underreported."

What are you seeing at the bedside regarding knowledge, skills and attitudes from nurses and providers when it comes to meeting LGBTQ+ health needs? CF, "We don't think it's [LGBTQ+] an issue at all. The providers have seen these patients prenatally and have already

established rapport. Regardless of their sexual orientation or ethnic background, our nurses treat every patient the same, no matter what."

What are your thoughts on how to best generate cultural responsiveness and competence in nursing; what could we do differently or better? CF shared their recommendations:

- Treating everybody the same
- Asking the patient and support person their pronouns. Using the phrase "Who is here with you today? " To not make assumptions about that person and their relationship
- Getting to know the support person and taking care of the family as a unit
- Treating the family unit with respect
- Completing competencies on cultural diversity with onboarding and annually

I asked CF to elaborate on the content of their current cultural competency modules compared to competency modules in 2018, which did not contain any DEI information. "It talks about same-sex couples, religious preferences, gender identity, and obesity." CF informed me further that Cape Fear Valley added cultural diversity as one of its values bringing greater awareness to the community. "Twenty years ago, it [LGBTQ+] wasn't socially accepted. By adding these values people are more cognizant. We think, as a society in general we are more accepting, and it's more familiar." Our dialogue concluded with a patient story told by the clinical educator:

> One of my favorite deliveries occurred last year. It was a same-sex male couple. They were surrogates, and it was the best delivery. They were the best parents you could ever know. They were both doing skin-to-skin with their baby. I mean, it was just an amazing delivery. (CF)

In their final remarks, CF reiterated that LGBTQ+ patient deliveries no longer stand out versus 20 years ago, when caring for same-sex couples was unprecedented. Now, it is just another day on L&D.

Conclusion

In this chapter I presented my findings from faculty interviews, student focus groups, and hospital data. The participants' narratives captured different viewpoints and experiences informing the research. Through schematic transcription and critical review common themes emerged among the participants' responses such as *the status quo, getting comfortable with the uncomfortable, communication, knowledge deficits, empathy, and lack of preparedness.* Other themes were unique. In Chapter Five, I provide a synthesis of themes across the total data sets with a detailed discussion and analysis of these findings.

CHAPTER FIVE: ANALYSIS

Chapter Five extends the analysis of my narrative inquiry and discusses the assumptions from the distinct participants in synthesis applying the selected framework and theory. This chapter also makes direct connections and provides inferences about my research question and the themes from the literature (Cultural Responsiveness and Cultural Competence). Further, I provide critique, present the study's limitations, render implications, and make recommendations for future application. Lastly, the chapter ends with a conclusion of this dissertation.

Discussion

The purpose of this study was to investigate the cultural content taught in the School of Nursing at an HBCU located in a large city in the Southeastern United States, which is my home organization. I investigated what existed in our curriculum and what our community envisions in terms of change. As demonstrated in the previous chapters, the convergence of healthcare needs for today's diverse patient population is necessary for our nursing students. We must define in what ways to address cultural competence and how to cultivate culturally responsive care for LGBTQ+ individuals. As a result, my study begins to contribute to this conversation by looking at the curriculum in my institution. I address the needed reform, basing it on the perspectives of our institution's stakeholders. Further, I focus the reforms on nursing education and healthcare for LGBTQ+ patients.

Cultural Responsiveness

The first lens that I applied to these reforms relates to culturally responsive teaching. Cultural responsiveness as defined by Ladson-Billings (1995) in a pedagogical sense, empowers students intellectually, socially, emotionally, and politically by using cultural referents to impart knowledge, skills, and attitudes. Campinha-Bacote (2007) relates this phenomenon to nursing as

the ongoing process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of the client, leading to increased cultural awareness, knowledge, sensitivity, and skills (Cai, 2016; Campinha-Bacote, 2007; Ladson-Billings, 1995). The participants identified multiple areas within the context of cultural responsiveness: *Empathy*, *the status quo,* and *getting comfortable with the uncomfortable* are the concepts that emerged ubiquitously, which I will discuss next.

