Heterosexism and Homophobia Among Students Participating in a Bachelor of Science Nursing Program

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HETEROSEXISM AND HOMOPHOBIA AMONG STUDENTS PARTICIPATING IN
A BACHELOR OF SCIENCE NURSING PROGRAM

By

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ABSTRACT

Purpose: To identify whether or not homophobia and heterosexism were present among students participating in a Bachelor’s of Science nursing program.

Design: A quantitative, descriptive, and non-experimental design was used.

Methods: The study employed a convenience sample of 245 nursing students recruited from a university’s nursing program located in the southeastern United States. Data collection and analysis took place from September 2013 to October 2013 and was accomplished using SPSS version 21 software package.

Results: Homophobia and heterosexism were both present in the sample. Levels of heterosexism were significantly higher than levels of homophobia. There was no relationship between student grade level and levels of homophobia or heterosexism.

Conclusion: As future nurses, nursing students must be prepared to offer culturally appropriate care for lesbian, gay, bisexual, and transgendered (LGBT) patients. Attitudes of heterosexism and homophobia create barriers to providing such care. While evidence suggests homophobia in health care is declining, heterosexism remains prevalent and negatively impacts LGBT patients. To mitigate this impact, nurses must develop culturally sensitive attitudes toward LGBT persons. By incorporating LGBT-health related content into nursing curricula, nurse educators can facilitate the development of cultural sensitivity and prepare their students to give quality nursing care to LGBT persons.
Key words: homophobia, heterosexism, nursing students, cultural sensitivity, homosexuality, LGBT, health disparities
CHAPTER ONE: INTRODUCTION

Persons who identify as gay, lesbian, bisexual, or transgendered (LGBT) experience unique health disparities resulting from a long history of discrimination and marginalization based on their sexual orientation (Institute of Medicine [IOM], 2011; United States Department of Health and Human Services [USDHHS], 2013). LGBT patients often have negative encounters with health care workers who hold biases against LGBT individuals. Such biases include hostile attitudes toward homosexuality, known as homophobia (Walls, 2008), as well as a subtler type of bias known as heterosexism. Walls (2008) defines heterosexism as behaviors or beliefs that hold heterosexuality as the superior and preferred form of sexual expression and denigrate, stigmatize, or segregate all forms of nonheterosexual behavior. Heterosexism includes obvious forms of discrimination, such as the refusal to care for a gay patient, but it also extends to less obvious forms of bias, such as the presumption that all people are heterosexual or the failure to consider a same-sex partner a legitimate family member (Morrison & Dinkel, 2012). It has been suggested that heterosexism is a more pervasive form of bias than homophobia (Morrison & Dinkel, 2012; Walls, 2008), and although not as adversarial as homophobia, heterosexism has been shown to negatively impact the health care experience of LGBT individuals (DeHart, 2008; Rondahl, Bruhner, & Lindhe, 2009; Rondahl, Innala, & Carlsson, 2006; Saulnier, 2002; Sinding, Barnoff, & Grassau, 2004).

In order to provide quality, patient-centered care to diverse patient populations, nurses are expected to practice in a culturally appropriate manner that takes into
consideration patients’ unique backgrounds, preferences, and experiences. This expectation extends to patients who identify as LGBT. To achieve culturally appropriate practice with LGBT patients, nurses must first become aware of their own biases and actively cultivate attitudes of respect, compassion, and sensitivity toward LGBT patients. The development of culturally appropriate nursing care begins in nursing school and as future nurses, nursing students must develop the awareness, attitudes, and behaviors that will allow them to practice effectively with diverse patient populations. Few studies have investigated nursing students’ attitudes toward LGBT persons, and those that have only identified negative attitudes associated with homophobia. To date, no studies have investigated or attempted to identify heterosexism in the nursing student population.

**Purpose**

The purpose of this study was to determine if heterosexism and homophobia were present in a sample of nursing students enrolled in a Bachelor’s of Science nursing program. Although a small number of studies have sought to measure homophobia in nursing students, no studies have sought to measure heterosexism within the same population. If nursing schools are preparing students to provide quality, patient-centered care for LGBT patients, an understanding of student attitudes toward homosexuality must be established. Such insight could assist nursing programs in identifying educational needs of their students with respect to caring for LGBT patients and could help determine how to best integrate LGBT specific content within the nursing curriculum.

**Background and Significance of Study**

Health disparities among those who identify as LGBT have been well documented. Gay men experience significantly higher rates of sexually transmitted
diseases such as HIV and syphilis (Center for Disease Control, 2010; Center for Disease Control, 2012). Lesbians experience higher rates of obesity (Boehmer, Bowen, & Bower, 2007; Struble, Lindley, Montgomery, & Burcin, 2010) which suggests an increased risk of morbidity and mortality from obesity-related health issues. Lesbians are also less likely to access preventative health screenings (Buchmueller & Carpenter, 2010; Dehart, 2008), and rates of breast cancer are increased in lesbians and bisexual women compared to heterosexual women (Valanis, et al., 2000). Moreover, the rates of substance abuse are significantly higher in the LGBT community compared to the general population (Office of Applied Studies [OAS], 2010).

Several studies found disproportionately high rates of homelessness within the LGBT population, indicating that as many as 20%-40% of homeless youth identify as LGBT. Once homeless, LGBT youth suffer poorer health outcomes than their heterosexual counterparts (Corliss et al., 2011; Hein, 2010; Van Leeuwen et al., 2006). Suicide rates in LGBT persons remain disproportionately high, especially in LGBT youth (Garofalo, Wolf, & Wissow, 1999). In addition, LGBT youth are more likely to be the victims of violent crimes (USDHHS, 2013).

LGBT patients also encounter disparities when accessing health care. Compared to persons in opposite-sex relationships, men and women in same-sex relationships are less likely to have health insurance or utilize preventative care (Heck, Sell, & Gorin, 2006). In addition, because of the perceived risk involved in disclosing their sexual orientation, many LGBT persons conceal their sexuality from health care professionals, or may avoid health care encounters (Neville & Henrickson, 2006).
Historically, LGBT health issues have not gained public notice, but recent shifts in policy have brought disparities faced by LGBT persons to the attention of the health care community. For the first time since its inception, the Healthy People Initiative now identifies gay, lesbian, bisexual, and transgendered health as an area of focus for its 2020 objectives (USDHHS, 2013). In 2011, the Institute of Medicine released a report on the state of LGBT health, calling for increased awareness of health issues faced by LGBT persons. These shifts in policy underscore the need for nursing to address the unique health challenges faced by LGBT persons.

Health disparities and barriers to health care encountered by LGBT persons are related to a history of discrimination and marginalization faced by nonheterosexuals (IOM, 2011; USDHHS, 2013). Namenek (2001) suggests that the health care challenges experienced by LGBT persons are not a direct product of sexual orientation, but arise from society’s attitudes and behaviors toward homosexuality. The most extreme form of such bias, homophobia, involves hostile attitudes toward nonheterosexual persons (Walls, 2008). Homophobic attitudes can manifest in discriminatory behaviors which, when displayed by nurses, compromise patient care. While earlier studies suggest that homophobia is common among nurses and nursing students (Eliason, 1998; Eliason & Randall, 1991; Stiernborg, 1992), more recent studies have found that homophobia among this population has declined (Boch, 2011; Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007). These apparent changes in attitudes among nurses and nursing students contrast with the continued health care challenges faced by the LGBT community. This disconnect could result from the continued presence of a more subtle form of bias against LGBT persons, that of heterosexism.
Heterosexism is a concept closely related to homophobia but is less understood and not as well researched. Because heterosexual norms are so rooted in society, heterosexism may go unrecognized by persons holding such attitudes. Walls (2008) characterizes heterosexism as a system of beliefs or values that elevates heterosexuality as the preferred manifestation of human sexuality while stigmatizing, denying, denigrating, or segregating other forms of sexual identity. Hostility toward homosexual persons is not a defining characteristic of heterosexism. Indeed, heterosexist attitudes can include apathy toward the challenges faced by LGBT persons as well as positive stereotypes of the LGBT lifestyle (Walls, 2008). Although not as extreme as homophobia, heterosexism has nevertheless been found to negatively impact the health care received by LGBT persons (DeHart, 2008; Saulnier, 2002; Rondahl, Bruhner, & Lindhe, 2009; Rondahl, Innala, & Carlsson, 2006). Heterosexism may be more difficult to recognize than homophobia and may be a more challenging problem to address. Yet if nurses are to play a role in improving the health of LGBT persons, the impact of heterosexism on LGBT health must be acknowledged. As a first step, an understanding of nursing’s attitudes toward LGBT persons should be established.

The demographics of the United States are shifting and nurses are caring for increasingly diverse populations. Acknowledging the impact that culture can have on health, nursing leaders have realized the need to cultivate cultural skills within the nursing profession. The development of such skills is commonly known as cultural competence. Key to the concept of cultural competence is the awareness of one’s own biases and ethnocentrism, “a universal tendency to believe one’s own worldview is superior to another’s” (Giger et al., 2007, p. 101).
The American Association for Colleges of Nursing (AACN) identifies cultural competence as an essential component for providing patient-centered care and mitigating health disparities among disadvantaged populations (AACN, 2008). As cultural competence is now considered an essential nursing skill, it is not surprising that most nursing schools include the ability to provide culturally competent care as a key outcome of their programs (Kardong-Edgren & Campinha-Bacote, 2008). The AACN (2008) further identifies cultural competence in several expected outcomes of baccalaureate degree nursing programs. If nurses are expected to provide holistic, patient-centered care to all persons, then the development of cultural competence must extend to LGBT patients. Heterosexism and homophobia can interfere with a nurse’s ability to give culturally appropriate care to LGBT patients by negatively influencing nurses’ attitudes and behaviors toward those patients. Furthermore, given the pervasiveness of heterosexism in modern society (Walls, 2008), nurses may be unaware of their own heterosexism. Because of their potential impact on patient care, there is a need to examine heterosexism and homophobia in nursing students.

**Problem Statement**

Nurses have a responsibility to provide culturally appropriate care to all patients, including those patients who identify as LGBT (Eliason, Chinn, Dibble, & DeJoseph, 2013). As societal attitudes shift, LGBT persons are becoming more visible and most nurses will likely care for LGBT persons during their careers. In order to understand the role that heterosexism plays in the health challenges faced by LGBT persons, it is important to examine the prevalence of heterosexism within nursing. Ideally, heterosexism should be addressed during nursing school when students are developing
their foundational skills; and recently there has been a call to integrate LGBT health-related content into the nursing curriculum (Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012; Lim & Bernstein, 2011; Lim, Brown, & Jones, 2013). The development of culturally sensitive attitudes in nursing students toward LGBT patients has the potential to mitigate the negative consequence of heterosexism in health care. However heterosexism, if unrecognized, will continue to have negative consequences for LGBT health.

