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A Mixed Methods Study of Beliefs, Behaviors, and Experiences of Advanced Practice Nurses with Lesbian and Gay Patients

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APRNs are increasingly providing more of the primary care services to diverse populations in the United States. The population includes persons of non-heterosexual identities who often encounter barriers when seeking health care. Given the minuscule focus in nursing education about these patient populations, a clearer understanding of APRNs' beliefs, behaviors, and experiences caring for lesbian and gay patients was essential.

The purpose of this mixed methods study was to explore and identify the beliefs, behaviors, and experiences of APRNs with lesbian and gay and patients. Social constructionism was the theoretical perspective that guided this study, and the philosophical perspective of pragmatism informed the methodology. The study followed a convergent parallel design informed by Creswell and Plano Clark (2011). A sample of 678 APRNs from a northeastern state completed an on-line survey comprised of the 30-item, Gay Affirmative Practice (GAP) (Crisp, 2002) Likert-type scale, 13 demographic items and an open-ended statement requesting a description of experiences of having cared for lesbian and gay patients. Quantitative data were analyzed using descriptive statistics and ANOVA. Qualitative data were analyzed using Krippendorff's (2013) content analytic technique of clustering units to form themes. ANOVA indicated statistically significant differences in GAP scale scores based on personal identity, having a lesbian or gay family member, political party, practice place, practice focus, and number of lesbian and gay patients. Eight thematic categories emerged from APRN experiences:

affirming, more education needed, witnessed discrimination, limited experience with lesbian/gay patients, sexual orientation only asked if relevant, treat all the same, non-affirming, and *sexual orientation not focus of practice*. The thematic categories of *affirming, have witnessed discrimination,* and *more education needed* consistently had the highest GAP scale scores compared to the other themes.

This study has helped to lay a foundation for understanding the beliefs, behaviors and experiences of APRNs who have cared for lesbian and gay patients. Results may inform health care providers to demonstrate greater individualized care for patients who are lesbian and gay, and inform nursing education, practice, policy, and research aimed to provide culturally appropriate and affirming care for these patient populations.

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A Mixed Methods Study of Beliefs, Behaviors, and Experiences of Advanced Practice Nurses with Lesbian and Gay Patients

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DEDICATION

I dedicate this dissertation to my mother, Luleanna (Lue) who has been with me in spirit throughout this journey. The strength, persistence and determination you demonstrated throughout your life guided me throughout this scholarly journey. The question that you asked me over thirty years ago still resonates in my mind: “What exactly do you do as a nurse?” I answered your question back then and will add that this scholarly endeavor is another equally important role of a nurse.

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Chapter One: Introduction

"The fact that we are here and that we speak these words is an attempt to break that silence and bridge some of those differences between us, for it is not difference which immobilizes us, but silence. And there are so many silences to be broken." (Lorde, 1984, p.44).

Background

There are currently approximately 267,000 Advanced Practice Nurses (APRN) in the United States and about 86.5% are practicing with a primary care focus (National Council of State Boards of Nursing, 2012). Moreover, APRNs provide health care services to an increasingly diverse population in the United States. This diverse population includes individuals with diverse sexual and gender identities often referred to as lesbian, gay, bisexual, or transgender or by the acronym LGBT. Nursing has had a long history of silence with regard to LGBT education (Eliason, Dibble, & DeJoseph, 2010); therefore, the dearth of nursing research about APRNs' beliefs, behaviors, and experiences in clinical practice with these individuals is not surprising. This lack of knowledge is of concern since recent conservative estimates show approximately 3.8% of the population in the United States is LGBT (Gates, 2011). Among adults who identify as LGB, bisexuals comprise a slight majority with 1.8% compared to 1.7% who identify as lesbian or gay (Gates, 2011). The population of individuals who are transgender in the United States is approximately 700,000 (Gates, 2011). A more precise population count is difficult to ascertain since sexual orientation (SO), and gender identity (GI) data are not routine demographic questions in the US Census and health forms. As such, the lack of more precise population counts serves to keep many who are LGBT invisible in society.

Greater focus is now given to the social and cultural determinants of health impact on healthcare disparities (Institute of Medicine, 2011; Kriger, 2001; Malterud et al., 2009),

including nursing that traditionally addressed health from the individual and family perspective. For example, the American Nurses Association (ANA) diversity awareness mission statement recognizes and appreciates "the existence of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations" (American Nurses Association, 2012, para 1). Sexual orientation and gender identity are not explicit in this statement but deserve consideration within the context of this provision. More recently, the revised ANA (American Nurses Association, 2015) Code of Ethics obliges nurses to "practice[s] with compassion and respect for the inherent dignity, worth and unique attributes of every person" (American Nurses Association, 2015, p. 1). The code further summons all nurses to reserve any bias or prejudice and consider "culture, value systems, religious, or spiritual beliefs, lifestyle, social support system, sexual orientation or gender expression, and primary language when planning individual, family, and population-centered care" (American Nurses Association, 2015, p.1)

National accreditation standards for healthcare professionals' licensure and health care policies, such as the Affordable Care Act, have emphasized the importance of cultural competency as a component of quality healthcare services (U.S. Department of Health and Human Services, OPHS Office of Minority Health, 2013). Historically, education about cultural competence and diversity has excluded information on diversity in sexual and gender identities and instead addressed race, ethnicity, and religion (Institute of Medicine, 2011). In 2013, the *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*) were, for the first time LGBT-inclusive (U.S. Department of Health and Human Services, OPHS Office of Minority Health, 2013). The term LGBT is an umbrella term used to represent the broader population of individuals whose sexual

orientation and gender identities do not follow heteronormative frameworks (Institute of Medicine, 2011; Makadon, Mayer, Potter, & Goldhammer, 2008). Reference to lesbian and gay in this study focuses on two subgroups within the broader LGBT population. The bisexual and transgender populations are equally important, and future studies will focus on them. Findings from this mixed methods study about APRNs' beliefs, behaviors, and experiences in clinical practice with lesbian and gay individuals, will inform future similar studies with other groups within the LGBT community.

Under the new health reform laws in the United States, Advanced Practice Nurses (APRN) are positioned to provide more of the primary health care services that have been traditionally provided by physicians. Hauer and colleagues (2008) published findings from a 2007 survey of 11 medical schools in the United States that showed only 2% of medical students planned to choose careers in internal medicine. Among the 267,000 APRNs in the United States (National Council of State Boards of Nursing, 2012), there were over 4,300 licensed APRNs in Connecticut in 2015 (Connecticut Department of Public Health., 2015). APRNs practice in a variety of healthcare environments including hospitals, primary care offices, and clinics. Individuals of diverse sexual and gender identities seek healthcare services in all these practice settings; however, little is known about the beliefs and behaviors or experiences of APRNs who provide healthcare services for LGBT individuals.

Addressing health disparities regarding race, ethnicity and sex has been a public health priority since the federal government published the Healthy People 2000 report (Public Health Service, 1990). Unfortunately, health disparities based on sexual and gender orientation were largely ignored until the Healthy People 2010 report (Lim & Bernstein, 2012). In a more recent report by the Institute of Medicine (2011), they found that people who identify as LGBT share

similar health care needs as the rest of society but often have additional health risks that worsen due to social stigma.

LGBT individuals experience health care disparities and have unique health care needs (Corliss, Shankle, & Moyer, 2007; Eliason et al., 2010; Institute of Medicine, 2011; Keepnews, 2011; Kelleher, 2009; Neville & Henrickson, 2006; Obedin-Maliver et al., 2011; Peate, 2008a; Peate, 2008b; Peate, 2008c; Smith, McCaslin, Chang, Martinez, & McGrew, 2010; Tracy, Lydecker, & Ireland, 2010; U.S. Department of Health and Human Services., 2010; Weber, 2010a; Weisz, 2009; Zaritsky & Dibble, 2010). Consequently, the LGBT population remains vulnerable and marginalized on its social status in a society where heteronormative cultural norms persist (Eliason et al., 2010; Institute of Medicine, 2011; Keepnews, 2011; Mays & Cochran, 2001). The IOM (2011) report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* called for routine data collection on sexual orientation and gender identity to better understand and address health disparities among this population. Each subgroup within the LGBT population has unique healthcare needs that healthcare providers should know to provide culturally appropriate care.

Many different health concerns were identified in the IOM (2011) and the Healthy People 2020 (USDHHS, 2014) reports that included issues about social determinants of health, the physical environmental and specific healthcare disparities. The following represents some of the concerns in each of these areas:

- Shortage of health care providers who are knowledgeable and culturally competent in LGBT health
- Access to health services
- Lack of laws to protect against bullying in schools

- Legal discrimination with respect to employment, housing, and adoption
- Lack of social programs targeted to and/or appropriate for LGBT youth, adults, and elders
- Safe schools, neighborhoods, housing, meeting places, and recreational facilities
- LGBT youth are two to three times more likely to attempt suicide
- LGBT youth are more likely to be homeless
- Lesbians are less likely to get preventive services for cancer
- Lesbians and bisexual females are more likely to be overweight or obese
- Gay men are at higher risk of HIV and other STDs, especially among communities of color
- Transgender individuals have a high prevalence of victimization, mental health issues, suicide, HIV/STDs, and are less likely to have health insurance than heterosexual or LGB individuals
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use (IOM, 2011; USDHHS, 2014)

The context of culturally appropriate and individualized patient care in this study refers to clinical practice informed by the concept of gay affirmative practice. This approach to practice is a culturally congruent way to provide care for individuals who identify as lesbian or gay, and is an essential step toward reducing health disparities in this population (Davies & Neal, 1996; Hunter & Hickerson, 2003). Pervasive societal heterosexism and homophobia are shown to contribute to healthcare disparities among the lesbian and gay populations particularly when

these ideologies persist throughout healthcare (Appleby & Anastas, 1998; Davies & Neal, 1996). Affirmative practice initially emerged from gay affirmative therapy in psychology and has since expanded to include a variety of affirmative approaches in clinical practice with lesbian, gay, bisexual, and transgender populations (Crisp, 2006). This approach to practice "affirms a lesbian, gay, or bisexual identity as an equally positive human experience and expression to heterosexual identity" (Davies & Neal, 1996, p. 25). Practitioners need to reflect upon their values and attitudes that inhibit or enhance their ability to demonstrate affirmative practice when caring for individuals who identify as lesbian or gay. There is certainly opportunity for nurses to incorporate this approach to practice when caring for individuals with diverse sexual and gender identities. A more in-depth discussion of this concept follows in chapter two.

Several national initiatives by prominent organizations were an impetus to conduct a mixed methods study on APRNs' beliefs, behaviors, and experiences in clinical practice with lesbian and gay patients. Further incentive emerged from the Healthy People 2000, 2010 and 2020 goals that have consistently addressed health disparities. In 2000, the goal was to reduce health disparities, 2010 it was to eliminate them, and the 2020 goals are to achieve health equity, eliminate disparities and improve the health for all. The most recent Healthy People 2020 (USDHHS, 2014) report defines a health disparity as:

> A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender

> identity; geographic location; or other characteristics historically linked to discrimination or exclusion (p. 28).

The aim to eliminate health disparities includes educating all nurses to work in a global society in collaboration with other healthcare disciplines.

In response to the paucity of data on the health of LGBT populations, the Institute of Medicine (IOM) published two significant reports. The first report, *Lesbian Health: Current Assessment and Directions for the Future*, addressed the state of the science of lesbian health, established lesbian health research priorities, and identified methodological challenges conducting research on this population (IOM, 1999). At that time, there was increasing focus on women's health, yet published studies seldom differentiated women based on diverse sexual and gender identities. As a result, it was difficult to identify the unique health needs of lesbian women. This report did challenge misconceptions such as the belief that preventative gynecologic care was not as important for lesbian women as it was for those who were heterosexual (IOM, 1999). Other findings of this report identified health conditions for which lesbian women were at greater risk than those who were heterosexual and acknowledged the lack of funding studies needed to stimulate research on key lesbian health issues and to identity barriers accessing health care (IOM, 1999). Understandably, the lack of funding has served to limit lesbian health research. Such inadequate research also serves to limit healthcare providers' understanding of best practices and knowledge of the unique health care needs of the lesbian population.

Then, the IOM (2011) report, *The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Building a Foundation for a Better Understanding*, presented a consensus on the state of the science of the health status of lesbian, gay, bisexual, and transgender populations.

Similar to the 2009 report, this report identified research gaps and recognized evolving research data on the LGBT population; however, few data focused on health issues. The IOM (2011) report acknowledged that the LGBT population experiences unique health disparities and identified gaps in research that limited our understanding of these disparities. For example, lesbian women are less likely to seek preventative cancer screening as mammography and Papanicolau tests and gay and bisexual men are at increased risk for sexually transmitted infections, and many risk becoming disabled by chronic health problems at a younger age than heterosexual persons (U.S. Department of Health and Human Services, 2014). Geographic residence, race, ethnicity, socioeconomic status, age, and societal stigma influence individual health care needs, experiences, and outcomes (IOM, 2011). Findings from the IOM (2011) study supported patient-centered care that identifies, respects, and addresses differences in patients' values, preferences, and expressed needs. Although the life experiences of individuals with diverse sexual and gender identifies are unique and should not be categorized or generalized, a clearer understanding of population specific health disparities provides a baseline of understanding from which to work. APRNs are well situated to lessen the burden of societal, cultural stigma toward the lesbian and gay populations by providing culturally appropriate health care services.

In the 2010 report, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, the Joint Commission outlined recommendations for meeting these goals from admission through discharge. The *Roadmap for Hospitals* outlined many recommendations and resources for hospitals to consider when caring for LGBT patients and broadened the definition of family to include friends and same-sex

partners (Joint Commision, 2010). This report advanced the conversation of providing culturally competent care for LGBT persons to the forefront of many health care organizations.

The following year, the Joint Commission (2011) published a field guide, *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care for the Lesbian, Gay, Bisexual and Transgender Community.* In this report, the Joint Commission asked health care leadership to ensure LGBT persons received safe, welcoming, and non-discriminating care at all levels in the organization (Joint Commission, 2011). Despite the federal, state, and local efforts to obtain additional data aimed at improving LGBT health care, the Joint Commission (2011) demanded more immediate action to mitigate LGBT health care discrimination. Healthcare environments are often frightening and lead to stress and anxiety for many patients; however, when compounded by discrimination and substandard care, LGBT patients risk feeling vulnerable and invisible in the health care setting (Lambda Legal, 2010). The field guide emphasizes nondiscrimination in patient care and focuses on patient-centered care intended to educate, inspire, and motivate health care providers to help improve the health care experiences of the LGBT community. Patient-centered care "encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient" (IOM, Committee on Quality of Health Care in America, 2001, p. 48).

These are also values embedded in the ANA Code of Ethics that serve to guide nursing practice. In the past decade, the American Association of Colleges of Nursing (AACN) has proposed integrating cultural competency in baccalaureate, master's, and doctoral nursing education curricula to establish a culturally competent nursing workforce (AACN, 2008; 2009). At the graduate level of education, the AACN (2009) calls nurses to broaden their perspectives and challenge their assumptions and to reflect critically on their practice. This call to action is

particularly affirming because gender identity and sexual orientation are inclusive attributes of being human. Aided by thoughtful self-reflection and action, nurses are urged to question their assumptions and those of colleagues and students about these diverse populations.

In 2011, the American Academy of Nursing (AAN) convened an expert panel of nurses to identify and discuss issues affecting the health of lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons and to promote nursing research and policy development on behalf of this community (AAN, 2014). The initial aim of this expert panel was to recommend health policy to decrease health disparities based on sexual orientation or gender identity. The academy's initiative demonstrates a commitment to diversity and inclusion and aligns with the Institute of Medicine's (2011) report, *The Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) People: Building a Foundation for a Better Understanding* that recognizes the importance of research efforts on LGBTQ health. Since the AAN panel convened, they have released several other position statements and policy briefs in support of culturally sensitive, high quality, and comprehensive health care for LGBTQ health. There is a discussion of these specific actions in the following paragraphs.

In 2012, the AAN released a position statement, *Health Care for Sexual Minority and Gender Diverse Populations* that resolutely opposed any discrimination based on a person's sexual orientation or gender identity and continued their support of research and health policy for this population. The AAN expert panel on LGBT health reminds us that human beings are complex and have existed with these varying dimensions of human sexuality throughout history and as such deserve respectful, dignified and culturally appropriate health care (AAN, 2012).

In their continued support, AAN (2015a) released a policy brief in support of the US Department of Health and Human Services (USDHHS) Centers for Medicare and Medicaid

Services (CMS) requirement of hospitals to allow patients to choose their visitors. This 2011 federal legislation prohibits discrimination based on sexual orientation and gender identity (AAN, 2015c). Although most U.S. hospitals are compliant with this ruling, there are still many that do not follow the policy or disregard it (Human Rights Campaign, 2014). Nurses are well positioned as patient advocates to insist hospitals uphold the visitation policy and educate their patient about these rights. Furthermore, the first provision of the ANA (2015) Code of Ethics proclaims the "nurse in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and unique attributes and human rights of all individuals" (p. 1). The actions of the AAN emulate the nursing Code of Ethics as they continue to support the rights of hospitalized LGBT individuals and their family of choice to visit them and participate in their care.

Later that same year, the AAN released several additional position statements in support of non-discrimination against LGBT persons. First, they advocated against any employment discrimination based on sexual orientation and gender identity (AAN, 2015b). Current federal employment non-discrimination laws protect federal employees and contractors but do not extend to protect LGBT persons in all fifty states (American Civil Liberties Union, 2015). Employment discrimination negatively impacts the ability to access employer-subsidized insurance; however, the Affordable Care Act (ACA) has helped to lessen this burden for many who are LGBT. The expanded coverage and non-discrimination safeguards of the ACA have greatly helped to provide greater access to health care services for LGBT persons (Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2015). Unfortunately, it is uncertain if this same healthcare coverage will continue under the new federal administration.

The AAN also publically opposes any reparative or conversion therapy aimed to change the sexual orientation of an LGBT individual (AAN, 2015a). Such practices are deemed unsafe, unsuccessful, and disregard the inherent dignity, worth, and uniqueness of lesbian and gay persons (American Medical Association (AMA), 2014; American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009; Pan American Health Organization, 2012). There are only five states that have passed legislation to ban the practice of using reparative therapies to change sexual orientation or gender identity, and more than 20 other states that have introduced similar legislation (HRC, 2017). Unfortunately, there are more states that have not taken any action. Based on the aforesaid, the AAN recognizes consensual same-sex relationships between adults as another variation of human sexuality (AAN, 2015c). Despite the opposition to reparative therapies, not all APRNs may share this view and as such could negatively impact the quality of care provided LGBT individuals.

Significance

Many lesbian and gay people continue to encounter barriers to care and culturally inappropriate treatment when they seek health services (Cahill et al., 2014; Corliss et al., 2007; Gay and Lesbian Medical Association (GLMA), 2001; Keepnews, 2011; U.S. Department of Health and Human Services., 2014). The literature supports that societal stigma and discrimination contribute to health care disparities. These disparities lead to added and unnecessary stress for this minority population and result in health issues that require healthcare intervention (Cahill et al., 2014).

All nurses have a moral and ethical obligation to provide culturally appropriate care to vulnerable and marginalized populations and doing so supports social justice, validates human

rights, and respects the inherent dignity of each person. Nurses are uniquely positioned to make a difference in health outcomes for these vulnerable and marginalized populations, yet there is evidence to support that heterosexism and homophobia exist in nursing (Blackwell & Kiehl, 2008; Blackwell, 2008b; Blackwell, 2007; Rondahl, Innala, & Carlsson, 2006; Rondahl, 2009; Rondahl, Bruhner, & Lindhe, 2009). Some nurses continue to provide culturally insensitive care despite being educated to preserve human dignity, honor individuality, serve as patient advocates, and provide culturally appropriate individualized, patient-centered services for all human beings. Understandably, the literature supports that lesbian and gay populations are underserved with respect to health care services, access, and culturally appropriate care.

For the reasons noted above, this study will help to raise awareness about the importance of providing more holistic, person-centered, and culturally appropriate care to lesbian and gay persons. The significance in the end will be that more health care providers, including APRNs, may provide greater individualized care that encompasses the physiological, psychosocial, emotional, spiritual, environmental, and sociocultural human dimensions essential to lesbian and gay people. Furthermore, the results may help to inform nursing education, practice, policy, and future research aimed to support culturally appropriate and gay affirming person-centered care for these patient populations.

Purpose

There is a paucity of data to explicate APRNs' experiences, beliefs, and behaviors in clinical practice with gay and lesbian patients in the U.S. Likewise, there are limited studies about primary care providers' knowledge and attitudes about lesbian and gay persons and health care issues (Makadon, 2011). The majority of studies in nursing about culturally appropriate care for gay and lesbian people were conducted outside the United States (Eliason et al., 2010;

Giddings, 2005). A few recent studies have addressed nurses' attitudes toward lesbian and gay individuals (Blackwell, 2008; Blackwell & Kiehl, 2008; Blackwell, 2007; Rondahl, Innala, & Carlsson, 2004), and nursing students' knowledge about LGBT persons (Rondahl, 2009). Other studies have identified, heterosexism and homophobia in nursing (Blackwell & Kiehl, 2008; Blackwell, 2007; Rondahl et al., 2004; Rondahl, Innala, & Carlsson, 2006), and registered nurses' attitudes toward the protection of lesbian and gay individuals in the workplace (Blackwell, 2007; 2008). Based on so few studies, additional data are needed to identify current beliefs and behaviors of APRNs in clinical practice with lesbian and gay individuals. The scarcity of such data is of concern as increasing numbers of APRNs continue to enter the workforce.

The purposes of this mixed methods study are to (a) identify the beliefs and behaviors of APRNs when caring for lesbian and gay and patients and (b) obtain a more complete understanding of those beliefs and behaviors through content analysis of the clinical experiences of APRNs in clinical practice with lesbian and gay patients. The four research questions that guided this study were:

1. What are the beliefs and behaviors of APRNs about providing care for lesbian and gay persons?
2. What demographic variables correlate with high or low Gay Affirmative Practice (GAP) scores?
3. What are the clinical experiences of APRNs who have cared for lesbian and gay patients?
4. How do findings from the experiences of APRNs in clinical practice with lesbian and gay patients enhance or elaborate the findings from the total GAP

scores?

Mixed methods research is the research approach that enables greater depth and breadth of understanding of the research question (Creswell & Plano Clark, 2011). By combining quantitative and qualitative data, it makes possible a richer perspective of APRNs' clinical practice experiences with lesbian and gay patients. Collecting, analyzing, and merging both quantitative and qualitative data findings helped to explicate a richer contextual understanding of this phenomenon, and provide a complementary perspective whereby the whole is greater than the individual parts (Creswell & Plano Clark, 2011); otherwise, each data set alone only provides a partial view to understand this phenomenon.

Summary

There is growing attention by the U.S. government and national organizations to increase awareness about LGBT health disparities, access to culturally competent care, and the need to fund LGBT research and education. It has only been in the past few years that the nursing profession has begun to dismantle its wall of silence on matters of LGBT health. Recently, the AAN has been a strong advocate for LGBT issues and they have helped to lead the effort to end nursing's silence by raising awareness and encouraging dialogue among nurses on matters of health and well-being of LGBT persons. Perhaps in time, other nursing organizations will take a similar stand on these issues. This study may help to fill a gap of understanding about APRNs current beliefs, behaviors, and experiences caring for lesbian and gay patients. Such insight will help to inform nursing education, practice, policy, and research.

Chapter one introduced the background, significance, and purpose of this research study. The background included current data on the APRN workforce, the percentage of LGBT within the population of the United States and discussion about inclusion of sexual orientation and

gender identity when referring to cultural diversity and health disparities. The significance of the study was presented within the context of recommendations and position statements published by the IOM, the Joint Commission, AACN, and AAN. Finally, the purpose of the study was discussed within the framework of a mixed methods approach to understand the phenomenon of APRNs beliefs, behaviors, and experiences caring for lesbian and gay patients. Chapter two presents the theoretical perspective that informed the study on gay affirmative practice in nursing and a review of the literature. Chapter three discusses the philosophical perspective that guided the convergent parallel, mixed methods design used to collect, analyze, and merge the quantitative and qualitative data for this study (Creswell & Plano Clark, 2011). Chapter four discusses the results of the quantitative data, and the various statistical tests used to support data analysis. Additionally, the results of the qualitative data analysis are presented using Krippendorff's (2013) content analysis to understand the narrative data of APRNs' experiences caring for lesbian and gay patients. Chapter five discusses the findings of the qualitative and quantitative findings and significance of the study for nursing education, practice, and research and compares the findings on semblance to inconsistency with other similar studies.

Chapter Two: Review of the Literature

Chapter two begins with a discussion about the theoretical underpinnings of social constructionism that helped to inform this study about gay affirmative practice in nursing. This discussion is followed by a synthesis of a review of the literature about nurses' attitudes toward lesbian and gay persons and the few studies on gay affirmative practice in the context of beliefs and behaviors of practitioners in clinical practice with lesbian and gay clients. These later studies were drawn primarily from the disciplines of social work and psychology. Any reference throughout this chapter to the LGBT community represents a shared sense of identity among a highly diverse population rather than a specific geographic location. The term gay with affirmative practice includes this broader community.

Theoretical Underpinnings

The theoretical underpinnings of social constructionism informed this study on B*eliefs, Behaviors and Experiences of APRNs with Lesbian and Gay Patients* because this view offers a broad theoretical perspective with expansive tenets that social phenomena develop in particular social contexts (Lock & Strong, 2010). Social constructionism does not have one definable methodology and recognizes that multiple study designs can guide the selection and use of methods when conducting research (Leishman, 2003; Lock & Strong, 2010). Burr (2003) argues that despite a lack of a universal definition, there are some features that social constructionists across different disciplines share. First, social constructionism requires a critical stance toward assumptions in the world and remaining open to multiple realities (Lock & Strong, 2010). Individuals and groups participate in the creation of their perceived social reality, and this reality continually evolves as social interactions occur. Second, the contexts by which to understand our world are culturally and historically based and can change over time (Burr, 2003). Third,

knowledge is sustained through language and social interactions rather than objective observations of our world (Burr, 2003). These perceptions of realities are formed in social contexts and evolve over time, and are not constant unless they are continually reproduced; otherwise, a new reality emerges (Lock & Strong, 2010). The fourth tenet holds that knowledge and social interaction are integrally bound (Burr, 2003). These underlying assumptions of social constructionism typically lead to greater understanding about how social phenomena or objects of consciousness develop in social contexts (Cruickshank, 2012). Gergen (1985) asserts the terms by which we understand our world are the artifacts of historically situated social interactions in particular contexts. In other words, humans derive understanding through action and experience rather than through laws of nature.

A social construction (also called a social construct) is a concept or practice that is believed true by a particular group or society (Cruickshank, 2012). When something is socially constructed, there is the focus on the dependence on conditional characteristics of our social selves rather than an absolute truth of the idea (Lock & Strong, 2010). Social constructionism is associated with relativist epistemology, which espouses all knowledge is about a person's location within a social context (Cruickshank, 2012). There is focus on the relationship between meanings and actions and the social contexts in which these arise. Meaning depends on context, and we act out of and into contexts (Davies & Neal, 1996).This theoretical perspective is linked to the postmodern movement and has been influential in cultural studies (Cruickshank, 2012; Leishman, 2003; Lock & Strong, 2010).

Within the social constructionist strand of postmodernism, the concept of socially constructed reality stresses the ongoing development of different world views by human beings in dialectical interaction with society at various times (Cruickshank, 2012; Lock & Strong,

2010). These imagined views of human social existence and activity gradually become more socially accepted by language, customs, and conventions of society (Lock & Strong, 2010). The numerous realities that exist collectively create an imagined world of humans in different social contexts. These views continue to exist provided they are supported by cultural language, values, beliefs, and norms until they are replaced by another paradigmatic perspective (Lock & Strong, 2010).