Empathy.

Initially, I introduced the concept of **e**mpathy in my problem statement and again through HCD within my methodology. Faculty, students, and nurse managers dwelt on this phenomenon. Bellet and Maloney (1991) define empathy as the capacity to place oneself in another person's position, that is, to understand or feel what another person is experiencing (Bellet & Malone, 1991). The Junior Group II students were the first to address the need of getting more exposure and "to really open our eyes on everything" (p. 82). Getting involved in patient care outside the hospital through cultural immersion helps to relate, confront intrinsic biases, and create empathy. One of the students summed it up as 'getting to see the other side and hearing the patients' stories,' "You know, it just gives you a completely different perspective" (p. 82), thus, evoking empathy. LGBTQ+ health education is vital to increase awareness, understanding, and empathy. DL, the Novant Health nurse manager, deems empathy to be one of the essentials in nursing. AM, the assistant nurse manager, views empathy through two different lenses: One, from the nursing perspective, that empathy is a virtue, and two, as the affected person, hoping for others to understand what it feels like to get up every morning and fake being straight, living under the constant pressure of being scrutinized (p. 89). Dr. A empathizes by expressing how the LGBTQ+ community's disparities affect every aspect of their lives, not only in healthcare but with

employment and self-esteem. She contests, “How does that make you feel when you are not accepted or respected?” (p. 58). Dr. A’s position validates the case of Bostock v. Clayton County of employees revealing when they identify as LGBTQ+, thus running the risk of losing their jobs, which contributes to healthcare iniquities (p. 10). Therefore, students must receive evidence-based, culturally appropriate education in caring for populations experiencing health disparities. In the literature, McNeil & Elertson (2018) posit that incorporating LGBTQ+ population-specific information into the curriculum increases awareness, understanding, empathy, and skills critical for effective nursing practice and enhances the ability of future nurses to engage in therapeutic professional relationships (p. 17).

The status quo.

In my literature review, several authors confirm that nursing faculty disseminate cultural knowledge selectively, either perpetuating cultural content taught from the twentieth century and not updating the curriculum to reflect current healthcare needs or foregoing culturally relevant subject matter (ACI, 2022; Dugan et al., 2017; IGI Global.com, 2022), (p. 25). In the interviews, every single faculty member regurgitated the identical “cultural” content about JW and religious practices, pain perception, diets, and African Americans and heart disease. The students across the cohorts corroborated the content they learned about culture in nursing. The Senior Group I declined any further specific cultural preparation to prepare them for the bedside. “We spoke more about cultural sensitivity in terms of personal space, touching, greeting, eye contact, and who is in charge of family chores and the family unit” (p. 71). To further illustrate this educational deficit and perpetuation of the status quo, CINAHL, the nursing and allied health database, only produced 55 papers from 2004 to 2022 about *LGBTQ education* related to baccalaureate undergraduate nursing programs and registered nurses’ education (p. 16).

My application of Fairclough's Three Levels of Analysis demonstrates the maintenance of the status quo through 1) sociocultural practices of the dominant ideology that heterosexuality is the norm; 2) Omitting cultural [LGBTQ+] health education from the text, and 3) through discursive practice such as cultural stereotyping and using deficit expressions for vulnerable populations (e.g., African American men are prone to heart disease; gay men are prone to HIV), (p.47). Au et al. (2017) assert that this outdated focus is problematic because it potentially racializes and stereotypes people from different origins, perpetuating the intentionally designed educational practices of the dominant culture (p. 2).

Inadvertently, the healthcare system disproportionately harms LGBTQ+ patients due to biases, stigmatization, and outdated policies (GLAAD, 2022; GLMA, 2021; GLSEN,2021; Overstreet et al., 2021). The history of stigmatization associated with the LGBTQ+ community since the 1980s and 90s considers certain diseases pervasive in this community (e.g., HIV, STDs), perpetuating the idea that non-normative gender identification is a disorder. Sadly, these flawed beliefs illustrate the sociocultural practices of the dominant culture, identified through Fairclough's analysis, which remain present in today's nursing literature.