**Conceptual Framework**

Wall’s (2008) conceptual framework of modern heterosexism was used to guide this study. Building upon theories of modern social dominance and modern prejudice, Walls proposed a context from which to view the evolving nature of prejudice against nonheterosexuals. Theories of modern prejudice propose that as outward discrimination against minority groups becomes socially unacceptable, prejudice tends to change, shifting from more hostile forms of discrimination to less obvious forms of bias. This evolution allows dominant groups to maintain societal advantage and perpetuates disparities experienced by disadvantaged groups.

Current research suggests that attitudes toward LGBT persons are improving and views of homosexuality are no longer predominantly negative (Ahmad & Bhurga, 2010; Rutledge, Siebert, Siebert, Chonody, 2011; Schellenberg, Hirt, & Sears, 1999). However, LGBT persons still experience many disparities. Walls (2008) proposed that current instruments used to measure attitudes toward LGBT persons only capture negative beliefs and do not consider the full spectrum of bias against homosexuality. In order to obtain a better understanding of society’s current attitudes, Walls sought to create a framework.
that would provide a holistic picture of modern views of homosexuality. While doing this work, Walls created a tool for measuring modern heterosexism, the Multidimensional Heterosexism Inventory (MHI).

Walls’s theory divides heterosexism into five domains. Although some of these domains include positive attitudes, Walls maintains that each subdomain contributes to the continued stigmatization of LGBT persons. Walls’s five domains, along with their definitions, are as follows:

**Aversive Heterosexism:** “Attitudes, myths, and beliefs that dismiss, belittle, or disregard the impact of sexual orientation on life chances by denying, denigrating, stigmatizing and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, p. 46). As an example, aversive heterosexism includes beliefs that LGBT persons push too hard for “special rights” and that those who pursue equality for LGBT persons are practicing reverse discrimination (Walls, 2008, p. 30).

**Amnestic Heterosexism:** “Attitudes, myths, and beliefs that deny the impact of sexual orientation on life chances by denying, denigrating, stigmatizing, and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, pp. 46-47). Amnestic heterosexism includes the belief that LGBT persons have already achieved equality (Walls, 2008).

**Paternalistic Heterosexism:** “Subjectively neutral or positive attitudes, myths, and beliefs that express concern for the physical, emotional or cognitive well-being of nonheterosexual persons while concurrently denying, denigrating, stigmatizing, and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, pp. 27-28). Paternalistic heterosexism expresses concern or support for
LGBT persons, while maintaining heterosexuality as the preferred form of sexual expression. An example of paternalistic heterosexism would be a person who would not want their child to be gay because he or she would be treated unfairly in school (Walls, 2008).

**Positive Stereotypic:** “Subjectively positive attitudes, myths, and beliefs that express appreciation of stereotypic characteristics often attributed to lesbians and gay men which function by denying, denigrating, stigmatizing, and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, p. 28). An example of positive stereotypic heterosexism would be the belief that lesbians are more capable of taking care of themselves than heterosexual women (Walls, 2008). Walls maintains that such attitudes, although somewhat altruistic, reinforce the marginalization experienced by LGBT persons.

**Hostile Heterosexism:** Walls integrated homophobia into his theoretical framework as the fifth domain, that of “hostile heterosexism”. In Walls’s framework, hostile heterosexism is defined as “negative attitudes, myths, and beliefs that function by denying, denigrating, stigmatizing, and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, p. 27). Walls’s MHI does not measure hostile heterosexism (homophobia). In developing his instrument, Walls relied on an existing instrument, Herek’s Attitudes toward Lesbians and Gay Men Scale (ATLG) to capture this domain (Herek, 1998).

Walls’s framework of modern heterosexism has the potential to provide a broader understanding of attitudes toward homosexuality. If Walls’s theory of modern heterosexism is assumed true, then past studies that utilized instruments designed to
capture homophobia have not provided a complete understanding of the spectrum of bias toward LGBT persons. Walls’s theory provides a possible explanation of how homophobic attitudes may be declining in nurses, even while LGBT patients continue to experience negative health care encounters.

**Research Questions**

The following research questions guided this study:

1. Among students enrolled and participating in a Bachelor of Science nursing program, is homophobia present?
2. Among students enrolled and participating in a Bachelor of Science nursing program, is heterosexism present?
3. Among students enrolled and participating in a Bachelor of Science nursing program, what is the relationship between homophobia and heterosexism?
4. Is there a difference in the level of homophobia and between junior and senior nursing students?
5. Is there a difference in the level of heterosexism between junior and senior nursing students?

**Definitions**

The following terms are used extensively in this study, and are defined below.

*A Bachelor of Science nursing student* was defined as a person currently enrolled and participating in a Bachelor’s of Science nursing program. The criteria for inclusion required that students had taken, or were taking, at least one nursing class in a Bachelor of Science nursing program. The focus of the study was on undergraduate student, and so graduate students were excluded, as were those students participating in
the school’s foreign trained physician-to-nurse practitioner program. A junior level nursing student was defined as a student participating in the nursing program who had not reached their final two semesters of the program. A senior level nursing student was defined as a student participating in the nursing program who was currently enrolled in one of the final two semesters of the program.

Because Walls’s theoretical framework of modern heterosexism is being used to guide this study, the choice was made to use Walls’s definitions of heterosexism and homophobia. Heterosexism is defined as “attitudes, myths, and beliefs that function by denying, denigrating, stigmatizing, and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, p. 27). Heterosexism will operationalized utilizing the MHI. Homophobia will be defined as “negative attitudes, myths, and beliefs that function by denying, denigrating, stigmatizing, and/or segregating any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, p. 27). Because homophobia can be seen as a domain of heterosexism and current societal attitudes view homophobia unfavorably, it is hypothesized that levels of homophobia will be lower than levels of heterosexism. Homophobia will be operationalized by the ATLG (Herek, 1998).

Assumptions

There were several assumptions associated with this study. The first assumption was that students’ ability to provide culturally appropriate nursing care is a positive and desired outcome of a baccalaureate nursing education program. The study further assumed that the need to provide culturally appropriate care to individuals extends to those of minority sexual orientation and LGBT persons have the right to nursing care that
considers and respects their unique experiences, situations, lifestyles, and beliefs.

Another assumption was that homophobia and heterosexism in nurses negatively impacts the ability of nurses to provide culturally appropriate care for LGBT patients and can perpetuate health care disparities among this population. Finally, the study assumed that, because of recent shifts in societal attitudes toward LGBT persons, participant levels of homophobia would be significantly lower than levels of heterosexism.

**Limitations**

A major limitation of this study was that it utilized a convenience sample from a single nursing program in one geographic location. Because the sample was not representative of the entire nursing student population, the results are not generalizable. Also, because the instruments used to measure heterosexism and homophobia only address attitudes toward gay men and lesbians, the study results cannot be directly applied to members of other sexual minorities, such as those who identify as bisexual, transgendered, or intersexed.
CHAPTER TWO: REVIEW OF LITERATURE

This chapter summarizes the major finding of the literature review that provided impetus and support for the study. When reviewing the literature related to the problem statement, two major themes emerged. The first theme described the impact of heterosexism on the health care of lesbian, gay, bisexual, and transgendered (LGBT) patients and their families. The second theme encompassed the attitudes of nurses and nursing students toward LGBT persons and their lifestyles. The following literature details the major findings in these areas and relates them to the purpose of this study. Because recent shifts in public attitude toward homosexuality may have resulted in a climate that is more accepting of LGBT persons, the literature review limited its primary focus to studies conducted within the past ten years.

The Effect of Heterosexism on Health Care

Based on the literature, heterosexism is present in today’s health care environment and directly impacts the quality of health care experienced by gay and lesbian patients. Heterosexism can create a barrier to effective provider-patient communication, impede access to health care, negatively influence the quality of care or lead to inappropriate care (DeHart, 2008; Saulnier, 2002; Rondahl, Bruhner, & Lindhe, 2009; Rondahl, Innala, & Carlsson, 2006; Heck, Sell, & Gorin, 2006).
Moreover, perceived heterosexist attitudes of nurses and other health care workers can alienate gay and lesbian patients, causing feelings of uncertainty and embarrassment. Such feelings may lead patients to avoid health care settings or conceal information from their providers (Dehart, 2008; Saulnier, 2002; Neville & Hendrickson, 2006; Ronahl, 2008).

One common theme that emerged from the literature review was a sense of uncertainty felt by LGBT persons when disclosing their sexuality to health care professionals. Many LGBT persons perceive revealing sexual orientation as a risk that may result in discrimination or suboptimal care (Klitzman & Greenberg, 2002). Because of the risk perceived in self-disclosure, LGBT persons may choose to conceal their sexual orientation from health care providers.

In a descriptive, exploratory study conducted in New Zealand, Neville and Henrickson (2006) examined lesbian, gay, and bisexual persons’ decisions to disclose their sexual orientation to health care professionals. The sample in this national study was 2,269 participants and the survey included 133 items. The majority of participants reported that provider attitudes toward sexual orientation were important to them. Seventy three percent of participants stated that health care providers usually or always presumed they were heterosexual and 33% of participants had chosen not to self-disclose their sexual orientation. The researchers concluded that assumptions of heterosexuality might increase the likelihood of non-disclosure, as LGBT patients may choose to remain silent rather than correct a provider’s misconception. They also suggested that nurses and other health care professionals be sensitive to such situations, not presume heterosexuality, and create opportunities for disclosure.
Another study, conducted by Rondahl, Innala, and Carlsson (2006) examined verbal and non-verbal communication between health care workers and gay and lesbian patients. The study used a descriptive explorative design that included semi-structured interviews. The inclusion criteria was self-identification as gay or lesbian and recent hospital exposure (within five years). All participants (n=27) had been hospitalized or were partners of a hospitalized patient. Similar to the study by Neville and Henrickson (2006), participants in this study reported that nurses and other health care workers usually presumed heterosexuality. When participants corrected this assumption, nurses often seemed uncertain how to react. The nurses also often failed to recognize same-sex partners as legitimate family members. Some described how nurses became overly cautious in their communications once the participant disclosed their sexuality. Several participants discussed how health care workers asked inappropriate questions or ordered inappropriate treatments, such as repeatedly asking a lesbian why she did not use contraception. Many participants felt that nursing staff lacked insight and knowledge about the lives of gay men and lesbians.

Rondahl (2008) conducted a second study that explored gay men’s and lesbians’ attitudes about nursing care. The study employed semi-structured interviews of 27 participants (17 men and 10 women) to explore recent experiences with nurses. One theme, which coincided with the Neville and Henrickson’s (2006) study, described participants’ uncertainty in disclosing their sexual orientation to nursing staff and how this interfered with the nurse-patient relationship. The majority of informants reported such insecurity. Uncertainty appeared especially pronounced in the partners of patients. Many of these partners reported feeling alienated and excluded in their partner’s care.
Another theme was the perceived attitudes of nurses toward gay and lesbian patients. Several patients described a feeling of distance between themselves and the nurses, which they attributed to the nurses’ ambivalent feelings toward homosexuality. An interesting theme, identified as a “pathological approach”, arose from several patients reporting that nursing staff appeared to consider nonheterosexuality abnormal.

