Queering Teaching: The Journey Towards Competence and Comfort

By

Diane M. Love

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The dissertation is approved by the following members of the Final Oral Committee

Elliot Tebbe, PhD, LP, Assistant Professor, Nursing
Lisa Bratzke, PhD, RN, ANP, FAHA, Professor, Nursing
Stephanie Budge, PhD, LP Associate Professor, Counseling Psychology
Madelyne Greene, PhD, RN, Patient Centered Outcomes Research Institute

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Abstract

LGBTQIA+ people experience significant health inequities that are driven by stigma and marginalization. Nursing professional values demand that nurses provide care that centers human dignity for any person, no matter their circumstances or experiences. Nursing education has the potential to disrupt stigma and the furtherance of marginalization by weaving content on LGBTQIA+ health across the curriculum and centering nursing professional values of human dignity. Unfortunately, there is very little time spent on including LGBTQIA+ health in nursing education, and nursing faculty feel under prepared and uncomfortable with the content. This descriptive qualitative study examined the experiences of nursing faculty that teach LGBTQIA+ health concepts in order to understand the challenges and supports they experience. Semi-structured interviews were conducted with 14 White nurse faculty that teach pre-licensure students in the US Midwest region. The results of this study are a conceptual model named Queering Teaching. The processes described highlight the journey that supported the participants in becoming comfortable and competent with teaching LGBTQIA+ health. Queering teaching is informed by three interrelated themes *Doing the Internal Work by Addressing Your Biases, Integrating Professional and Personal Values to Create a New Values Way,* and *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes in Teaching*. These findings add important depth to understanding the extent of personal effort and time needed to examine cultural biases and deconstruct their impact on teaching. These findings also highlight the need to integrate personal and professional values, which nursing education rarely addresses. These two factors combine to create an experience of teaching that is queer, and also provide potential avenues to address the needs of addressing bias and integrating values. Last, these findings

provide a robust understanding of what competence means regarding LGBTQIA+ health practice and education.

Chapter 1: Introduction

LGBTQIA+ Health Inequities

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and more expansive identities of people (LGBTQIA+), consistently face stigma and marginalization in healthcare settings (Ayhan et al., 2020; Casey et al., 2019). There is a considerable amount of evidence that those stigma and marginalization experiences negatively impact LGBTQIA+ people's health (Dyar et al., 2019; Hatzenbuehler & Pachankis, 2016; Meyer, 2003). LGBTQIA+ people report significantly worse health, have lower health-related quality of life, and experience greater prevalence of disability than non LGBTQIA+ people (National Academies of Sciences et al., 2021). These inequities extend across all body systems, including cardiovascular health (Alzahrani et al., 2019; Caceres et al., 2017); gastrointestinal health (Vélez et al., 2022); respiratory health (Blosnich et al., 2010; Veldhuis et al., 2019); brain and neurological health (Diaz & Rosendale, 2023; Rosendale et al., 2021); mental and emotional health (Garcia-Perez, 2020; Lee et al., 2016; Lett et al., 2022; Rees et al., 2021; Su et al., 2016); and sexual and reproductive health (Charlton et al., 2019; Everett et al., 2019; Leonardi et al., 2019). Additionally, LGBTQIA+ people are less likely to have health insurance, to receive important cancer screenings, and are more likely to delay or be denied access to medical care (Baker, 2019; Baker et al., 2016; Gonzales & Henning-Smith, 2017; Heer et al., 2023; Kcomt et al., 2020).

Definitions

To provide a clear and consistent examination of the data from this study and the evidence regarding LGBTQIA+ health inclusion, I have provided definitions of important concepts. To best understand how binary sex, gender, and sexuality norms match onto LGBTQIA+ people, the definitions are divided into categories of sex, gender, and sexuality.