> For instance, Mrs. B's textbook contains one paragraph about transgender patients using deficit language (p. 62). Moreover, she ignored LGBTQ+ content in her lectures and did not know that her textbook mentioned LGBTQ+ care. Mrs. B concluded that LGBTQ+ patients are human beings, and *we* should treat *them* the same because it [LGBTQ+] is not a contagious disease, revealing the use of deficit expressions and omission of text as pointed out through Fairclough's analysis (p. 63).

Other participants also applied the same deficit verbiage when talking about the LGBTQ+ population. For example, "I think, we could be a little bit more sensitive to *them*" (p.

70), or “It took me a while to be comfortable around *them*” (p. 75), and “But people who weren't raised like that, we still don't know how to approach *them*” (p. 78). These quotes demonstrate the deeply seeded biases, the *us versus them* mentality, which exist in our School of Nursing and society. Dugan et al. (2017) point out that cultural knowledge, sensitivity, and awareness do not include the concept of instituting change. Consequently, the nursing faculty is responsible for students receiving evidence-based, culturally appropriate education and creating an environment that is more inclusive and has space to challenge the dominant status quo (p. 17).

Getting comfortable with the uncomfortable.

Another area that impedes cultural responsiveness in nursing is a general discomfort in interacting with patients and talking about culturally sensitive issues or addressing questions that are considered ‘personal.’ Dugan et al. (2017) correspond that leading change can be difficult and uncomfortable, and it is challenging to facilitate critical sociocultural dialogue where stereotypes, biases, and privileges are exposed (p. 27-28).

During the interviews, the three faculty members stated several reasons for their discomfort with teaching LGBTQ+ health content. Dr. A mentioned that many faculty members have never taken care of transgender patients or interacted with patients and their families from the LGBTQ+ community. Thus, students have verbalized to Dr. A that they feel uncomfortable having these conversations and that the faculty has not exposed or better prepared them (p. 56-57). Mrs. B asserted that we need LGBTQ+ -specific training at the SON to improve communication practices for ourselves and the students, wishing that she had a better script of how to prepare our students instead of saying, “Swallow down your beliefs and care for these patients” (p. 62). Mrs. B admitted that even as a nursing instructor, getting comfortable with the uncomfortable takes training. Mrs. C confessed that as a nurse, she does not know what is

“appropriate” in communicating with an LGBTQ+ patient and is not very good at addressing sexuality with her patients. Mrs. C feels uncomfortable teaching LGBTQ+ health needs because of incorrectness and concern about insulting her patients’ dignity (p. 66). Hence, LGBTQ+ content in her lectures is non-existent. Subsequently, this discomfort expressed by the faculty was transferred onto the students, causing educational gaps and impairment in confidence and self-efficacy in caring for LGBTQ+ patients.

The students also mentioned distinct reasons for being uncomfortable in caring for LGBTQ+ patients. One reason for discomfort is not having practiced in the classroom how to speak to an LGBTQ+ patient from a nursing and medical aspect. The participants agreed that it would be beneficial for faculty to include communication practices for building rapport with their patients before attending clinicals. The Vietnamese student expressed that she feels uncomfortable due to her upbringing, also mentioned by others, who grew up in a religious household or the Bible belt. The participants' prior military service was another factor that led to split opinions among the students about being uncomfortable communicating and interacting with LGBTQ+ patients. The older generation held vast to the “don’t ask-don’t tell” policy, which created discomfort once people came out (p. 75). The younger generation of students stated they are less uncomfortable because of personal encounters with friends from the LGBTQ+ community and having been in the military (p. 73-74). Consequently, all student participants agreed that the lack of LGBTQ+ education in the School of Nursing added to their discomfort (p. 79).