LGBT patients experience uncertainty and encounter unhelpful attitudes across all health care settings. In maternity care, a trusting relationship between the patient and the caregiver is particularly important (Halldorsdottir & Karlsdottir, 1996). In a meta-ethnography, Dahl, Fylkesnes, Venke, and Malterud (2012) compared research studies that explored the experiences of lesbian couples in perinatal settings. Analyses of 13 studies produced four common themes. The first theme was described as experiences with homophobic and discriminatory attitudes that negatively impacted the birthing experience. Conversely, the second theme demonstrated how positive attitudes and supportive behaviors can mitigate feelings of uncertainty in lesbian mothers. The third theme identified the perceived risk that lesbian partners felt in disclosing their sexuality, and how the risk necessitated the need to control situations during health care encounters. The final theme was the importance of acknowledging and respecting both partners as co-mothers.

Two recent studies support Dahl, et al.’s (2012) findings. In the first study, Erlandsson, Linder, and Haggerstrom-Nordin (2010) examined the lived experience of same-sex partners among women giving birth. Six Swedish women who took an active role in the birthing experience of their partner were interviewed. These women were considered “co-mothers” and were present with their partners during labor and delivery.
The study utilized an interview format during which the co-mothers were encouraged to tell their stories freely, with minimal guidance by interviewers. During prenatal care, participants reported feeling excluded and vulnerable, and that they had to repeatedly establish themselves as a co-parent. Participants felt that prenatal classes were predominantly aimed at heterosexual couples, particularly the needs of fathers, and were not suited to address the unique experiences of same-sex couples. Participants described both positive and negative encounters with nurses. Some participants encountered tense, uncertain staff, and these encounters had a negative impact on the experience. Positive attitudes among health care staff were also reported and participants described how such attitudes contributed to the joy of the experience. Clearly, attitudes of the nursing staff had a significant impact on the overall birth experience.

In a second study, Rondahl, Bruhner, and Lindhe (2009) used a qualitative, descriptive design to explore the experiences of seven lesbian families with perinatal care and childbirth. The study was conducted at health care facilities in three Swedish cities. Like Erlandsson, et al.’s (2010) study, participants described feelings of uncertainty when interacting with the health care staff, which were mitigated or reinforced depending on the attitudes of the health care workers. Although participants reported overall positive experiences, they also reported a lack of appropriate perinatal education; none of the participating couples were offered classes on childbirth or pregnancy.

In addition, an assumption of heterosexuality was conveyed throughout the pregnancy. Like Erlandsson, et al.’s (2010) study, the nursing staff often appeared uncertain in their interactions with the co-mother and frequently addressed her as the father. Participants reported feeling embarrassed by these experiences and co-mothers
reported a lack of acknowledgement as legitimate parents. Participating couples also reported that at times their sexuality became a focus that overshadowed the pregnancy.

Clearly, the attitudes of health care workers toward sexuality influence how LGBT patients perceive the quality of their care. Saulnier (2002) examined this influence in an exploratory, qualitative study that explored lesbian preferences in health care providers. The study included five focus groups with 33 total participants, all of whom identified as lesbian or bisexual. Group sizes ranged between four to 15 women and group sessions lasted between 1 to 1.5 hours. During the sessions, participants shared their perspectives on health care interactions with nurses and other health care professionals.

Health care providers’ attitudes toward the participants’ sexual orientation emerged as an important theme for all participants. Although few women experienced overt homophobia during health care encounters, many women described provider attitudes and behaviors that the researchers categorized as heterosexism. Due to a particularly offensive encounter with a provider, one participant avoided having a PAP smear for several years. Some participants described how health care workers often failed to respect the diversity of their family structure. Still other providers applied negative stereotypes to participants based on their sexual orientation. These stereotypes included the assumption that, because a participant was a lesbian, she was likely to have a sexually transmitted disease or be mentally ill. Participants indicated that their preference in health care providers included those who were tolerant, comfortable with lesbianism, and had a “matter-of-fact” attitude about the participant’s sexuality.

Saulnier’s (2002) study illustrates the role that attitudes of health care providers, including nurses, can have on the health behaviors of LGBT patients. The study also
illuminates how the concept of heterosexism is likely more widespread than homophobia. In categorizing provider behavior, the researchers determined that few of the behaviors qualified as homophobia, while a significant amount of them met the criteria for heterosexism.

In a similar study, Sinding, Barnoff, and Grassau (2004) explored experiences with heterosexism and homophobia among 26 lesbians who were receiving cancer care. The study employed a participatory action research model; the researchers and participants collaborated in conducting the study. In a series of interviews, participants described homophobic and heterosexist encounters with nurses, physicians, and other health care providers. Common themes that emerged from the study were a disregard for the sexual identity of participants, deficit of psychosocial support, and denial of quality care. In one instance, a provider’s feelings of discomfort with a lesbian patient resulted in the discontinuation of a PAP smear. However, many participants expressed appreciation and gratitude for health care workers who adopted accepting attitudes and took actions to ensure that participants felt valued as human beings. Those patients who experienced positive or accepting attitudes reported a higher quality of care than those who encountered insensitive attitudes.

In yet another study, Dehart (2008) used the Health Belief Model to examine how heterosexism and homophobia influenced the breast health behaviors of lesbians. Employing a convenience sample of 173 women who identified as exclusively lesbian, the study used a nine item Likert-style survey that “assessed perceived benefits, perceived barriers, perceived severity, self-efficacy beliefs, and cues to action as these related to breast health” (Dehart, 2008, p. 8). The survey included additional items to
capture participants’ perceived susceptibility to breast cancer and to identify persons who had encouraged the participant to seek breast care. Dehart’s results indicated that the attitudes of health care workers significantly affected the health choices of lesbian patients. More than 50% of participants reported that heterosexual assumptions influenced the frequency of their health care visits, how much information they shared with their provider, or the quality of health care received. One third of participants acknowledged that homophobia influenced their health care and health seeking behaviors, including how often they sought health care. The researchers suggested that there is a need for enhanced training in culturally appropriate care for LGBT persons.

Student and Faculty Attitudes, Knowledge, and Beliefs about Homosexuality

Considering the influence that heterosexism and homophobia have on patient care, it is important to examine the attitudes and behaviors of nursing students toward nonheterosexual persons. Nursing students represent the future of nursing, and nursing school should create an environment to cultivate the attitudes necessary to provide culturally appropriate care for LGBT patients. There are few recent studies that examine nursing students’ attitudes and beliefs about LGBT persons. Older studies report significant levels of homophobia in nursing (Eliason, 1991; Eliason 1998; Stiernborg, 1992); however, these studies cannot take into account the impact that recent shifts in the social and political climate have had on current attitudes toward LGBT persons. Therefore, this section of the literature review focused on studies conducted within the past 10 years, as recent research can better provide insight into current attitudes toward homosexuality.
Rondahl, Innala, and Carlsson (2004) examined nurses’ and nursing students’ attitudes toward LGBT persons and whether or not they would decline caring for them if given a choice. The study design was descriptive and comparative. The researchers collected data using a self-created instrument, the *Affect Adjective Checklist and Nursing Behavior Questionnaire*. Results found that 36% of nursing staff and 9% of nursing students would decline caring for homosexual patients if given the option. Conversely, many nursing students also exhibited positive attitudes toward caring for homosexual patients. The researchers suggested that nursing students’ positive attitudes reflect a change in perception of homosexuality in the younger generation. However, they also noted that many responses exhibited evidence of social desirability and a desire to provide an acceptable response. This may have skewed results to reflect a more positive attitude. The study was limited by its small sample size (57 nursing staff and 165 nursing students) as well as geographic location. In addition, the instrument used was not tested for validity or reliability.

With a focus on nursing faculty, Sirota (2013) conducted a descriptive, correlational study about attitudes toward homosexuality among nurse educators. An electronic survey was administered to nursing faculty throughout the United States. Of the 6,000 surveys sent, 1,282 were returned. The instrument utilized to measure participants’ attitudes was the *Attitudes toward Lesbians and Gay Men scale* (ATLG). In previous studies, the instrument demonstrated high reliability, with alpha coefficients consistently higher than 0.90 (Herek, 1998). In this study, the instrument demonstrated an alpha coefficient of 0.917. A supplementary form that asked demographic questions and participants’ opinions on the importance of incorporating LGBT related content into the
nursing curriculum was also included in the study. Although there was a long negative skew that demonstrated several participants held extremely negative attitudes, the results found most participants held positive attitudes toward LGBT persons. The supplemental questions found that while most participants believed that providing LGBT related content within the nursing curriculum was important, many felt uncomfortable and unprepared to do so. The uncertainty expressed by these educators calls into question the effectiveness of nursing curricula to develop caring attitudes toward LGBT patients in their students. The study further illustrates the need to fully explore attitudes toward homosexuality within nursing and nursing education.

Dinkel, Patzel, McGuire, Rolfs, and Purcell (2007) examined homophobia among nursing students and faculty at a Midwestern university. The study used a convenience sample of 126 students and 15 faculty members. Participants completed a demographic tool as well as two instruments designed to measure levels of homophobia: the *Index of Attitudes toward Homosexuals* (IAH) and the *Homophobic Behavior of Students Scale* (HBSS). The demographic information collected included gender, age, sexual orientation, religious beliefs, political affiliation, and previous associations with LGBT friends or family members.

Similar to the research by Rondahl, et al. (2003) and Sirota (2013), this study reported low levels of homophobia among nursing students and nursing faculty. The study found no significant differences between the scores of faculty and students and no significant correlation between academic progression of students and levels of homophobia. Interestingly, the researchers suggested that the low scores reflected neutrality toward issues of sexual orientation. They further acknowledged that such
neutrality may conceal less hostile forms of heterosexism (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007), and that their instruments only captured homophobia. This acknowledgement echoes Wall’s (2008) theory of modern heterosexism and suggests that further examination of nursing students’ attitudes toward homosexuality is needed.

In a similar study, Boch (2011) examined behaviors, knowledge, and attitudes about LGBT persons among nursing students and nursing faculty at a Midwestern university in the United States. The study’s design was descriptive and non-experimental. The sample consisted of 36 nursing faculty and 333 students, with the student sample evenly distributed between second, third, and fourth year students.

Four instruments were used to capture the variables of interest. The first instrument, Knowledge about Homosexuality Questionnaire (KAH) was designed to capture knowledge about sexual orientation. The other instruments, Index of Homophobia (IAH), Homophobic Behavior of Students Scale (HBSS), and an adoption of a survey (unnamed instrument) created by Eliason and Randall (1989) designed to capture phobic attitudes toward lesbians, focused on levels of homophobia.