Lock and Strong (2010) also recognize there is no one school of social constructionism, but assert that the following five core tenets frame social constructivism. First, meaning and understanding are core features of human interactions. Second, these meanings and understanding evolve from social interaction and agreement about what they represent. Third, meaning-making is dependent on socio-cultural contexts. Fourth, there is an uneasy relationship between social constructionism and essentialism, which suggests that humans have essential characteristics that describe them. In other words, social constructionism disagrees that human beings are pre-defined entities capable of full delineation through some predetermined objective method. Rather, humans are self-defining and socially construct their sense of being in the world. The fifth tenet involves assuming a critical reflective perspective about the social world.

Other tenets of social constructionism include that knowledge is socially constructed and co-created with other human beings, and language helps people express and construct their experiences (Leishman, 2003). We make sense of our experience through the descriptions available to us (Gergen, 1985). The meaning of these experiences depends on context. As such, nurses who acknowledge the relationship between meanings and actions and the social contexts from which they emerge may be able to identify the nature of the relationships they have with

patients. In the context of gay affirmative practice, the nurse and patient collaboratively deconstruct practice and communication barriers and co-create meaning within the experience.

Social constructionist theory also acknowledges the importance of culture, social, historical, and political factors in understanding social events, processes, and experiences, including the production of knowledge (D'Augelli & Patterson, 1995). The underpinnings of social constructionism are significant to the analysis of APRN experiences in clinical practice with lesbian and gay individuals. The APRNs contextualize these experiences through membership in various professional organizations or identification with the lesbian and gay community (social factors), professional education programs (cultural factors), and recognize the need for affirming and culturally appropriate health services (historical and political factors).

The social construct of gay affirmative practice is understood as an evolving practice in response to increasing social acceptance and acknowledgment of the unique concerns of lesbian and gay patients in healthcare environments (Hunter & Hickerson, 2003). Human beings are viewed as meaning-generating, continually co-constructing our identity and understanding of the world in different contexts. An APRN co-creates understanding with the patient about his or her life experiences during a clinical encounter; therefore, learning about social contexts of lesbian and gay lives may enhance meaning and understanding between the nurse and patient. APRNs' descriptions of experiences caring for lesbian and gay individuals will help elucidate their understanding of beliefs and behaviors that correlate with gay affirmative practice.

This mixed methods study includes quantitative and qualitative data to understand more completely the beliefs and behaviors of APRNs in clinical practice with lesbian and gay individuals. These human attributes are constructed within social contexts. The meaning of clinical practice experiences of APRNs who care for lesbian and gay patients evolves through

discourse and social interactions they have with their patients. These social contexts predominate over an individual's internal world.

The following historical overview explicates the basis for using social constructionism to guide gay affirmative practice, and discusses the empirical and theoretical perspectives that have informed this approach. The pioneering 1957 study by Evelyn Hooker included a sample of heterosexual and gay men who were matched for age, educational level, intelligence, and same-gender sexual orientation and concluded there was no significant differences in mental health between the two groups and that same-sex orientation was not pathological. Nearly every one of the 100 studies conducted after this study confirmed Hooker's findings that showed no significant differences between the mental health of gay and lesbian samples and samples of heterosexual men and women (Hunter & Hickerson, 2003). In 1973, the American Psychiatric Association voted to remove homosexuality as a diagnostic category from the *Diagnostic and Statistical Manual (DSM) of Mental Disorders* (Hunter & Hickerson, 2003). The American Psychological Association endorsed this vote and afterwards greater attention focused to remove societal stigma associated with homosexuality (Biaggio, Orchard, Larson, Petrino, & Mihara, 2003). Despite this ruling, societal stigma toward lesbian and gay communities persists. Gay affirmative practice strives to eliminate this stigma.

Before these changes, homosexuality was considered an illness because this behavior did not fit the socially constructed heterosexual norms of society. The antigay psychotherapies that aimed to cure or convert (or change the sexual orientation of the gay, lesbian, or bisexual person) individuals who were homosexual were oppressive and inhumane (Hunter & Hickerson, 2003). Since then, greater attention has been directed toward creating more affirming practice environments and approaches to counsel and offer health care services for the LGB population.

Since the 1980s, the psychotherapeutic disciplines have discussed and developed various approaches to gay affirmative therapies (Langdridge, 2007).

Review of the Literature

One of the challenges of conducting a literature review for this study was the absence of any publications or mixed-methods research in the nursing literature about gay affirmative practice. The search in the on-line databases included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Pubmed, Psych Info, Social Work Abstracts, Academic Search, and LGBT Life. Given that the concept of gay affirmative practice is relatively new, the literature search was limited to published studies within the past ten years. Key words used to conduct the search included *gay affirmative practice, affirmative practice, cultural competence, individualized care, lesbian, gay, nurse attitudes, cultural competence, cultural humility, LGBT, sexual orientation, advanced practice nurses, registered nurses,* and *nurses*. The search revealed very few recent studies that have examined nurses' attitudes, beliefs, and knowledge, about lesbian or gay patients. Some of these studies examined the construct of homophobia, although this term is now less frequently used in research about LGBT populations. Studies about gay affirmative practice that identified and examined beliefs and behaviors of practitioners with lesbian and gay clients are presently limited to social work, psychology, and the counselling literature; therefore, recent studies in these disciplines were also included.

The few nursing studies that have addressed nurses' perspectives about lesbian and gay persons have primarily focused on levels of homophobia among nurses (Blackwell & Kiehl, 2008; Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007; Rondahl, 2009), and nurse attitudes toward lesbian and gay persons (Eliason, 1993; Rondahl, Innala, & Carlsson, 2004) and were primarily quantitative by design. Dorsen (2012) conducted an integrative review of the literature

on nurse attitudes toward LGBT patients and critically analyzed 17 relevant studies published from 1990 – 2010. The majority of the studies were descriptive correlational, and 11 were about nurse attitudes toward persons with HIV or AIDS and five of the studies were conducted outside the United States. There were no mixed methods studies that gathered quantitative and qualitative data and then merged these data in the analysis. The table in Appendix A displays specific details of the studies included in this review of the literature.

Knowledge and Competence

Rondahl (2009) conducted a study to compare differences in knowledge about the LGBT population among a sample of Swedish nursing and medical students. The study findings revealed that nursing students had statistically significant lower knowledge about how to care for LGBT persons compared to medical students and gender differences showed men had lower psychological knowledge than women. Furthermore, students who identified as being religious also had lower total knowledge scores about LGBT persons than non-religious students. These findings suggest that perhaps students in medical education programs have more education about LGBT population than those in nursing programs.

In the same year, Starr and Wallace (2009) examined cultural competence among a convenience sample of public health nurses. In this study, participants were asked to select from among a list of culturally diverse experiences with various racial/ethnic and special population groups that included LGBT populations. Interestingly, while 22 of 31 participants identified having had experiences caring for LGBT persons, reference to these self-identified experiences were not included in the published data. One has to wonder the reason for such an omission given the available data.

Attitudes

Compared to studies about nursing knowledge, there were a few more studies in the literature that examined nursing attitudes toward lesbian and gay persons. In two studies, Blackwell (2007) and Blackwell and Kiehl (2008) found overall positive attitudes among registered nurses toward lesbian and gay persons, but did find a strong association between the belief that homosexuality is a choice and less positive attitudes. They also reported a strong association between non-support of workplace nondiscrimination policies and lower attitude scores (Blackwell & Kiehl, 2008; Blackwell, 2007). These later findings demonstrated that at the time of these studies, negative attitudes among registered nurses toward lesbian and gay people persisted. In their study, age and ethnicity were correlates of less positive attitude; however, higher education was not associated with more positive attitudes (Blackwell & Kiehl, 2008). The latter finding was in contrast with previous social science research that found higher educational levels correlate with more positive attitudes toward lesbian and gay persons (Battle & Lemelle, 2002; Ellis, Kitzinger, & Wilkinson, 2002; Lewis, 2003).

In an earlier study, Dinkel, Patzel, McGuire, Rolfs, and Purcell (2007) examined Midwestern nursing student attitudes toward lesbian and gay people; whereas, Rondahl and associates (2004) measured attitudes of Swedish nursing students toward lesbian and gay individuals. Findings from these studies overall supported positive attitudes among the sample of students. Dinkel and colleagues suggested the positive scores may have indicated non-committal or neutrality, and cautioned that such ambivalence could lead nurses to avoidance rather than interaction. The researchers disclosed that some of the students and faculty participating in the study and two of the researchers were known by study participants as lesbian, which may have influenced the attitude scores (Dinkel, et al., 2007). Demographic variables that accounted for

the greatest variance in attitudinal scores were religious affiliation and having family members or acquaintances who are LGBT (Dinkel, et al., 2007). A larger random sample of participants from several different nursing programs would have helped to strengthen the study and enable greater generalizability of the findings. In contrast, Rondahl and associates (2004) used a sample of registered nurses, assistant nurses and students in each of these practice levels and found the assistant nursing students had less positive attitudes compared to registered nurses. This finding also suggested a possible association between higher education levels and more positive attitides toward lesbian and gay persons.

Up to this point, the studies in this literature review have focused primarily on nurse knowledge and attitudes toward lesbian and gay. While these studies used a variety of instruments to measure attitudes or knowledge, none specifically measured beliefs, behaviors, and experiences when caring for these patients. For this reason, the review of the literature was expanded to include the recent studies from social work and psychology that examined these constructs.

Beliefs and Behaviors

The review of the literature showed there was a valid and reliable instrument to measure practitioners' beliefs and behaviors towards lesbian and gay persons. Crisp (2002) developed the Gay Affirmative Practice (GAP) Scale to measure the degree to which practitioners demonstrate gay affirming practice beliefs and behaviors with lesbian and gay clients. Until now, the GAP scale has only been used to examine these constructs in samples of social workers and psychologists. Therefore, a discussion of gay affirmative practice is essential to broaden understanding about this concept before discussing studies that used the GAP instrument to measure beliefs and behaviors among various practitioners.

Gay affirmative practice initially emerged from gay affirmative therapy in psychology, and later expanded to include a variety of affirmative approaches in clinical practice with LGBT populations (Crisp, 2006). Schools of counselling and psychotherapy were the first disciplines to introduce gay affirmative therapy to challenge traditional counselling theories and theories of personality development that influenced clinical practice during the 1980s (Davies & Neal, 1996). Afterwards, the concept was introduced to social work by Appleby and Anastas (1998) and Hunter and Hickerson (2003) as *gay affirmative practice,* an approach to practice that provides culturally competent care for individuals who identify as LGBT.

Appleby and Anastas (1998) identified the following six fundamental principles of gay affirmative practice to guide social work practitioners in clinical practice:

1. Never assume a person's sexual orientation.
2. Recognize that societal homophobia is the problem rather than the sexual orientation.
3. Acknowledge an identity as lesbian or gay as a positive outcome of the therapeutic process.
4. Work with clients to mitigate internalized homophobia to attain a positive self-identity as lesbian or gay.
5. Learn about the different theories of the 'coming out' process.
6. Critically reflect on one's own heterosexual and homophobia biases.

More recently, McGeorge and Stone Carlson (2011) offered another viewpoint by which to understand gay affirmative practice. They proposed a three-step, critical self-reflective model (as shown in Appendix B) to assist heterosexual practitioners gain insight about their heteronormative assumptions. Heterosexism is a belief process that marginalizes individuals whose sexual orientation is contrary to the beliefs and assumptions that heterosexuality is the

preferred norm (Herek, 2004). To avoid heterosexist influence when caring for lesbian and gay clients, a heterosexual practitioner is encouraged to first explore his or her sexual identity. A heterosexual identity is unique to the individual and represents the understanding that one has of his or her sexual orientation, which is different from sexual orientation itself (Mohr, 2002). In essence, a heterosexual identity addresses the manner in which people who are heterosexual interpret their attractions toward the opposite sex.

In addition to learning about lesbian, gay, and bisexual (LGB) topics and concerns, a heterosexual therapist must also understand how they developed a heterosexual orientation before they can identify as an affirmative LGB therapist (McGeorge & Stone Carlson, 2011). The following steps outline a process for questioning these assumptions and include exploring: (1) heteronormative assumptions, (2) heterosexual privileges, and (3) the development of a heterosexual identity (McGeorge & Stone Carlson, 2011). McGeorge and Stone Carlson (2011) provided many sample questions to guide the heterosexual therapist in a self-reflective journey; however, a more detailed discussion of this model is beyond the scope of this chapter.

At the time these principles were published, there was less information about bisexual and transgender identities, so they do not encompass the broader range of sexual and gender identities recognized today. Building on this groundwork, Crisp (2002) developed the GAP Scale, the first instrument to measure affirmative practice constructs of beliefs and behaviors among practitioners in clinical practice with lesbian and gay clients. These principles are equally relevant to nurses who care for these patient populations.

Although the concept of gay affirmative practice is absent in nursing, publications in other disciplines such as social work (Crisp, 2006; Hunter & Hickerson, 2003; Mullins, 2012) and psychology (Davies & Neal, 1996; Kort, 2008) provide various conceptualizations,

definitions, and guidelines to elucidate this concept relative to clinical practice with persons of diverse sexual and gender identites. A preliminary review of the literature about the concept of gay affirmative practice culminated in sixteen attributes that characterize the knowledge, skills and attitudes integral to this practice.

The concept of gay affirmative practice is multifaceted so understood more clearly as a sum of its collective parts; therefore, easier to understand when viewed as a series of attributes. These attributes (as displayed in Table 2.1) are a compilation of knowledge, skills, and attitudes integral for culturally supportive care of patients of diverse sexual and gender identities. The meaningfulness and sincerity of this approach to practice is ultimately for the person who identifies as LGBT to decide.

Table 2.1 *Gay Affirmative Practice (GAP) Knowledge, Skills and Attitudes*

GAP Knowledge
• Understand that all LGBT persons have experienced some form of oppression related to their sexual and gender identity, which may manifest for some as internalized homophobia. • Revise current nursing curricula to include LGBT education without limiting the content to sexual behaviors. • Learn about community resources supportive of LGBT persons and refer LGBT persons when necessary. • Attend an LGBT pride event, educational conference, or other community venues that advocate and educate all who attend. • Recognize that all people have a sexual and gender identity
GAP Skills
• Encourage the LGBT person to establish supportive networks with others who will respect and affirm their identity. • Affirm statements of personal disclosure shared by anyone who identifies as LGBT. • Challenge stereotypes and harmful generalizations about LGBT persons and refer LGBT people when necessary. • Advocate for legal relationship status among LGBT couples. • Foster a welcoming culture of affirmation and respect for persons of all sexual and gender identities. • Encourage an LGBT person to discuss feelings about their identity in a non-judgmental and affirming manner.
GAP Attitudes
• Acknowledge the power imbalances inherent in nursing that exclusively follow heteronormative standards in all practice domains. • Explore basic assumptions about identifying as LGBT and recognize the hazards of seeking self-acceptance based on heteronormativity. • Avoid disingenuous actions that impose personal value systems to contradict an LGBT identity. • Advocate for more inclusive language for sexual and gender identity on all forms where this information is relevant. • Display safe zone signs and provide literature and brochures depicting LGBT persons in school and work settings.

Two more recent studies used the Crisp (2006) GAP Scale to compare the beliefs and behaviors of practitioners toward lesbian and gay clients. Mullins (2012) examined these constructs in a sample of social workers and found high belief and behavior scores within the

sample, including a significant positive correlation between these two domains. In this sample, there was a positive correlation between prior knowledge and experiences caring for lesbian and gay persons, which helps to emphasize the significant influence that these features have on practitioners who provide culturally competent care to this population. In an earlier study, Crisp (2005) measured the attitudes, beliefs, and behaviors in a sample of social workers and psychologists and found both groups were highly affirming toward lesbian and gay clients. Despite significant differences in demographic characteristics between the two groups, there were no significant differences in the GAP scores between them when controlling for demographic characteristics. The data from these studies suggest affirming beliefs and behaviors among these practitioners support positive attitudes toward lesbian and gay populations.

In a broad context, gay affirmative practice is an attitude and approach to care of a person whose sexual orientation or gender identity differ from a heteronormative perspective. The essence of gay affirmative practice is a professional comportment that acknowledges an LGBT identity is a meaningful and constructive way of life compatible with a sense of well-being. Furthermore, it expresses non-discrimination, validation, and affirmation for a person's self-identity as lesbian, gay, bisexual, or transgender (Hunter & Hickerson, 2003). The practitioner that demonstrates gay affirming beliefs and behaviors helps to preserve the dignity and show respect for individuals who are LGBT.

An explication of gay affirmative practice for nursing is an attempt to break the silence surrounding this concept and move beyond the prescriptive societal norms for gender and sexual identity that continue to influence nursing practice domains of clinical practice, education, and research. In essence, this approach to practice must convey that an LGBT identity is an equally constructive and meaningful way of being human (Perlman, 2003). Exploring gay affirmative

practice will provide insight and clarification of its meaning and relevancy in nursing practice, education, and research.

Nursing scholars have identified that stereotypes about LGBT persons exist and influence behaviors and attitudes of healthcare providers including nurses (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007; Eliason et al., 2010; Keepnews, 2011). If nurses lack knowledge about different LGBT lifestyles and healthcare practices, it could steer them to ask inappropriate questions about sexual behavior, illness, and healthcare practices based on societal norms of heteronormativity (Burch, 2008; Lim & Bernstein, 2012; Rondahl, 2009). Persistent negative attitudes will continue to promulgate societal stigma toward this population and reinforce barriers to culturally competent and comprehensive care.

Summary

This chapter presented a synthesis of the current literature on attitudes and beliefs of nurses toward lesbian and gay persons. An overview of the concept of gay affirmative practice provided some insight about recent studies that have used the Crisp (2002) GAP Scale, a valid and reliable instrument to measure beliefs and behaviors of practitioners in social work and psychology in clinical practice with lesbian and gay clients. The sources that were used to explicate gay affirmative practice have helped to show the dynamic and reciprocal nature of gay affirmative practice for nursing.

Nursing has experienced a long history of silence concerning lesbian, gay, bisexual, and transgender (LGBT) education at all preparation levels (Eliason et al., 2010); hence, it is not surprising that the concept of affirmative practice with persons who are LGBT may be foreign to the profession. When compared to the disciplines of psychology, social work, and medicine, nursing reticence to conduct research related to the LGBT community persists. This reluctance to

conduct and publish research appears to be common across all nursing practice domains – education, practice, and research. Instead, nurses should be at the forefront of modelling gay affirmative practice among healthcare providers. To accomplish this, nurses must first cultivate self-awareness about personal biases and assumptions related to sexual orientation and gender identity. They must be willing to set aside those biases to provide non-judgmental, culturally competent and individualized nursing care to persons of diverse sexual orientation and gender identity in any practice setting.

The review of the literature presented the relevant, albeit limited, research on nursing attitudes and knowledge about lesbian and gay patients. The few published studies that have used the GAP scale to measure social workers' and psychologists' beliefs and behaviors toward lesbian and gay clients were discussed; however, these studies were primarily quantitative by design. This study is believed to be the first mixed methods study to employ the GAP scale and use both quantitative and qualitative narrative data to explore these constructs in advanced practice nurses.

Chapter three explicates the convergent parallel, mixed methods design of Creswell and Plano Clark (2011) used to collect and analyze the data, then merge the quantitative and qualitative findings. It also discusses the philosophical underpinnings of the mixed methods methodology that informed the research methods. Finally, the data collection and quantitative and qualitative analyses used to answer the research questions are presented.

Chapter Three: Method

Chapter three begins with a description of the philosophical framework that informed the methodology of conducting a mixed methods study followed by a discussion of the specific mixed method design that was used. Next, the specific research questions, protection of human subjects and institutional review approval process, the sampling approach and sample, and finally the steps used to analyze the quantitative and qualitative data are delineated.

Philosophical Perspective

Methodology

Whereas social constructionism was the theoretical perspective that guided this study, pragmatism is the philosophical perspective that informed the methodology of this mixed method design. Pragmatism is a philosophic world-view introduced in the United States in the late 1800s and is commonly associated with several contemporary classical pragmatists, namely Charles Sanders Pierce, William James, and John Dewey (Creswell & Plano Clark, 2011). Each of these philosophers offers a similar and slightly different perspective of the pragmatic method. Peirce (1878) believed that our beliefs are essentially rules for action, and to develop meaning for our thoughts, we first had to decide the outcome for this action. This belief was expressed when he said that we ought to "consider what effects, which might conceivably have practical bearings, we conceive the object of our conception to have. Then our conception of these effects is the whole of our conception of the object" (Peirce, 1878, p. 293).

James (1910) contributed his view on pragmatism in a lecture dedicated to the memory of John Stewart Mill, titled *A New Name for Some Old Ways of Thinking*, when he posited the pragmatic method as a means "of settling metaphysical disputes that otherwise might be

interminable" . . . [and] offers guidance to resolve opposing ideas by identifying the consequences of each action" (James, 1910, p. 45).

Dewey's (1920) contribution to pragmatism evolved through his work in education, and he said "to discover the meaning of an idea ask for its consequences. . . The practical meaning of the situation – that is to say the action needed to satisfy it - is not self-evident. It has to be searched for" (p.163). The views of these three American philosophers provide a way to approach research from a pluralistic perspective that recognizes the contributions of multiple forms of data to answer the research question with quantitative and qualitative research findings (Evans, Coon, & Ume, 2011).

Pragmatism is less concerned about truths and reality and more concerned with solving the problem or answering the research question (Johnson & Onwuebuzie, 2004); therefore, the ontological and epistemological foundations of pragmatism are less precise when compared to other philosophical views. Asking what is out there to know is variable and not fixed. Truth is what is known at the moment, and the epistemology will depend on the methodology and methods chosen. Use of eclectic and pluralistic approaches is a practical means to understand humans and the world. An integrative methodology is consistent with pragmatism (Evans et al., 2011). Solutions are those that work and resolve problems; therefore, mixed methods research should use a method and philosophy that help explicate the qualitative and quantitative data to answer the research questions. When linked to mixed methods research, pragmatism favors the research question over the specific method used to answer it (Tashakkori & Teddlie, 2003).

Morgan (2007) recommends using abduction, intersubjectivity, and transferability as a guiding framework to work reciprocally between the quantitative and qualitative methods. Abductive reasoning enables a researcher to connect theory and data by moving beyond a single

immediate study and “search[ing] for useful points of connection” based on existing qualitative and quantitative data (Morgan, 2007, p.71). From a pragmatic standpoint, an intersubjective approach allows the researcher simultaneously to acknowledge a single truth and multiple interpretations of the world (Morgan, 2007). From a methodological perspective intersubjectivity is concerned with the social processes from which consensus and contentions arise when determining the extent to which research findings bring meaning to other settings (Morgan, 2007). Transferability requires the researcher to address the practical application of the research findings and question factors that may influence the process (Morgan, 2007). This multidimensional standpoint endorses inclusive, pluralistic, and corresponding views of reality and truth, thereby rejecting traditional dualism.

Pragmatism provides an alternative perspective to resolve philosophical debates about dualism and methodological selection (Johnson & Onwuebuzie, 2004). Those guided by this philosophical perspective recognize conclusions are seldom absolute or perfect and are based on context. Knowledge is constructed and based on the realities and experiences one has in life, which are different for each person. Research is another way to learn about life, similar to what people do each day when they ask questions and solve problems using practical approaches (Johnson & Onwuebuzie, 2004). The complexity of human reasoning involves a reciprocal process that employs induction-deduction and subjectivity-objectivity to solve problems or to answer research questions (Evans et al., 2011). In a mixed methods study, there are often several research questions that require multiple approaches to answer them.

Pragmatism arises from cultural values, and social contexts (Evans et al., 2011), particularly those that are shared as democracy, freedom, and equality, and as such provides a value-oriented approach to research (Johnson & Onwuebuzie, 2004). The meaning and nature of

an idea is discerned when it is applied to real-world situations; thereby, extending the pragmatic test for truth beyond the scientific principle of verification to asking about its practical consequences (Peirce, 1878). In fact, ideas formed in the mind are less substantive and less relevant than our actions.

Based on these arguments, pragmatism is the philosophical world-view that guided this mixed method study because it values practicality and recognizes singular and multiple realities of truth by mixing objective quantitative data with the qualitative data derived from participants' multiple perspectives (Creswell & Plano Clark, 2011). This pluralistic worldview focuses on the consequences of the research, the importance of the research question, and recognizes that multiple methods rather than a single method are a better approach to answer the research questions. Collectively, the strengths of both inductive and deductive methods were mixed in a practical manner to answer the research questions in this study.

Mixed Method Research Design

A variety of mixed methods definitions appear in the literature. Each definition provides a blended focus about the methods, purpose, philosophy, methodology, and research design. The following definitions are examples of these variations. Tashakkori and Creswell (2007) defined mixed methods as "research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study, or a program of inquiry (Tashakkori & Creswell, 2007, p. 4). Greene (2008) proposed that mixed method research ". . .invites us to participate in dialogue about multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and cherished" (p. 20). A mixed methods

research approach acknowledges the contributions of the natural physical world and human experiences (Johnson & Onwuebuzie, 2004).

Among the different definitions of mixed methods research, the following description by Creswell and Plano Clark (2011) was used to guide this study:

> Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases of the research process. As a method, it focuses on collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone (Creswell & Plano Clark, 2007, p. 5. as cited in Creswell & Plano Clark, 2011).

In this mixed methods study, a *convergent parallel design* was used to answer the research questions. This well-known mixed methods design has been used since the early 1970s when it was referred to as the triangulation method (Kettles, Creswell, & Zhang, 2011), and has been used since then across different disciplines. According to Morse (2009), the purpose of this design is to achieve a complementary view between the findings from the two data sets. A convergent parallel design includes collecting both quantitative and qualitative data in the same phase, analyzing each data set separately, and then merging the findings from the two data sets to derive a more complete understanding of the phenomenon of interest (Creswell & Plano Clark, 2011). The strength of this design includes placing equal emphasis on both data sets and collecting data during the same phase (Creswell & Plano Clark).

Protection of Human Subjects

This study utilized human subjects and as such measures were taken to protect the anonymity and confidentiality of each participant during data collection and analysis. The nature of the study and data collection procedures met the requirements for an exempt or expedited review by the University of Connecticut Institutional Review Board (IRB). IP addresses were disabled and the Qualtrics electronic survey software computer generated alphanumeric codes for each participant who accessed and returned the survey. No participant names are linked to the survey. After the survey closed, all data were downloaded to a secure and password-protected laptop computer retained by this graduate researcher and saved to two different password protected USB flash drives. One flash drive was locked in the office of the Chair of the Dissertation Committee, and the second was locked in this graduate researcher's office at work.

Quantitative Research Questions

The following four research questions guided this mixed methods study:

Question 1: *What are the beliefs and behaviors of APRNs about providing care for lesbian and gay persons?*

Question 2: *What demographic variables correlate with high or low Gay Affirmative Practice (GAP) scores?*

Qualitative Research Question

Question 3: *What are the clinical experiences of APRNs who have cared for lesbian and gay patients?*

Mixed Methods Research Question:

Question 4: *How do findings from the experiences of APRNs in clinical practice with lesbian and gay patients enhance or elaborate the findings from the total GAP scores?*

Procedure

Sample

The prospective study sample was derived from an email list of all actively licensed Connecticut (CT) APRNs obtained from the CT Department of Public Health (DPH). An email was sent to 4,233 CT APRNs inviting them to participate in an electronic survey located on Qualtrics, an on-line survey program. Unbeknownst to this researcher, the initial email list did not include Certified Nurse Midwives (CNMs) because although, CNMs are considered advanced practice nurses, in CT they are listed separately from other APRNs through the DPH. Upon learning this designation, this researcher submitted a second request to the DPH to obtain the email list of the 217 CT CNMs registered at that time, and invited them to participate in the survey. In total, 4,450 APRNs were sent the invitational email, and 84 emails bounced as undeliverable, which reduced the number of potential participants to 4,366 APRNs. A total of 678 respondents returned a completed survey, which resulted in a 15.5% response rate for this survey.