When I reviewed a survey from May 2022, which assessed the knowledge and understanding our nursing faculty possess about the LGBTQ+ community and incorporating LGBTQ+ health education into the nursing curriculum, it revealed that most faculty are either

disengaged, uncomfortable, or knowledge deficient (p. 25). Next, I will address the theme of cultural competence with its distinguishing concepts.

Cultural Competence

The second lens I applied was to gain an understanding of how my stakeholders and participants viewed curriculum change needs to reflect cultural competence. To remind us, the research on inter- or transcultural nursing education and cultural competence indicates that the relationship between nurse educators' cultural competence levels and culturally responsive teachings is not meeting the healthcare needs of the present day culturally diverse population (Haller, 2018; O'Brien et al., 2021). Multiple informants concur that cultural competence involves systems, agencies and providers having the ability to respond to the unique needs of populations whose cultures are different from the "dominant" culture and to function effectively within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cuellar et al., 2008; Day & Beard, 2019; NPIN/CDC.gov, 2021; Prosen, 2015). My findings from Chapter Four support these statements. In the remainder of this chapter, I am illustrating details that incumber and facilitate cultural competence. These include the concepts of *knowledge deficits* and *lack of preparedness.*

Knowledge deficits.

Nursing knowledge provides the understanding and perspective for practicing nurses to care for people and to suspend judgments of their behavior (UMB.edu, 2022), (p. 34). Previously, I identified when faculty discomfort gets transferred onto the students, it creates a learning deficit; the same thing happens when there is a knowledge deficit among faculty in caring for LGBTQ+ patients.

Dr. A gave the most reflective account of faculty being knowledge deficient. Her response was, “They [faculty] don't know what to do. They don't know how to address it [LGBTQ+ education]. Faculty may be experts to some degree, but in this area, most of us are nervous” (p. 56). Dr. A suggests for faculty to take ownership, admitting they are in uncharted territory and doing their homework to meet the needs of this population. Increasing knowledge and awareness about this topic directly affects patient care and professional performance. Mrs. C contributes her knowledge deficit to the inexperience with LGBTQ+ patients and does not know any LGBTQ+ terminology (p. 64, 66). Multiple authors from my literature review contest that faculty must advance their own cultural knowledge and skills to improve patient care (Gonzalo, 2021; Leininger, 2000; Prosen, 2015; Nahas, 2000). Mrs. B's knowledge deficit became apparent after finding out that her textbook did contain LGBTQ+ education, but she never taught (p. 62). Further, Traister (2020) determined that with the scarcity of LGBTQ+ content in nursing education and curricula, faculty are unable to provide nurses with the baseline knowledge to care for and interact with LGBTQ+ people (Traister, 2020). Next, we will see the knowledge deficit from the students’ perspective.

The students gave their account. “I have some knowledge, but I don't feel I have enough, but I will gain it through my experience as I continue to work as a nurse” (p. 70). That is a false assumption. Traister (2020) posits, unless cultivated in the schools of nursing, nurses will not be able to deliver care that is culturally congruent with the populations served (Traister, 2020). Lacking LGBTQ+ specific health education and LGBTQ+ terminology is consequential. For example, the students realized that they would have never thought to ask a transgender female if she still had a prostate (p. 74). Through my conversations with all participants inquiring about

transgender care, Mrs. C realized that she needs to show concern about heart health in transgender women and the effects of estrogen (p. 66).