While each of the instruments demonstrated strong reliability in previous studies, two instruments (IAH and HBSS) showed only moderate reliability in Boch’s study, with alpha coefficients of .69 and .62 respectively. The KAH, modified for Boch’s study, demonstrated better reliability, with an alpha coefficient of .77. How the KAH was modified was not addressed. The unnamed instrument performed strongly, with an alpha coefficient of .98. In addition to the four instruments, a demographic form collected information such as gender, age, sexual orientation, religious orientation and political affiliation. Finally, the researcher developed a questionnaire that asked whether members
of particular groups (such as nonreligious people, male nurses, democrats, or HIV positive people) were more likely to be LGBT. Response to this particular tool was poor and several participants criticized its inclusion.

Compared to Dinkel, et al.’s (2007) findings, this study found higher prevalence of homophobic attitudes, although overall homophobia was still low among participants. The study found no relationship between progression through the nursing program and levels of homophobia. The study reported low levels of knowledge of homosexuality among nursing students, with a significant difference (p = .013) between students based on progression through the nursing program. This knowledge deficit of LGBT issues suggests an opportunity for nursing education.

Rondahl (2009) examined psychological, care, and public knowledge of LGBT persons in medical and nursing students in a descriptive, comparative study. The sample included 71 nursing students and 53 medical students, each in their sixth semester of education. Knowledge of homosexuality was measured using a version of the KAH, modified for Swedish respondents. The instrument demonstrated strong reliability with an alpha coefficient of .82. Similar to Boch’s (2011) results, this study reported overall low knowledge of homosexuality among nursing and medical students. Eighty two percent of participants received failing scores on their total knowledge level, with scores less than 70%. Notably, 90% of nursing students failed to achieve a passing score on the “care knowledge” subdomain which contained items that were considered important in the provision of quality, appropriate health care for LGBT individuals. The study found that the male gender and strong religious convictions also correlated with lower total LGBT knowledge.
The low knowledge levels of homosexuality reported by Boch (2011) and Rondahl (2009) suggest the need to examine how well health care education is providing LGBT content. In an effort to do so, Rondahl (2010) conducted a qualitative study at a Swedish university that explored medical and nursing students’ academic exposure to LGBT-related health issues. The study included eight participants, five nursing students and three medical students. Semi-structured group interviews were used to collect data about the students’ experiences with LGBT-related curricular content. Data analysis revealed the programs lacked substantive information about LGBT health. Discussion of gay men’s health issues was confined to the subject of sexually transmitted diseases, while discussion of lesbian health was limited to the legalization of artificial insemination for lesbians.

Overall, informants felt that health care education promoted “invisibility” of LGBT persons and that the academic environment failed to facilitate open discourse on sexuality. Participants described teachers as passive with respect to LGBT knowledge and the need for academic programs to integrate LGBT content throughout the curriculum’s theoretical and practical components. One informant suggested that an obstetric case study involving a lesbian couple be used in place of a traditional husband/wife scenario.

Summary

In summary, heterosexism impacts the quality of health care among LGBT persons, despite the apparently decreasing levels of homophobia. LGBT patients often face assumptions of heterosexuality and ambivalent or uncomfortable attitudes from
nurses and other health care professionals. Often, LGBT patients report that their needs are not understood by nurses. Such attitudes create feelings of uncertainty and alienation in LGBT patients. On a more assuring note, several studies indicated that positive and supportive attitudes in nurses can mitigate feelings of uncertainty in LGBT patients (Dehart, 2008; Erlandsson, et al., 2010; Rondahl, et al., 2009; Sinding, et al., 2004).

Much like the professional health care setting, nursing education programs often fail to consider the unique needs of LGBT persons and do not consistently incorporate LGBT-related content into their nursing curriculum. Without such content, programs may not be preparing students to provide culturally appropriate care for LGBT patients. Although the concept of homophobia in nursing students has been the focus of a limited number of past studies, no studies have attempted to identify the potentially more prevalent attitudes associated with heterosexism in the same population. Heterosexism could contribute to the lack of LGBT content within nursing curricula and the continued prevalence of heterosexism within the health care system. For these reasons, the literature supports the need to examine heterosexism and homophobia in nursing students.
CHAPTER THREE: METHODS

The purpose of this study was to determine if heterosexism and homophobia were present within a nursing student population. The study also examined the relationship between heterosexism and homophobia and whether or not levels of heterosexism and homophobia differed significantly between junior and senior level nursing students. This chapter provides an overview of the research methodology that were used in this study. Prior to implementation, the university’s institutional review board reviewed and approved the study (See Appendix A).

Design and Setting

The design of this research study was descriptive and non-experimental. A descriptive design provided the researcher with the opportunity to identify and describe the variables of interest (heterosexism and homophobia) within a selected population (nursing students enrolled and participating in a Bachelor of Science nursing program). This design is appropriate for research into areas of which there is very little knowledge. Descriptive research provides a foundation of knowledge from which other types of research can be initiated. This study included no intervention or manipulation of variables and was therefore non-experimental.

The setting for the study was a state university located in the southeastern United States. In 2012, the university had a student population of 22,684 students, of which 42% were male and 58% female (Kennesaw State University [KSU], 2013).
The university’s College of Health and Human Services, of which the nursing program is a part, has a significantly different gender demographic, with 73% female students and 27% male students.

Minorities make up 31% of the university’s student body, with the largest minority being African-American (at 17.8%) and the second largest being those of Hispanic ethnicity (at 7.2%). Students of Asian descent make up 4.2% of the student body, while students who identify as Native American, Native Alaskan, and Pacific Islander constitute less than 1% of the student body. The average student age is 23 (KSU, 2013).

The university’s nursing school includes a Bachelor of Science (BSN) nursing program that has both a traditional and accelerated track, as well as an RN to BSN degree program. The university’s academic calendar is divided into three semesters (fall, spring, and summer), and the nursing program admits approximately 100 BSN students per semester. In 2012, the nursing program awarded a total of 220 BSN degrees (KSU, 2013).

Population and Sample

The population for the study included all students accepted and participating in the university’s Bachelor of Science nursing program. This included traditional and accelerated BSN students, as well as those in the RN to BSN program. Since the focus of this study was on nursing students pursuing BSN degrees, students pursuing graduate nursing degrees and physician-to-nurse practitioner students were excluded from the study. Students accepted into the program who had not yet started their nursing coursework were also excluded, as were students taking pre-nursing requirements.
The sample was recruited from five semester-specific nursing courses. Those courses were NURS 3209 (Holistic Nursing), NURS 3313 (Adult Health Nursing), NURS 3314 (Mental Health Nursing), NURS 4414 (Complex Health Nursing), and NURS 4416 (Nursing Leadership). Recruitment from these courses was used to potentially capture all eligible participants. In addition, recruitment took place twice in the common area of the nursing building, on two separate dates. This allowed an opportunity for students who were not in class on the day that data were collected to participate in the study. Participants could only participate once in the study.

**Data Collection Plan**

Data were collected using printed demographic forms and surveys that were distributed to participants as a packet. The packets were unmarked envelopes that contained a cover consent letter (See Appendix B), a demographic sheet (See Appendix C), and two measurement instruments. Data collection occurred one time immediately after each of five semester-specific classes. The time and date were coordinated with the course faculty members. Data were also collected on two specific dates at a common area on the third floor of the nursing building. Prior to data collection, the researcher requested that faculty for the selected courses place an announcement in the online classroom platform that invited students to participate in the study. In addition, flyers were distributed in the nursing building one week prior to data collection (See Appendix D). The flyers described the study, provided the date and location of data collection, and invited all current nursing students to participate. To protect against participants submitting multiple surveys, the researcher was present during all data collection sessions and asked each participant if they had previously submitted a survey.
The researcher explained the study to all participants and answered any questions that arose. After participants completed the surveys and demographic form, they were instructed to place the documents in the unmarked envelopes and seal them. Data packets were stored in a locked safe in a secure office with a security system. Because demographic questionnaires could allow the researcher to unintentionally identify participants (for example, if only one male respondent was present at a particular data collection session) the researcher only opened individual survey packets after all data collection sessions were complete.

**Instruments**

The first assessment instrument used was the *Multidimensional Heterosexism Inventory* (MHI), a Likert-style survey that examined four subdomains of heterosexism: amnestic, aversive, paternalistic, and positive stereotypical (See Appendix E). Permission to use the instrument was obtained through personal communication with the instrument’s developer (E. Walls, personal communication, April 26, 2013. See Appendix F). The instrument included twenty-three items and used a seven point scale for the amnestic, aversive, and positive stereotypical subdomains, and an eight point scale for the paternalistic subdomain. The item breakdown, per subdomain, is as follows:
Table 1

*Overview of total items for MHI subscales*

<table>
<thead>
<tr>
<th>Subdomain</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amnestic heterosexism</td>
<td>Four items</td>
</tr>
<tr>
<td>Aversive heterosexism</td>
<td>Six items</td>
</tr>
<tr>
<td>Paternalistic heterosexism</td>
<td>Seven items</td>
</tr>
<tr>
<td>Positive stereotypic heterosexism</td>
<td>Six items</td>
</tr>
</tbody>
</table>

Each subdomain was scored separately. For all subdomains except paternalistic heterosexism, a value of one indicated strong disagreement with an item while a value of seven indicated strong agreement. For the paternalistic heterosexism subdomain, a value on one indicated strong disagreement with an item while a value of eight indicated strong agreement.

The MHI has demonstrated strong validity and reliability with student populations. The previously established Cronbach’s alpha for the subscales were .94 (paternalistic), .87 (positive stereotypic), .91 (aversive), and .79 (amnestic). The scale has an overall alpha of .80, however, the instrument’s developer advises that because the subdomains have different relationships to outside constructs, the overall reliability score is not as meaningful as subscale scores. The developer used experts in scale development and research into discriminatory attitudes to develop the item pool. An exploratory iterative factor process established four distinct factors that supported the four subdomains of heterosexism. Validity was established through a series of studies that tested theorized relationships between performance on the instrument and outside constructs such as political affiliation and religious fundamentalism.
The studies also demonstrated theoretically sound relationships between the various subdomains and other established instruments (Walls, 2008).

The second instrument used was the *Attitudes toward Lesbians and Gay Men Scale* (ATLG) which identifies negative attitudes associated with homophobia (Herek, 1998. See Appendix G). It included 20 Likert-style items and two subdomains: attitudes toward lesbians and attitudes toward gay men. The items were scored on a nine point scale, with a score of one indicating strong disagreement with the item and a score of nine indicating strong agreement. Some of the items were reverse scored. The ATLG scale has been used extensively in past studies to measure attitudes toward lesbians and gay men. The ATLG scale has repeatedly demonstrated strong reliability, with alphas consistently above .85 for the subdomains and .90 for the overall scale. The ATLG correlates with outside constructs such as religious fundamentalism and traditional conservatism. Discriminant validity has been established as well. Scores from members of LGBT organizations reflect consistently positive attitudes, while scores of members of groups opposed to LGBT initiatives reflect consistently negative attitudes (Davis, et al., 1998).