Regarding sex, intersex is a term used to describe people with sex traits that fall outside of expected male and female sex traits (Lee et al., 2006), while endosex refers to individuals for whom sex traits are considered to fall within an expected range of male or female. The term intersex includes people with visibly apparent sex trait variations, as well as people with no visibly apparent variations (Lee et al., 2006). These are also called differences or variations in sex development (DSD or VSD [Lee et al., 2006]). Regarding gender, transgender people are people who have a gender identity different than their sex assigned at birth, while cisgender refers to individuals whose gender identity matches that which is typically expected based on cultural norms for sex assigned at birth (Oxford English Dictionary, 2023b). Transgender, used both as an identity label itself as well as an umbrella term, may include individuals whose identities align with common gender identity labels used among cisgender populations as well (e.g., man, woman), sometimes referred to as binary gender identities, as well as those with genders that are not experienced or expressed within existing binary conceptualizations. Regarding sexuality, sexual orientation identity labels exist to capture a range of sexual orientations centering sexual attraction (e.g., heterosexual/straight, lesbian, gay), relationship structures (e.g., monogamous, polyamorous), and other facets of sexuality.

Nursing practice competencies are often considered in relationship to the necessary knowledge, skills, and attitudes required for safe and effective nursing practice (American Association of Colleges of Nursing, 2023; Baartman & de Bruijn, 2011). Comfortable is another concept that is sometimes used in nursing education, especially regarding LGBTIQA+ health (Reed, 2022). Competence is another important concept that is often used in nursing education research broadly (Lejonqvist & Kajander-Unkuri, 2022; Meretoja et al., 2004); but is sometimes applied to LGBTQIA+ health (Hall, 2021). When it is used, it is most often seen as cultural

competence (Caboral-Stevens et al., 2018; Hickerson et al., 2018; Kim, 2023; Strong & Folse, 2015). Other key facets that relate to nursing education are knowledge, skills, attitudes, comfort, and competence. Knowledge is defined as the act or condition of knowing something (Oxford English Dictionary, n.d.). In nursing it denotes having the necessary information required to perform nursing practice (American Association of Colleges of Nursing, 2021). Skills refer to an ability to perform a function, acquired or learned through practice (Oxford English Dictionary, 2024c). In nursing this includes the ability to perform the functions required of nurses in any setting (American Association of Colleges of Nursing, 2021). Attitudes refer to behaviors or a manner of acting that are representative of feelings or opinions (Oxford English Dictionary, 2023a). In nursing practice attitudes are most important in relationship to potentially biased, stigmatizing, or discriminatory feelings or opinions toward patients (American Association of Colleges of Nursing, 2021).Comfort, or the experience of being easy, tranquil, or undisturbed (Oxford English Dictionary, 2024a) can be conceptualized in nursing practice as the feeling of being able to provide care for patients, and not feel disturbed by that process. The feeling of comfort can arise related to knowledge, skills, and/or attitudes (Reed, 2022). Competence captures the notion of having enough qualifications to adequately deal with a subject (Oxford English Dictionary, 2024b). In nursing practice this includes being able to combine the knowledge, skills, and attitudes needed to provide the compassionate and safe care patients need (American Association of Colleges of Nursing, 2021). Finally, cultural competence is conceptualized as comprising six defining attributes, which include cultural awareness, cultural knowledge, cultural sensitivity, cultural skill, cultural proficiency, and dynamicity (Sharifi et al., 2019). Cultural proficiency is focused on applying the knowledge, skills, and attitudes needed

(Sharifi et al., 2019). Dynamicity is focused on the action of cultural competence emerging from frequent interactions with different types of patients (Sharifi et al., 2019).

Cultural Roots of Binary Sex, Gender, and Sexuality Norms

These individuals are grouped together under the LGBTQIA+ umbrella as they share a common experience of having sex, gender, and/or sexuality identities outside of Western cultural binary norms (Hughes et al., 2022; Nye & Dillard-Wright, 2023). Western cultural binary norms related to sex, gender, and sexuality are intertwined and interdependent. Specifically, norms are centered on expectations that people are born with exclusively male or female sex traits, they will have a matching cisgender identity throughout their life, and they will become adults who are sexually active with people of the "opposite" sex (Worthen, 2020). LGBTQIA+ people have bodies, lives, or behaviors that are outside of those expectations, creating conditions that are ripe for stigma and marginalization.