The email scripts (as seen in Appendix C) invited the recipient to participate in an anonymous survey of APRN's Beliefs, Behaviors, and Experiences with Lesbian and Gay Patients and concluded by asking if they wanted to participate in the survey. If the respondent selected *yes* they were directed to begin the survey. If they selected *no* they were directed to the end of the survey and thanked for their time. The survey included questions about beliefs and behaviors related to clinical practice with lesbian and gay patients, followed by a single, open-ended narrative request of participants to describe their experiences caring for patients who are lesbian or gay, and concluded with 13 demographic variables. Participants gave their consent to

participate after accepting the invitation to participate, reading the information sheet before proceeding to the survey, and electronically returning the survey.

For this survey to conform with response rates typically observed in other successful, unsolicited surveys and for it to hold the prospect of being reasonably representative of *beliefs* and *behaviors* in the population of CT APRNs, required a goal of achieving a minimum of 15% response rate from the population of APRNs. At the time of the study, there were 4,450 licensed APRNs in CT that included cetified nurse midwives; hence, to provide 80% power required a sample size of 670 survey respondents. An 80% power was required to detect correlations between demographic variables and the GAP belief or behavior scores that are 0.16 or greater in magnitude. This estimate falls in the range between small (0.1) and medium (0.3) thresholds in Cohen's (1988) classifications of effect sizes. It assumes a two-sided, 5% level of significance with adjustment for testing across multiple independent variables (13 demographic assessments), and across a two-dimensional dependent variable (the GAP beliefs and behaviors scales). The power analysis addressing sample size is necessary to decrease the probability of a Type II error (Polit & Beck, 2012).

Data Collection

Quantitative Data

Upon approval from the University of Connecticut's Institutional Review Board (IRB), the quantitative and qualitative data were collected in phase one of the study. A diagram of the research design and procedures in each phase is located in Appendix E. The quantitative data was collected using Crisp's (2006) GAP Scale, (see Appendix F) and a demographic profile (see Appendix G). The 30-item, GAP scale is comprised of two 15–item domains, practice *beliefs* and practice *behaviors* and were used to measure practitioners' (APRNs) beliefs and behaviors in

clinical practice with gay and lesbian patients. Both domains are measured on a 5-point, Likert-type scale. The *beliefs* domain scale ranges from strongly (5) agree to strongly disagree (1), and the *behaviors* scale includes response options of never (1) to always (5). The range of individual scores is 30 to 150 for a total score and 15 to 75 for each subscale (Crisp, 2006). GAP scale scores in this mixed methods study are expressed as mean summary scores in the data analysis.

Reliability and validity of the GAP scale were established during scale development. The standard error of measurement (SEM) was computed for each scale domain to compensate for differences in sample standard deviations and showed the SEM of 1.91 for the *beliefs* domain and 2.71 for the *behavior* domain as evidence for reliability of the scale based on the data from the study sample of social workers (Crisp, 2006). The final version of the scale demonstrated an overall Cronbach's alpha of .95, with a value of .93 for the *beliefs* domain and a value of .94 for the *behaviors* domain (Crisp, 2006). In this study, Cronbach's alpha was calculated for each scale construct to evaluate internal consistency of the instrument among a sample of APRNs. The Pearson's *r* was used to determine if a correlation existed between GAP beliefs and behaviors.

Quantitative Data Analysis

SPSS 22 software was used for quantitative data analysis. Descriptive statistics, including frequency tabulations of all study variables including GAP scores, demographics, and practice characteristics were used to answer the first research question. The frequencies were first inspected for illogical and missing values. GAP scale reliability was determined by the Cronbach's alpha for the GAP beliefs and behaviors subscales and for the GAP total scale. The Pearson's *r* was used to determine if a correlation existed between GAP beliefs and behaviors. Histograms were examined to depict graphically the distribution properties of independent and

dependent variables in the APRN population. The distribution of each variable was summarized using percentages, means, standard deviations, and minimum/maximum values as appropriate.

Prior to statistical testing, each demographic variable was configured to a categorical variable with multiple levels. Mean values for GAP beliefs, behaviors, and total scores were determined across the categories of each of these independent variables. Statistical analyses related to research question 2 were then conducted using several series of analysis of variance (ANOVA) to compare the mean GAP scale and subscale scores relative to levels of different personal and practice characteristics. The threshold for statistical significance was lowered to $p \leq .005$ to account for multiple testing. The eta-squared (η^2) statistic was used to identify the proportion of variance in the GAP scale scores accounted for by each independent, personal or practice demographic variable. An eta-squared (η^2) value of .02, .13, and .26 indicates a small, medium, and large standardized effect respectively (Cohen, 1988). Subsequently, a series of multivariate analyses of variance (MANOVAs) was run to compare the combined, "bivariate" dependent variable of beliefs and behaviors to the 13 independent variables. The purpose of the MANOVA was to determine whether results of statistical testing differed for those of the ANOVA analyses that did not account for correlations between beliefs and behavior scores.

Before conducting the qualitative data analyses, frequencies were run to determine how many APRNs in the sample did not answer the narrative statement, *"Please describe in as much detail as you can your experiences of having cared for patients who are gay or lesbian. Specific examples to clarify your response are extremely helpful."* Among the sample of 678 APRNs, 209 (30.8%) chose not to answer the narrative statement. Given the large percentage of participants who did not provide a narrative statement, attention turned to the question of whether the

characteristics of those who provided a statement differed from the characteristics of those who did not.

A series of *t*-tests was run to compare mean GAP beliefs, behavior, and total scores between those who provided a response and those who did not, but this comparison did not reveal any statistically significant differences. Next, attention turned to differences in personal or practice characteristics between those who did and did not provide a narrative statement; however, many of the 209 APRNs who did not provide a narrative statement also did not respond to various demographic or practice items on the survey questionnaire.

Finally, findings of the quantitative and qualitative data were merged using a series of ANOVA testing to identify mean differences in total GAP and subscale scores for each thematic category. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. *Post hoc* comparisons were run to determine where statistically significant differences existed between the thematic categories.

Qualitative Data Analysis

Research question 3 was answered by reviewing the participant's descriptive responses to the open-ended statement at the end of the survey that reads: *"Please describe in as much detail as you can your experiences of having cared for patients who are gay or lesbian. Specific examples to clarify your response are extremely helpful."* Krippendorff's (2013) method for content analysis was used to guide this exploration.

Content analysis as a research method dates back to the 18th century in Scandinavia (Rosengren, 1981) and later introduced in the United States at the beginning of the 20th century (Barcus, 1959). Krippendorff (2013) defined content analysis "as a research technique for making

replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use" (p. 24).

The narrative statements were initially downloaded from the Qualtrics Survey, loaded into SPSS ver. 22 then saved to a Word document. Each participant's narrative was printed onto a separate five by seven index card with a single numeric number to identify the participant. All 469 participant descriptions were read by this researcher in their entirety multiple times to help identify segments from each APRN's narrative. This process helped to better understand the varied perspectives of APRNs' clinical experiences caring for patients who are lesbian or gay. Krippendorff's (2013) analytical technique of clustering was used to group segments of similar description into eight thematic categories. Finally, tree-like diagrams called dendograms were used to display how participant descriptions were collapsed into categories of similar qualities; then categories were clustered into themes (Krippendorff, 2013). These thematic units were used to represent an aspect of APRNs' clinical experiences caring for patients who are lesbian or gay. The following steps guided this iterative process:

1. All participant comments were read closely to derive a sense of the whole. Segments that conveyed specific participant attributes were categorized and coded based on the research question.
2. Comments related to the research question were coded as unique or recurring passages.
3. Comments not related to the research question were coded as an outlier and reflected upon in the discussion, and considered for possible future research.
4. Similar phrases and sentences were clustered to categorize subsequently.
5. Overarching themes were identified based on the categorical groupings.

6. Finally, a dendogram was used to display examples of participants' comments and categories for each overarching theme and to show how the themes represent dimensions on the GAP Scale.

Mixed methods data collection and analysis

The primary reason for merging the qualitative data with the quantitative data is to compare the results of two simultaneous perspectives (Creswell & Plano Clark, 2011). The mixed method research question 4 was answered in Phase 3 by comparing themes derived from the content analysis of the qualitative data to the quantitative mean summary scores for beliefs and behaviors on the GAP Scale and to mean responses for individual GAP items. An outcome of this process is to reveal the extent to which summary scores and item responses on the GAP Scale dimensions converge with the qualitative data about APRNs descriptions of their experiences caring for patients who are lesbian or gay.

Challenges of this design

There were several considerations before implementing this mixed method design. First, it is possible that the GAP survey items may have influenced participant's responses to the open-ended narrative statement; however, this researcher believes such an effect is a positive attribute of this study design. Participants were provided an opportunity to expand upon their GAP beliefs and behaviors beyond the survey items. Narrative descriptions of clinical experiences helped to provide a more comprehensive understanding of GAP beliefs and behaviors. Second, there was potential for sampling bias based on the self-selection of participants who chose to respond to this survey. To mitigate this occurrence, this researcher planned to compare available demographic characteristics of APRNs in CT to those in the study sample. Unfortunately, at the time of data collection, the demographic profiles of CT APRNs were not available. Third, some

participants may have elected not to answer the open-ended statement, which may potentially have resulted in fewer qualitative data compared to the quantitative; however, all qualitative data was analyzed to mitigate this problem. A fourth concern pertains to response rates when using electronic surveys, which tend to be lower than mailed surveys (SurveyMonkey FAQ., 2009). One study by Mullins (2012) with a sample of 600 social workers had a 21% response rate and another by Crisp (2005) using a sample of 1,500 psychologists had a 17.1% response. After sending the initial email to CT APRNs on May 12, 2015, two subsequent email reminders were sent on May 29 and June 12, 2015. The CNMs received their initial email invitation on May 29, 2015 and two subsequent reminders on June 5 and 12, 2015. The reminder emails were to help increase achieving at least a 15% response rate; otherwise, it would not have been possible to generalize findings to the population of APRNs in CT.

Summary

This study used a *convergent parallel* mixed method design that included quantitative and qualitative data to answer the four research questions. The philosophical underpinnings that guided the mixed methods design for this study was pragmatism. The UCONN Institutional Review Board (IRB) approved the study and measures were taken to protect the research participants. The study sample, data collection and the steps for quantitative and qualitative data analysis were described for each phase of the study. Chapter four presents a detailed discussion of the results of quantitative and qualitative data analysis.

Chapter Four: Results

Introduction

Chapter four begins with an overview of the study participants and summary of the descriptive statistics that highlight the GAP Scale summary scores (dependent variable) and demographic (independent variables) items and study participants. Next, there is an overview of the significant findings from the quantitative data based on personal then professional practice characteristics with respect to *beliefs*, *behaviors*, and *total* GAP scale scores. A discussion of qualitative findings are organized around the eight themes that emerged during content analysis. Dendograms (as shown in Appendix I) of each theme display the connections between the theme category, clustered units, and descriptive segments of participants' narratives. The chapter concludes with a discussion of the findings after merging the qualitative and quantitative data including the GAP scale scores for each thematic category.

Sample

At the time of data collection, all licensed APRNs (n = 4,233) and certified nurse midwives (CNMs) (n = 217) in Connecticut were sent an email invitation (see Appendix C) to participate in this study. Of the 4,450 emails sent, 4,366 reached the intended recipient and 84 were returned as undeliverable. Two reminder emails were sent three and six weeks after the initial email. If the email recipient agreed to participate in the study, they were directed to begin the survey through Qualtrics, an on-line survey software program. The first page of the electronic survey was the information sheet (see Appendix D) describing the study. After reading the information sheet, participants could choose to stop at that point or select to continue on to the Qualtrics GAP scale survey (Appendix H) that included an open-ended descriptive statement, and concluded with 13 demographic items. Participants also had the option to stop responding to

the survey at any point after they began. Of the 906 (21%) initial respondents who selected 'yes' to participate in the survey only 775 (85.5%) answered the first question of the survey. Of those who answered the first question, 135 (17.4%) selected to only answer portions of the instrument resulting initially in 640 (14.6%) completed surveys.

In addition to the 640 (14.6%) completed surveys, 38 additional respondents skipped only one or two GAP scale items. However, they disproportionately represented individuals who were over 60 years old. It was important to include the responses of these 38 participants because they represented the perspectives of older participants; therefore, for the respondents who were found to be missing one or two items on the GAP scale, sample modes for those items were substituted for the missing values. This allowed survey responses from a sample of $N = 678$ (15.5% response rate) participants to be used in subsequent data analyses.

Dependent Variables – GAP Scale and Subscales

Prior to statistical testing, GAP scale reliability was determined based on 678 participants in this sample. The Cronbach's alpha for the GAP *beliefs* and *behaviors* subscales, and *total* GAP scale scores are presented in Table 4.1. These statistics provided basic evidence of GAP scale internal consistency and reliability and showed it fundamentally performed as it was intended in this sample of APRNs. The Cronbach's alpha was similar to findings in studies that used the GAP scale with samples of social workers and psychologists.

Table 4.1. *Cronbach's Alpha Statistics for Subscale and Total Scale of the GAP Instrument*

Beliefs	Behaviors	Total
.95	.93	.95

To answer the first research question, and determine the beliefs and behaviors of APRNs with lesbian and gay persons, mean GAP scale summary scores were determined for the sample

of 678 APRNs. Based on participants' responses to the questionnaire, it was possible to calculate a primary and two secondary GAP scores on all participants in the study. Mean belief scores in the sample were greater than mean behavior scores. These means as well as standards deviations and minimum and maximum scores for the sample of 678 are presented in Table 4.2.

Pearson's *r* correlation provided evidence of a moderately strong positive correlation, $r = .629$, $p < .001$, between GAP belief and behavior scores in this sample of 678 APRNs. The correlation suggests that variation in person-to-person beliefs account for 39.6% of the variation in behavior. Although beliefs is a moderately strong indicator of behaviors, 60% of behaviors are still not predicted by beliefs nor are 60% of beliefs predicted by behaviors.

Table 4.2. *Descriptive Statistics for GAP Scale Summary Scores in the Analytic Sample for the Quantitative Component of the Study*

N = 678	Min.	Max.	*M*	*SD*
Beliefs	21	75	65.4	8.9
Behaviors	19	75	56.3	12.8
Total	43	150	121.7	19.6

To identify outlying observations, histograms were examined to determine the range of scores on each scale, and assess consistency with normality for the GAP total score and its subscales. While there were no obvious outliers, distributions of all three variables were noticeably left skewed as shown in figures 4.1 through 4.3.

Figure 4.1. Histogram of GAP Belief Scores

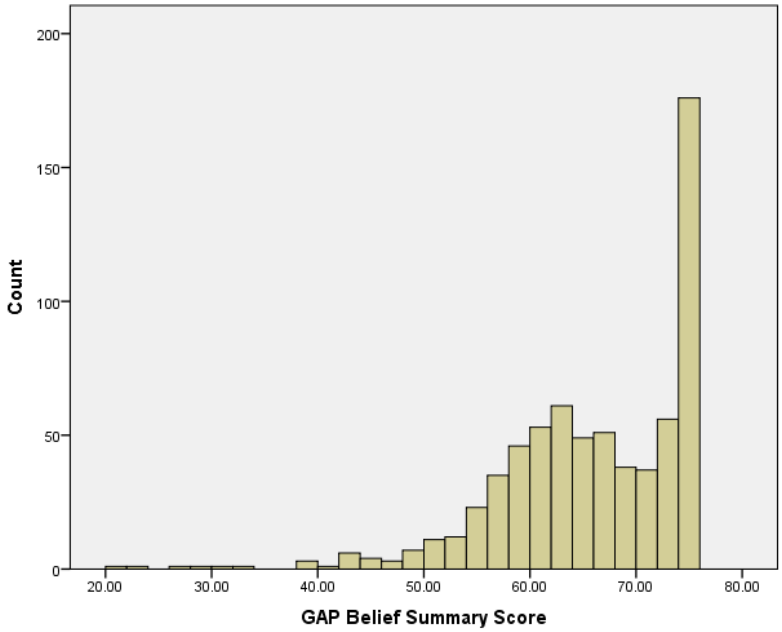


Figure 4.2. Histogram of GAP Behavior Scores

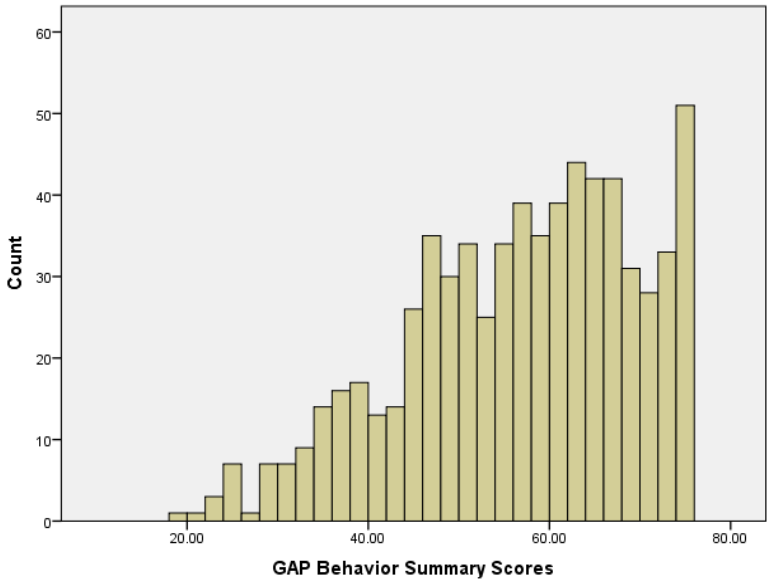
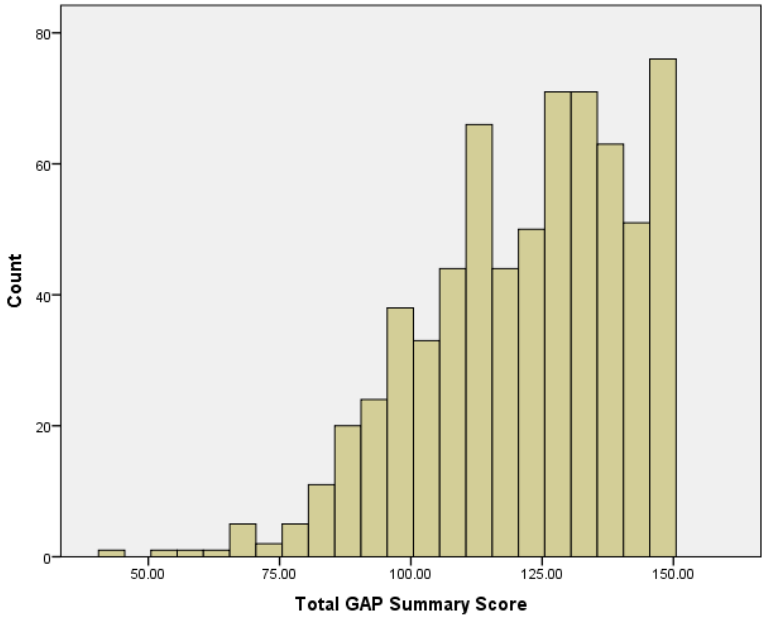


Figure 4.3. Histogram of Total GAP Scores



Independent Variables

Demographic Characteristics

Characteristics of the 678 APRNs can be described by a number of personal and practice variables. Personal characteristics included age, gender, race, ethnicity, highest education level attained, number of lesbian or gay family members, personal identity, religion and political party affiliation. The largest blocks of participants were white (85%, *n* = 573), heterosexual (83%, *n* = 564), non-Hispanic or Latino (88%, *n* = 594,), female (85%, *n* = 581), aged 51 – 60 years (31%, *n* = 9), and had an earned Master's degree (83 %, *n* = 566,) as their highest level of education. The largest groups of participants in the political party and religion categories identified as Democratic (46%, *n* = 312) and Catholic (35%, *n* = 235,) respectively. Lastly, 57.5% (*n* = 390) selected having one or more lesbian or gay family members compared to 42.5% (n = 288) that had none or did not answer.

The professional practice characteristics included number of years practiced as an APRN, place of practice, number of lesbian or gay patients cared for, and the primary practice focus. The largest blocks of participants had been in practice for over 15 years (38%, *n* = 260), practiced in outpatient settings (33%, *n* = 225), had multiple areas of practice focus (65%, *n* = 437) and noted they had cared for more than six different lesbian or gay patients (77%, *n* = 521) throughout their careers. Table 4.3 presents additional details of the demographic distribution of the study sample based on all the personal and professional practice characteristics. There were particular demographic factors that seemed to have an effect on GAP beliefs, behaviors and total scores. Unfortunately, comparable demographic data was unavailable to determine the representativeness of the study sample to the population of Connecticut APRNs.

Table 4.3. *Demographic Profile of Sample of APRNs*

Variable	*n*	%
Age		
21-30	43	6.3
31-40	124	18.3
41-50	137	20.2
51-60	209	30.8
>60	119	17.6
None Stated	46	6.8
Gender		
Female	581	85.7
Male	44	6.5
Transgender	1	.1
None Stated	52	7.7
Race		
White	573	84.5
Black	24	3.5
Other	24	3.5
None Stated	57	8.4
Ethnicity		
Hispanic / Latino	20	2.9
Non-Hispanic/Latino	594	87.6
None Stated	64	9.4
Education		
Masters	566	83.5
DNP	40	5.9
PhD	19	2.8
EdD	5	.7
None Stated	48	7.1

Variable	*n*	%
Personal Identity		
Straight/Heterosexual	564	83.2
Gay	12	1.8
Lesbian	26	3.8
Bisexual	17	2.5
None Stated	59	8.7
No. of Lesbian / Gay Family Members		
1	192	28.3
2	99	14.6
≥3	99	14.6
None	224	33.0
None Stated	64	9.4
Religion		
Protestant	119	17.6
Catholic	235	34.7
Jewish	39	5.8
Other	92	13.6
None Stated	193	28.5
Political Party		
Democratic	312	46.0
Republican	81	11.9
Independent	140	20.6
Other	36	5.3
None Stated	109	6.1

Group Mean Comparisons

To answer the second research question, *what demographic variables correlate with high or low GAP scores?*, a comparison of means for GAP scale and subscale scores relative to demographic variables was conducted using a series of one-way analyses of variance (ANOVA).

The next several tables display each demographic category and the corresponding means for GAP scale *beliefs, behaviors,* and *total* scores for each group.

The bivariate comparisons showed statistically significant differences with respect to beliefs, behaviors, and total GAP scores among groups defined by personal and practice demographic variables. The next several sections that follow describe only the significant findings. All other results are presented in respective tables that present group-specific means for the three GAP scale variables.

GAP Belief Scores

Personal factors

Personal factors that were found to have a statistically significant effect on GAP belief scores were having a lesbian or gay family member, $F(4, 673) = 4.2$, $p = .002$, $\eta^2 = .02$; personal identity, $F(4, 673) = 4.96$, $p = .001$, $\eta^2 = .03$; and political party affiliation $F(4, 673) = 10.12$, $p < .001$, $\eta^2 = .06$. There were significant difference in mean GAP belief scores between APRNs having two ($M = 67.4$ $SD = 8$) and ≥ 3 ($M = 67.3$, $SD = 8$) lesbian or gay family members compared to those with none ($M = 64$, SD 8.9). Also, participants who identified as lesbian had higher belief scores ($M = 71.5$, $SD = 5$) than those who were heterosexual ($M = 65$, $SD = 9$) or chose not to respond to this survey item ($M = 65.2$, $SD = 9$). A Democratic political affiliation yielded higher belief scores ($M = 67.4$, $SD = 7.9$) compared to those who were Independent ($M = 64.6$, $SD = 8.3$), Republican ($M = 61.2$, $SD = 10.1$), or those who chose not to identify a political party ($M = 63.8$, $SD = 10$). Mean group comparisons of all personal demographic factors are displayed in Table 4.4. Of all the variability from person-to-person in GAP belief scores, 6% is accounted for by political party; whereas, personal identity and having a lesbian or gay family member only accounted for 3% and 2% respectively.

Table 4.4. *Personal Characteristics and Belief Score Group Mean Comparisons*

Grp	Demographic	*N*	*M (SD)*	*F*	*df*	*p*	η^2	Tukey's HSD
	Age		Belief	0.83	5, 672	0.525	.00	*NS*
1	21-30	43	65.2 (8.2)					
2	31-40	124	66.5 (8.9)					
3	41-50	137	64.9 (7.9)					
4	51-60	209	65.1 (9.2)					
5	>60	110	66.1 (9.4)					
6	None Stated	46	64.1 (9.4)					
	Gender			7.89	2, 675	0.019	.02	*NS*
1	Female + Transgender	582	66 (8.1)					
2	Male	44	61.4 (13.3)					
3	None Stated	52	62.9 (11.1)					
	Race			0.69	3, 674	0.557	.00	*NS*
1	White	573	65.6 (8.9)					
2	Black	24	63 (8.3)					
3	Other	24	65.5 (9.1)					
4	None Stated	57	64.9 (8.9)					
	Ethnicity			1.05	2, 675	0.349	.00	*NS*
1	Hispanic / Latino	20	64.3 (8.2)					
2	Non-Hispanic/Latino	594	65.6 (8.8)					
3	None Stated	64	64.1 (10)					
	Education			0.92	4, 673	.449	.00	*NS*
1	Masters	566	65.4 (8.9)					
2	DNP	40	66 (9.7)					
3	PhD	19	68.2 (6.7)					
4	EdD	5	62.2 (10.2)					
5	None Stated	48	64.1 (9.2)					
	No. L/G in my family			4.16	4, 673	*.002	.02	4 < 2, 3
1	1	192	65.6 (9)					
2	2	99	67.4 (8)					
3	≥3	99	67.3 (8)					
4	None	224	64.0 (8.9)					
5	None Stated	64	64 (10.2)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. Group numbers in the last column are used to designate which groups were significantly different from others using the Tukey's HSD method for pairwise, post-hoc comparisons.

Table 4.4 cont. *Personal Characteristics and Belief Score Group Mean Comparisons*

Grp	Demographic	*N*	*M (SD)*	*F*	*df*	*p*	η^2	Tukey's HSD
	Personal identity			4.96	4,673	<.001	.00	1, 5< 3
1	Straight /Heterosexual	564	65 (9)					
2	Gay	12	69.9 (6.3)					
3	Lesbian	26	71.5 (5)					
4	Bisexual	17	68.9 (5.8)					
5	None Stated	59	65.2 (9)					
	Religion			2.02	4,673	0.09	.01	*NS*
1	Protestant	119	65.3 (9.2)					
2	Catholic	235	64.2 (9.6)					
3	Jewish	39	65.7 (7.9)					
4	Other	92	66.7 (7.7)					
5	None Stated	193	66.3 (8.4)					
	Political Party			10.19	4,673	<.001	.06	2, 3, 5< 1 2< 3, 4
1	Democratic	312	67.4 (7.9)					
2	Republican	81	61.2 (10.1)					
3	Independent	140	64.6 (8.3)					
4	Other	36	66 (8.8)					
5	None Stated	109	63.8 (10)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$

Professional practice factors

Number of lesbian or gay patients cared for throughout one's career $F(4, 673) = 3.86$, $p = .004$, $\eta^2 = .02$ was associated with statistically significant differences in mean scores among APRNs. Post-hoc comparisons showed that the greatest difference in belief scores occurred between the APRNs who had cared for more than 6 lesbian or gay patients (*M* =-66.0, *SD* = 8.9) and those who indicated that they had never cared for such patients (*M* = 59.3, *SD =11*.0).