Another area of knowledge deficit is the use of pronouns in the curriculum. As far as recognizing and asking how a patient identifies, Mrs. C acknowledges a deficit. Dr. A gathers that LGBTQ+ specific health education still needs to be integrated, such as preferred pronoun usage for instance. “I think, beginning in semester one, when students come into the program, hearing that repetitive language, helping students to understand and apply LGBTQ+ terminology is going to be critical” (p. 55). The literature advises that nurses need to become aware of the non-binary ways individuals identify their gender. Professionals must understand that pronouns convey gender information. For LGBTQ+ patients, the social transition may involve asking others to refer to them with new and different pronouns to reflect their true gender identity. Many LGBTQ+ people face harassment, embarrassment, or discrimination when seeking routine healthcare (p. 9-10). Regrettably, the patient gender identity questionnaire remains optional to complete for healthcare staff at the hospitals. Mrs. C pointed out that they [nurses] do not ask questions about pronoun use and sexual identity even though it is integrated into the admission assessment (p. 67). This particular knowledge deficit was also confirmed by the nurse managers from two separate health systems (p. 86, 88, 91).

A student from Senior Group II recalled her recent encounter with a transgender patient, divulging that she lacked the education and terminology to provide appropriate patient care (p. 74). Contrary to the student from Junior Group II, who was aware of pronoun usage and gender identification from another course. “It was perfect, because I understood what I needed to do, how to address the patient. That’s very important, because we get to see that more” (p. 81). Only a couple of students across the cohort were familiar with pronoun usage, and many systems still

lag in the inclusion of pronouns and gender identity information. Despite this, healthcare facilities, organizations, and government databases are updating their demographic identifiers to be respectful and inclusive of LGBTQ+ people, which must also include the schools of nursing.

Lack of Preparedness.

Nursing schools address cultural health aspects during one commonly required course titled *Transcultural Nursing.* The overall goal of transcultural nursing is to use cultural knowledge to develop nursing actions that will promote cultural competence and foster culturally responsive teachings to achieve positive patient outcomes (Campesino, 2008; Day & Beard, 2019; Prosen, 2015; Tosun, 2021). In our School of Nursing, this course is not part of the pre-licensure nursing curriculum, and only offered to RN-to-BSN students at this university. Hence, the pre-licensure students must rely on receiving cultural teachings from the courses within their curriculum.

Dr. A teaches the transcultural nursing course in the RN-to-BSN program and other nursing courses in the pre-licensure curriculum. She stresses that one course alone does not readily prepare students. It is critical to thread this content [LGBTQ+] throughout the curriculum for the pre-licensure students to prepare our nurses to manage and meet the needs of the LGBTQ+ population (p. 55). Mrs. B reasons that faculty falls short of incorporating cultural aspects because we have not gone beyond the race and religion component in the schools of nursing. Mrs. C affirms that LGBTQ+ health education needs threading throughout the curriculum. LGBTQ+ education does not only belong in one course, but students need constant exposure. Mrs. B agrees that culturally responsive teachings should start on day-one of nursing school. It should be woven into health assessment, pathophysiology, and continued into pediatrics and so on (p. 61). In her opinion, greater LGBTQ+ content needs to be delivered in the

pediatrics course. Student responses across the cohorts confirm Mrs. B's assumptions. Also, the students encountered most of their LGBTQ+ experiences with adolescents (p. 70, 79). The Trevor Project (2022) reports that rejection of identity is particularly hard on young people. LGBTQ+ youth are not inherently prone to suicide risk because of their sexual orientation or gender identity but are at higher risk because of how they are mistreated and stigmatized in society (p. 12).

The effects of public ridicule and fallacy that I addressed previously foster the health disparities amongst the LGBTQ+ community to include a higher rate of suicide (GLAAD, 2022; Ramchand et al., 2021). The American Hospital Association's (AHA) position statement on *Cultural Competence* (2022) affirms that hospitals and care systems must prepare their clinicians and staff to help eliminate cultural disparities in care (AHA Institute for Diversity and Health Equity, 2022). An absence of LGBTQ+ conversations in nursing schools emphasizes that nurses are not prepared to treat this population (p. 2). Hence, we must sufficiently prepare our students to care for our culturally diverse patients to positively impact culturally insensitive care and the challenges that nurses experience, as reported by O'Brien et al. (2021).