The demographic form used was developed by the researcher. The form included questions about participants’ gender, age, sexual orientation, religious beliefs, political affiliation, personal experience with LGBT family members or friends, health care experience, current progression in the nursing program, and particular nursing program track. The form did not ask for any information that could be used as a personal identifier.
Threats to Validity

The study used a convenience sample from one nursing program located in the southeastern United States. The researcher attended a graduate program at the same school and had taught many of the potential participants. This familiarity may have led participants to answer items in a way that they perceived the researcher would want them to answer. In addition, participants may have chosen to accept or decline participation in the study based on unidentified variables, so the sample may not have been representative due to self-selection or self-exclusion from the study. Efforts to increase sample size included multiple data collection sessions and multiple announcements of the study, in the form of online classroom bulletins and flyers distributed at the nursing building.

Social desirability presented another significant threat to validity. Current negative attitudes toward discrimination could have influenced participants to respond to survey items in a way they perceived as socially acceptable. To mitigate the impact of social desirability responses, instruments previously tested for strong validity and reliability were used. In addition, the researcher emphasized to participants the steps taken to ensure anonymity of responses and the importance of honest responses for the study’s veracity.

Data Analysis

Data were analyzed using the SPSS version 21 software package developed by IBM. Data analysis took place in October 2013. Both descriptive and inferential statistics were used. Descriptive statistics were used to describe study participants and identify whether or not heterosexism and homophobia were present in the study sample (research questions 1 and 2). The mean scores, frequencies, and standard deviations for the
sample’s results on the MHI and ATLG were established. The Pearson’s $r$ test was used to examine correlations between participants’ scores on the MHI and scores on the ATLG. By determining this correlation, the researcher established whether or not there was a relationship between homophobia and heterosexism in participants (research question 3). Paired $t$-tests were used to determine statistically significant differences between scores on the ATLG and various subscales of the MHI. For both the MHI and ATLG, independent $t$-tests were used to determine if there was a statistically significant difference between the scores of junior and senior nursing students (research questions 4 and 5).

**Ethical Considerations**

Potential participants were advised that their participation was strictly voluntary, and that they could decline participation or withdraw from the study at any time. Participants may have felt uncomfortable answering questions about personal beliefs and attitudes toward sexuality. They may also have been uncomfortable answering questions about their religious beliefs, political affiliation, and sexual orientation. The researcher explained to participants that they could choose to not answer questions. In addition, the researcher did not impinge on classroom hours. All data collection sessions were conducted at the end of classes or outside of classroom settings. Prior to data collection, students were informed that class was over and that they were not required to stay and participate in the study.

Student participants could have felt obliged to participate in the research study because it was being conducted within the school of nursing. They may also have believed that their participation or lack thereof would influence their grade or status in the
nursing program. Participants were advised that their choice to participate would not affect their grades or their academic progression. They were also informed that their responses would remain anonymous and that no one, not even the researcher, could determine how they responded on the survey instruments or demographic form.

To ensure anonymity, no personal identifiers, such as name or student identification numbers, were collected. Data were collected in sealed, unmarked envelopes that were not opened until all data collection sessions were complete. Students were provided with a consent form that fully disclosed the nature of the study and explained steps taken to ensure anonymity. Since collection, all surveys and forms have been kept in a locked safe and stored on a password protected computer. The safe and computer are located in a locked building that has a security system.
CHAPTER FOUR: RESULTS

The purpose of this study was to determine whether or not homophobia and heterosexism were present among students participating in a Bachelor of Science nursing program and to examine the relationship between progression through the program and levels of homophobia and heterosexism. In addition, the relationship between heterosexism and homophobia was also examined. This chapter summarizes the results of the study and describes the specific statistical tests used to answer the proposed research questions.

Sample Demographics

The sample consisted of 253 participants, but eight surveys were returned incomplete and could not be included in data analysis. Therefore, there was a total of 245 valid surveys. Six of the surveys returned were blank. On the other two incomplete surveys, participants expressed disagreement with phrasing used in survey items. One participant stated that the instruments did not allow for “loving disagreement”. Another participant stated that by completing the surveys it would appear that she hated gay persons, and that such a portrayal would not accurately represent her views.

The majority of participants \( n = 215 \) were female, which was consistent with the program’s high female-to-male student ratio. Age of participants ranged from 19 to 59, with a mean age of 28.57 \( (SD = 8.38) \). Over half \( (n = 147, 60\%) \) of participants were between the ages of 21 and 28. Most participants \( (n = 174, 71\%) \) were Caucasian, with African American being the next largest group \( (n = 35, 14.3\%) \). The
remaining participants reported their race/ethnicity as either Asian \(n = 17, 6.9\%\), Hispanic \(n = 17, 6.9\%\), or “other” \(n = 2, 0.8\%\). Most participants \(n = 196, 80.0\%\) were traditional BSN students, with 16.3\%(n = 40) accelerated BSN students and 3.7 \%(n = 9) RN-BSN students. Participants were almost equally divided among juniors \(n = 132, 53.9\%\) and seniors \(n = 113, 46.1\%\).

With respect to sexual orientation, 95.9\%(n = 235) of participants identified as heterosexual, 2.4\%(n = 6) as bisexual females, 0.8\%(n = 2) as lesbian, and 0.8\%(n =2) as “queer” females. All male participants identified as heterosexual. The majority \(n = 179, 73\%\) of participants reported having lesbian, gay, bisexual, or transgendered (LGBT) friends, while 29\%(n =71) had LGBT family members. Most participants \(n = 117, 47.7\%\) did not know if they had taken care of LGBT patients, although 32.7\%(n = 80) reported they had provided such care. The remaining participants \(n = 48, 19.6\%\) had no previous experience caring for LGBT patients.

Because religious and political beliefs traditionally have significant influence on attitudes toward LGBT persons, participants were asked about both. The predominant religion was Christian/Protestant \(n = 171, 69.8\%\), while Catholicism \(n = 28, 11.4\%\) and Agnosticism \(n = 8.2\%\) were the next most frequently reported. Political views were distributed mainly between conservative \(n = 86, 35.1\%\), liberal \(n =20.4\%\), and moderate \(n = 65, 26.5\%\) viewpoints.

**Instrument Scoring**

Total scores on the *Attitudes toward Lesbians and Gay Men* (ATLG) scale were divided by the number of instrument items to generate a final score that was on the same scale as the response set and on a scale similar to the *Multidimensional Heterosexism*
(MHI) subscales. Possible scores ranged from one to nine, with higher scores indicating greater levels of homophobia. The mean sample score of $3.08 (SD = 2.17)$, indicated low levels of homophobia among study participants, although there was a long positive skew that indicated considerably higher levels of homophobia in a small number of participants.

Independent $t$-tests were utilized to identify statistically significant scoring differences between junior and senior level students, as well as between those with or without LGBT family members and friends. A one-way ANOVA was used to determine significant differences between participants based on previous LGBT patient care. There were no significant differences in ATLG scores between junior and senior level students. ATLG scores were significantly higher for participants who reported no LGBT family members ($p = .004$), no LGBT friends ($p < .001$), and no experience caring for LGBT patients ($p = .009$).
Participant levels of heterosexism were measured by the MHI. Scores on the amnestic, aversive, and positive stereotypic heterosexism subscales had a range of one to seven, while the paternalistic heterosexism subscale had a range between one and eight. Higher scores on these subscales indicated greater levels of heterosexism. The mean scores for the individual subscales were as follows: amnestic ($M = 2.36$, $SD = 1.24$), aversive ($M = 3.97$, $SD = 1.60$), positive stereotypic ($M = 3.07$, $SD = 1.31$), and paternalistic ($M = 4.33$, $SD = 2.50$). Scores on the aversive heterosexism subscale were the
highest, with 28.6% of participants scoring five or greater on the seven point scale.

Independent t-tests revealed no significant differences between scores of junior and senior level students for any of the subscales. Scores were significantly higher on the amnestic ($p < .001$), aversive ($p < .001$), and positive stereotypic ($p = .047$) subscales for participants without LGBT friends. Those participants without LGBT family members scored significantly higher ($p = .015$) on the paternalistic subscale. Finally, a one-way ANOVA uncovered no significant differences in scoring based on previous LGBT patient care for any of the subscales.

*Figure 2.* Histogram showing frequency distribution of participant scores on the Amnestic Heterosexism subscale.
Figure 3. Histogram showing frequency distribution of participant scores on the Aversive Heterosexism subscale.
Figure 4. Histogram showing frequency distribution of participant scores on the Positive Stereotypic Heterosexism subscale.
Figure 5. Histogram showing frequency distribution of participant scores on Paternalistic Heterosexism subscale.
Correlations between Instruments

Significant correlations between the ATLG and the MHI subscales were established by 2-tailed Pearson’s $r$ tests. The ATLG had significant positive correlations with the amnestic ($r = .62, p = .01$) and aversive ($r = .67, p = .01$) heterosexism subscales, and the amnestic and aversive subscales were significantly correlated with each other ($r = .63, p = .01$). The positive stereotypic subscale also had significant positive correlations with the amnestic ($r = .29, p = .01$) and aversive ($r = .33, p = .01$) subscales. The paternalistic heterosexism subscale had no significant correlations to any of the other instruments.