The place of practice was significantly associated with b*elief* scores, and APRNs who practice in primary care settings had the highest belief scores (*M* = 66.7, *SD* = 8.9) compared to those in all other practice settings. Those who practice in subacute or long-term care (*M* = 63.5,

SD = 8.8) and those who work in hospitals (*M* = 64, *SD* = 9.2) had the lowest belief score means. Additional group mean comparisons are found on Table 4.5.

Table 4.5. *Practice Characteristics and Belief Score Group Means Comparisons*

Grp	Demographic	*N*	*M (SD)*	*F*	*df*	*p*	η^2	Tukey's HSD
	Years Practiced			1.10	4,673	0.35	.00	*NS*
1	1-5	171	65.7 (8.4)					
2	6-10	108	65.9 (8.5)					
3	11-15	94	63.9 (9.1)					
4	>15	260	65.8 (9.2)					
5	None Stated	45	64.3 (9.4)					
	Place of Practice			2.40	4, 673	.049	.01	2 < 1
1	Primary Care	198	66.7 (8.9)					
2	Hospital	172	64 (9.2)					
3	Subacute / LTC	26	63.5 (8.8)					
4	Out patient	225	65.7 (8.7)					
5	None Stated	57	65.1 (8.4)					
	Number of L/G patients cared for			3.86	4,673	*.004	.02	4 < 3
1	1-3	34	62.3 (6.5)					
2	4-6	58	64.6 (7.9)					
3	>6	521	66.0 (8.9)					
4	none	17	59.3(11.0)					
5	None Stated	48	64.6 (9.1)					
	Practice focus			2.41	6,671	0.026	.02	*NS*
1	Adult Men	8	64.9 (5.8)					
2	Adult Women	62	66.6 (8)					
3	Children/Adol.	63	68 (6.8)					
4	Psych	51	67.4 (7.7)					
5	Neonatal	8	60.9 (9.5)					
6	Multiple Areas	437	65 (9.1)					
7	None Stated	49	63.7 (10.6)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. Group numbers in the last column are used to designate which groups were significantly different from others using the Tukey's HSD method for pairwise, post-hoc comparisons.

GAP Behaviors Scores

Personal factors

Table 4.6 displays the GAP behavior score group mean comparisons for all personal demographic factors. Personal factors that were significantly associated with GAP behavior scores included age, $F(5, 672) = 3.43$, $p = .005$, $\eta^2 = .02$; having a lesbian or gay family member

$F(4,673) = 5.82$, $p < .001$, $\eta^2 = .03$; personal identity, $F(4, 673) = 8.93$, $p < .001$, $\eta^2 = .05$; and political party affiliation, $F(4, 673) = 5.68$, $p < .001$, $\eta^2 = .03$. Significant mean differences were found when comparing APRNs who were over 60 years old ($M = 59.5$, $SD = 11.8$) to the 31 – 40 year old ($M = 54.8$, $SD = 12.6$) and the 41-50 year old ($M = 54.1$, $SD = 13.4$) age groups. Having at least two lesbian or gay family members accounted for a statistically significant higher behavior score ($M = 60$, $SD = 11.6$) when compared to those without ($M = 53.8$. $SD = 14.1$) or not answering ($M = 54.1$, $SD = 12.5$). Although 564 (83%) APRNs identified as heterosexual, there was a statistically significant higher behavior score among lesbian participants ($n = 26$, $M = 69.6$, $SD = 6.5$) compared to heterosexual participants ($n = 564$, $M = 55.5$, $SD = 16.6$) and those who chose not to answer ($n = 59$, $M = 55.1$, $SD = 13$). A Democratic political affiliation yielded significantly higher behavior scores ($n = 312$, $M = 58.5$, $SD = 12.3$) compared to identifying as Republican ($M = 52$, $SD = 12.7$) or not stating a political party ($M = 54.1$, $SD = 13.2$).

Table 4.6. *Personal Characteristics and Behaviors Score Group Means Comparisons*

Grp.	Demographic	*N*	*M (SD)*	*F*	*df*	*p*	η^2	Tukey's HSD
	Age			3.43	5, 672	*.005	.02	2, 3 < 5
1	21-30	43	54.9 (11.9)					
2	31-40	124	54.8 (12.6)					
3	41-50	137	54.1 (13.4)					
4	51-60	209	57.4 (12.8)					
5	>60	110	59.5 (11.8)					
6	None Stated	46	54 (12.4)					
	Gender			3.78	2, 675	0.069	.01	*NS*
1	Female / Transgender	582	56.8 (12.3)					
2	Male	44	52.2 (16)					
3	None Stated	52	53.7 (13.6)					
	Race			1.83	3, 674	0.140	.00	*NS*
1	White	573	56.7 (12.6)					
2	Black	24	51.1 (12.2)					
3	Other	24	54.7 (14.8)					
4	None Stated	57	54.9 (13)					
	Ethnicity			1.08	2,675	0.342	.00	*NS*
1	Hispanic Latino	20	54.6 (12.6)					
2	Non-Hispanic/ Latino	594	56.5 (12.8)					
3	None Stated	64	54.3 (12.8)					
	Education			2.42	4,673	.047	.01	*NS*
1	Masters	566	56.1 (12.8)					
2	DNP	40	59.6 (11.4)					
3	PhD	19	61.7 (11.9)					
4	EdD	5	56.8 (8.1)					
5	None Stated	48	52.9 (13)					
	Number L/G in my family			5.82	4,673	<.001	.03	4, 5 < 2; 4 < 3
1	1	192	56.5 (11.2)					
2	2	99	60 (11.6)					
3	≥3	99	58.9 (12.4)					
4	None	224	53.8 (14.1)					
5	None Stated	64	54.1 (12.5)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. Group numbers in the last column are used to designate which groups were significantly different from others using the Tukey's HSD method for pairwise, post-hoc comparisons.

Table 4.6. cont. *Personal Characteristics and Behavior Score Group Means Comparisons*

Grp	Demographic	*N*	*M (SD)*	*F*	*df*	*p*	η^2	Tukey's HSD
	My identity			8.93	4,673	<.001	.05	1, 5 < 3
1	Straight/ Heterosexual	564	55.5 (16.6)					
2	Gay	12	61.4 (12.7)					
3	Lesbian	26	69.6 (6.5)					
4	Bisexual	17	60.1 (11.1)					
5	None Stated	59	55.1 (13)					
	Religion			1.88	4,673	0.112	.01	*NS*
1	Protestant	119	55.8 (12.9)					
2	Catholic	235	54.8 (13.3)					
3	Jewish	39	55.5 (12.9)					
4	Other	92	57.8 (12)					
5	None Stated	193	57.8 (12.2)					
	Political Party			5.68	4,673	<.001	.03	2, 5 < 1
1	Democratic	312	58.5 (12.3)					
2	Republican	81	52 (12.7)					
3	Independent	140	55.3 (12.3)					
4	Other	36	56.8 (14.4)					
5	None Stated	109	54.1 (13.2)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$

Professional practice factors

Professional practice factors that significantly associated with behaviors scores were the primary place of practice, $F(4, 673) = 10.03$, $p < .001$, $\eta^2 = .06$, number of lesbian or gay patients cared for, $F(4, 673) = 21.34$, $p < .001$, $\eta^2 = .11$, and practice focus, $F(6, 671) = 8.02$, $p < .001$, $\eta^2 = .07$. The group mean comparisons of APRNs that practice in primary care settings ($n = 198$, $M = 59$, $SD = 11.2$) and in outpatient settings ($n = 225$, $M = 58$, $SD = 11.9$) showed significantly higher mean behavior scores than for the group that works in hospitals ($n = 172$, $M = 51.7$, $SD = 13.9$). Having cared for greater than six ($n = 521$, $M = 58$, $SD = 11.9$) lesbian or gay patients yielded significantly higher behavior scores compared to never having cared for these

patients (*n* = 17, *M* = 39.4, *SD* =12.7) or having only cared for 1-3 (*n* = 34, *M* = 48.2, *SD* =12.9) throughout an APRN's career. APRNs whose practice focus is psychiatric nursing (*n* = 51, *M* = 64.2, *SD* = 8.9) had significantly higher behaviors scores compared to all other practice groups except for APRNs whose practice is primarily with adult men (*n* =8, *M* = 58.1, *SD* = 6.2).

Table 4.7. *Practice Characteristics and Behavior Score Group Means Comparisons*

Grp	Demographic	*N*	Mean (SD)	*F*	*df*	*p*	η^2	Tukey's HSD
	Years Practiced			1.73	4,673	0.142	.01	*NS*
1	1-5	171	55.5 (12.2)					
2	6-10	108	55.5 (14)					
3	11-15	94	54.8 (12.7)					
4	>15	260	57.8 (12.5)					
5	None Stated	45	54.6 (12.7)					
	Place of Practice			10.03	4,673	*< .001	.06	2 < 1;2 < 4
1	Primary Care	198	59 (11.2)					
2	Hospital	172	51.7 (13.9)					
3	Subacute / LTC	26	54.3 (14.5)					
4	Out patient	225	58 (11.9)					
5	None Stated	57	54.1 (12.8)					
	Number of L/G patients cared for			21.34	4,673	*< .001	.11	1, 2 < 3 4 < 1, 2, 3, 5
1	1-3	34	48.2 (12.9)					
2	4-6	58	53.1 (12)					
3	>6	521	58 (11.9)					
4	none	17	39.4 (12.7)					
5	None Stated	48	53.9 (12.9)					
	Practice focus			8.02	6,671	*< .001	.07	2,3,5,6,7 < 4 5 < 1 4, 6, 7
1	Adult Men	8	58.1 (6.2)					
2	Adult Women	62	54.5 (11.5)					
3	Children/Adol.	63	57.2 (12.1)					
4	Psych	51	64.2 (8.9)					
5	Neonatal	8	35.1 (10)					
6	Multiple Selection	437	56.1 (12.9)					
7	None Stated	49	53.7 (12.9)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. Group numbers in the last column are used to designate which groups were significantly different from others using the Tukey's HSD method for pairwise, post-hoc comparisons.

GAP Total Scores

Personal factors

Total GAP score group means relative to categories of personal characteristic variables are shown in Table 4.8. Personal factors that had statistically significant associations with GAP total scores included personal identity, $F(4, 673) = 8.64$, $p < .001$, $\eta^2 = .05$, having a lesbian or gay family member, $F(4, 673) = 6.24$, $p < .001$, $\eta^2 = .04$, and political party affiliation, $F(4, 673) = 9.04$, $p < .001$, $\eta^2 = .05$. APRNs with at least 2 lesbian and /or gay family members ($n = 99$, $M = 127.4$, $SD = 17.1$) or ≥ 3 ($n = 99$, $M = 126.2$, $SD = 18.8$) had significantly higher total GAP scores compared to those that selected none in their family ($n = 224$, $M = 117.9$, $SD = 21.1$). APRNs who identified as lesbian also had significantly higher scores ($M = 141.1$, $SD = 9.7$) than those who identified as heterosexual ($n = 564$, $M = 120.5$, $SD = 19.5$) or chose not to answer ($n = 59$, $M = 120.4$, $SD = 20.5$). Lastly, a Democratic political affiliation yielded a significantly higher total score ($n = 312$, $M = 125.9$, $SD = 17.7$) compared to a Republican affiliation ($n = 81$, $M = 113.3$, $SD = 21.2$), an Independent political preference ($n = 140$, $M = 119.9$, $SD = 18.7$), or not answering ($n = 109$, $M = 117.9$, $SD = 20.9$) groups. Among the independent variables that reached statistical significance, personal identity and political party affiliation had the largest eta-squared indicating that among all the independent variables these two variables were the strongest predictors of total GAP scores.

Table 4.8. *Personal Characteristics and Total GAP Score Group Means Comparisons*

Grp	Demographic	*N*	Mean (SD)	*F*	*df*	*p*	η^2	Tukey's HSD
	Age			1.89	5,672	0.94	.01	*NS*
1	21-30	43	120.0 (17.8)					
2	31-40	124	121.3 (19.5)					
3	41-50	137	119.0 (19.3)					
4	51-60	209	122.5 (20.3)					
5	>60	119	125.6 (19.0)					
6	None Stated	46	118.0 (19.8)					
	Gender			6.45	2,675	.025	.01	*NS*
1	Female / Transgender	582	122.7 (18.3)					
2	Male	44	113.6 (27.2)					
3	None Stated	52	116.6 (22.8)					
	Race			1.55	3,674	0.2	.00	*NS*
1	White	573	122.2 (19.5)					
2	Black	24	114.2 (17.4)					
3	Other	24	120.2 (22.6)					
4	None Stated	57	119.9 (20.0)					
	Ethnicity			1.30	2,675	0.272	.00	*NS*
1	Hispanic / Latino	20	118.9 (19.5)					
2	Non-Hispanic / Latino	594	122.1(19.4)					
3	None Stated	64	118.3 (21)					
	Education			1.95	4,673	0.10	.01	*NS*
1	Masters	566	121.5 (19.7)					
2	DNP	40	125.6 (18.2)					
3	PhD	19	129.9 (15.9)					
4	EdD	5	119 (17.1)					
5	None Stated	48	117.1 (20.2)					
	Number L/G in my family			6.24	4,673	*<.001	.04	4 < 2, 3;
1	1	192	122 (17.8)					5 < 2
2	2	99	127.4 (17.1)					
3	≥3	99	126.2 (18.8)					
4	None	224	117.9 (21.1)					
5	None Stated	64	118.1(20.9)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. Group numbers in the last column are used to designate which groups were significantly different from others using the Tukey's HSD method for pairwise, post-hoc comparisons.

Table 4.8 cont. *Personal Characteristics and Total GAP Score Group Means Comparisons*

Grp	Demographic	N	Mean (SD)	*F*	*df*	*p*	η^2	Tukey's HSD
	My identity			8.64	4,673	*<.001	.05	1, 5 < 3
1	Straight/Heterosexual	564	120.5 (19.5)					
2	Gay	12	131.3 (17.2)					
3	Lesbian	26	141.1 (9.7)					
4	Bisexual	17	128.9 (15)					
5	None Stated	59	120.4 (20.5)					
	Religion			2.33	4,673	0.055	.01	*NS*
1	Protestant	119	121.1 (20.5)					
2	Catholic	235	119.0 (20.5)					
3	Jewish	39	121.2 (19.1)					
4	Other	92	124.5 (17.5)					
5	None Stated	193	124.1 (18.7)					
	Political Party			9.04	4,673	*<.001	.05	2, 3, 5 < 1
1	Democratic	312	125.9 (17.7)					
2	Republican	81	113.3 (21.2)					
3	Independent	140	119.9 (18.7)					
4	Other	36	122.8 (22)					
5	None Stated	109	117.9 (20.9)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$.

Professional practice factors

Among potential associations between professional practice characteristics and total GAP scores (see Table 4.9), place of practice, $F(4, 673) = 7.44$, $p < .001$, $\eta^2 = .04$, number of lesbian and gay patients cared for, $F(4, 673) = 14.96$, $p < .001$, $\eta^2 = .08$, and practice focus, $F(6, 671) = 5.48$, $p < .001$, $\eta^2 = .05$, had the most significant relationships with total GAP scores. APRNs who practiced in primary care (n =198, M =125.7, SD = 18.1) and outpatient settings (n = 225, M = 123.8, SD = 18.5) had significantly higher mean total scores than APRNs that work in hospitals (n = 172, M = 115.7, SD = 20.9). The group that had cared for more than 6 lesbian or gay patients (n = 521) during their career also had significantly higher total scores (M = 124, SD = 18.9) compared to those who had only cared for 1 to 3 (n = 34, M =110.5, SD = 17.3) or

none (*n* =17, *M* = 94.3, *SD* = 10.6). Mean comparisons of practice focus categories demonstrated that psychiatric nurse practitioners had higher total scores (*M* = 131.5, *SD* 14.8) than groups whose practice concentrated on women (*n* = 62, *M* = 121.1, *SD* = 17.8), children and adolescents (*n* = 63, *M* = 125.3, *SD* = 17), neonatal (*n* = 8, *M* = 96, *SD* = 16.3), multiple selection (*n* = 437, *M* =121, *SD* = 20) or not stating a particular practice (*n* = 49, *M* = 117.4, *SD* = 21.8).

Table 4.9. *Practice Characteristics and Total GAP Score Group Means Comparisons*

Grp	Demographic	*N*	Mean (SD)	*F*	*df*	*p*	η^2	Tukey's HSD
	Years Practiced		Total Score	1.47	4,673	0.209	.00	*NS*
1	1-5	171	121.2 (18.6)					
2	6-10	108	121.4 (20.9)					
3	11-15	94	118.7 (19.6)					
4	>15	260	123.7 (19.6)					
5	None Stated	45	118.9 (19.9)					
	Place of Practice			7.44	4,673	*<.001	.04	2 < 1, 4
1	Primary Care	198	125.7 (18.1)					
2	Hospital	172	115.7 (20.9)					
3	Subacute / LTC	26	117.8 (21.8)					
4	Out patient	225	123.8 (18.5)					
5	None Stated	57	119.1 (19.2)					
	Number of L/G patients			14.96	4,673	*.00	.08	1 < 3; 4 < 1, 2, 3
1	1-3	34	110.5 (17.3)					
2	4-6	58	117.8 (17.9)					
3	>6	521	124.0 (18.9)					
4	none	17	94.3 (19.6)					
5	None Stated	48	118.5 (19.9)					
	Practice focus			5.48	6,671	*<.001	.05	2,3,5,6,7 <4 5 < 1, 2, 3, 4, 6, 7
1	Adult Men	8	123 (10.2)					
2	Adult Women	62	121.1 (17.8)					
3	Children/Adol.	63	125.3 (17)					
4	Psych	51	131.5 (14.8)					
5	Neonatal	8	96 (16.3)					
6	Multiple Selection	437	121 (20)					
7	None Stated	49	117.4 (21.8)					

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. Group numbers are used to designate which groups were significantly different from others using the Tukey's HSD method for pairwise, post-hoc comparisons.

MANOVA

A series of multivariate analyses of variance (MANOVAs) was conducted with 13 demographic characteristics as independent variables and with GAP beliefs and behaviors as a single bivariate dependent variable. The objective of these analyses was to determine whether testing results for the demographic characteristics might change if the statistical analyses fully

accounted for correlations between GAP beliefs and behaviors scores. The threshold for statistical significance in the MANOVAs was lowered to $p \leq .0038$ to account for multiple comparisons. Table 4.10 shows the statistically significant multivariate effects for beliefs and behaviors based on personal and practice characteristics for the sample of 678 APRNs. There were statistically significant differences in belief and behaviors scores based on age, gender, number of lesbian or gay family members, personal identity, political party, place of practice, number of lesbian and gay patients care for, and practice focus. With the exception of gender, all of these demographic variables had also reached statistical significance in either the ANOVAs on the GAP belief scores, GAP behavior scores, or both.

Table 4.10. *Statistically Significant Differences in Beliefs and Behaviors Based on Personal and Practice Characteristics (N = 678)*

Demographic	Wilks' Lambda	*F*	*df*	*p*
Age	.956	3.04	10, 1342	< .001
Gender	.977	3.94	4, 1348	.003
No. L/G in My Family	.965	3.16	8, 1344	.002
Personal Identity	.946	4.75	8, 1344	< .001
Political Party	.941	5.18	8, 1344	< .001
Place of Practice	.939	5.38	8, 1344	< .001
No. L/G Cared For	.880	11.05	8, 1344	< .001
Practice Focus	.905	5.69	12, 1340	< .001

Note. To account for multiple comparisons the threshold for statistical significance was lowered to $p \leq .0038$

Table 4.11 compares the statistically significant *p*-values from the MANOVA and ANOVA testing. Results from the multivariate testing supported the significant findings from the ANOVA for number of lesbian or gay family members ($p = .002$), personal identity ($p < .001$), and political party ($p < .001$), and number of lesbian and gay patients cared for ($p < .001$). There was an indication of possible significance in the ANOVA testing with gender beliefs ($p = .019$) and behaviors ($p = .069$); however, the reduced threshold for statistical significance ($p \leq .005$) to

account for multiple comparisons may have prevented gender from reaching statistical significance in these analyses. As shown in Table 4.11, these was no demographic variable that reached statistical significance in the ANOVAs but not in the MANOVAs.

Table 4.11 *Comparison of Statistically Significant p - values From MANOVA and ANOVA Testing (N = 678)*

Demographic Variable	MANOVA Wilks' Lambda *p*-value	ANOVA Beliefs *p*-value	ANOVA Behaviors *p*-value
Age	.001	*NS*	.005
Gender	.003	*NS*	*NS*
No. L/G in My Family	.002	.002	<.001
Personal Identity	<.001	.001	<.001
Political Party	<.001	<.001	<.001
Place of Practice	<.001	*NS*	.001
No. Cared for	<.001	.004	<.001
Practice Focus	<.001	*NS*	<.001

Qualitative Data

Prior to undertaking the qualitative data analysis, frequencies were run to determine how many of the 678 participants in the sample answered or did not answer the narrative descriptive statement. Of the 678 participants in the study, 469 (69.2%) provided a descriptive statement of their experiences caring for patients who are lesbian or gay. The remaining 209 (30.8%) participants chose not to respond to the narrative statement. In a similar fashion, many of these 209 participants also chose not to answer all items on the demographic profile.

Of the 469 respondents who provided narrative text, five noted that they could not read the descriptive statement on the electronic device used to access the survey. Not providing answers on multiple demographic characteristics seemed to be predictive of also not providing a response to the descriptive statement. Participants who did not respond to the qualitative

statement in the survey were more likely to be between the ages of 31 and 40 (n = 50, 27.6%), and to have between 1 and 5 years of experience as an APRN.

A detailed comparison of the demographic characteristics between those who did not or did respond to the descriptive statement are shown in Table 4.12 and Table 4.13. The standardized residual represent the extent to which the demographic characteristic as opposed to random variation accounted for the likelihood of either providing or not providing a narrative statement. Values of $\geq \pm 2$ are considered statistically significant (Glen, 2016) and are an indication of the categorical blocks that are contributing the most (positive) or least (negative) to the statistically significant value. To account for multiple comparisons, the threshold for statistical significance was lowered to $p \leq .0038$. APRNs between 31 and 40 years old (n = 74, 16.4%) and who had been in practice between 1 and 5 years (n = 64, 35.4%) were less likely to provide a narrative statement for this survey. In contrast, APRNs who were older than 60 years and those whose political affiliation is Independent were more likely to provide a narrative statement.

Table 4.12. *Comparisons of Personal Demographics Without and With a Narrative Response*

Demographic Variable	% *Without Narrative*	Std. Residual	% *With Narrative*	Std. Residual	X^2
Age (*N* = 632)	n_1 = 181		n_2 = 451		*< .001
21-30	8.3	.8	6.2	-.5	
31-40	27.6	2.4	6.4	-1.5	
41-50	25.4	1.1	20.2	-.7	
51-60	29.3	-.9	34.6	.6	
>60	9.4	-2.9	22.6	1.9	
Gender (*N* = 626)	n_1 = 178		n_2 = 448		.6
Female/Transgender	92.1	-.1	93.3	.1	
Male	7.9	.4	6.7	-.3	
Race (*N* = 621)	n_1 = 179		n_2 = 442		.6
White	91.1	-.2	92.8	.1	
Black	5.0	.8	3.4	-.5	
Other	3.9	0	3.8	.0	
Ethnicity (*N* = 614)	n_1 = 176		n_2 = 438		.254
Non-Hispanic/Latino	95.5	-.2	97.3	.1	
Hispanic /Latino	4.5	.9	2.7	-.6	
Education (*N* = 630)	n_1 = 180		n_2 = 450		.135
Masters	92.2	.3	88.9	-.2	
DNP	6.1	-.1	6.4	.1	
PhD	0.6	-1.9	4	1.2	
EdD	1.1	.5	0.7	-.3	
No. L/G in My Family (*N* = 614)	n_1 = 176		n_2 = 438		.359
1	31.3	.0	31.3	.0	
2	19.9	1.2	14.6	-.8	
≥3	13.6	-.8	17.1	.5	
None	35.2	-.3	37	.2	
Personal Identity (*N* = 619)	n_1 = 179		n_2 = 440		.983
Straight/Heterosexual	91.1	.0	91.1	.0	
Gay	2.2	.3	1.8	-.2	
Lesbian	3.9	-.2	4.3	.1	
Bisexual	2.8	.0	2.7	.0	
Religion (*N* = 485)	n_1 = 136		n_2 = 349		.834
Protestant	22.1	-.6	25.5	.4	
Catholic	50.7	.4	47.6	-.2	
Jewish	7.4	-.3	8.3	.2	
Other	19.9	.2	18.6	-.1	
Political Party (*N* = 569)	n_1 = 157		n_2 = 412		*.001
Democratic	57.3	.4	53.9	-.3	
Republican	17.8	1.2	12.9	-.7	
Independent	14.6	-2.5	28.4	1.6	
Other	10.2	1.9	4.9	-1.2	

Note. Did not answer demographic data blocks excluded from analyses; $p \leq .0038$

Table 4.13. *Comparisons of Practice Demographics Without and With a Narrative Response*

Demographic Variable	% *Without Narrative*	Std. Residual	% *With Narrative*	Std. Residual	X^2
Years Practiced (*N* = 633)	n_1 = 181		n_2 = 452		.005
1-5	35.4	2.2	23.7	-1.4	
6-10	19.3	.7	16.2	-.5	
11-15	13.3	-.6	15.5	.4	
>15	32	-1.9	44.7	1.2	
Place of Practice (*N* = 621)	n_1 = 179		n_2 = 442		.380
Primary Care	31.3	-.1	32.1	-.1	
Hospital	31.8	1.1	26	-.7	
Subacute /LTC	2.8	-.9	4.8	.6	
Outpatient	34.1	-.5	37.1	.3	
No. of L/G Patients Cared for (*N* = 630)	n_1 = 179		n_2 = 451		.896
1-3	4.5	-.5	5.8	.3	
4-6	10.1	.4	8.9	-.2	
>6	82.7	.0	82.7	.0	
None	2.8	.1	2.7	.0	
Practice Focus (*N* = 629)	n_1 = 178		n_2 = 451		.677
Adult Men	1.1	-.2	1.3	.1	
Adult Women	9.5	-.1	10	.1	
Children/ Adolescents	10.1	.0	10	.0	
Psych	10.7	1.2	7.1	-.8	
Neonatal	0.6	-.8	1.5	.5	
Multiple Selection	68	-.2	70.1	.2	

Note. Did not answer demographic data blocks excluded from analyses; $p \leq .0038$

T-tests were run to compare GAP *beliefs*, *behaviors*, and *total* scores between the APRNs who did not provide a narrative statement and those who did. Findings showed no statistically significant differences in the different GAP scores between these two groups as shown in Table 4.14.

Table 4.14. *Comparison of GAP Scores of Did Not Answer to Answered on Descriptive Statement*

GAP Scores	Did not answer (*N*=209)	Answered (*N*=469)	*F*	Sig.
Beliefs	64.7 (9.8)	65.8 (8.4)	2.8	0.095
Behavior	55.4 (12.4)	56.7 (12.9)	2.6	0.108
Total	4.0 (0.7)	4.1 (0.6)	.06	0.8

Note. Statistically significant at $p \leq .05$

Qualitative Data Analysis

The qualitative data helped to answer research question 3: *What are the clinical experiences of APRNs who have cared for lesbian and gay patients?* Krippendorff's (2013) method for content analysis was used to analyze participant responses to the descriptive statement: *"Please describe in as much detail as you can your experiences of having cared for patients who are gay or lesbian. Specific examples to clarify your response are extremely helpful."* This aim of this approach is to enable duplicating and validating interpretations of the narrative texts within the context in which they were written (Krippendorff, 2013). The narrative descriptions help to provide a richer understanding of the clinical experiences of APRNs who have cared for lesbian and gay patients. The narratives ranged in length from a single sentence to over 450 words in some instances.