Critique

The goal of my study, as defined by Merriam and Tisdell (2016) in Chapter Three (p. 39-40), is to critique, challenge, and transform the current cultural teachings at my institution, in anticipation that the community will act because of the study. Through my analysis, I want to share four key points of critique following my process and supported by literature:

1. Faculty is perpetuating the status quo of 20th-century cultural education

Au et al. (2017) assert that curriculum focuses on dominant cultural content which potentially racializes and stereotypes people from different origins (Au et al., 2017). Hence, the school of

nursing curriculum perpetuates the status quo by maintaining educational practices from the 1980s and 1990s, with their stereotypical health needs assumptions of African Americans, Asians, and Latinos instead of becoming more inclusive of 21st-century cultural health teachings.

2. Training and continued education to meet the academic standards for culturally competent nursing care are ignored by faculty

The American Academy of Nursing (AAN) requires that nursing schools implement standards for culturally competent nursing care encompassing LGBTQ+ health needs (Expert Panel on Global Nursing & Health (AAN), 2010). The school of nursing has no specific requirement for faculty to complete culturally relevant training to meet this standard. Currently, there is no oversight assuring the application of this requirement.

3. Important teachings about health conditions and patient care are not addressed because of dominant ideology [heteronormativity] and the neglect of intersectionality

Heteronormativity is an incorrect assumption that all individuals are, by default, heterosexual (Lim et al., 2014). LGBTQ+ health education is not considered integral due to the cis-heteronormativity of the entire nursing faculty. In fact, the consequences of neglecting intersectionality in nursing education can have detrimental effects on patient outcomes. The NIMH supports that suicide risk varies considerably depending on the intersectionality between sexual identity, gender, age, and race/ethnicity (Ramchand et al., 2021). Many layers of identity, including socioeconomic status, language, and culture, affect individuals' well-being (Anzaldua, 1987; Crenshaw, 1991).

4. There is a misconception and belief of faculty and students that being LGBTQ+ is a choice. People simply choosing a gender or sexual orientation that is not consistent with their biological sex is an erroneous assumption.

Healthcare professionals must understand the differences between sex, gender, and sexual orientation and not make assumptions. There is a misconception that sex is biologically determined while gender identity is a choice (Skoufalos, 2018). Through my interviews, it became evident that faculty and students are misinformed and knowledge deficient about the spectrum of human sexuality.

I want to reiterate when participants were asked questions in interviews about their experiences related to gender, race, class, or sexual orientation, "the very act of talking about issues changes their consciousness about these things and hence invites change" (Kemmis et al., 2014; Merriam & Tisdell, 2016, p. 63). I saw a transformation take place during our dialogues, lending itself to curriculum reform.

Limitations

There are several limitations associated with this study. My inquiry is qualitative participatory action research with a purposefully selected sample of participants from the PI's organization(s). The sample size is small (*N=21*); the project focuses on a specific problem at a single school of nursing and does not lend itself to generalization. Correspondingly, I critiqued existing conditions to lead change and generate curriculum reform, viewed through the lens of a critical care nurse and nurse educator. Moreover, my research exists only in one small-scale microcosm. Through the recently increased emergence of literature focusing on LGBTQ+ education and cultural competence in healthcare and nursing programs, cross-institutional studies would provide a grander/deeper perspective on this subject. The participants' and PI's gender identities, sexual orientation, personal experiences, and knowledge influence the data and conclusions, indicating a concern for subjectivity and potential bias.