Significant Differences between Instrument Scoring

In order to determine significant differences between instrument scoring, the ATLG and the positive stereotypic subscale of the MHI were re-scaled for equivalent comparison to the other subscales of the MHI. Once rescaled, paired $t$-tests were used to analyze differences between scores on the various scales. The mean score on the ATLG was significantly less than the mean scores for the aversive, positive stereotypic, and paternalistic heterosexism subscales. The mean score for the positive stereotypic subscale was significantly less than the mean scores for the aversive and paternalistic heterosexism subscales, but was significantly larger than the mean for the amnestic heterosexism subscale. Finally, the mean score for the amnestic heterosexism subscale was significantly smaller than the aversive and paternalistic subscales.
<table>
<thead>
<tr>
<th>Instrument/Subscale Pair</th>
<th>Paired Differences</th>
<th>Std. Error Mean</th>
<th>Std. Error</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 ATLG – Pos. Stereo. Heterosexism</td>
<td>-.67893</td>
<td>2.018383</td>
<td>.128948</td>
<td>-5.265</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 2 ATLG - Amnestic Heterosexism</td>
<td>.03093</td>
<td>1.34531</td>
<td>.08595</td>
<td>.360</td>
<td>244</td>
<td>.719</td>
</tr>
<tr>
<td>Pair 3 ATLG - Aversive Heterosexism</td>
<td>-1.57485</td>
<td>1.340025</td>
<td>.0856111</td>
<td>-18.39</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 4 ATLG – Paternalistic Heterosexism</td>
<td>-1.39764</td>
<td>2.67465</td>
<td>.17088</td>
<td>-8.179</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 5 Pos. Stereo Hetero. - Amnestic Hetero.</td>
<td>.709863</td>
<td>1.519035</td>
<td>.0970476</td>
<td>7.315</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 6 Pos. Stereo. Hetero. - Aversive Hetero.</td>
<td>-.895918</td>
<td>1.710271</td>
<td>.1092652</td>
<td>-8.199</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 7 Pos. Stereo. Hetero. – Paternalistic Hetero.</td>
<td>-.718707</td>
<td>2.429794</td>
<td>.1552339</td>
<td>-4.630</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 8 Amnestic Hetero. - Aversive Hetero.</td>
<td>-1.60578</td>
<td>1.267390</td>
<td>.0809706</td>
<td>-19.83</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 9 Amnestic Hetero. – Paternalistic Hetero.</td>
<td>-1.42857</td>
<td>2.47746</td>
<td>.15828</td>
<td>-9.026</td>
<td>244</td>
<td>.000</td>
</tr>
<tr>
<td>Pair 10 Aversive Hetero. – Paternalistic Hetero.</td>
<td>.177210</td>
<td>2.510446</td>
<td>.1603865</td>
<td>1.105</td>
<td>244</td>
<td>.270</td>
</tr>
</tbody>
</table>
**Instrument Reliability**

Reliability was assessed for the ATLG scale and the MHI subscales using Cronbach’s alpha. Both instruments and all subscales demonstrated acceptable reliability. Cronbach’s alpha for the instruments were as follows: ATLG scale ($\alpha = 0.97$), MHI composite score ($\alpha = 0.90$), the amnestic heterosexism subscale ($\alpha = 0.86$), aversive heterosexism ($\alpha = 0.92$), positive stereotypic heterosexism ($\alpha = 0.86$), and paternalistic heterosexism ($\alpha = 0.98$) subscale.
CHAPTER FIVE: DISCUSSION

The purpose of this section is to discuss the findings of the study and relate them to the proposed research questions set forth in the first chapter. Specifically, data interpretation will describe how the study results answer each of the following research questions: 1) Among students enrolled and participating in a Bachelor of Science nursing program, is homophobia present? 2) Among students enrolled and participating in a Bachelor of Science nursing program, is heterosexism present? 3) Among students enrolled and participating in a Bachelor of Science nursing program, what is the relationship between homophobia and heterosexism? 4) Is there a difference in levels of homophobia between junior and senior nursing students? 5) Is there a difference in levels of heterosexism between junior and senior nursing students? In addition, limitations of the study are described and recommendations for future study are offered. Lastly, implications for nursing education are discussed.

Levels of Homophobia

The mean participant score (3.08) on the Attitudes toward Lesbians and Gay Men (ATLG) suggests that low levels of homophobia were present in the study sample. This finding coincides with other recent studies examining homophobia within a nursing student population.
Boch (2011) and Dinkel, et al., (2007) reported low levels of homophobia in nursing students attending universities in the Midwestern United States, although older, similar studies found higher levels of homophobia present (Eliason, 1998; Eliason 1991; Stiernborg, 1992). Considering Walls’ theory of modern heterosexism, declining levels of homophobia may have resulted from a shift in societal attitudes which no longer condone aggressive forms of bias against LGBT persons (Walls, 2008). Still, ATLG scores did reveal a long positive skew (see Figure 1), indicating a small percentage of participants held considerably higher levels of homophobia. With a maximum possible ATLG score of nine, 26.1% \((n = 64)\) of participants scored over 50% \((4.5)\) of the highest possible score, and 8.5% \((n = 21)\) scored 75% \((6.75)\) or greater of the score maximum. These higher scores suggest that, while overall levels of homophobia may be low, considerably higher levels were present in a small percentage of the population. In addition, ATLG mean scores were significantly higher for those groups that had no LGBT friends or family and for those who reported no previous LGBT patient contact. Similar results were reported by Boch (2011) and Dinkel, et al., (2007). These findings suggest that closer associations with LGBT persons may mitigate homophobic attitudes and that nursing students may benefit from clinical experiences that provide them the opportunity to care for LGBT patients.

**Levels of Heterosexism**

Scoring on the *Multidimensional Heterosexism Inventory’s* (MHI) amnestic, aversive, and positive stereotypic subscales ranged from one to seven, while the paternalistic subscale scores ranged from one to eight. The mean scores for the amnestic
(2.36), aversive (3.97), positive stereotypic (3.07), and paternalistic (4.33) heterosexism subscales suggest that several different types of heterosexism were present in the study sample. Walls (2008) proposes that composite MHI scores are less meaningful than individual subscale scores, since each subscale measures a specific aspect of heterosexism that relates differently to outside constructs than other forms of heterosexism. Therefore, this study considered each MHI subscale separately.

**Amnestic Heterosexism**

The mean score (2.36) for the amnestic heterosexism subscale suggests low levels of this variable in the study sample. Similar to ATLG scores, frequency distribution for the amnestic subscale revealed that the majority of participants had very low scores, while a small number of participants had considerably higher levels of amnestic heterosexism. Overall, the scores of amnestic heterosexism were the lowest of all the MHI subscales. Scores on the amnestic heterosexism subscale correlated significantly with ATLG scores, as well as with the aversive and positive stereotypic subscales, correlations supported by Walls’s theory of modern heterosexism. The amnestic heterosexism subscale identified attitudes and beliefs that deny the impact that sexual orientation has on life opportunities and societal treatment of minority sexual orientation status (Walls, 2008). Amnestic heterosexism was identified by statements such as: “Gay men are treated as fairly as everyone else in today’s society” and “discrimination against lesbians is virtually non-existent in today’s society”. Low scores achieved on the amnestic heterosexism subscale suggest that the majority of study participants recognized the continued marginalization and discrimination faced by LGBT persons in today’s society, although a small number of participants held views that modern societal bias
against LGBT persons is minimal to non-existent. Nursing students who hold such beliefs could disregard the impact that sexuality plays on a patient’s health, in spite of the findings of continued health disparities within the LGBT population (IOM, 2011).

**Aversive Heterosexism**

With a mean score of 3.97, scores of aversive heterosexism were the highest of all the MHI subscales. Frequency was similar to a bell-curve distribution, with the greatest number of scores falling mid-range, and a considerable number of participants achieving substantially higher scores. These findings suggest that participants held views consistent with strong levels of aversive heterosexism. With a maximum possible score of seven, 62.0% \((n = 152)\) of participants scored over 50% \((3.5)\) of the highest possible score, and 22.4% \((n = 55)\) scored 75% \((6.75)\) or maximum possible aversive subscale total. Scores on the aversive heterosexism subscale correlated significantly with ATLG scores, as well as with the amnestic and positive stereotypic subscales, correlations supported by Walls’s (2008) theory of modern heterosexism. Walls further theorized that aversive heterosexism is characterized by attitudes that disregard the impact sexual orientation has on social position and opportunity. The aversive subscale measures these attitudes with statements such as “lesbians have become too radical in their demands” and “gay men should stop shoving their lifestyle down everyone else’s throats” (Walls, 2008). Aversive heterosexism purports that homosexuality is too prominent in society and subsequently disregards the continuing marginalization of nonheterosexual persons. It may correspond to the “backlash” against feminism that arose as women’s issues of equality became prominent in the social consciousness (Faludi, 1991).
Similar to Faludi, Walls (2008) theorized that aversive heterosexism serves to counteract the LGBT equality movement and reinforces the predominance of heteronormativity.

Several studies found that LGBT persons often conceal their sexual orientation from health care providers (Dehart, 2008; Saulnier, 2002; Neville & Hendrickson, 2006; Rondahl, 2008). Aversive heterosexism in nurses and other health care providers reinforces such concealment by creating an unwelcoming environment for honest discussions of an LGBT person’s sexuality. By communicating views that LGBT persons are becoming too visible in today’s society, aversive heterosexism in nurses and nursing students may perpetuate the invisibility of the LGBT community and contribute to the continued health disparities experienced by this population.

**Positive Stereotypic Heterosexism**

The mean sample score for the positive stereotypic subscale was 3.07, with a possible maximum score of seven. Scores correlated significantly with the amnestic and aversive subscales and Walls’s (2008) theory of modern heterosexism supports these correlations. No correlation was found between homophobia and positive stereotypic heterosexism, a finding that corresponds to the results of a study conducted by Brown and Groscup (2009) that examined the relationship between homophobia and positive stereotypes. The majority of scores ($n = 136$) fell in a range between 2.5 and 4.5. Walls (2008) describes positive stereotypic heterosexism as positive bias based on common LGBT stereotypes that reinforces segregation and marginalization of nonheterosexual persons. The MHI identified this type of bias with items such as “lesbians are better at physically defending themselves than heterosexual women” and “gay men are more compassionate than heterosexual men”. Overall, scoring on the positive stereotypic
subscale suggests moderate levels of this particular form of heterosexism, although scoring on individual items was widely varied. For example, only 6.5% \((n =16)\) of participants scored a 5 or greater on the positive stereotypic subscale and 37.1% \((n =91)\) scored five or more on item five, which stated that “gay men take better care of their bodies than heterosexual men”. This variation may indicate that certain stereotypes are more commonly accepted than others.

Positive stereotypes may seem innocuous, however Walls (2008) proposed that they inadvertently contribute to the continued marginalization of LGBT persons. Nurses and nursing students who apply positive stereotypes to patients can compromise nursing care through erroneous assumptions. For example, if a nurse holds the stereotype that “gay men are more compassionate than heterosexual men” (item 13 on the MHI scale), he or she may fail to assess gay patients for domestic abuse, even though intimate partner violence occurs with at least the same frequency among gay partnerships as within heterosexual relationships (Freedberg, 2006). A nursing student who holds the belief that “lesbians are more independent than heterosexual women” (item 8 on the MHI scale) may fail to offer needed physical and emotional support to a patient who is lesbian.

**Paternalistic Heterosexism**

The mean score of the paternalistic heterosexism subscale was 4.33, with a possible range of one to eight. Note that paternalistic heterosexism is scored on a different scale than the other MHI subscales, which have possible ranges of one to seven. According to Walls (2008), paternalistic heterosexism is characterized by attitudes that profess concern for LGBT persons while simultaneously marginalizing those of nonheterosexual orientation. Paternalistic heterosexism was identified by statements such
as “I would prefer my daughter not be homosexual because she would unfairly face discrimination” and “I would prefer my son not be homosexual because it would unfairly be harder for him to adopt children”. Instructions on the survey indicated that if a participant disagreed with any wording or part of the paternalistic scale item, then they should indicate that they “disagree” with the statement.