Thematic Categories

The qualitative data analysis provided a deeper understanding of the varied experiences of APRNs in clinical practice with lesbian and gay patients. Each dendogram (as shown in Appendix I) depicts the broad thematic category and the clustered units that emerged to form the theme. These clustered units evolved from descriptive segments of APRNs' narrative descriptions of their experiences caring for lesbian and gay patients.

Theme 1. Affirming Beliefs and Behaviors

This theme, illustrated in Figure 1 (Appendix I) embodies the positive and supportive perspectives of APRNs in clinical practice with lesbian and gay patients. Eight clustered units or subthemes emerged during the analysis and comprise the affirming beliefs and behaviors category: *being aware of community resources*, *provide a supportive environment*, *dispel myths and homophobic remarks*, *treat with respect*; *provide a safe environment*; *demonstrate nonjudgmental care*; *advocacy through education*; *remain open-minded*. The following descriptive statement is one example that shows the importance of being aware of community resources to support patients of diverse sexual identity:

> I have a few LGBT patients in my care in my practice. I am up to date on specific screening practices for this specific community and am able to facilitate an open discussion about whether a patient has experienced discrimination based on sexual orientation and whether they are open to or in need of community resources for support.

Affirming participant statements included phrases such as "promote a supportive environment," "offer support, assurance, and guidance," and "support them in their attempts to navigate the legal system." The following participant statement is representative of the support offered to patients of diverse sexual and gender identities:

> My patient clientele is often that of the teenage years, a very sensitive and vulnerable time for those who identify at LGBT. In any case, where it is appropriate, I will offer a [sic] [them] support, assurance, and guidance with regards to inclusivity and acceptance of anyone who identifies [as] at [sic] LGBT. This may also include parents of the patients.

Other APRNs made attempts to dispel myths and homophobic remarks by others with statements such as, "I try to dispel myths and challenge others who are homophobic in my own personal life", and "I do not promote homophobic opinions from my [heterosexual] patients- I

stop them and let them know that we care for everyone and they can have their opinion, but I do not tolerate hate in any form."

Respect for the individual patient was another recurring statement in this thematic category. Some APRNs noted it was import to show respect for their lesbian and gay patients as exemplified in the following statement, "I take care of many patients who come in with same sex partners/husbands/wives. I am open-minded and do not judge when they come into the office together and respect their family and relationship dynamics." It was important for affirming APRNs to provide a safe environment and demonstrate nonjudgmental care with their adolescent and adult patients who are lesbian and gay. The following two testimonials help to highlight this behavior:

> I see adolescents in a primary care setting. Some of my patients self-identify as gay/lesbian. In every visit with these patients, I attempt to create an open, safe, and honest environment for discussion and treatment. I attempt to educate gay/lesbian patients of health risks specific to them.

> I treat a number of gay couples in my practice. I let them know that this is a safe environment to discuss any issues that they may have and encourage open discussion.

Other APRNs advocated for their patients by joining a support group and attending health education opportunities to learn more about diverse sexual identities and some acknowledged learning so much from their patients as conveyed in the following statement:

> I am committed to supporting clients in feeling comfortable in the full expression of their sexuality; gender preference, choices for love and family, and needs for compassionate and appropriate health care and mental health services. My clients are continuously teaching me, and I am honored to be a willing student. Thank you for this important area of clinical research and advocacy.

It was important for practicing APRNs who expressed affirming perspectives to remain open-minded. The following statement by an APRN communicates this point:

> I'm very open minded about gay and lesbian clients, actually all LGBT patients. I do believe that this comfort level is due to my age, and exposure. I welcome all races, and I identify the patient and their identity as they identify themselves. I believe in an open door policy, and the more open minded you are, the more you can truly help your patients with all of their primary health concerns. I do this on a daily basis.

Theme 2. Sexual Orientation Only Asked if Relevant

The second thematic category focused on the practice of only asking a patient their sexual orientation if the practitioner believed it was relevant to the visit. Figure 2 (Appendix I) represents the descriptive segments of APRN experiences caring for lesbian and gay patients that formed two clustered units identified as *Don't ask unless it relates to care* and *Don't ask sexual orientation*. The following two examples of narratives highlight this thematic category:

> Unless a patient specifically mentions to me that they are gay/lesbian, the subject isn't addressed. I don't ask anybody about their sexual orientation. If a patient chooses to bring up sexual orientation or problems they may be facing regarding their lifestyle choices I have no problem acknowledging them and assisting them.

> I don't typically discuss the emotions behind being gay/lesbian with clients unless they bring it up or it directly relates to the chief complaint at the appointment. I have directed gay/lesbian clients to community support when it is brought up as an issue.

Theme 3. Limited Experience with Lesbian and Gay Patients

This thematic category emerged from the descriptive segments of participants' statements that acknowledged they had either never cared for or had limited experience caring for lesbian and gay patients and is represented by Figure 3 (Appendix I). The following three clustered units emerged to form this thematic category: *limited experience in general*; *limited experience based on patient population*; *limited experience – patients don't always self-identify*. Participants perceived their limited or lack of experience to being a new practitioner, working in a practice that they believed did not care for this patient population or because not all patients identify their

sexual orientation. The following participant statements exemplify the reasons some participants noted they had limited experiences caring for lesbian and gay patients:

> I am still relatively new to practice and at this time have only a few patients who have self-identified as gay/lesbian, most of whom have let me know during conversation at the start of their visit without me asking about their sexual preferences.

> I work with a geriatric population so do not have as much exposure or clients opening up as much about it.

> I rarely have interactions with patients who have openly identified their sexual orientation. I have never noticed any questions regarding sexual orientation in patient's admission nursing history or otherwise addressing sexual orientation. You see questions about safety with your partner. But vague info. I have not met many people pre-op who are forthcoming with issues or concerns.

Some APRNs with limited experiences chose to identify their practice specialty in their narrative statements and these include oncology, pediatric, long-term care, anesthesia, family practice, hospice and palliative care.

Theme 4. Sexual Orientation is Not Focus of Practice

This theme as illustrated in Figure 4 (as shown in Appendix I) shows how some participant narrative descriptions conveyed that sexual orientation of a patient is simply not a focus of their clinical practice. The reasons offered included having few opportunities to discuss sexual orientation during a patient's assessment or the APRN did not perceive a patient's sexual orientation pertinent to the reason for the health care visit. Three clustered units formed this overarching thematic category and include: *not a main focus and rarely relevant*; *is a non-issue and not my concern*; *few opportunities to address with elderly*. One participant who works as a psychiatric APRN shared the following experience that illustrates this theme:

> I am a psych APRN, working in med management. I work in a hospital IOP, and therefore see many people, but for time limited periods. Sexual orientation is acknowledged respectfully, if at all, but rarely has come up as a problem for my patients

> in the context for which I am treating them. For the most part, in my practice, a patient's sexual orientation is a non-issue. In the context of my work, many of the questions you have raised in this survey would be dealt with by other team members, such as the social workers.

Another APRN shared the following statement noting reasons why a patient's sexual orientation was not a focus of practice:

> I did care for patients who were gay or lesbian while working in primary care. I did treat them for typical medical problems i.e. hypertension, dyslipidemia, etc. Their sexual orientation was not a main focus of my care unless it involved psychological or physical manifestations. Time constraints (15 min visits) does not allow for a lot of [time] to address all problems.

Theme 5. Non-affirming Beliefs and Behaviors

The theme, as shown in Figure 5 (Appendix I), reveals the non-affirming beliefs and behaviors of APRNs when having cared for lesbian and gay patients. Three clustered units emerged from the descriptive segments of some of the participant narratives. These clustered units are *role of victim is their identity*; *do not tolerate or support this lifestyle*; and *fed up, don't care, not my responsibility*. These phrases were explicit in many of the narratives shared by some APRNs. Examples of statements that APRNs noted include: "I do not tolerate the gay/lesbo lifestyle," "I find many of the questions in this survey to be biased and patronizing to the gay community," "The issues are less about victimization because of their sexuality and more about continuing in the role of victim," "I have always viewed them as individuals with the freedom to choose sexual orientation." The following narrative offered by one APRN epitomizes non-affirming beliefs and behaviors:

> Approach and seek help to leave the lifestyle and want to feel accepted by all [sic]. Often when GLBTQ is a result of trauma and abuse, clients are most willing to explore those issues. When a client is atheist or agnostic they often refuse to engage in any kind of spiritual approach. I am very honest and tell them that I am not the provider who can best meet their current needs but if they desire the approach I take they are always welcome to return. I am very against the modern approach to destruction of the

> traditional family. We are seeing children and youth growing up very confused and it is not serving society well at all. To see that young children are being taught about 2 mommies and 2 daddies is just flat out wrong. Society is facing consequences of this identity confusion. We are continually having GLBTQ issues thrown in our face on TV and in movies and as a result I choose not to watch or support these efforts. Often people that are GLBTQ are portrayed as victims of society and as most have been-- not because of their sexual orientation but because of what drove them to their sexual orientation and lifestyle of choice. I believe that these individuals are in great need of help and support to find their true identities and purpose in life and that the role of the psychotherapist is to get past the outward manifestation of identity confusion and to help the individual find their core identity.

Theme 6. Treat All the Same

Some APRNs use a 'one size fits all' approach when caring for lesbian and gay patients. Figure 6 (as shown in Appendix I) represents the compilation of descriptive segments and clustered units that illustrate this approach. The four clustered units that resulted from quotes in APRNs' full narrative descriptions include: *treat the same as heterosexual patients; treat the same as other diverse patients; offer same support for lesbian/gay parents as any parents; and I treat them same as any other patient.* One APRN believed that patients from the LGBT community were no different than the heterosexual patients that they had cared for in their practice as conveyed in the following narrative statement:

> I don't believe special education and training is necessary, I believe that would only be necessary if you had minimal exposure to the LGBT community. I also do not believe that patients from the LGBT community were any different than the heterosexual patients I cared for. There are issues specific to their community that they must deal with; however, the patients I encountered from the LGBT community sought me out for their physical or mental health care and they did not voice concerns of oppression or persecution. Additionally many of the issues that the LGBT community encounters like coming out to family etc., were already addressed by the time they reached me. Even the young adults in their late teens or early 20's did not have horrible coming out stories; most stated their parents knew before they did. Maybe in the Bible belt or more rural areas oppression or persecution occurs more, I live and work in the inner cities of Bridgeport and New Haven CT. Also many of the LGBT patients I cared for were practicing Christians in this area and they did not report religious persecution.

Another APRN expressed strong views about treating all the patients the same regardless of their sexual orientation. Interestingly, a patient's sexual orientation seems only to matter in the event there is concern about an STD. The following APRN's narrative helps to elaborate this perspective:

> I feel that most of the questions asked thus far are somewhat unfair. In my practice setting sexuality does not come up often, I treat everyone with respect regardless of their sexual orientation, and quite frankly their sexual orientation in critical care really doesn't impact their medical care at all unless there is concern for STD, that being said, there is no emphasis placed on STDs in this population more so than a heterosexual population. In addition, all patients are educated about the resources in their community available to them. When gay and lesbian couples come in, I treat them as I would any spouse I don't [sic] offer them the same respect, it make no differentiation [sic] about their relationship. I feel that all patients deserve the same level of respect and in that spirit, I do not go out of my way to treat gay/ lesbian couples any differently that I would treat an Asian or African American.

Theme 7. Have Witnessed Discrimination

Some APRNs described instances when they had witnessed discrimination toward lesbian and gay patients. As shown in Figure 7 (Appendix I), this thematic category was comprised of three clustered units that highlighted sources of this discrimination and included, *discrimination in the community, discrimination from family and friends, discrimination in health care*. The unkind and judgmental treatment was not limited to a particular age or developmental level and included adolescents, adults, and the elderly. Some examples of witnessed discrimination include hearing defamatory remarks among community members, families that rejected a gay or lesbian members after they disclosed their sexual orientation, and hearing stories of poor treatment by health care providers. One APRN described challenges encountered when trying to provide holistic care for teenagers who are lesbian or gay in the following statement:

> I work in pediatrics and in a highly Christian community. I always try to speak with teens about safe sex and discrimination/family issues. The biggest barrier, as always, is the lack of time practitioners are given to spend with their clients. For example, a well

> teen in for their annual physical, may open up about their sexual orientation and practices. Given that we have about 15 minutes per patient (including charting and billing) it is nearly impossible to address every issue, and unfortunately, these social issues are the first to go. It is also very difficult to support teens and encourage them to be honest when the community is extremely homophobic. How can you encourage a teen to be honest with their parents when you know that will either mean a beating or that the teen will be kicked out of the house? I try to help the teens find support groups and always tell the parents that they must address any bullying at the school, but, like I said, given the small amount of time we have to see patient, it is nearly impossible. Usually, all I can do is tell the teens how to have safe sex and encourage them to continue coming to the office for additional visits if they have more questions.

Another APRN shared how the limitations of a basic intake form can potentially influence whether or not a patient feels welcomed during an office visit:

> I have worked with several lesbian clients. I mostly see lesbian clients for obstetric care and rarely see lesbian clients for annual gyn care. Our intake form for obstetric clients does not ask about sexual orientation nor does it ask about the client's current partner. The intake form asked about the father of the baby. For a lesbian client, this usually opens up a conversation about how the patient got pregnant and I end up determining that the client is a lesbian and I get to know her partner. However, this process may be somewhat intimidating to a lesbian couple. Our intake form for gyn clients asks for sexual orientation and whether the woman has sex with men, women, or both. This form is filled out on paper by the client before they are seen by the provider. I then discuss the answers during the visit. I believe this format is more welcoming to our lesbian clientele.

Theme 8. More Education Needed

APRN descriptions that formed this thematic category identified the need for more education about lesbian and gay populations. Figure 8 (Appendix I) displays how the descriptive segments and subsequent clustered units support this thematic category: *more resources needed*, *more education needed in nursing*, and *care is more challenging without education*. The narrative accounts ranged from lack of any awareness about community resources to personal knowledge limitations to provide the most culturally appropriate care for these patients. One APRN offered the following statement that highlights the need for more community resources:

> I work in pediatrics only, so I [sic] my experience with gay or lesbian patients is limited. I sometimes have an adolescent that is open enough to share their sexual identity with me and I have 1 lesbian couple that have just had a baby. I admit that I'm not very aware of community resources that would be helpful to adolescents who are "coming out" or gay/lesbian couples who are having children. I could use more info in this area.

Another APRN expressed the lack of educational resources about diverse sexual and gender identities and advocated for more education about how to best support a patient during "coming out" or acknowledging their sexual identity. The following statement helps to illustrate this view:

> I have a private practice and I provide psychotherapy and/or medication management to adults. I do not specialize in gay/lesbian issues, but I have always had at least six patients at any point in time who identify themselves as gay/lesbian. I have a new patient who may be struggling with coming out as an older, divorced man, but he has not acknowledged it and he is in therapy with another practitioner. I provide med management. I must admit that I was not comfortable when he acknowledged holding a "secret" that bothered him—wasn't really sure whether to suggest that as a possibility or wait for him to be ready to share. It's still a work in progress. I probably would benefit from some more education about talking to people who have not yet come out. I have others who talk freely about their partners and occasionally about societal rejection (one couple were flatly denied the use of a congregational church for their wedding because of their homosexuality). I am not uncomfortable when patients are already out.

Other APRNs have found that their the lack of education about lesbian and gay health care issues when they entered practice posed specific challenges for them as shared in the following narrative:

> When I was first in practice, I was uncomfortable with lesbian patients because I was unfamiliar with gay/lesbian lifestyle and issues. I felt unequipped to provide thorough care. Over the years I have purposely learned more through continuing education seminars, journal articles, and patients. With the advent of EMR, I have less time for patient care. I strive to accept every woman for who she is when I see her. I try to meet everyone's need for acceptance and support.

Phase 3 – Merging the Quantitative and Qualitative Findings

In this phase of the mixed method study (as displayed in Appendix E), findings from the quantitative and qualitative data were merged in a manner to answer the fourth research question: *How do findings from the experiences of APRNs in clinical practice with lesbian and gay patients enhance or elaborate the findings from the total GAP scores?* A series of one-way analyses of variance was used to determine mean GAP beliefs, behaviors, and total summary scores for each thematic category including the missing (n = 209) and could not read the question (n = 6) categories. Tables 4.14 through 4.16 display the results of these group mean comparisons. Statistically significant findings are bolded in each of these tables. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$. The thematic categories are ranked in each table from highest to lowest mean GAP scale scores. The number in parentheses after each theme name reflects the order in which it was discussed in the qualitative findings. These numbers are also used to identify the themes in the post hoc comparisons.

GAP Scale Scores and Thematic Categories

As shown in Tables 4.15 through 4.17, there were statistically significant ($p < .001$) differences in mean GAP beliefs, behaviors, and total scores relative to the thematic categories identified in the qualitative analyses. The graphs shown in Appendix J offer a visual comparisons of the mean GAP scale scores compared to the thematic categories that are described below. The thematic categories are shown along the x-axis from highest to lowest GAP score and the mean GAP scale scores align with the y-axis in ascending order from lowest to highest score. The *missing* and *cannot read the question* categories were included in this comparison to show despite not having any qualitative data, these groups consistently had higher mean GAP scales scores compared to the *treat all people the same*, *sexual orientation is only asked if relevant*,

limited experience with lesbian and gay patients, *sexual orientation not focus of practice* and the *non-affirming* categories.

The thematic categories of *affirming*, (*n* = 251, *M* =68.2, *SD* =7.4) and *have witnessed discrimination* (*n* = 10, *M* = 68.2, *SD* = 5.6) consistently had highest scores on GAP *beliefs, F*(9, 668), 6.9, $p < .001$, $\eta^2 = 0.09$, GAP *behaviors, F(*9, 688*)*, 16.2, $p < .001$, $\eta^2 = 0.22$, GAP *total, F*(9, 668), 6.9, $p < .001$, $\eta^2 = 0.19$ scores. Post hoc analysis found significantly higher mean belief scores in the *affirming* (*n* = 251, *M* = 68.2, *SD* =7.4) category compared to the *missing* (*n*=209, *M*=64.7 *SD*= 9.8), *treat all patients the same* (*n* = 63, *M* = 62.2, *SD* =8.6), *sexual orientation not focus of practice* (n =33, M = 60.9, SD = 9.6), and *non-affirming* (*n* = 12, *M* = 58.2 *SD* = 10.4) categories.

Table 4.15. *Thematic Categories and Beliefs Score Group Mean Comparisons*

Theme	*n*	*M* (*SD*)	*F*	*df*	*p*	η^2	Tukey's HSD
			6.9	9, 668	< .001	.09	
Have Witnessed Discrimination (7)	10	68.2 (5.6)					*NS*
Affirming (1)	251	68.2 (7.4)					1 > 4, 5,6,10
More Education Needed (8)	25	67.3 (7.3)					*NS*
Can't Read the Question (9)	6	65.7 (9.1)					*NS*
Missing (10)	209	64.7 (9.8)					10 <1
Limited Experience with L/G Patients (3)	46	63.3 (8.7)					*NS*
Sexual Orientation Asked Only if Relevant (2)	23	62.4 (7.0)					*NS*
Treat All Patients the Same (6)	63	62.2 (8.6)					6 < 1
Sexual Orientation Not Focus of My Practice (4)	33	60.9 (9.6)					4 < 1
Non-affirming (5)	12	58.2 (10.4)					5 < 1

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$

Table 4.16 shows the significantly higher mean behavior scores in the *affirming* (*n* =251, *M* = 68.2, *SD* = 7.4) thematic category compared to *missing* (*n* = 209, *M* = 55.4, *SD* = 12.4), *treat all patients the same* (*n* = 63, *M* = 52.9, *SD* = 12.3), *sexual orientation asked only if relevant* (*n* = 23, *M* = 48.3, *SD* = 9.8), *limited experience with lesbian and gay patients* (*n* = 46, *M* = 46.3, *SD* = 15.3), and *sexual orientation not focus of my practice* (*n* = 33, *M* = 45, *SD* = 11.1). Findings showed that the *non-affirming* and *sexual orientation not focus of practice* categories had the two lowest mean belief scores; however, this did not hold true for mean behavior scores where *limited experience with lesbian and gay patients* and *sexual orientation not the focus of practice* were the lowest.

Table 4.16 *Thematic Categories and Behaviors Score Group Mean Comparisons*

Theme	*n*	*M* (*SD*)	*F*	*df*	*p*	η^2	Tukey's HSD
			16.1	9, 668	< .001	0.22	
Affirming (1)	251	61.9 (10.5)					1 > 2,3,4,6,10
Have Witnessed Discrimination (7)	10	60.6 (7.6)					*NS*
Can't Read the Question (9)	6	58.3 (11.3)					*NS*
More Education Needed (8)	25	56.6 (10.3)					*NS*
Missing (10)	209	55.4 (12.4)					10 > 3, 4; 10 < 1
Treat All Patients the Same (6)	63	52.9 (12.2)					6 < 1
Non-affirming (5)	12	50.5 (10.3)					*NS*
Sexual Orientation Asked Only if Relevant (2)	23	48.3 (9.8)					2 < 1
Limited Experience with L/G Patients (3)	46	46.3 (15.3)					3 < 1, 10
Sexual Orientation Not Focus of My Practice (4)	33	45 (11.1)					*NS*

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$

Post hoc comparisons of total mean GAP scores (Table 4.17) showed significantly higher scores in the *affirming* category compared to the *missing* (*n* = 209, *M* = 120.1, *SD* = 20.4), *treat*

all patients the same (*n* = 63, *M* = 115.1, *SD* = 18.2) *sexual orientation asked only if relevant* (*n* = 23, *M* =110.7, *SD* =14.9), *limited experience with lesbian and gay patients* (*n* = 46, *M* = 109.5, *SD* = 21.1), *non-affirming* (*n* =12, *M* = 108.7, *SD* = 19.6), and *sexual orientation not focus of my practice* (*n* = 33, *M* = 105.9, *SD* = 18.1). Likewise, the *more education needed category* (*n* = 25, *M* = 123.9, *SD* = 15.8) yielded statistically significantly higher total mean scores than having *limited experience with lesbian and gay patients* (*n* = 46, *M* = 109.5, *SD* = 21.1) and *sexual orientation not focus of my practice* (*n* = 33, *M* = 105.9, *SD* = 18.1).

Table 4.17 *Thematic Categories and Total Score Group Mean Comparisons*

Theme	*n*	*M* (*SD*)	*F*	*df*	*p*	η^2	Tukey's HSD
			14	9, 668	< .001	0.19	
Affirming (1)	251	130.1 (20.4)					1 > 2,3,4,5,6,10
Have Witnessed Discrimination (7)	10	128.8 (11.5)					*NS*
Can't Read the Question (9)	6	124 (18.7)					*NS*
More Education Needed (8)	25	123.8 (15.8)					8 > 3, 4
Missing (10)	209	120.1 (20.4)					10 > 4; 10 < 1
Treat All Patients the Same (6)	63	115.1 (18.2)					6 < 1
Sexual Orientation Asked Only if Relevant (2)	23	110.7 (14.9)					2 < 1
Limited Experience with L/G Patients (3)	46	109.5 (21.1)					3 < 1
Non-affirming (5)	12	108.7 (19.6)					5 < 1
Sexual Orientation Not Focus of My Practice (4)	33	105.9 (18.1)					4< 1, 10

Note. To account for multiple testing, the threshold for statistical significance was lowered to $p \leq .005$

Summary

In chapter four, the results of this mixed method study were presented. The chapter began with a discussion of quantitative findings including descriptive statistics of the study sample,

statistically significant findings of group mean comparisons for demographic categories and GAP scale scores with post hoc analyses. A synthesis of qualitative findings culminated in eight thematic categories that represented the descriptive statements of practicing APRNs having cared for lesbian and gay patients. Significant descriptive statements that exemplified each theme were presented. The chapter concluded with a discussion about the merged qualitative and quantitative findings that compared mean GAP scale scores across themes and that used ANOVA and post hoc comparisons to identify statistically significant differences in mean scores relative to thematic categories. Chapter five will provide a discussion of these findings and implications for nursing education, practice, policy, and future research.

Chapter Five: Discussion

Introduction

Chapter five begins with a discussion comparing the GAP scale reliability and correlation between GAP beliefs and behaviors to other studies that have used this scale. This dialogue is followed by a comparison of the quantitative findings to the review of the literature about nurses' attitudes toward lesbian and gay persons. Next, quantitative findings from the ANOVA testing are compared and contrasted to other studies that measured beliefs, behaviors, and attitudes toward lesbian and gay persons. Then, the findings of qualitative data are discussed within the context of gay affirmative practice and the basic tenants of social constructionism. This discussion is followed by an explication of the findings after mixing the quantitative and qualitative data. Lastly, recommendations for nursing research, education, and practice are presented, including a discussion of the strengths and limitations of this study.

The findings from this convergent, parallel mixed method study provided rich quantitative and qualitative data to explicate the beliefs, behaviors, and experiences of APRNs with lesbian and gay patients. The eight themes that emerged from the qualitative data that helped illuminate a more complete understanding of APRNs clinical experiences caring for lesbian and gay patients were: *Affirming Beliefs and Behaviors, Sexual Orientation Only Asked if Relevant, Limited Experience with Lesbian and Gay Patients, Sexual Orientation is Not Focus of Practice, Non-affirming Beliefs and Behaviors, Treat All the Same, Have Witnessed Discrimination,* and *More Education Needed*.

Scale Reliability and Correlations

The GAP instrument demonstrated evidence of scale reliability based on a Cronbach's alpha of .95 for the total scale, .95 for the beliefs domain and .93 for the behaviors domain in this study. These data are similar to the results that Crisp (2002) reported during scale development that showed an overall Cronbach's alpha of .95 and .93 for the beliefs and .94 for behaviors. The similarity of these results for the GAP instrument provides some confidence of its reliability and stability across different samples.

Findings also provided evidence to support a significant moderate, positive correlation ($r = .629$, $p < .001$) between GAP beliefs and behaviors; however, overall mean behavior scores were slightly lower than beliefs scores. Mullins (2012) also found a significant moderate, positive correlation between practice beliefs and behaviors ($r = 0.551$, $p < .01$) when examining the relationship between these two constructs among social workers with lesbian and gay clients, and overall mean behavior scores were lower than beliefs. Crisp (2005) reported similar differences between beliefs and behaviors in a sample of social workers and psychologists. These findings suggest that practitioners with affirming beliefs about practice with lesbian and gay clients are more likely to demonstrate gay affirmative practice behaviors; however, the behaviors are not consistent with the level of belief. One can also conclude that while beliefs have a significant influence on practice behaviors, they are not the only factors. For example, the extent to which practitioners demonstrate gay affirming behaviors may be influenced by their personal value system, religion, political party, place of practice, particular patient population, and / or prior experiences with this patient population. As a profession, nurses must understand the multiple factors that influence the care they provide and the extent to which personal and professional characteristics contribute to affirming and non-affirming practice behaviors.