Implications

Various implications of my research are already detailed in the Discussion section. Subsequently, I want to converge on the three distinct concepts from our stakeholders: *Bearing the burden, changing the mindset,* and *lack of experience*. In addition, I need to bring further attention to *intersectionality.*

Bearing the Burden

The consequences that arise from having to bear the burden of either being LGBTQ+ or having to deny any affiliation with LGBTQ+ people is horrendous. I formerly discussed the effects on health and well-being. I want to bring additional attention to the emotional trauma caused by a non-acceptance and a dominant ideology. The African participants (p. 83) disclosed the seriousness of this problem in their country, thus, affirming global implications. Currently, there are 71 countries listed where it is illegal to identify as LGBTQ+ (Browning, 2022). Though LGBTQ+ is no longer considered a legal offense in the United States, covert punishment remains prevalent, demonstrated by bullying, exiling, and hate crimes, strikingly affecting family units. Mothers, fathers, siblings, and grandparents are forced to choose sides or keep penetrating secrets because a family member or a friend does not fit the heterosexual 'norm'. Families are mourning the loss of a loved one because their life was taken by a senseless hater. This behavior and mindset proliferates health disparities, which lead me to my next implication of changing the mindset.

Changing the Mindset

The students of Junior Group I discussed how to provide better care for LGBTQ+ patients, "We need to figure out how to break out of this mindset and just treat people like people" (p. 78). Senior Group II had similar suggestions about not being biased or judgmental

towards the patient and questioning their beliefs or bringing up one's personal beliefs during the patient encounter. "That could either delay their care or change their care altogether" (p. 76). The participants concluded that there needs to be more training and teaching for the medical community and within the school of nursing to break that mindset of intrinsic bias.

Lack of Experience

Lastly, lack of experience and training amongst faculty and health care providers disseminate LGBTQ+ health disparities and constitutes the need for cultural responsiveness and competence. Curriculum specialists agree that *one-stop* cultural training is inappropriate to cultivating culturally responsive and competent professionals (Blanchet Garneau, 2016; Brown et al., 2021). To recap, LGBTQ+ population-specific information is not only missing from our nursing curriculum but also missing from the medical education curricula for physicians, physician assistants (PAs), and nurse practitioners (NPs) (GLAAD, 2022; GLMA, 2021; National LGBTQIA+ Health Education Center, 2019). Ultimately, a culturally competent, interdisciplinary, collaborative healthcare team is needed to combat LGBTQ+ health disparities (GLMA, 2021, p. 2). These implications support that culturally competent healthcare professionals of all disciplines and all levels of practice play a vital role in caring for LGBTQ+ patients.

Intersectionality

In Chapters One and Two, I wholly expounded on the phenomenon of intersectionality with its effects on patient care and the need for LGBTQ+ health education. Intersectionality can describe these factors and their relationship with health inequities:

> The concept of intersectionality is also recognized by the World Health Organization (WHO) and consists of an analysis of health based on the recognition of social

> determinants by identifying how power relationships interact at different levels and thereby create health inequities at the individual, institutional, and global levels. (Medina-Martinez et al., 2021)

My literature review demonstrates that the LGBTQ+ population experiences more health disparities compared to the cis-heterosexual population. These inequalities are related to minority stress, encompassing their distrust of healthcare professionals and fear in this setting, impacting each individual differently within the broader LGBTQ+ community, depending on their sexual orientation and gender identity. In turn, the impact of these factors alters the intersections of race/ethnicity, geographic region, and socioeconomic factors (Anzaldua, 1987; Crenshaw, 1991; Martinez et al., 2021; Ramchand et al., 2021; Rice, 2019). Martinez et al. (2021) suggest that interventions by nurses such as gender diversity inclusive education and bullying- and suicide prevention programs can provide gender-affirming and family-centered care, which, as I previously stated in support of my findings, needs to start at the school of nursing.

Recommendations

My findings illustrate a need for curriculum reform to generate cultural responsiveness and competence in LGBTQ+ health education at our School of Nursing. Lim and Borski (2015) advise incorporating LGBTQ+ content into the classroom and clinical education for nursing students, such as ingrained in simulations, case studies, nursing care plans, test questions, and elective courses (Lim & Borski, 2015). Chapter Four houses a plethora of recommendations from our community and what they [faculty and students] envision in terms of change (p. 57, 62, 68, 72, 75, 80, 82). LGBTQ+- specific faculty training is vital to facilitate student knowledge, skills, and attitude.