The frequency distribution of the paternalistic heterosexism subscale was irregular, with no characteristic response pattern. Although Walls’s (2008) theory identified negative correlations between homophobia and paternalistic heterosexism and positive correlation between paternalistic heterosexism and positive stereotypic heterosexism, no correlations were identified in this study. The paternalistic heterosexism subscale did not significantly correlate to the ATLG or any of the other MHI subscales. Several participants expressed confusion when answering the paternalistic subscale items, seeking clarification during survey administration. Other participants approached the researcher after survey administration and stated that they were uncertain how to answer items on the paternalistic subscale. Considering the erratic frequency distribution, the lack of correlation between homophobia and other forms of heterosexism, and the considerable confusion participants expressed when responding to the items, the validity of the paternalistic heterosexism subscale is questionable in this study. Because its validity is uncertain, the paternalistic heterosexism subscale is not considered a trustworthy indicator of heterosexism within the context of this study.

Relationship between Homophobia and Heterosexism

Although levels of homophobia were lower than all other forms of heterosexism, significant positive correlations were noted between homophobia and the amnestic ($r =$
0.62, \( p = 0.01 \)) and aversive \((r = 0.67, \ p = 0.01)\) heterosexism subscales. These correlations were supported by Walls’s theory of modern heterosexism and demonstrate a significant relationship between homophobia and certain types of heterosexism. No significant relationship was found between positive stereotypic heterosexism and homophobia which suggests that persons who are not homophobic may still prescribe to positive LGBT stereotypes.

Mean scores on the ATLG were lower than any of the MHI subscales and were significantly lower than the amnestic, aversive, and positive stereotypic subscales (see Table 1). This supports the theory that low levels of homophobia do not necessarily translate into low levels of heterosexism and that levels of heterosexism would be higher than levels of homophobia. This finding is compelling, as previous studies into nursing students’ attitudes toward LGBT persons have been limited to homophobia and so may fail to consider other forms of bias that could impact the quality of nursing care. The study by Dinkel, et al. (2008) supports this view, acknowledging that the study’s low reported levels of homophobia may conceal a more subtle and pervasive form of heterosexism. According to Morrison and Dinkel (2012), distinguishing between homophobia and heterosexism is imperative, as nurses and other health care practitioners who are not homophobic may still create unrecognized barriers for LGBT patients due to heterosexist practices. In addition, studies investigating attitudes toward LGBT persons that limit their examination to homophobia may fail to capture the full spectrum of bias toward LGBT persons.
Student Progression and Levels of Homophobia and Heterosexism

The study found no significant difference between mean ATLG and MHI scores of junior and senior level students. Studies by Boch (2011) and Dinkel, et al., (2007) also reported no significant differences in levels of homophobia based on student grade level. While these findings may suggest that participation in these nursing programs had little influence on student attitudes toward LGBT persons, it is possible that different student cohorts possessed significantly disparate baseline levels of homophobia or heterosexism. Therefore, without comparing true counterfactuals, a causal relationship between progression through the nursing program and levels of homophobia/heterosexism cannot be determined.

Limitations

This study has several limitations. A convenience sample was used to recruit participants which limits its representativeness of the population. Participants may have selected whether or not to participate in the study based on unidentified variables and so there is a further risk of sampling bias. In addition, the study recruited participants from a single nursing program located in the Southeastern United States which limits generalizability of the results.

Studies that address controversial social issues such as attitudes toward LGBT persons may be subject to social desirability response bias, in which participants answer items based on the perceived social appropriateness of their response. Furthermore, the researcher conducting the study was a graduate student in the nursing school where the sample was recruited and previously taught many of the study participants.
Such familiarity may have lead participants to answer items in a way which they perceived the researcher would want them to answer.

Because there is no true counterfactual and baseline attitudes before entering the program were not determined, a causal relationship between progression through the nursing program and levels of homophobia/heterosexism cannot be determined. In addition, participant scores may not be a true reflection of levels of paternalistic heterosexism due to questionable validity of the paternalistic heterosexism subscale in this study.

Finally, instruments used in this study were designed to capture attitudes toward gay men and lesbians and did not include any items specific to bisexual, transgendered, or intersexed patients. Therefore, the results of this study cannot be generalized to these populations. Further studies that examine attitudes toward bisexual, transgendered, and intersexed persons would be beneficial.

**Recommendations**

Based on the results of this study, several recommendations for future research can be made. First, further exploration of nurses’ and nursing students’ attitudes toward LGBT persons is needed. The small number of past studies examining these attitudes have been limited to homophobia, which may not capture the full spectrum of bias toward LGBT persons. To date, this study is the first to explore heterosexism among the nursing student population and similar studies are necessary to support or disprove this study’s findings.
Longitudinal studies that examine student attitudes upon entering the nursing program and just before graduation would be of particular benefit, as they would be able to better determine the impact that nursing programs have on attitudes toward LGBT persons.

Based on recommendations by the Institute of Medicine and the Department of Health and Human Services [IOM] (IOM, 2011; USDHHS, 2012), there has been a call to integrate LGBT-health related content into BSN nursing programs (Brennan, et al., 2012; Lim & Bernstein, 2012; Lim, Brown, & Jones, 2012). Such content could potentially mitigate obstructive attitudes of homophobia and heterosexism in future nurses. However, it is uncertain how and if this content is being incorporated into current nursing curricula. Siorta (2013) found that nursing faculty often feel unprepared to offer LGBT-content. Studies by Obedin-Maliver, et al., (2011) and Rondahl (2009) reported minimal LGBT-related content in the nursing programs they examined. Further research is needed to investigate how nursing programs are currently offering content on LGBT health issues and to discover effective methods that can be used to integrate such content.

Conclusion

With the continuing demographic changes in modern society, nurses are increasingly called upon to care for diverse patient populations. The diversity that nurses encounter includes patients who identify as LGBT. As societal attitudes toward homosexuality continue to shift, LGBT persons are becoming more visible within the health care environment, and the specific health care needs of this population are being identified. Nurses can expect to care for LGBT patients during their careers and should recognize how their attitudes toward nonheterosexual persons impact the care they provide. Although this study found low levels of homophobia among nursing students,
higher levels of heterosexism were present. Past studies have established that heterosexism in nurses can have adverse consequences on the health care provided for LGBT persons. As future nurses, students have a responsibility to offer culturally appropriate care to all patient populations, including patients who identify as LGBT. Ultimately, it is the responsibility of nursing education to provide these students with the skills they need to provide sensitive, patient-centered care for LGBT persons and their families.
REFERENCES

doi:10.1080/14681994.2010.515206


Brennan, A., Barnsteiner, J., de Leon Siantz, M., Cotter, V. T., & Everett, J. (2012). Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula.


Retrieved from http://medicalsexuality.org/


Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., & ... Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender-related content in


Appendix A

Kennesaw State University IRB Approval Letter
7/15/2013

Johnathan Steppe, Student
KSU Wellstar School of Nursing

RE: Your application dated 7/12/2013, Study #14-002: Heterosexism and Homophobia among Students Participating in a Bachelor of Science Nursing Program

Dear Mr. Steppe:

I have reviewed your application for the new study listed above. This study qualifies as exempt from continuing review under DHHS (OHRP) Title 45 CFR Part 46.101(b)(2) - educational tests, surveys, interviews, public observations. The consent procedures described are in effect. You are free to conduct your study.

Please note that all proposed revisions to an exempt study require IRB review prior to implementation to ensure that the study continues to fall within an exempted category of research. A copy of revised documents with a description of planned changes should be submitted to irb@kennesaw.edu for review and approval by the IRB.

Thank you for keeping the board informed of your activities. Contact the IRB at irb@kennesaw.edu or at (678) 797-2268 if you have any questions or require further information.

Sincerely,

Christine Ziegler, Ph.D.
Institutional Review Board Chair

cc: bblake@kennesaw.edu
Appendix B

Original Research Consent Form
Research Consent Form

**Title of Research Study:** Heterosexism and Homophobia among Students Participating in a Bachelor of Science Nursing Program

**Researchers Contact Information:** Johnathan Steppe, RN, BSN, CCRN (404-661-3470, jds8853@students.kennesaw.edu). Faculty advisor, Barbara Blake, PhD, RN (770-423-6385, bblake@kennesaw.edu).

**Introduction:** You are being invited to take part in a graduate research study conducted by Johnathan Steppe. Before deciding whether or not to participate in the study, please read the following material that explains the study and the benefits and risks involved. You should ask questions about anything you do not understand. The researcher will be present during administration of the study materials, and is also available to answer any questions or concerns at the above listed email address and telephone number.

**Description of Project:** Heterosexism can be defined as attitudes, values, or beliefs that stigmatize, denigrate, or discriminate against any form of sexual identity other than heterosexuality. Homophobia can be defined as internalized fear, hatred, or disgust toward nonheterosexual persons. Research has found that heterosexism and homophobia in nurses can negatively impact the quality of nursing care received by lesbian, gay, bisexual, and transgendered (LGBT) patients. The purpose of this study is to examine whether or not heterosexism or homophobia is present in the nursing student population, and if so, to what extent.

**Explanation of Procedures:** You are being asked to complete two brief surveys, designed to measure heterosexism and homophobia. The first instrument is the Multidimensional Heterosexism Inventory. The second instrument is Attitudes toward Lesbians and Gay Men Scale. In addition, we ask that you complete a short demographic form. Completion of the two instruments and the demographic form should take no more than 20 minutes.

The first assessment instrument is the Multidimensional Heterosexism Inventory which examines four domains of heterosexism: amnestic, aversive, paternalistic, and positive stereotypical. It includes 23 questions. The second instrument is the Attitudes toward Lesbians and Gay Men Scale identifies and measures homophobic attitudes. It includes 20 questions. There are no right or wrong answers to the questions, and you should answer the questions as honestly as possible. The Demographic Survey includes 15 questions.

Participation in this study is strictly voluntary. Participants must be 18 years or older to participate. You must be currently accepted and participating in either the traditional, accelerated, or RN to BSN nursing programs to participate in the study. Non-nursing majors, graduate level nursing students, and international physician-to-nurse practitioner
students are not eligible to participate. You have the right to not participate, and you may change your mind at any time and withdraw from the study. You may choose not to answer specific questions for any reason. Whether you choose to participate or not will have no effect on your grade or your status in the nursing program. Only the researcher and faculty advisor will see the answers to your questions. Your completed surveys and demographic forms contain no personal identifiers; therefore your answers cannot be linked to you as an individual. After completing the surveys and demographic form, you should place all materials back in the envelope provided and seal it before returning it to the researcher. The researcher will secure all collected envelopes and will open them only in private and only after all data for the study has been collected.

**Risks or Discomforts:** The only known risk to you is that you may be uncomfortable answering questions about personal beliefs and attitudes toward sexuality. You may also be uncomfortable answering questions about your religious beliefs, political affiliation, and sexual orientation.