In this survey, there also appeared to be a relationship between not responding to the descriptive statement and having incomplete demographic data. Initially, when examining for differences in personal or practice characteristics between APRNs who did and did not provide a description of their experiences, many of the 209 APRNs who did not respond to the descriptive statement also did not answer some of the demographic items on the survey. The overlap between individuals who did not provide a narrative and who did not answer individual demographic variables made it impossible to identify which informative categories of those variables were also associated with failure to respond to the descriptive statement. Therefore, a decision was made *a posteriori* to exclude the *did not answer groups* for all demographic categories from the second series of cross tabulations to examine the relationships between specific informative categories of the demographic and practice variables and response or non-response to the narrative statement. This finding could also reflect the ability or willingness of APRNs in this study to demonstrate gay affirming practice.

Quantitative Findings

The similarities in overall mean GAP scale scores were compared to other studies. In this study, overall mean scores for beliefs (M = 65.4, SD = 8.9) and behaviors (M = 56.3, SD) and total (M = 121.7, SD = 19.6) were relatively high considering the highest score possible is 75 for each scale domain and 150 for the total score. Although there are no studies in nursing to compare these findings, these results were similar to GAP scores in two other studies that measured these constructs in social workers and psychologists (Crisp, 2005; Mullins, 2012). In a comparison between psychologists and social workers, Crisp (2005) reported a mean GAP score for psychologists of 123.17 (SD = 15.09) and for social workers it was 125.03 (SD =17.32). Mullins (2012) compared practice beliefs to behaviors in a sample of social workers and found

mean belief scores were 64.7 (*SD* = 11.51) and behaviors scores were 51.33 (*SD* = 18.54), but average total GAP scores were not reported. It is worth noting that APRNs in this study had slightly higher mean belief and behavior scores compared to social workers in Mullins' (2012) study. Crisp (2005) only reported mean total scores for social workers and psychologists, yet these were slightly higher than among the APRNs in this study. One can surmise that APRNs were lower in one or both subscale scores compared to the later study. The lower behaviors scores in this study suggest that while the APRNs reported affirming beliefs about practice, some may lack knowledge and skills to practice affirmatively or perhaps discount the relevance of certain affirming behaviors when caring for lesbian or gay patients.

The data supported statistically significant differences among certain demographic characteristics with respect to APRNs' GAP beliefs, behaviors, and overall total scores that have been reported in other studies. In this study, these characteristics included personal identity, political party, number of lesbian or gay family members, the number of lesbian and gay patients they had cared for, place of practice, and practice focus. While not all of the studies presented in the literature review used these same demographic variables, those that did are compared and contrasted with respect to either GAP scale scores or overall attitudes toward lesbian and gay persons.

Personal Identity

Findings showed that identifying as lesbian was associated with statistically significant higher GAP score than those who identified as heterosexual. Crisp (2007) reported a similar result in a sample of social workers; however, findings from an earlier study by Crisp (2005) and another by Mullins (2005) contradicted the significance of sexual orientation and GAP scores. Various factors may account for these dissimilar results including confounding factors such as

prior experiences and education congruent with gay affirmative practice. Also, sample size and variability within the demographic group may have accounted for these differences. Understandably, having a lesbian or gay practitioner is not a guarantee of gay affirmative practice, but it is also not surprising to find higher GAP belief and behavior scores among this group. Lesbian or gay persons have likely experienced some form of discrimination during their lifetime based on their sexual identity (Institute of Medicine, 2011; National Senior Centers Law Center, 2010); therefore, lesbian or gay practitioners may have a better understanding of the difficulties that patients of diverse sexual and gender identities have encountered.

Political party

Findings showed a Democratic political party affiliation had a statistically significant positive association with belief and behavior scores; however, Crisp (2005) did not report these same findings. Political party may not have influenced the perspectives about lesbian and gay clients among social workers and psychologists. In addition, the sample in Crisp's (2005) study was drawn from the National Association of Social Workers (NASW) and the American Psychological Association (APA), so it may have reflected a more representative sample of the population of social workers and psychologists. The sample in this study was drawn from a single northeastern state that has been historically Democratic. Additionally, the population in the northeastern United States has historically had a larger Democratic population with more liberal social views. Political party was not a demographic factor included or discussed in the other comparative studies.

Number of Lesbian and Gay Patients

In this study, having cared for six or more lesbian and gay patients or having had frequent contact with these patients was associated with statistically significant higher GAP scale scores

compared to those who had cared for less than six or none. Mullins (2012) and Crisp (2007) reported similar findings in their studies. These findings suggest that having increased opportunity to care for lesbian and gay patients can have a positive association on practitioners' beliefs and behaviors about this population.

Number of Lesbian and Gay Family Members

Findings showed that APRNs who had two or more lesbian or gay family members had statistically significant higher GAP scale scores compared to those who had none. Similar findings were found by Crisp (2005) among social workers and psychologists. Dinkel and colleagues (2007) also reported that having a family member identified as lesbian or gay was one of the factors that accounted for the greatest variance in attitude scores in their study. Mullins (2012) noted higher belief and behavior scores for participants who had lesbian or gay family members, but did not specify a number. Although the samples were different in each of these studies, they provide evidence that having a lesbian or gay family member has a positive effect on attitudes toward lesbian and gay persons across different study samples. One can surmise that practitioners who have lesbian or gay family member have strong beliefs about equity and justice and are more knowledgeable about lesbian and gay identities. These practitioners are also more likely to espouse gay affirming beliefs and behaviors in clinical practice.

Place of Practice and Practice Focus

The practice setting and focus of clinical practice accounted for significant mean group differences in these demographic categories. APRNs who practiced in primary care had statistically significant higher belief and behavior scores than those who practiced in hospitals. There were no other studies that measured GAP beliefs and behaviors with respect to place of practice. Although Mullins (2012) identified practice setting as a demographic variable in that

study, it referred to geographic location rather than the practice settings identified in this study. Some possible reasons for the disparate beliefs and behaviors among places of practice among APRNs include: the lack of perceived time to engage with their patients; believing the principles of gay affirmative practice were irrelevant to the patient visit or that sexual orientation was not a focus of their practice.

Religion

There are mixed findings in the literature about the effects of religion on attitudes toward lesbian and gay persons. In this study, religion did not have a statistically significant association with GAP scores; however, APRNs who selected *other* for religion had higher GAP scores compared to those that identified Jewish, Protestant, Catholic, or chose not to respond to the question. This finding suggests that for paticipants in the *other* category, religion is less likely to negatively influence their practice beliefs and behaviors. Crisp (2005) also reported that religion and its association with lower GAP scores did not reach statistcial significance in that study. A year later, Crisp (2007) also found that although religious affiliation was not significantly associated with GAP scale scores, it was associated with significantly lower scores on two additional scales to measures cognitive beliefs and attitudes about lesbian and gay persons. Mullin (2012) also collected demographic data about religious affiliation, importance of religion, and religious involvement but did not report any statistically significant associations between these variables and GAP scale scores. Some possible reasons for this lack of association between religion and GAP belief and behavior scores include a low response rate, confounding variables not controlled for in each study, or the ability of practitioners to consciously set aside opposing religious beliefs when caring for lesbian and gay clients.

In contrast to this study, Dinkel and colleagues (2007) discovered that having a religious affiliation accounted for the greatest variance in attitude scores, but explained a larger sample size was needed to generalize those findings. Rondahl (2009) also reported that nursing students who were religious had lower total knowledge scores about lesbian and gay persons than non-religious students. One may infer that this lack of knowledge could negatively influence the care nurses provide patients. A strong religious identity appears to have a negative effect on GAP scores, but it was not statistically significant. This lack of significance may be attributed to a small sample size or other confounding factors in these two studies.

Education

The social science research has historically shown that higher educational levels correlate with positive attitudes toward lesbian and gay persons (Battle & Lemelle, 2002; Ellis et al., 2002; Lewis, 2003). In this study, higher education levels were associated with higher GAP scores; however, they did not reach statistical significance. Similarly, Rondahl and associates (2004) and Blackwell and Kiehl (2008) reported that higher education levels were associated with more positive attitudes toward lesbian and gay persons. A small sample size and other confounding factors such as prior cultural diversity education or experiences caring for lesbian or gay patients may have had a greater impact on GAP scores than the higher education levels in this study.

MANOVA Findings

Findings for statistically significant differences in mean belief and behavior scores in the ANOVA analyses were similar after using MANOVA to test beliefs and behaviors as a single bivariate variable except for gender. Although the ANOVA for beliefs and behaviors was not statistically significant, the female/transgender group was different from everybody else. Specifically, the female/transgender group was consistently higher in mean GAP belief,

behavior, and total scores than the males and those who selected none stated groups. There was a pattern in the relationship between gender and beliefs and gender and behaviors. A review of Tables 4.4 (p. 61- 64) and 4.5 (p. 66 - 68) from the univariate analyses for beliefs and behaviors for gender, suggested significance for beliefs (p =.019) and behaviors (p = .069) and total score (p = .025); however, the threshold for statistical significance was set at $p \leq .005$ rather than $p \leq .05$ to account for multiple comparisons.

In the MANOVA testing, one of the reasons for the difference in the result for gender was that the bivariate analyses led to an increase in power that in turn represented an increase in the effective sample size. Although this was not a literal increase, the impact of combining the information on beliefs and behaviors in MANOVA testing provided a strength in power equivalent to having a sample size between 678 and twice that many participants. The moderately strong correlation (r = 0.629) between beliefs and behaviors indicates that beliefs predicts approximately 40% of the behaviors, but not all behavior. Had the correlation between these two variables been a positive 1, one could conclude that beliefs predicts 100% of behaviors. In that case, the effective sample size would have remained at 678 in the MANOVA testing. The results from the bivariate analyses showed there was a statistically significant difference in mean belief and behavior scores between the different gender groups.

Qualitative Findings– Not all the same; Equity is the lens

The qualitative data was greatly enhanced by the richness of the narratives that 469 (69.2%) APRNs provided when they described their clinical experiences having cared for lesbian and gay patients. Such a robust response rate suggests that this research topic is important and was valued by the APRNs who provided a narrative statement. There were eight themes identified after analyzing the descriptive statements of APRNs' experiences caring for lesbian

and gay patients. These eight themes include: 1) *Affirming Beliefs and Behaviors*; 2) *Sexual Orientation Only Asked if Relevant*; 3) *Limited Experience with Lesbian and Gay Patients*; 4) *Sexual Orientation is Not Focus of Practice*; 5) *Non-affirming Beliefs and Behaviors*; 6) *Treat All the Same*; 7) *Witnessed Discrimination*; and 8) *More Education Needed*. There are very few studies to compare the qualitative data with in this study. Given the lack of other similar mixed methods studies, the literature on gay affirmative practice provides the framework for this discussion. Where applicable, the thematic category is compared or contrasted to the guiding principles of gay affirmative practice.

Affirming Beliefs and Behaviors (Theme 1)

Participant statements that supported affirming beliefs and behaviors espoused many of the principles of gay affirmative practice described in the literature. Some have defined gay affirmative practice as an "unconditional positive regard and acceptance of a client that affirm a client's sense of dignity and worth" (Van Den Bergh & Crisp, 2004, p. 226). Several principles are integral to gay affirmative practice and include respect for personal integrity, respect for lifestyle and culture, and respectful attitudes and beliefs (Davies & Neal, 1996; Hunter & Hickerson, 2003). Gay affirmative practitioners value and demonstrate this approach to practice and view it as an essential step to reduce health disparities in this population.

To practice affirmatively, the practitioner acknowledges that ". . . a lesbian, gay, bisexual, [and transgender] identity as an equally positive human experience and expression to heterosexual identity" (Davies, 1996, p. 25). Furthermore, practicing affirmatively encompasses a practice without discrimination (Crisp, 2006). Affirmative practitioners affirm lesbian and gay identities, their communities, lifestyles and assist them with community resources as needed. They are acutely aware of heteronormative privilege and attuned to the subtle microaggressions

of verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory insults toward members or oppressed groups (Alessi, Dillon, Kim, 2015). This thematic category provided some preliminary evidence that the narrative statements of APRNs with affirming beliefs and behaviors aligned with some of the guidelines of gay affirmative practice. For example, these practitioners described being aware of community resources supportive of lesbian and gay patients and noted creating safe and welcoming environments in their practice places. They wrote about providing nonjudgmental care and remaining open-minded about how their patients lived. These APRNs also valued advocacy through education and sought resources and attended conferences to learn about the health care issues and concerns of this population. Some advocated for legal relationship status for these patients even before same sex marriage was federally recognized. Others described instances when they challenged stereotypes and disingenuous statements made by other health care providers.

Sexual Orientation Only Asked if Relevant (Theme 2)

Descriptive statements that aligned with this thematic category provided some evidence that sexual orientation is seldom addressed by these participants during the patient encounter or only asked if the practitioner believes it is relevant to the visit. APRNs are encouraged to reflect upon their specific practice settings and question the extent to which the intake or health history forms provide an option for their patients to identify their sexual orientation. Not all patients may feel comfortable disclosing their sexual orientation at a healthcare visit, but when a written form of disclosure is available, it offers patients another option to disclose. Different factors have been shown to influence disclosure of sexual orientation and include age, gender, ethnicity, relationship status or reason for seeking care (Adams, 2016). Failing to ask the question or not

including sexual orientation identification on intake forms, serves to perpetuate silence about sexual orientation. Only asking about sexual orientations based on whether the health care provider deems it important is paternalistic and may be perceived as heterosexist. While not every healthcare encounter requires asking about sexual orientation, updating health forms to offer all patients the opportunity to identify their sexual orientation and gender identity is one step closer to acknowledging patients of diverse sexual identities and making them more visible.

Limited Experience with Lesbian and Gay Patients (Theme 3)

APRNs from many different practice specialties described having limited experiences caring for lesbian and gay patients. The mean GAP scores within this thematic category were significantly lower than found in the affirming beliefs and behaviors group. Data in this study showed that having frequent opportunities to care for lesbian and gay patients positively associated with higher belief and behavior scores. Some APRNs attributed their limited experiences caring for lesbian and gay patients to the particular focus of patient population in their practice. For example, neonatal nurse practitioners described working with a patient population whose sexual orientation is not yet known; however, their patient population may have same-sex parents or partners. Gay affirmative practice approaches are also important when working with the parents or guardians of neonates.

Other APRNs described primarily caring for elderly patients and did not believe that sexual orientation was pertinent to this population. Healthcare providers need to understand that when older LGBT patients enter long-term care they may be silent about their sexual orientation because of generational differences, the lack of legal protection and fear of discrimination and mistreatment (NSCLC, 2010). Elderly LGBT persons may also face dual discrimination due to their age and their sexual orientation or gender identity (Adams, 2016). Social isolation is also a

concern among elderly LGBT persons who are more likely to be single, live alone, and less likely to have children than their heterosexual counterparts (NSCLC, 2010).

These narratives failed to acknowledge the fact that elderly people also have a sexual orientation and some may identify as lesbian or gay. These perspectives imply that concern about sexual orientation is not relevant after a certain age and highlights an opportunity to educate APRNs about elderly LGBT persons. Many who have endured discrimination throughout their life after coming out will become silent about their sexual orientation when entering long-term care or assisted living (NSCLC, 2010).

Sexual Orientation is Not Focus of Practice (Theme 4)

The notion that sexual orientation is not a focus of practice may imply it is viewed as a clinical specialty; therefore, for some APRNs it is not seen as a focus of practice. Some APRNs noted few opportunities to even address a patient's sexual orientation or did not believe it was their concern to discuss this in the clinical encounter. Others did not believe that sexual orientation was an important issue for their elderly patients and others attributed the time constraints of fifteen-minute patient visits as the reason why a patient's sexual orientation was not their focus. Other APRNs believed that matters of sexual orientation were best dealt with by social workers. Perhaps these different perspectives show that some APRNs lack the self-efficacy or knowledge to discuss certain concerns with lesbian and gay patients. For these APRNs, educational programs and continuing education opportunities may help to better inform them about this patient population.

While the majority of the population are heterosexual, similar views are rarely considered when providing health services to them. If instead sexual orientation is viewed as a human dimension, then the sexual orientation of any patient must be considered in the context of holistic

and individualized patient care. Perceiving a patient's sexual orientation as a clinical specialty rather than acknowledging that every human being has a sexual orientation risks labeling a non-heterosexual identity as an illness.

Non-affirming Beliefs and Behaviors (Theme 5)

The descriptive statements that suggested non-affirming beliefs or behaviors often referred to a lesbian or gay sexual orientation as a choice, preference, or something that could be corrected. There is evidence to support a strong association between the belief that homosexuality is a choice and less positive attitudes toward lesbian and gay persons among nurses (Blackwell, 2007; Blackwell & Kiehl, 2008). Understandably, the mean GAP score for this thematic group was significantly lower than the affirming group. The narrative statements communicated that among some APRNs discrimination and bias toward patients of diverse sexual and gender identities exists. There was little evidence to support these practitioners had the knowledge, skills, or attitudes indicative of gay affirmative practice.

Treat All the Same (Theme 6)

Narrative statements in this thematic group shared the categorical assertion that "I treat all patients the same." Proclaiming to treat every patient the same may be an attempt to convey non-bias and non-discrimination; however, doing so diminishes the value of individualized patient care that the nursing professional standards and code of ethics maintain. Perhaps a more inclusive and affirming approach would be to challenge the golden rule that says to treat all others as we wish to be treated and instead treat each person as they want to be treated. Furthermore, belief and behavior scores for this category were statistically significantly lower than among the affirming thematic group.

Have Witnessed Discrimination (Theme 7)

APRNs who described having witnessed discrimination against lesbian and gay patients in their practice did so with great empathy. The descriptive statements helped provide evidence that discrimination toward persons of diverse sexual and gender identities persists in healthcare and in the nursing profession. Some of these APRNs also advocated for their lesbian and gay patients when they observed implicit and explicit bias and discrimination toward them in various healthcare settings. One of the features of gay affirmative practice is the ability to challenge stereotypes and harmful generalizations about LGBT persons.

More Education Needed (Theme 8)

The theme of *more education needed* was evident in the APRNs' descriptive statements. This thematic category also demonstrated statistically significant higher GAP scores than the following two themes: *limited experience with lesbian and gay patients* and the belief that *sexual orientation was not the focus of practice*. Although, descriptive statements in these two categories did not explicitly refer to needing more education, having limited experiences with this population or belief that sexual orientation is a practice specialty may have contributed to the lower GAP scores in those categories compared to those who acknowledged that more education was needed.

Participants described a lack of educational content in nursing programs about LGBT health issues, appropriate care services, and culturally appropriate communication for these patient populations. Based on personal experiences as a student and an educator in several different nursing programs, this researcher acknowledges the lack of nursing education about affirming LGBT healthcare practices. These narratives also validate findings of Rondahl (2009) that showed nursing students had statistically significantly lower knowledge about how to care

for LGBT persons compared to medical students. Eliason and colleagues (2010) suggested that the silence among nursing educators and leadership about LGBT issues also permeates nursing curricula. These findings are an opportunity for nursing leadership in all practice settings to end the silence and advocate for curricular content inclusive of LGBT issues and healthcare. Nursing education programs would benefit by including more content and clinical experiences related to this diverse population. It is affirming to read that other health professions already include LGBT and clinical experiences in their educational programs; however, nursing should lead rather than lag in this endeavor. The quantitative data showed higher belief and behavior scores among APRNS with higher education levels. Higher education level was also found to associate with more positive attitudes toward lesbian and gay persons as previously reported by Rondahl and associates (2004).

Mixed Quantitative and Qualitative Findings

The thematic categories tend to slightly shift in rankings across the different GAP scale scores as shown in the graph of mean comparisons of GAP belief, behavior, and total scores to qualitative thematic categories in Appendix J. For example, for mean GAP beliefs, the non-affirming category was ranked in last position with the lowest score; however, for behaviors it was in the seventh position and then moved to the ninth place for total GAP score. This shift tends to occurs because the categories with fewer people have means with larger standard errors, so it is not uncommon to observe this shift in position when comparing highest to lowest mean scores. Despite the minor shifts in ranking, there did appear to be three categories consistently with the highest GAP scores and a couple that often had the lowest scores.

Analysis of the mean GAP scores relative to the different theme categories provided some validation of the theme. The results of merging the quantitative and qualitative findings

provided a more complete understanding about the meaning of higher and lower GAP scale scores among this sample of APRNs. The ANOVA and *post hoc* comparisons of GAP scale scores for the eight thematic categories provided evidence of statistically significant differences in mean GAP scores.

The thematic categories of *affirming, have witnessed discrimination*, and *more education needed* consistently had the highest beliefs, behaviors, and total GAP scale scores (as shown in Appendix J). The descriptive statements that formed these thematic categories embodied characteristics of gay affirmative practice. In contrast, the themes of *treat all patients the same*, *sexual orientation asked only if relevant, sexual orientation not focus of practice, limited experience with lesbian and gay patients* and *non-affirming* had lower GAP scale scores and included descriptive statements not supportive of gay affirmative practice.

We Are Not All the Same

The idea of treating all patients the same is in reality a misnomer because the nursing profession espouses to provide individualized, patient-centered care that meets the unique needs of each person. Relegating a person's sexual orientation to a practice focus also risks labeling it a pathological condition that requires medical treatment. Only asking about sexual orientation if the practitioner perceives it relevant to care may be interpreted as paternalistic. These thematic categories represent the spectrum of gay affirmative practice from most affirming to less affirming and provide some insight about APRNs' beliefs and behaviors caring for lesbian and gay patients.

Among the 678 APRNs who participated in this study, 209 (30.8%) did not provide any narrative data. The larger sample in the *missing* group contributed to a smaller standard error and thereby less variability in mean GAP scale scores. This consistency resulted in belief, behavior,

and total GAP scores that consistently fell in the middle when compared to the scores across the other thematic groups. Unfortunately, the absence of qualitative data from the *missing* group limits a more complete understanding about the meaning of the GAP scale scores.

Gay Affirmative Practice and Social Constructionism

The criteria used to express the concept of gay affirmative practice emerged from a synthesis of the different sources of evidence in various contexts including many of the tenants of social constructionism. To practice affirmatively providers must first believe it is important when caring for patients of diverse sexual and gender identities. It also requires understanding the harmful effects that stigma, heterosexism, and homophobia have on these human beings that are inconsistent with the mainstream (Irwin, 2007; McGeorge & Stone Carlson, 2011; Perlman, 2003; Weber, 2010b). These oppressive forces are often likened to the negative effects that racism and sexism have had on persons (McGeorge & Stone Carlson, 2011). Accordingly, it requires healthcare practitioners to make a concerted effort to learn about the diverse lifestyles and cultures that exist within the LGBT communities (Davies & Neal, 1996), and examine the impact that societal oppression has had on LGBT persons. Given society's trust in the nurses, our profession has great potential to combat stigma and oppression across all practice settings.

Social constructionism recognizes that human beings self-define who they are and construct how they see themselves in the world (Lock & Strong, 2010). Therefore, the practitioner must remain open to the possibility of multiple realities that emerge during a patient clinical encounter. To mitigate bias and assumptions during a health care encounter, the health care provider should focus on co-creating an understanding with the patient rather than about the patient. This intersubjective stance between the practitioner and patient helps to provide a foundation for shared understanding and respect.

The quintessence of gay affirmative practice portrays a professional comportment that acknowledges that the broad range of diverse sexual and gender identities as a meaningful, practical, and constructive way of life compatible with a sense of well-being (Davies & Neal, 1996). Furthermore, this standpoint expresses non-discrimination, validation, and affirmation of a non-heterosexual identity in a manner that fosters dignity and respect for the individual. This study explored the beliefs, behaviors, and experiences of APRNs in clinical practice with lesbian and gay patients. The findings revealed that knowledge gaps about gay affirmative practice exist in nursing yet there are opportunities to close them through nursing education, practice, policy, and research. Nurses have the potential to emerge as the leaders to close these gaps and distinguish nursing as a gay affirming profession.

The nursing profession embodies many of the tenants of social constructionism and pragmatism. Nurses are educated to be open-minded and willing to listen to patients perspectives to better understand them as a unique human being. During nurse-patient interactions knowledge and understanding are co-constructed; therefore, nurses must remain open to multiple versions of realities and truth to better solve problems. The earliest versions of pragmatic thought emphasized respect for the views of others and the notion that conversations and social interactions are the basis for developing beliefs rather than dogma or universal truths (Warms & Schroeder, 1999). This perspective coincides with the belief that knowledge is socially constructed as viewed through the lens of social constructionism. The pragmatic perspective thereby summons us to examine the value of our actions, and the knowledge gained through our social interactions should be used to improve the lives of others.

Implications for Nursing Education

A significant need identified in this study is a more explicit integration of LGBT health issues into a nursing curriculum. APRNs expressed that more education is needed and many noted they had never had content in their former educational programs about the care of lesbian and gay patients. Pre-licensure and graduate nursing education programs have historically lacked content related to the health promotion, well-being and healthcare disparities of patients of diverse sexual orientation and gender identities. Eliason and colleagues (2010) emphasized this point, noting the silence in nursing education and among many nursing leaders has served to suppress curricular content about LGBT people in nursing programs. It has only been in the last several years that professional nursing journals have begun to publish review articles about LGBT health; however, compared to professional journals in medicine, social work, and psychology, nursing continues to lag. Given the lack of substantive content about the LGBT population in nursing textbooks, nursing educators need to search other reliable, evidence-based sources to learn of culturally appropriate and affirming care practices to teach their students.

The time has come for nursing to move beyond the historical and sociocultural reasons for the profession's reluctance to address LGBT content in the curriculum. Nursing educators across all programs have an ethical responsibility to teach their students about LGBT health disparities and gay affirming practice approaches that support individualized and culturally appropriate care for patients. Nursing educators should review the topics they teach and determine the extent to which they include content related to the care of LGBT patients beyond discussions about sexuality or sexually transmitted diseases. If faculty choose not to integrate this content, they should explore the reasons for the omission. Lastly, including sexual

orientation and gender identity when addressing cultural diversity will help students understand the broader context of diversity beyond race and ethnicity.

The following recommendations are ways in which to support LGBT affirming care through nursing education.

- Evaluate current curricula for depth and bread of content about patients of diverse sexual orientation and gender identities
- Provide students with opportunities to self-reflect on their preconceptions and perspectives about caring for patients of diverse sexual and gender identities.
- Adopt a lifespan development approach to help students understand the broader context of growth and development, wellness and health issues of people with diverse sexual and gender identities.
- Determine the extent to which class content, case studies, on-campus and off-campus clinical activities provide the students with opportunities to assess, plan, intervene and evaluate care of LGBT patients.
- Objectively evaluate nursing textbooks used throughout the curriculum at the pre-licensure and graduate levels for evidence of content about LGBT patients that move beyond the topic of sexuality. For example, is the content about LGBT integrated throughout the textbook or is any reference to this population limited to a few sentences or paragraphs in the book?
- Integrate educational content and clinical experiences throughout the curriculum rather than limiting discussions related to LGBT topics to a single class.

- Utilize simulation experiences to provide students an opportunity to develop patient interview skills, obtain health histories and perform physical assessments on LGBT patients.
- Collaborate with members of the LGBT community to develop a standardized patient program for teaching physical assessment and communication skills.
- Convene a panel of members from the LGBT community to speak with students
- Engage students in discussions during class and clinical conferences to help them understand the diverse perspectives of their peers related to the care of LGBT patients.
- Assign writing assignments to enable students to critically reflect on their knowledge, skills, and attitudes related to the care of patients of diverse sexual and gender identities.
- Nurses should review the attributes of gay affirmative practice aimed to inform the knowledge, skill, and attitude of practitioners when caring for lesbian and gay patients.

Many other helpful and free resources are available through the various national organization websites to educate health care providers. Appendix K lists a few of these on-line resources. Nurses who seek educational resources about LGBT persons can proactively search the available information at these internet sites. Many of the resources are applicable to assist nursing educators to integrate LGBT content into their courses.