Besides embedding these culturally inclusive teachings throughout the nursing curriculum, discussing LGBTQ+ health in the first semester and imparting continuous content exposure to enhance communication practices are essential. Ozkara et al. (2019) describe a way to foster cultural competence by applying a multidimensional education strategy using Transgender Standardized Patient Simulation (TSPS). This evidence from the literature coincides with the recommendations from our community. Kamen et al. (2019) proposes that nursing [students] inquire and respond professionally to patients' identities and identifiers, to include chosen support people, provide care relevant to patients' gender identities, and address treatments' effects on sexuality (Kamen et al., 2019). Ideally, organizing academic community engagement (ACE) and cultural immersion service-learning (CISL) experiences assist nursing students and faculty in improving their cultural consciousness and empathy. These strategies are also suggestions from the participants and demonstrated in the literature. James and Al-Kofahy (2021) endorse ACE, and Alexander-Ruff and Kinion (2019) suggest a similar approach to promoting culturally conscious care through CISL. O'Brien et al. (2021) stress that cultural competence should be paramount for students and nurse educators in all learning and teaching approaches (O'Brien et al., 2021). Irrevocably, Kirby et al. (2021) recommend that faculty receive [LGBTQ+] diversity and inclusion content through continuing education programs and consequently review all nursing courses for LGBTQ+ DEI content, completing curricular blueprinting (Kirby et al., 2021). Brown et al. (2021) emphasize that cultural competence is guided by explicit learning outcomes or course objectives in syllabi (Brown et al., 2021). The faculty at my School of Nursing is very team-oriented and has implemented blueprinting across the curriculum to update other educational standards. Hence, refining culturally relevant

teachings to generate cultural responsiveness and competence in our nursing students is a priority.

The next steps in this process can continue to follow the HCD Model entering the ideation and implementation phases. The collective recommendations will need to be shared with the Associate Dean and the entire faculty to determine how best to infuse LGBTQ+ health education into each course of the prelicensure curriculum. In the ideation phase, further brainstorming through faculty teamwork must occur, including a blueprint crosswalk, before the implementation phase can begin. Some faculty members have been proactive in their teachings by incorporating some LGBTQ+ content. Yet, continuous assessment and iteration are warranted to establish a sustainable curriculum.

Conclusion

My inquiry [PAR] reveals the disparities for LGBTQ+ people, identifies significant gaps in LGBTQ+ health education and patient care, and a deficit approach to cultural responsiveness with an emphasis on my community. The review of the literature illustrates that a lack of cultural competence and adequate LGBTQ+ education is problematic for nursing students and the execution of culturally congruent care and patient outcomes (Alpert et al., 2017; Dorsen & Van Devanter, 2016; Eickhoff, 2019; Stewart & O'Reilly, 2017). McNeil and Elertson (2018) validate that incorporating LGBTQ+ population-specific information into the curriculum increases awareness, understanding, empathy, and skills critical for effective nursing practice and enhances the ability of future nurses to engage in therapeutic professional relationships when caring for LGBTQ+ individuals (McNeil & Elertson, 2018). Faculty is responsible for teaching concepts of diversity and inclusion [LGBTQ+ content] to generate cultural competence (Brown et al., 2021). The AAN requires that nursing schools implement standards for culturally

competent nursing care encompassing LGBTQ+ health needs, yet lags in implementation. The participant responses from my data were positive, lending themselves to curriculum reform. Cultural competence is an attribute that develops over time. Preskill and Russ-Eft (2016) define this process as “learning, unlearning, and relearning” by understanding the cultural lenses and appreciating cultural context (Preskill & Russ-Eft, 2016; Walser & Trevisan, 2020). Applying recommendations from the findings of this study can lead the change for our School of Nursing to generate and cultivate cultural responsiveness for our students to become culturally competent.

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