These cultural binary norms are also a result of colonization that enforced Western, Christian, and capitalist values across the world (Czyzewski, 2011). In these values what is normal is centered around people are White and Eurocentric (Czyzewski, 2011) In addition, these norms are shaped by Christianity which center around the needs and experiences of heterosexual Christian men (Czyzewski, 2011). Capitalism centers around the norms of people who are able bodied for work (Oliver, 1994). People who are closest in identity to those norms are more valued, and those farther from these norms are excluded from or offered minimal resources and support (Nye et al., 2022; Oliver, 1994; Worthen, 2020). In the United States, settler colonization was carried out on the lands of Indigenous people, which included physical genocide where Indigenous people and communities were murdered, and where lands were seized, with Indigenous people being physically removed and relocated, most often onto

reservations deemed to be low quality land that colonizers did not want (Glenn, 2015). Beyond physical genocide, colonization practices also created conditions of cultural genocide, where Indigenous culture, language, and religious practices were made illegal, and children were sent to boarding schools in order to replace traditional cultural teaching with Western cultural teaching (Kingston, 2015).

Those forces of settler colonization have had lasting effects on US cultural norms that continue to this day. In many Indigenous Turtle Island belief systems, there is recognition, and even community honoring, for people who have sex, gender, and/or sexuality experiences that are not binary (Jacobs et al., 1997; Smithers, 2022). During the process of settler colonization, there were attempts to erase those beliefs and values and replace them with cultural norms that all people have binary sex, cisgender identities, and heterosexual experiences (Jacobs et al., 1997; Smithers, 2022). Additionally, settler colonization creates stigma and marginalization of any person that does not have the culturally valued identities and experiences of White, male, heterosexual, and/or able to contribute to capitalism through able bodied work. Any person carrying intersecting non-normed identities means people that have variable access to power, resources, and support based on their closeness to the norms of settler colonization (Mink et al., 2014; Moradi, 2017). This intersecting access to power also equates to variable levels of stigma and marginalization across identities of race, ethnicity, work ability, language, citizenship status, and many more experiences.

Guiding Theory

Currently, nursing education primarily relies on a biomedical model with biological essentialist underpinnings (Gowaty, 2018; Priddle et al., 2023). In a biomedical and biologically essentialist framework those cultural binary sex, gender, and sexuality norms are treated as

biological facts, despite the reality that LGBTQIA+ people have bodies, experiences, and behaviors that do not match those norms. Additionally, when teaching about LGBTQIA+ health, needs for healthcare are often discussed as a medical condition that must be addressed, rather than people having normative experiences that are slightly different than cultural norms, and that represent the diversity of human experience. Another concept used to frame LGBTQIA+ health in nursing education is cultural competence (Caboral-Stevens et al., 2018; Hickerson et al., 2018; Kim, 2023; Strong & Folse, 2015; Yu, 2024). The framing of cultural competence requires there to be a group of people whose "culture" is so far outside of a cultural norm that the culture must be learned about and then incorporated into care practices.

Those lenses impact how nurse educators can conceptualize teaching about LGBTQIA+ health, particularly when related to utilizing binary concepts of sex, gender, and sexuality (Nye et al., 2022; Priddle et al., 2023). Most faculty are comfortable with binary norms, and may not have spent time questioning the cultural, political, institutional, interpersonal, or individual impacts of those norms, or how nursing education perpetuates the centering of those norms (Nye et al., 2024; Priddle et al., 2023). At the heart of LGBTQIA+ stigma, marginalization, and health inequities are how society centers the needs and experiences of people with binary sex, gender, and sexuality at all Social Ecological levels (Mink et al., 2014).