Implications for Nursing Practice

Findings from this study provided evidence that not all APRNs are well informed about culturally supportive communication and care of lesbian and gay patients. The APRNs' beliefs about these patients are reflected in the narratives they provided; however, the care was at times inconsistent with nursing's social policy statement. Descriptions of APRN experiences caring for lesbian and gay patients conveyed that among some APRNs, there is a belief that sexual

orientation is a practice specialty as opposed to understanding it as an essential dimension of being human. Also, only inquiring about a person's sexual orientation if the practitioner believes it relevant may be perceived as paternalistic and lacking a patient-centered focus. Similarly, treating all patients the same discounts the uniqueness of each person; therefore, patients ought to receive holistic and individualized care. Care in this manner is more representative of the nursing code of ethics and the profession's social policy statement.

Many of the resources mentioned previously are also applicable to guide and inform nursing practice. An additional resource includes the Joint Commission (2011) field guide, *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care for the Lesbian, Gay, Bisexual and Transgender Community.* This guide provides a collection of resources including specific strategies and practice examples to assist hospital staff in providing individualized care in a welcoming and supportive environment that is inclusive of LGBT patients and families (Joint Commission, 2011). The strategies outlined in the field guide are also applicable to healthcare providers practicing outside of the hospital settings.

Nurses have an ethical responsibility to uphold the standards of practice for the profession and demonstrate respect for the inherent dignity of each person. APRNs with their advanced education and experiences ought to be the role models of professional nursing practice. Examples of actions that nurses can take to communicate inclusivity and respect for LGBT patients include the following:

- Make no assumptions about sexual orientation or gender identity.
- Post the agency's nondiscrimination policy and the patients' bill of rights in publicly accessible locations such as waiting rooms and websites.

- Display visible LGBT symbols such as the rainbow flag, pink triangle or safe zone to affirm these patients and their families.
- Advocate for visitation policies that are inclusive of LGBT patients and families.
- Ensure that healthcare forms are inclusive of LGBT patients and include gender-neutral language for patients to self-identify their sexual orientation and gender identity. For example, instead of only noting married, single, or divorced, also include an option to select 'partnered' on the form.
- Display literature and signage in waiting rooms that depict LGBT couples and families.
- Inquire about who the LGBT person refers to as their family, and consider the important people in their life. Listen to the words used when they describe their partnership, family, and relationship.
- If there are children present during the visit, remain respectful of the fact that the children may be adopted or biologically related to one parent. Listen to the names that the children use to refer to their parents or guardians or simply ask. Provide the opportunity for the parents to disclose additional details about their family structure (The Joint Commission, 2011).

Given the various theoretical and epistemological assumptions underlying sexual orientation and gender identity within a dominant binary sociocultural context, nurses are wise to familiarize themselves with these different perspectives and determine what guides their practice. The theoretical lens that informs a nurse's understanding of sexual orientation and gender identity will influence his or her approach to practice affirmatively with LGBT persons. If a linear model of identity development such as the six stages identified by Cass (1979) inform practice, then gay affirmative practice should celebrate the achievement of a self-identity

endpoint (Bilodeau & Penn, 2005). Alternatively, nurses who espouse the feminist, postmodern perspective, might believe that a lesbian or gay identity is influenced by sociopolitical and cultural systems throughout a person's life and are fluid and non-linear, so may vary over time. Nurses bring different perspectives to inform and guide their practice; therefore, they should also recognize the distinctiveness of each patient.

An essential component of gay affirmative practice is to understand that an LGBT identity is based on how a person identifies himself or herself. To understand how a person forms their identity, nurses should familiarize themselves with different identity formation and coming out models. Nurses who identify as LGBT know that being LGBT is not a choice or preference, but merely another innate representation of being human. Heterosexual nurses also need to understand that a dominant heteronormative lens of society guides many beliefs and stereotypes made about people. Therefore, all nurses should critically self-reflect on the influence that their perspective may have on individuals who do not fit the dominant heteronormative contexts.

Nurses who want to demonstrate gay affirmative practice are encouraged to examine the factors that influenced their own sexual and gender identity and critically reflect on the role that sexuality has played in their identity formation. The path that a nurse follows to become a gay affirming practitioner is not always linear and may impose unique hurdles for some. All people express sexual orientation and gender identities in a unique manner; these identities help define their way of being human.

To aid nurses in this self-reflective process, they are encouraged to review McGeorge and Carlson's (2011) model to understand the influence that many heteronormative assumptions, heterosexual privilege, and identities have in practice, particularly within the context of a

dominant binary system. The model includes a series of reflective questions to help deconstruct heterosexist perspectives. Examples of these questions are presented in Appendix B. Nurses who reflect on these questions may gain additional insight into the influences that have contributed to form their understanding of different sexual orientations and gender identities.

Implications for Nursing Research

This is the first known study to use a mixed method design to identify beliefs, behaviors, and experiences of APRNs with lesbian and gay patients. The findings have laid the groundwork for future similar research focused on LGBT health either from the perspective of the patient, healthcare provider, or both. Additional research questions to consider include the following:

- What are the perceptions of lesbian and gay patients about healthcare experiences with APRNs?
- What are the correlates of gay affirmative practice among nurses in different practice settings?
- What educational methods are most effective to teach nurses about gay affirmative practice?
- What is the level of self-efficacy among nurses to demonstrate affirming practice behaviors when caring for lesbian, gay, bisexual and transgender patients?
- What are the perceived barriers and facilitators among nursing faculty to discuss gay affirmative practice knowledge, skills and attitudes with pre-licensure and graduate nursing students?
- What are nurses' beliefs and behaviors about the care of elderly lesbian and gay patients?

The nursing profession is well-positioned to take the lead in contributing to research on LGBT health disparities and help fill these gaps of knowledge. Faculty in graduate nursing

programs are in an influential position to encourage students to pursue research studies in these areas. The body of knowledge about LGBT healthcare needs and nursing care practices for this population will continue to grow provided nursing researchers are encouraged and supported in these endeavors, and they do not have to encounter institutional barriers that attempt to silence their efforts.

In October of 2016, the National Institute of Health (NIH) formally announced that sexual and gender minorities are a designated health disparity population for research purposes. This announcement will help to advance further research on behalf of this population. No longer can the assumptions of heterosexuality be the status quo in nursing research samples. Healthcare providers who are better informed about the health disparities encountered by these populations are more likely to demonstrate gay affirmative practice when working with LGBT patients.

Implications for Policy

In addition to the focus on health disparities addressed since the Healthy People 2000 report, other recent federal initiatives have helped to support and advance research in LGBT health. Nurses should be informed about these actions and continue to advocate for federal and state laws that protect and improve healthcare access, broaden visitation policies, protect the integrity of same-sex marriage and family, eliminate employment discrimination, diminish stigma and increase inclusivity for this population. Examples of advocacy that nurses should take to support these initiatives include the following actions.

- Request funding to support on-going research aimed at improving healthcare equity and access for the LGBT population.

- Communicate with state and federal legislators to improve healthcare access and insurance coverage for all LGBT individuals.
- Advocate for legislation that requires data about sexual orientation and gender identity in electronic health records, including federally funded surveys.
- Support non-discrimination for LGBT individuals in all healthcare settings and the workplace.
- Ensure grant applications explicate the inclusion or exclusion of LGBT populations in their samples.
- Promote mandatory education and training of all healthcare providers working with LGBT persons in clinical settings and those doing research with this population.
- Collaborate with healthcare agency leadership to attain the health equity index (HEI) that recognizes healthcare institutions with policies and practice that support patient non-discrimination, equal visitation, employment non-discrimination, and requires training in LGBT patient-centered care for its employees (HRC, 2014).

Strengths and Limitations

This was the first mixed method study in nursing that used a parallel, convergent design with quantitative and qualitative data to examine APRNs' beliefs, behaviors, and experiences in clinical practice with lesbian and gay patients. It is also the first study to use the Crisp (2002) GAP scale to measure these constructs in a sample of APRNs. The sample size and robust qualitative data are unique strengths of this study. Among the 678 participants who completed the survey, an impressive 69.2% (n = 469) also provided meaningful qualitative data that revealed a richer and more complimentary perspective of APRNs' experiences having cared for lesbian and gay patients. Although the response rate of 15.5% is less than this researcher had

anticipated, it did enable cautious generalizations of the study finding to the larger population of APRNs. The qualitative themes helped show that some commonly held notions about honest and nonjudgmental beliefs and behaviors are in fact non-affirming when caring for lesbian and gay patients.

Limitations in this study are also recognized. When setting up the survey in Qualtrics, this researcher may have overlooked settings to enable better viewing of the survey on portable electronic devices. This oversight may have been a reason why some of the 209 participants did not respond to the descriptive statement. The sample of APRNs was not randomized and instead drawn from a single northeastern state, so the demographic characteristics, perspectives, and experiences caring for lesbian and gay patients may not reflect those of the larger population of APRNs. APRNs who received an invitation to complete the on-line survey could self-select to participate in the study. Given the overall large percentage of high GAP scale scores, it is possible that APRNs who decided to participate also had a genuine interest and positive beliefs and experiences caring for lesbian and gay patients. Unfortunately, comparable demographic data about the population from which the sample was drawn were not available.

Conclusion

Results from this mixed method study helped to provide a clearer understanding of the beliefs, behaviors, and experiences among APRNs in clinical practice with lesbian and gay patients. It was the first known study in nursing to explore these constructs and add to this limited body of knowledge. The defining attributes of gay affirmative practice in nursing are a compilation of beliefs and behaviors that epitomize holistic and individualized nursing care for all persons with sexual and gender identities that do not follow a heterosexual perspective. Gay affirmative practice applies to nursing care in all clinical practice settings. Data in this study

provided some evidence to suggest a lack of knowledge and understanding about gay affirmative practice exists among some APRNs.

Developing a comportment to practice affirmatively, requires the nurse to first critically self-reflect about his or her personal biases and assumptions related to sexual orientation and gender identity, and be able to acknowledge and question heteronormative assumptions. Nurses in all practice settings should refrain from reinforcing stereotypes when communicating with persons of diverse sexual orientation and gender identities. Nurses can help to widen the web of advocacy by learning to set aside those biases and demonstrate non-judgmental and culturally informed care with persons who self-identify as LGBT. A gay affirming practice must convey that a non-heterosexual identity is an equally constructive and meaningful way of being human (Perlman, 2003). More explicit integration of LGBT content in nursing education including continuing education opportunities supportive of advancing culturally appropriate quality care for this population may help to close the health disparity gap, and perhaps move us closer to the day when these discussions are no longer necessary.

This study was conducted to answer four research questions about the beliefs, behaviors, and experiences of APRNs in clinical practice with lesbian and gay patients. The dissertation began by presenting the background, significance, and aims of this study. The review of the literature discussed recent research on nurse attitudes toward lesbian and gay persons including a few studies that examined the beliefs and behaviors of social workers and psychologists in clinical practice with this patient population. Gaps in the literature about APRNs' experiences caring for lesbian and gay were presented. Next, an explication of the theoretical underpinnings to use a convergent parallel mixed method study were presented then followed by a detailed explanation of the particular quantitative and qualitative methods used to interpret the data.

Findings from each data set were presented including the results after merging them and compared to the review of the literature. Strengths and limitations of the study were acknowledged followed by recommendations for nursing education, practice, and research. This study is believed to be the first to examine the beliefs, behaviors, and experiences in a sample of APRNs and has helped to fill this GAP of understanding in the literature. Information from this study will contribute to informing all nurses about the implications of using gay affirmative practice guidelines when caring for patients of diverse sexual orientation and gender identities.

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Appendix A

Table 1. Articles Used in Review of the Literature

Author/ Year	Type of Study	Sample	Instrument	Constructs	Findings
Mullins (2012)	Quantitative	Social workers (*N*= 127)	Gay Affirmative Practice Scale (GAP) (Crisp, 2002)	Beliefs and Behaviors	GAP Beliefs (*M* = 64.7, *SD* = 11.51) and Behavior (*M* =51.33, *SD* 18.54) scores were high and there was a significant positive correlation (*r* = 0.551, *p* <.01) between beliefs and behaviors
Rondahl (2009)	Descriptive, Comparative Quantitative	Sample (*N* = 124) Swedish nursing students (*n* =71); medical students (*n* = 53)	Modified the *Knowledge about Homosexuality (KHQ) Scale* (Harris, Nightingale, & Owen, 1995) and renamed new scale *Knowledge about Homo- and Bisexual and Transgender Persons Questionnaire (KHBT)*	*Public* knowledge, *Care* knowledge, *Psychological* knowledge about LGBT population	Nursing students had lower *care* knowledge compared to medical students; men scored lower than women on *psychological* knowledge; religious students had lower total LGBT knowledge than non-religious students
Blackwell (2008)	Quantitative	Sample of RNs in Florida (*N* = 480)	Attitudes Toward Lesbian and Gay Men (Herek, 1984)	Attitudes	Findings showed a strong association between belief in the free choice or acquired model of homosexuality and homophobia. Nurses who did not support workplace nondiscrimination policies had higher levels of homophobia

Table 1 cont. Articles Used in Review of the Literature

Author/ Year	Type of Study	Sample	Instrument	Constructs	Findings
Blackwell and Kiehl (2008)	Quantitative	Randomized stratified sample of Registered Nurses (RN) (*N* =480)	*Attitudes Toward Lesbian and Gay Men (ATLG) Scale* (Herek, 1984)	Attitudes, knowledge, and experience	78% of RNs had positive attitudes and 22% had negative attitudes toward lesbian and gay persons
Dinkel, Patzel, McGuire, Rolfs, and Purcell (2007)	Quantitative	Convenience sample of nursing students (*n* = 126) and nursing faculty (*n* =15)	*Index of Attitudes Toward Homosexuals (IAH)* (Hudson & Ricketts, 1980); *Homophobic Behaviors of Students Scale (HBSS)* (Van de Ven, Bornholt & Bailey, 1996)	Attitudes	Overall low levels of homophobia; however, researchers attributed this finding to possible non-committal or neutrality among participants
Crisp (2005)	Quantitative	Randomly selected sample of Social workers (*n* = 257) Psychologists (*n* = 220)	Gay Affirmative Practice (GAP) Scale; Heterosexual Attitudes Toward Homosexual (HATH) Scale (Larson, Reed, & Hoffman, 1980); Attitudes Toward Lesbians and Gay men (ATLG) (Herek, 1988)	Attitudes, Beliefs, and Behaviors	The sample of social workers and psychologists had mean scale scores indicative of highly affirming attitudes, beliefs and behaviors toward lesbian and gay clients. No significant differences is scale scores when controlling for demographic characteristics

Table 1 cont. Articles Used in Review of the Literature

Author/ Year	Type of Study	Sample	Instrument	Constructs	Findings
Rondahl, Innala, and Carlsson, (2004)	Quantitative	Convenience sample (N = 222) of Swedish RNs (n = 34) and Assistant nurses (n = 23); nursing students (n = 79) and assistant nursing students (n = 86)	Short form of Attitudes Toward Homosexuality (ATHS) Scale (Herek, 1984); Causes of Homosexuality (CHQ) scale (Ernulf, Innala, & Witham, 1989)	Attitudes and Beliefs	Overall positive attitudes toward lesbian and gay persons. RNs were more positive than assistance nursing students; more positive attitudes among those who believed homosexuality was congenital than among those who believed it was acquired

Appendix B

Samples of Self-reflective Questions

Self-Reflective Questions to Explore Heteronormative Assumptions
1. What did my family of origin teach me about sexual orientation, bisexuality, transgender, and same-sex relationships? 2. Were sexual and gender identity discussed in my family? If so what values were communicated? If not what did the silence communicate? 3. Are there any members of my family who are LGBT? If so, how were they treated and talked about in my family? 4. What are my experiences using or hearing phrases like "that's so gay" or "fag" during my growing up years and today? What values are associated with these terms? 5. When I first meet someone, how often do I assume that he or she is heterosexual? 6. What values and beliefs inform this assumption? 7. What is my initial reaction when I see a gay or lesbian couple expressing physical affection? 8. What is my initial reaction when I see a heterosexual couple expressing physical affection? 9. If my child came out to me, what would my first reaction be?
Self-reflective Questions to Explore Heterosexual Privilege
1. How has your involvement in heterosexual relationships been encouraged, rewarded, acknowledged, and supported by your family, friends, and the larger society? 2. As a child, how were you encouraged to play according to heterosexual norms? 3. Have you ever had to question questioned your heterosexuality? 4. Have you ever worried that you might lose your job because of your heterosexuality? 5. Have you ever wondered why you were born heterosexual? 6. Has anyone ever asked you to change your heterosexuality? 7. Have you worried that you might be "outed" as a heterosexual? 8. Have you been afraid that your work accomplishments would be diminished because of your Heterosexuality?
Self-reflective Questions to Explore Heterosexual Identity
1. What role does sexual identity play in who you are as a person? 2. How do you describe your sexual identity? How do you explain how you came to identity as a heterosexual? Why do you think you identify as a heterosexual? 3. What societal, religious, or family beliefs or norms influenced your development of a Heterosexual identity? 4. When did you have your first opposite-sex attraction? What meaning did you assign to that attraction? If you experienced that attraction as normal, where did those beliefs come from? 5. Do you understand your heterosexual identity as a stable factor in who you are as a human being or do you perceive it as fluid and changeable? Why? 6. Do you understand your heterosexual identity as existing on a continuum or do you perceive your sexual orientation as "either/or" (i.e., either I am straight or I am gay)? Why? 7. How does your identification as a heterosexual influence how you make sense of how a person comes to identify as an LGBT individual? How does your identification as a heterosexual influence how you perceive LGBT-identified individuals?

Note. From "Deconstructing Heterosexism: Becoming an LGB Affirmative Heterosexual Couple and Family Therapist," by C. McGeorge and T.S. Carlson, 2011, *Journal of Marital and Family Therapy*, 37, p. 14 – 26. Copyright 2011 by John Wiley & Sons, Inc., Adapted with permission.

Appendix C

Initial Email Invitation

To:

From: marianne.snyder@uconn.edu

Subject: Request to participate in a study of *APRNs beliefs, behaviors, and experiences with lesbian and gay patients*.

Dear Colleague:

You are invited to participate in an anonymous survey of APRN's Beliefs, Behaviors, and Experiences with Lesbian and Gay Patients as part of my dissertation research. Very little data exist to understand APRNs' clinical practice with these patient populations. Data from this study will help to inform nursing education, research and practice. I sincerely appreciate your time and consideration to complete this electronic survey, demographic questions, and respond to one open-ended statement about your experiences caring for lesbian and gay patients. I anticipate the survey will take 15 - 20 minutes to complete.

Do you wish to participate in this survey?

□ *Yes*

□ *No*

Appendix D

Information Sheet for Survey

UCONN
UNIVERSITY OF CONNECTICUT

Principal Investigator: Dr. Carol Polifroni
Student Investigator: Marianne Snyder RN, MSN
Title of Study: Advanced Practice Nurses' Beliefs, Behaviors, and Experiences with Lesbian and Gay Patients

Dear Colleague:

You are invited to participate in an anonymous survey of "Advanced Practice Nurses' Beliefs, Behaviors, and Experiences with Lesbian and Gay Patients" as part of my dissertation research. Very little data exist to understand APRNs' clinical practice with these patient populations. Data from this study will help to inform nursing education, research, and practice. If you agree to take part in this study, you will be asked to complete this electronic survey, demographic questions, and respond to one open-ended statement that requests you to *"Please describe in as much detail as you can your experiences of having cared for patients who are lesbian or gay. Specific examples to clarify your responses are extremely helpful."* then submit your completed survey.

The survey is designed to complete in 15 to 20 minutes; however, your completion time may vary. We believe there are no risks associated with participating; however, a possible inconvenience may be the time it takes to complete the survey. No one, including myself, other people affiliated with the University of Connecticut (UCONN) or any affiliated organizations will be able to link your responses with your name. We will do our best to protect the confidentiality of the information we gather but we cannot guarantee 100% confidentiality. Your confidentiality will be maintained to the degree permitted by the technology used. No computer IP addresses are collected; therefore, reminder emails to participate sent at 1 and 3 weeks cannot discriminate between those who previously participated or declined the invitation. You do not have to answer any question that you do not want to answer for any reason, and you may stop the survey at any time. You may not benefit directly from this research; however, we hope that your voluntary participation in this study may contribute to a more comprehensive understanding about APRNs' beliefs and behaviors in clinical practice with lesbian and gay patients.

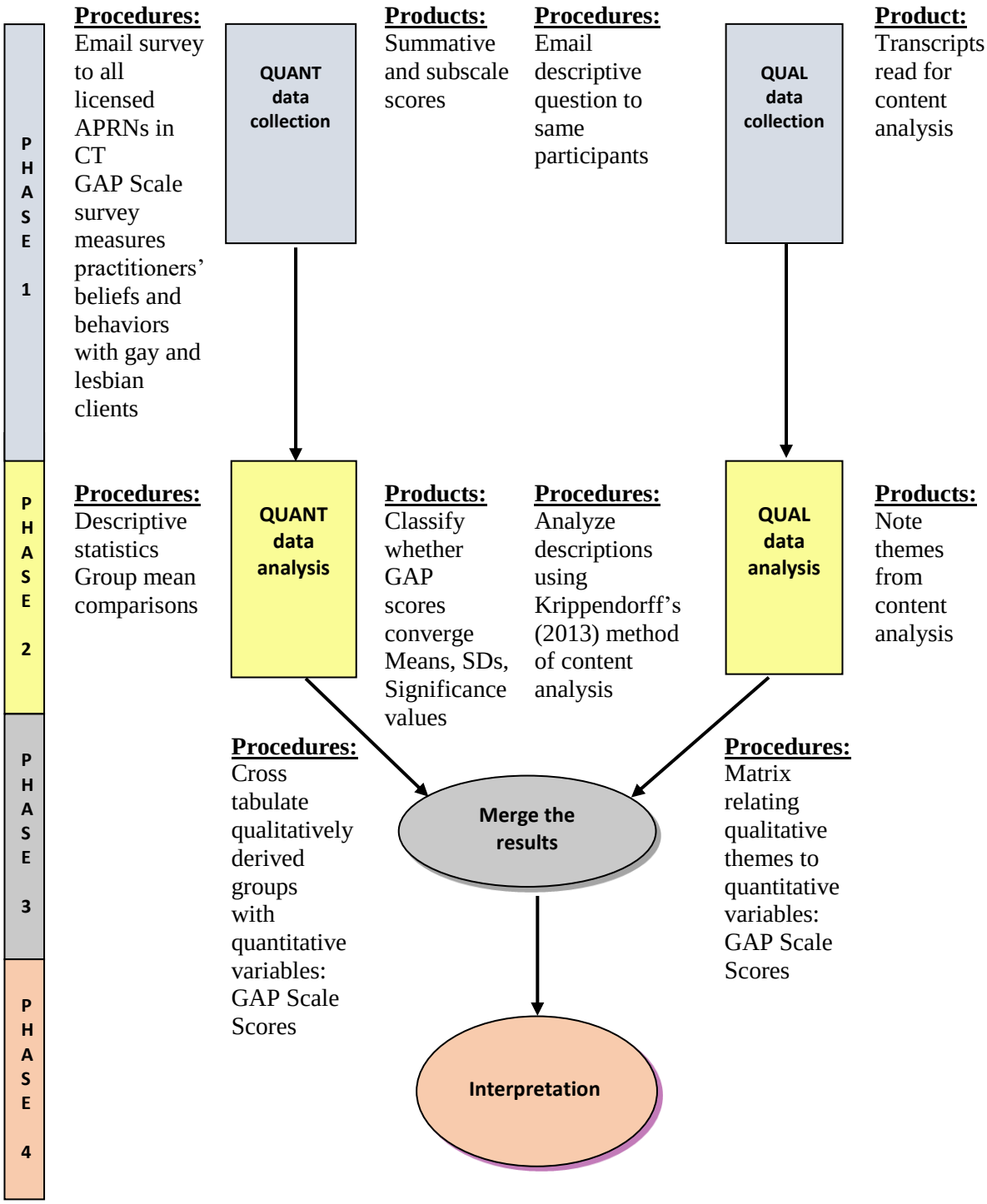
There are no costs and you will not be paid to be in the study. There are no penalties or consequences of any kind if you decide that you do not want to participate. You should also know that UCONN's Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement.

If you have any questions about the study, please contact me by phone at (860) 377-5798 or by email at marianne.snyder@uconn.edu or you may contact the Chair of my dissertation committee, Dr. Carol Polifroni at 860-486-0511. If you have any questions concerning your rights as a research participant, you may contact the UCONN Institutional Review Board (IRB) at 860-486-8802.

Sincerely,
Marianne Snyder RN, MSN
Doctoral Candidate

Appendix E

Diagram for the Mixed Methods Convergent Parallel Design to Investigate APRNs' Beliefs, Behaviors and Experiences in Clinical Practice with Lesbian and Gay Patients



Appendix F

GAP Scale Questionnaire

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

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

SA = Strongly agree
A = Agree
N = Neither agree nor disagree
D = Disagree
SD = Strongly disagree

1. In their practice with gay/lesbian clients, practitioners should support the diverse makeup of their families. _____
2. Practitioners should verbalize respect for the lifestyles of gay/lesbian clients. _____
3. Practitioners should make an effort to learn about diversity within the gay/lesbian community. _____
4. Practitioners should be knowledgeable about gay/lesbian resources. _____
5. Practitioners should educate themselves about gay/lesbian lifestyles. _____
6. Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals. _____
7. Practitioners should challenge misinformation about gay/lesbian clients. _____
8. Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients. _____
9. Practitioners should encourage gay/lesbian clients to create networks that support them as gay/lesbian individuals. _____
10. Practitioners should be knowledgeable about issues unique to gay/lesbian couples. _____
11. Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients. _____
12. Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients. _____
13. Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients. _____
14. Practitioners should help clients reduce shame about homosexual feelings. _____

15. Discrimination creates problems that gay/lesbian clients may need to address in treatment.

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

A = Always
U = Usually
S = Sometimes
R = Rarely
N = Never

16. I help clients reduce shame about homosexual feelings. _____

17. I help gay/lesbian clients address problems created by societal prejudice. _____

18. I inform clients about gay affirmative resources in the community. _____

19. I acknowledge to clients the impact of living in a homophobic society. _____

20. I respond to a client's sexual orientation when it is relevant to treatment. _____

21. I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation. _____

22. I provide interventions that facilitate the safety of gay/lesbian clients. _____

23. I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation. _____

24. I demonstrate comfort about gay/lesbian issues to gay/lesbian clients. _____

25. I help clients identify their internalized homophobia. _____

26. I educate myself about gay/lesbian concerns. _____

27. I am open-minded when tailoring treatment for gay/lesbian clients. _____

28. I create a climate that allows for voluntary self-identification by gay/lesbian clients. _____

29. I discuss sexual orientation in a non-threatening manner with clients. _____

30. I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced. _____

Appendix G

Demographic Profile

1. My current age is:
    a. 21-30
    b. 31-40
    c. 41-50
    d. 51-60
    e. Over 60 years old

2. My Race is: (select all that apply)
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White

3. My ethnicity is:
    a. Hispanic or Latino
    b. Not Hispanic or Latino

4. In my family, there are _____ members who are lesbian, gay, bisexual, or transgender:
    a. 1
    b. 2
    c. 3 or more
    d. None
    e. Prefer not to answer

5. I have cared for _____ patients who identify as lesbian or gay:
    a. 1 - 3
    b. 4 – 6
    c. more than 6
    d. None

6. I identify my gender as:
    a. Female
    b. Male
    c. Transgender
    d. Prefer not to answer

7. I consider myself to be:
    a. Straight
    b. Gay
    c. Lesbian
    d. Bisexual
    e. Prefer not to answer

8. My religious affiliation is:
    a. Protestant
    b. Catholic
    c. Jewish
    d. Other
    e. Prefer not to answer

9. Current Political party
    a. Democrat
    b. Republican
    c. Independent
    d. Other
    e. None

10. Primary place of practice
    a. Primary care
    b. Hospital
    c. Subacute / long-term care
    d. Walk-in clinic / outpatient

11. Primary focus of clinical practice (select all that apply)
    a. Adult
    b. Women
    c. Pediatric
    d. Neonates
    e. Behavioral health

12. Highest education earned
    a. Masters
    b. DNP
    c. PhD
    d. EdD

13. Number of years in practice as an APRN
    a. 1 - 5
    b. 6 -10
    c. 11 -15
    d. >15

Appendix H

Qualtrics GAP Survey

Q1-5 This questionnaire is designed to measure practitioners' beliefs about treatment with gay and lesbian clients and their behaviors in clinical settings with these clients. There are no right or wrong answers. Please try to answer every question as honestly as possible. There are 30 total statements, one narrative response, and 13 demographic items in this survey.