**Costs, Benefits and Compensation:** There is no cost for participating in this study. After submitting the completed research packet, you will receive a bag containing an assortment of candy, dried fruit, nuts, and snack bars. This is the only benefit or compensation for you. However, your participation may contribute to the future quality of nursing care for LGBT patients.

**Confidentiality:** No personal identifiers, such as name or student identification number, shall be collected. The information packets contain no identifiers, and shall not be opened until all surveys have been collected. No one, including the researcher, will be able to identify which research packet is yours. Research results will be reported only as group data. The collected surveys will be kept in a locked safe and all electronic data will be kept on a secure, password-protected computer. The computer and the safe will be kept in a locked location protected by a security system. Collected data shall be kept for 5 years and then shall be destroyed. Electronic data shall be erased once it has been analyzed.

The purpose of this research has been explained and my participation is voluntary. I have the right to stop participation at any time without penalty. I understand that the research has no known risks, and I will not be identified. By completing the surveys, I acknowledge that I am 18 years or older, and I am agreeing to participate in this research project.

**THIS PAGE MAY BE REMOVED AND KEPT BY EACH PARTICIPANT**

Research at Kennesaw State University that involves human participants is carried out under the oversight of an Institutional Review Board. Questions or concerns regarding these activities should be addressed to the Institutional Review Board, Kennesaw State University, 1000 Chastain Road, #0112, Kennesaw, GA 30144-5591, (678) 797-2268.
Appendix C

Demographics Sheet
Demographic Questionnaire

Do not write your name or any personal identifiers on this form. The information collected will allow us to accurately describe the study’s sample. It will not be used to identify you. In the questions, LGBT stands for “lesbian, gay, bisexual, or transgendered”.

1. What is your gender? ________________________________
2. What is your age? ________________________________
3. What is your race/ethnicity? _______________________________
4. I would describe myself as:
   - [ ] Heterosexual/Straight
   - [ ] Gay
   - [ ] Lesbian
   - [ ] Bisexual
   - [ ] Transgender
   - [ ] Other (describe):
     ___________________________________________________
5. Do you have sex with men, women, or both?
    __________________________________________
6. Do you have lesbian, gay, bisexual, or transgendered (LGBT) family members?
    YES     NO
7. Do you have LGBT friends?
    YES     NO
8. During your clinical experiences, have you provided nursing care for LGBT patients?
    YES     NO     DON’T KNOW
9. I would describe my political beliefs as:
   □ Conservative
   □ Liberal
   □ Moderate
   □ Independent
   □ Other (describe):

   ________________________________________________________________

10. What is your religion? ___________________________________________

11. How often do you attend religious services? _________________________

12. Which nursing courses are you currently taking?

   ________________________________________________________________

   ________________________________________________________________

13. Are you enrolled in the traditional, accelerated, or RN-BSN nursing program?

   ________________________________________________________________

14. Besides nursing school, do you have other health care experience?

   YES       NO

15. If you answered “yes” to question 14, what experience(s) do you have?

   ________________________________________________________________

   ________________________________________________________________

Thank you for completing the surveys. Please place all of the surveys back into the envelope, seal it, and return the sealed envelope to the researcher.
Appendix D

Recruitment Flyer
Current Nursing Students Needed for Research Study

Students currently enrolled and participating in Kennesaw State University’s Bachelor of Science in nursing program are needed to participate in an original research study. The purpose of the study is to identify whether or not heterosexism and homophobia are present among nursing students, and if so, to what extent. All students participating in the traditional, accelerated, or RN to BSN programs are eligible to take part in the study. Participation is voluntary and not required as part of your academic program. Whether or not you choose to participate has no impact on your grades or academic progression. Non-nursing majors, Graduate nursing students, and international physician-to-nurse practitioner students are excluded from participation.

The assessments that will be used are the Multidimensional Heterosexism Inventory and the Attitudes Toward Lesbians and Gay Men Scale. You will also be asked to answer some demographic questions at the end of the two assessments. The assessments will take no more than 20 minutes to complete. At the end of the assessments you will be given a small bag containing an assortment of candy, dried fruit, nuts, and snack bars.

**When:** Wednesday, September 18 and Thursday, September 19 from 10:00 am until 2:00 pm.

**Where:** Prillaman Hall, Third floor sitting area, outside the nursing faculty offices.

If you are have questions about the study, please contact Johnathan Steppe at 404-661-3470, jds8853@kennesaw.edu
Appendix E

Multidimensional Heterosexism Inventory
Multidimensional Heterosexism Inventory

For this first group of questions, please check the answer that best matches your agreement or disagreement with the statement.

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<th></th>
<th>Strongly Disagree</th>
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<th>Neither Agree nor Disagree</th>
<th>Slightly Agree</th>
<th>Somewhat Agree</th>
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<tr>
<td>1. Lesbians are given too much attention in today's society.</td>
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<td>2. Gay men are treated as fairly as everyone else in today's society.</td>
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<td>3. Lesbians are better than heterosexual women at physically defending themselves.</td>
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<td>4. Lesbians make too much noise about their sexuality.</td>
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<td>5. Gay men take better care of their bodies than do heterosexual men.</td>
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<td>6. Most people treat lesbians as fair as they treat everyone else.</td>
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<td>7. Gay men should stop showing their lifestyle down everyone else's throat.</td>
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<td>8. Lesbians are more independent than heterosexual women.</td>
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<td>9. Things would be better if lesbians would quit trying to force their lifestyle on everyone else.</td>
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<td>10. Gay men no longer face discrimination in the U.S.</td>
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<td>11. Lesbians have become too radical in their demands.</td>
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<td>12. Gay men are more compassionate than heterosexual men.</td>
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<td>13. Lesbians excel at outdoor activities more than heterosexual women.</td>
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<td>14. There is too much attention given to gay men on television and in the media.</td>
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<td>15. Discrimination against lesbians is virtually non-existent in today's society.</td>
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<td>16. Lesbians are better than heterosexual women at auto maintenance and repair.</td>
<td>Strongly Disagree</td>
<td>Somewhat disagree</td>
<td>Slightly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Slightly Agree</td>
<td>Somewhat Agree</td>
<td>Strongly Agree</td>
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For this second group of questions, we **ASSUME** that you have a son/daughter or we ask you to **IMAGINE** that you have a child if you do not have one. Please check the answer that most closely matches your agreement or disagreement with each statement. Also note, that sometimes the question refers to having a daughter and sometimes to having a son.

If you agree with **ALL** parts of the statement then your answer should be on the agree side of the scale. If you disagree with **ANY** part of the statement then your answer should be on the disagree side of the scale. If you are just as happy having a gay/lesbian kid as a heterosexual kid, then you can check the **OK with Gay Kid** answer.

<table>
<thead>
<tr>
<th>17. I would prefer my daughter <strong>NOT</strong> be homosexual because she would <strong>unfairly</strong> be stopped from adopting children.</th>
<th>Okay with gay kid</th>
<th>Strongly Disagree</th>
<th>Somewhat disagree</th>
<th>Slightly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Slightly Agree</th>
<th>Somewhat Agree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>18. I would prefer my son <strong>NOT</strong> be homosexual because most churches would <strong>unfairly</strong> reject him.</td>
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<td>19. I would prefer my daughter <strong>NOT</strong> be homosexual because she would face <strong>unfair</strong> discrimination.</td>
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<td>20. I would prefer my son <strong>NOT</strong> be homosexual because he would <strong>unfairly</strong> be denied the right to marry the man he loved.</td>
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<td>21. I would prefer my daughter <strong>NOT</strong> be homosexual because religious institutions <strong>unfairly</strong> reject lesbians.</td>
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<td>22. I would prefer my son <strong>NOT</strong> be homosexual because it would <strong>unfairly</strong> be harder for him to have or adopt children.</td>
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<tr>
<td>23. I would prefer my son <strong>NOT</strong> be homosexual because he would <strong>unfairly</strong> be discriminated against.</td>
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Appendix F

Permission to Use Multidimensional Heterosexism Inventory and Attitudes toward Lesbians and Gay Men Scale
Johnathan Steppe <jds8853@students.kennesaw.edu> Apr 24

to Eugene.Walls

Dear Dr. Walls,

I am a nursing graduate student with a focus in nursing education, and am writing you to request permission to utilize the Multidimensional Heterosexism Inventory for my Master's thesis. My topic is heterosexism in nursing education, a topic which to date has not been addressed. Other studies have focused on homophobia, and have used instruments to reflect that particular phenomenon. I believe your instrument would prove valuable in assessing levels of heterosexism within the nursing student population. I would be very appreciative if you would consider my request. Thank you for your time.

Sincerely,

Johnathan D. Steppe, RN, BSN, CCRN
jds8853@students.kennesaw.edu

Reply Forward

Johnathan Dear Dr. Walls, I am a nursing graduate student with a focusing on nursing ed...

Dear Dr. Walls, I am a nursing graduate student with a focusing on nursing ed...

Eugene Walls <Eugene.Walls@du.edu> Apr 26

to me

Johnathan,

Feel free to use the scale. And, let me know how your study turns out!

Peace,

Eugene

N. Eugene Walls, MSSW, PhD

Associate Professor

PhD Program Director
Blanket permission to use the Attitudes toward Lesbians and Gay Men scale was given by the instrument’s designer in the Handbook of Sexually Related Measures (Herek, 1998).
Appendix G

Attitudes toward Lesbians and Gay Men Scale
# Attitudes Toward Lesbians and Gay Men Scale

Darken the box of the number that best represents your opinion.

**Key:**
- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lesbians just can't fit into our society.</td>
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<td>2. A woman's homosexuality should not be a cause for job discrimination in any situation.</td>
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<td>3. Female homosexuality is bad for society because it breaks down the natural divisions between the sexes.</td>
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<td>4. State laws against private sexual behavior between consenting adult women should be abolished</td>
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<td>5. Female homosexuality is a sin.</td>
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<td>6. The growing number of lesbians indicates a decline in American morals.</td>
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<td>7. Female homosexuality in itself is no problem unless society makes it a problem</td>
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<td>8. Female homosexuality is a threat to many of our basic social institutions</td>
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<td>9. Female homosexuality is an inferior form of sexuality</td>
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<td>10. Lesbians are sick</td>
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<td>11. Male homosexual couples should be allowed to adopt children the same as heterosexual couples</td>
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<td>12. I think male homosexuals are disgusting</td>
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<td>13. Male homosexuals should not be allowed to teach school</td>
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<td>14. Male homosexuality is a perversion</td>
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<td>15. Male homosexuality is a natural expression of sexuality in men</td>
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<td>16. If a man has homosexual feelings, he should do everything he can to overcome them</td>
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<tr>
<td>17. I would not be too upset if I learned that my son were a homosexual</td>
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<td>18. Sex between two men is just plain wrong</td>
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<td>19. The idea of male homosexual marriages seems ridiculous to me</td>
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<td>20. Male homosexuality is merely a different kind of lifestyle that should not be condemned</td>
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