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

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
1. In their practice with gay/lesbian clients, practitioners should support the diverse make-up of their families.	❍	❍	❍	❍	❍
2. Practitioners should verbalize respect for the lifestyles of gay/lesbian clients.	❍	❍	❍	❍	❍
3. Practitioners should make every effort to learn about diversity within the gay/lesbian community.	❍	❍	❍	❍	❍
4. Practitioners should be knowledgeable about gay/lesbian resources.	❍	❍	❍	❍	❍
5. Practitioners should educate themselves about gay/lesbian lifestyles.	❍	❍	❍	❍	❍

Q 6 -10 Please rate how strongly you agree or disagree with each statement about treatment with gay and lesbian clients on the basis of the following scale.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
6. Practitioners should help gay/lesbian clients develop positive identities as gay/lesbian individuals.	❍	❍	❍	❍	❍
7. Practitioners should challenge misinformation about gay/lesbian clients.	❍	❍	❍	❍	❍
8. Practitioners should use professional development opportunities to improve their practice with gay/lesbian clients.	❍	❍	❍	❍	❍
9. Practitioners should encourage gay/lesbian clients to create networks that support them as gay /lesbian individuals.	❍	❍	❍	❍	❍
10. Practitioners should be knowledgeable about issues unique to gay/lesbian couples.	❍	❍	❍	❍	❍

Q11-15 Please rate how strongly you agree or disagree with each statement about treatment with gay and lesbian clients on the basis of the following scale.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
11. Practitioners should acquire knowledge necessary for effective practice with gay/lesbian clients.	❍	❍	❍	❍	❍
12. Practitioners should work to develop skills necessary for effective practice with gay/lesbian clients	❍	❍	❍	❍	❍
13. Practitioners should work to develop attitudes necessary for effective practice with gay/lesbian clients.	❍	❍	❍	❍	❍
14. Practitioners should help reduce shame about homosexual feelings.	❍	❍	❍	❍	❍
15. Discrimination creates problems that gay/lesbian clients may need to address in treatment.	❍	❍	❍	❍	❍

Q16 -20 Please rate how frequently you engage in each of the behaviors with gay and lesbian clients on the basis of the following scale:

	Never (1)	Rarely (2)	Sometimes (3)	Usually (4)	Always (5)
16. I help clients reduce shame about homosexual feelings.	❍	❍	❍	❍	❍
17. I help gay/lesbian clients address problems created by societal prejudice.	❍	❍	❍	❍	❍
18. I inform clients about gay affirmative resources in the community.	❍	❍	❍	❍	❍
19. I acknowledge to clients the impact of living in a homophobic society.	❍	❍	❍	❍	❍
20. I respond to a client's sexual orientation when it is relevant to treatment.	❍	❍	❍	❍	❍

Q21- 25 Please rate how frequently you engage in each of the behaviors with gay and lesbian clients on the basis of the following scale:

	Never (1)	Rarely (2)	Sometimes (3)	Usually (4)	Always (5)
21. I help gay/lesbian clients overcome religious oppression they have experienced based on their sexual orientation.	❍	❍	❍	❍	❍
22. I provide interventions that facilitate the safety of gay/lesbian clients.	❍	❍	❍	❍	❍
23. I verbalize that a gay/lesbian orientation is as healthy as a heterosexual orientation.	❍	❍	❍	❍	❍
24. I demonstrate comfort about gay/lesbian issues to gay/lesbian clients.	❍	❍	❍	❍	❍
25. I help clients identify their internalized homophobia	❍	❍	❍	❍	❍

Q26 - 30 Please rate how frequently you engage in each of the behaviors with gay and lesbian clients on the basis of the following scale:

	Never (1)	Rarely (2)	Sometimes (3)	Usually (4)	Always (5)
26. I educate myself about gay/lesbian concerns.	❍	❍	❍	❍	❍
27. I am open-minded when tailoring treatment for gay/lesbian	❍	❍	❍	❍	❍
28. I create a climate that allows for voluntary self-identification by gay/lesbian clients.	❍	❍	❍	❍	❍
29. I discuss sexual orientation in a non-threatening manner with clients.	❍	❍	❍	❍	❍
30. I facilitate appropriate expression of anger by gay/lesbian clients about oppression they have experienced.	❍	❍	❍	❍	❍

Descriptive Statement

Please describe in as much detail as you can your experiences of having cared for patients who are lesbian or gay. Specific examples to clarify your response are extremely helpful.

Demographic Items

Please select the best descriptor about you for each statement.

Q1 My current age is:

- ❍ 21 - 30
- ❍ 31 - 40
- ❍ 41 - 50
- ❍ 51 - 60
- ❍ Older than 60

Q2 I identify my gender as:

- ❍ Female
- ❍ Male
- ❍ Transgender
- ❍ Prefer not to answer

Q3 My race is: (Select all that apply)

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian or Other Pacific Islander

Q4 My ethnicity is:

- ❍ Hispanic or Latino
- ❍ Not Hispanic or Latino

Q5 My highest education earned is:

- ❍ Masters
- ❍ DNP
- ❍ PhD
- ❍ EdD

Q6 Numbers of years I have practiced as an APRN is:

- ❍ 1 - 5
- ❍ 6 - 10
- ❍ 11 - 15
- ❍ more than 15 years

Q7 My primary place of practice is:

- ❍ Primary care
- ❍ Hospital
- ❍ Sub-acute / long-term care
- ❍ Walk-in clinic / outpatient

Q8 The primary focus of my clinical practice is with: (Select all that apply)

- ❍ Adult - Men
- ❍ Adult - Women
- ❍ Children /Adolescents
- ❍ Psychiatric
- ❍ Neonatal

Q9 I have cared for _____ different patients who identify as lesbian or gay.

- ❍ 1 - 3
- ❍ 4 - 6
- ❍ more than 6
- ❍ None

Q10 In my family, there are _____ members who are gay, lesbian, bisexual, transgender.

- ❍ 1
- ❍ 2
- ❍ 3 or more
- ❍ Prefer not to answer

Q11 I identify myself as:

- ❍ Straight or heterosexual
- ❍ Gay
- ❍ Lesbian
- ❍ Bisexual
- ❍ Prefer not to answer

Q12 My religious affiliation is:

- ❍ Protestant
- ❍ Catholic
- ❍ Jewish
- ❍ Other
- ❍ None

Q13 My current political party affiliation is:

- ❍ Democrat
- ❍ Republican
- ❍ Independent
- ❍ Other
- ❍ Prefer not to answer

Appendix I

Figure 1. Dendogram for Theme 1 – Affirming Beliefs and Behaviors

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Category
• Being aware of community resources - just being nonjudgmental and following the golden rule • Am able to facilitate an open discussion about whether a patient has experienced discrimination based on sexual orientation and whether they are open to or in need of community resources for support • Offer support in any way, by providing resources available within the community • Each individual further enlightens me and enhances my knowledge and understanding of the issues faced by the LGBT community and the resources available	Being aware of community resources	Affirming Beliefs and Behaviors
• Counsel and allow patients to verbalize whatever concerns they have whilst providing a supportive, non-judging environment • Support them in their attempts to navigate the legal system so partners can attend the birth without difficulties from the hospital • Promote a supportive environment in my office and demand that patient respect from my staff • Committed to supporting clients in feeling comfortable in the full expression of their sexuality • Offer a support, assurance, and guidance with regards to inclusivity and acceptance of anyone who identifies at LGBT	Provide a supportive environment	
• Dispel myths and challenge others who are homophobic in my own personal life • Do not promote homophobic opinions from my [heterosexual] patients • I'm proactive about discussing their homophobic remarks and jokes when I witness them	Dispel myths / homophobic remarks	
• Treat LGBTQ patients with respect, with caring, with state of the art information, with understanding • Treat lesbian and gay patients with respect • Ensure they are treated with empathy, approval, and respect • Normalize non-heteronormative lifestyles by routinely asking the same sexual history of all patients and by correcting staff member's assumptions that affect clinical care • Respect their family and relationship dynamics	Treat with respect	

Figure 1 cont. Dendogram for Theme 1 – Affirming Beliefs and Behaviors

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Category
• Make sure that teens who are gay or lesbian or questioning feel safe to express themselves at school and home • Provide a safe space for patients to openly discuss their sexuality • Create an open, safe, and honest environment for discussion and treatment • Let them know that this is a safe environment to discuss any issues that they may have and encourage open discussion • Non-judgmental environment created safe haven	Provide a Safe Environment	Affirming Beliefs and Behaviors
• Want anyone under my care to feel comfortable that they can discuss concerns/thoughts in a safe non-judgmental environment • My job as a provider is not to condemn anybody but to provide the most safe and appropriate care in a non-judgmental manner • Open ended non-judgmental questions go a long way, as does comfort with asking and talking about all types of sex • Nonjudgmental practice by: listening, asking open ended questions • Make efforts to use nonjudgmental language when obtaining sexual and relationship	Demonstrate nonjudgmental care	
• I am comfortable with LGBT patients in discussing issues and admitting my knowledge gaps • I joined the support group and attended health education functions that cleared up myths about homosexuals and the genesis of certain STDs • Educate yourself on issues that affect gay/ lesbian community • My clients are continuously teaching me, and I am honored to be a willing student	Advocacy through education	
• A family member is gay and has taught me a tremendous amount about listening, paying attention, caring and needing to view things with an open mind • Create an open atmosphere for any issues to be discussed • Believe in an open door policy, and the more open minded you are, the more you can truly help your patients with all of their primary health concerns • I am open-minded and do not judge when they come into the office together	Remain open-minded	

Figure 2. Dendogram for Theme 2 – Sexual Orientation Only Asked if Relevant

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Category
• Sexual orientation is only relevant to me as it pertains to patient care • What factors are focused on relate to the priorities of care for the individual • I will address situations where those situations directly affect the health of a person • I do not feel the need to specifically point out sexual orientation in primary care or endocrinology unless it applies directly to the reason for the visit • I do not explore these issues unless it becomes relevant to med management • I don't typically discuss the emotions behind being gay/lesbian with clients unless or it directly relates to the chief complaint • Unless their diagnosis is directly related to their life style, I don't discuss their sexual orientation during the visit • Sexual orientation is not an issue except if it pertains to risk factors to their medical care • If they bring up the issue of homosexuality then I'm willing to talk with them about it • When gay/lesbians patients arrive they are treated for their condition and rarely discuss identity	Don't ask unless it relates to care	Sexual Orientation Only Asked if Relevant
• I don't feel as though is my role to run interference in someone's religious, political or community involvement • I have cared for lesbian and gay clients without addressing their sexual orientation • I don't ask anybody about their sexual orientation • Unless a patient specifically mentions to me that they are gay/lesbian, the subject isn't dressed • I do not often go into much detail regarding a patient's sexual orientation	Don't ask Sexual orientation	

Figure 3. Dendogram for Theme 3 - Limited Experience with Lesbian and Gay Patients

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Categories
• I am FNP and see very few if any patients who are lesbian or gay • I have only cared for a handful of patients who are gay or lesbian • I have had very little experience with lesbian or gay clients • I have very little clinical contact with these patients • I am still relatively new to practice and at this time have only a few patients who have self-identified as gay/lesbian • I've been limited to patients who have identified themselves as gay/lesbian • I rarely have interactions with patients who have openly identified their sexual orientation	Limited Experience in General	Limited Experience with L/ G Patients
• I am a new practitioner working in oncology and have not worked with gay/lesbian clients in my few months of practice • Practice has been largely pediatric. Limited experience with gay clients • No active experiences that are worth mentioning, because I work in critical care exposure is usually to the patients spouse and family • I work in anesthesia. I don't care about sexual orientation • I am limited in discussion with these patients as I am an anesthetist • I work in a long-term facility and to my knowledge have not encounter any issues affecting lesbian/gay individuals • I work with a geriatric population so do not have as much exposure or client opening up as much about it	Limited Experience Based on My Practice	
• Do not have awareness of gay persons in my hospice/palliative care practice • I have not cared for any patients that have openly identified their sexual orientation as gay or lesbian to me • I do not have many pts who identify as gay or lesbian • I cannot think of one instance when I've addressed specific gay/lesbian issues with parents	Limited Experience - Patients Don't Always Self-identify	

Figure 4. Dendogram Theme 4 - Sexual Orientation is Not Focus of Practice

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Categories
• Their sexual orientation was not a main focus of my care • Sexual orientation issues are rarely relevant to an anesthetic • I work in a procedural specialty and sexual orientation does not have any bearing on the necessary treatment • My practice is with oncology patients . . .their sexual orientation is not at the forefront of our interactions	Not a main focus and rarely relevant	Sexual Orientation is Not Focus of Practice
• Sexual orientation is not my concern before going to the OR • Sexual orientation is not the primary concern when dealing with renal function • In my setting [cardiology] their sexuality has not really come to be an issue • In my population [critical care] of patients, sexual orientation is rarely a topic/issue • For the most part, in my practice [psych], a patient's sexual orientation is a non-issue	Is a non-issue and not my concern	
• In this age [geriatrics] group there a very few opportunities to address gay/lesbian issues • Sexual orientation is rarely an issue in my practice both because of the age [geriatrics] range • Sexuality is not a major focus of my practice given my patient population [long-term care]	Few opportunities to address with elderly	

Figure 5. Dendogram for Theme 5 – Non-affirming Beliefs and Behaviors

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Categories
• There have been many individuals who have chosen to blame their lack of success with care of being oppressed due to their sexuality concerns • I've had [L/G] patients try to use being gay or lesbian as an excuse for their poorly controlled diabetes • They blame their medical problems on how they had not been listened to by previous medical providers • The issues are less about victimization because of their sexuality and more about continuing in the role of victim • Often people that are GLBTQ are portrayed as victims of society	Role of victim is their identity	Non-affirming Beliefs and Behaviors
• I do not tolerate gay/lesbo lifestyle • To see that young children are being taught about 2 mommies and 2 daddies is just flat out wrong • I do not ""support"" straight lifestyle choices, so why would I support ""alternative"" ones? • I can accept a gay lifestyle and assist a gay patient with health concerns without respecting gay marriage or parenting issues • Have strong religious background that does not condone homosexuality • Women and men both have come to me for help to move out of the homosexual lifestyle • I have always viewed them as individuals with a freedom to choose sexual orientation	Do not tolerate or support this lifestyle choice	
• I am tired of the sometimes militant approach being taken - I don't really care how someone gets their orgasm. • I am so fed-up with so much emphasis in nursing about a very small sexual minority • Every time I turn around there's something about GBLTQ being thrown in my face • It's not my responsibility to facilitate their level of comfort with their lifestyle choice as your questions suggest • I find many of the questions in this survey to be biased and patronizing to the gay community	Fed up, don’t care, not my responsibility	

Figure 6. Dendogram for Theme 6 – Treat All the Same

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Categories
• I do not treat my gay, lesbian or transgender patients any differently than I treat my heterosexual patients • I provide the same care for a homosexual as I would to a heterosexual patient • I treat them no differently than heterosexual parents • They were treated as if they were a heterosexual couple without prejudice • I don't feel that my experience in caring for gay/lesbian patients is any different than my experience with heterosexual patients • I also do not believe that patients from the LGBT community were any different than the heterosexual patients I cared for	Treat the same as heterosexual patients	Treat all the Same
• I care for ALL patients the same way -no matter what their race, age, religion or sexual orientation • I provide care to patients who are gay or lesbian in the same manner as patients who are of different sex, religion, culture, etc. than myself • I do not go out of my way to treat gay/ lesbian couples any differently that I would treat an Asian or African American. • I treat them like any other diverse family that comes to our facility • Do not spend a lot of time addressing social issues but treat every patient equally • All patients are treated with the same care and respect, regardless of sexual identity or preferences	Treat the same as other diverse patients	
• My patients are infants . . . .but I don't speak to gay parents any differently than I would heterosexual parents • Focus is the couple's baby and making sure I meet their needs as parents, offering the same support I would to any parent • I just treat them like I do any other parents-with respect • My goal is to establish a working relationship no different than I would have with any parent • Treat them like we treat all of our families	Offer same support for lesbian/gay parents as any parent	
• It has been my practice and belief to treat them as I would any other patient • I treat them like I would treat any patient • Treating them with the same dignity as anyone else • I treat them medically the same as I do any other patients • I care for all pts in the same way for their medical needs	I treat them the same as any other patient	

Figure 7. Dendogram for Theme 7 – Witnessed Discrimination

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Categories
• Cultural values of the community were strongly opposed to the glbt community and would "kick them out of home" if pt divulges glbtq status • It is also very difficult to support teens and encourage them to be honest when the community is extremely homophobic	Discrimination in the community	Have Witnessed Discrimination
• In my years of practice . . . . I personally had to address discrimination or defamatory statements about my son (gay) • I have treated a number of adolescents who were/are grappling with defining their sexuality and sharing their identities with friends and family who may or may not be supportive • How can you encourage a teen to be honest with their parents when you know that will either mean a beating or that the teen will be kicked out of the house? • It is a heartbreaking experience to walk with a young adult whose once loving parents completely reject them when they come out • Young people had families with cultural and religious beliefs rejecting of gays and lesbians	Discrimination from family and friends	
• I have encountered many patients with strong feelings of anger and mistrust toward healthcare providers • The intake form asked about the father of the baby • I have a number of patients including very young inexperienced but self-identified gay clients as well as elderly who have endured a lot of prejudice, hiding over the years • Our intake form for obstetric clients does not ask about sexual orientation nor does it ask about the client's current partner	Discrimination in health care	

Figure 8. Dendogram for Theme 8 – More Education Needed

Descriptive Segments of APRN Experiences Caring for Lesbian and Gay Patients	Clustered Units	Thematic Categories
• I'm always looking for more information about these populations and resources • It is often difficult to locate resources within the gay community, although I find that many providers are very open to providing care • I am not aware of many resources to offer specific to this population • Resources seem a little sparser here [compared to NYC] • It would be helpful if someone who has compiled resources of different types for GLBT would/ could distribute them to practitioners in printed form or on-line resources • With the limited population of this population makes finding resources for them/us as well • I admit that I'm not very aware of community resources that would be helpful to adolescents who are "coming out" or gay/lesbian couples who are having children. • Not aware of many local resources that support couples and families in my community • My limitations, I believe would be in my knowledge of gay and lesbian community resources • I am not aware of resources and services geared toward lesbian/gay couples	More Resources Needed	More Education Needed
• Unfortunately there is not a lot of continuing education in the medical or nursing communities regarding LGBTQ issues for the general practitioners • Health care providers require more education • I probably would benefit from some more education about talking to people who have not yet come out • I definitely do not think schools of nursing give enough attention to educating future health care providers about the LGBT community and when they claim they do, I think it is mostly lip service • I would require more education if I were to have ongoing gay and lesbian clients who were dealing with deeper issues • I am interested in learning about alternative life styles • I wish here were more educational opportunities available • I believe that this is the bigger issue and that heath care providers require more education	More Education Needed in Nursing	

Figure 8.cont. Dendogram for Theme 8 – More Education Needed

• It's more challenging for me to talk about safe sex with lesbians, as I feel offering dental dams is often the extent of it • I do not feel qualified to give sexual health information to these patients • Unfortunately I did not have specific resources in the community for them and this would have helped • I was uncomfortable with lesbian patients because I was unfamiliar with gay/lesbian lifestyle and issues	Care more challenging without education / resources	More Education Needed

Appendix J

Figure 9. *Mean Comparisons of GAP Belief Scores to Qualitative Thematic Categories*

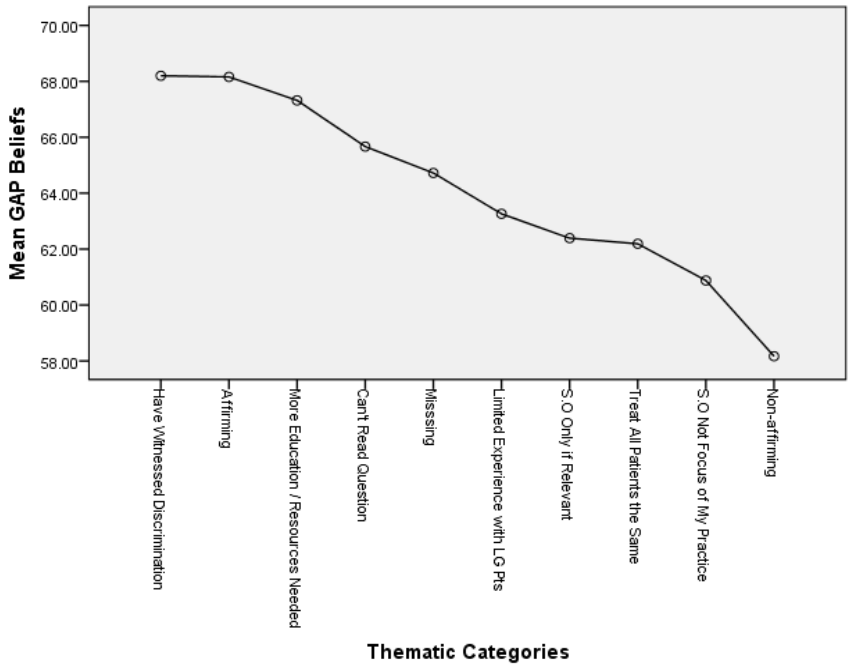
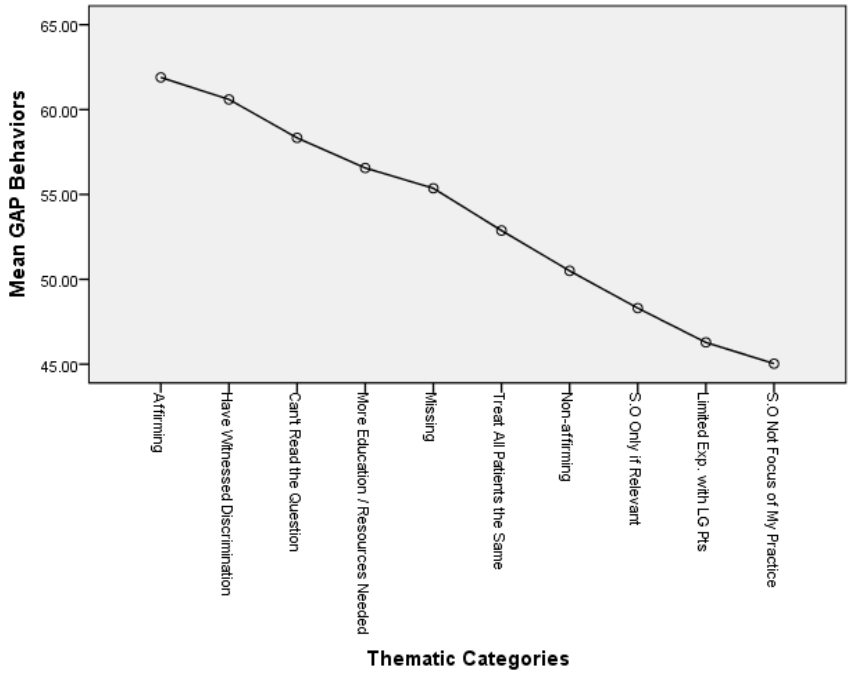
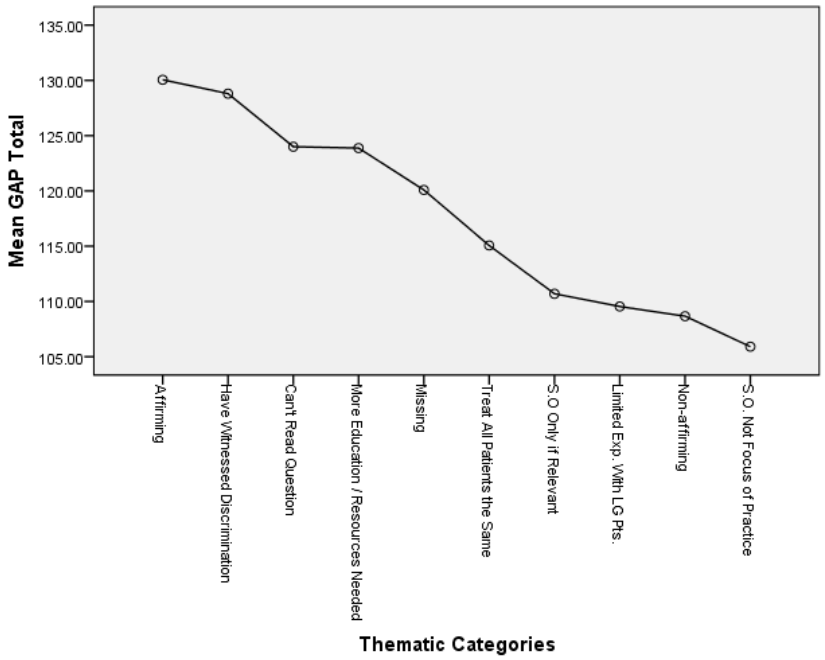


Figure 10. *Mean Comparisons of GAP Behavior Scores to Qualitative Thematic Categories*



Appendix J cont.

Figure 11. *Mean Comparisons of GAP Total Scores to Qualitative Thematic Categories*



Appendix K

LGBT Educational Resources for Healthcare Providers

Organizations

GLMA - Health Professionals Advancing LGBT Equality

*Offers a*n *on-line, three-part cultural competence webinar series to educate about quality healthcare practices for LGBT people*
http://glma.org/index.cfm?fuseaction=Page.viewPage&pageId=1025&grandparentID=534&parentID=940&nodeID=1

The Fenway Institute National LGBT Health Education Center

*Provides resources, and consultation to health care providers and Organizations to promote quality and cost effect*ive health care for LGBT persons
http://www.lgbthealtheducation.org/

Lavender Health

Provides resources to guide practice and understanding about the LGBT community
https://lavenderhealth.org/

Healthcare Equality Index (HEI)

A benchmarking tool that evaluates healthcare facilities' policies and procedures that pertain to the equitable care and inclusion of LGBT patients, families and visitors
http://www.hrc.org/

The Veterans Health Administration

Offers free, online education webinars about health care topics concerning LGBT veterans
http://www.vehu.va.gov/Events.cfm?event-search-terms=do+ask&event-search-date

The National Resource Center on LGBT Aging

Offers on-line an on demand training modules and resources about culturally competent care for LGBT elderly
http://www.lgbtagingcenter.org/index.cfm

PFLAG (formerly known as Parents, Families and of Lesbians and Gays)

Offers support, education, and advocacy to family, friends and allies of the lesbian, gay, bisexual, transgender and queer (LGBTQ) community
https://www.pflag.org/

Straight for Equality

A national organization that was begun by PFLAG to provide information and resources to heterosexual allies of the LGBT community
http://www.straightforequality.org/