A theoretical model will be used to investigate the impact of binary *norms* utilized by nurse educators, how continuing the use of those norms contributes to the *"othering"* of LGBTQIA+ people, and how not addressing the use of norms allows the *power* of institutions like healthcare and education to use those categories of "other" to control affirming and appropriate care (Nye et al., 2022; Nye & Dillard-Wright, 2023) (Figure 1). The Norm Critical Theory of Nurse Education (NCTNE) utilizes concepts of *norms, othering,* and *power* to

understand how the processes of exclusion and erasure of marginalized people are perpetrated in nursing education settings (Nye et al., 2022; Nye & Dillard-Wright, 2023). Figure 1 illustrates how norms, othering, and power operate as interlocking gears that grind together to uphold and maintain stigma, marginalization, discrimination, and healthcare inequities (Nye et al., 2022).

According to the authors, the grinding of these gears creates an immense force that reinforces norms through power and othering (Nye et al., 2022). The reinforcement of norms creates the routine and consistent erasure of natural human variation in sex, gender, and sexuality, among many other non-normed identities (McGlynn et al., 2020; Priddle et al., 2023; Saewyc, 2017). Without offering an expansive view of sex, gender, and sexuality, nursing students and faculty will default to binary norms that are so consistently used they feel natural and normal (Nye & Dillard-Wright, 2023; Pinto et al., 2022; Priddle et al., 2023; Saewyc, 2017). Another consequential issue with relying on these binary norms is the ability to then also ignore the ways institutions like education and healthcare use those norms to exclude or deny access to resources for people outside of the norm (Jacob et al., 2021; Mink et al., 2014; Nye et al., 2023). This process, known as structural "*othering*", carries significant health impacts through minority stress, stigma, and marginalization (Crear-Perry et al., 2021; Jacob et al., 2021; Metzl & Hansen, 2014; Mink et al., 2014; Nye et al., 2023). Structural othering is the link between norms and power, providing the avenue for institutions to use power to inflict negative consequences on people who exist outside of norms (Nye et al., 2022; Nye & Dillard-Wright, 2023). Structural othering is created when institutions like healthcare use their *power* to create categories of *"other"* that are based on a lack of adherence to social *norms*, in order to exclude the "*others'*" access to resources. Some of those resources describe the social determinants of health: the conditions where people are born, live, learn, work, play, worship, and age (Office of Disease

Prevention and Health Promotion, n.d.). Nursing education has incorporated the concepts of how the social determinants impact health, but has just begun to examine structural competencies, where discussions of social determinants include awareness of how social norms are used by institutions to dictate how the resources of social determinants are distributed (American Association of Colleges of Nursing, 2021; Metzl & Hansen, 2014; Murray, 2021). There have been increasing calls to improve nursing education to better prepare students to not only provide care to diverse communities, but also to address the structural and social determinants of health (American Association of Colleges of Nursing, 2021; Murray, 2021; Nye & Dillard-Wright, 2023).

Categorizing people as other, or as being outside of a norm, also reinforces pre-existing biases, furthering the urgency to address othering in nursing education (Jacob et al., 2021; Krabbe, 2021; Nye et al., 2023). The NCTNE provides a framework for addressing structural and social determinants of health without relying on norms that blame people for being structurally excluded rather than addressing the systems that create and maintain norms in the first place (Crear-Perry et al., 2021; Metzl & Hansen, 2014; Nye et al., 2022). Therefore, the NCTNE is a framework that can help bridge understanding the challenges nursing faculty face in teaching LGBTQIA+ health with a lens that could be utilized to address those challenges long term.

Format of Nursing Education

Nursing education praxis is a complex web of interrelated educational processes that draw on didactic and theoretical methods to address care concepts; skills learned and reinforced through clinical education; and professional standards and values that are woven throughout settings (Lyckhage & Pennbrant, 2014; Pitcher & Browne, 2023). Nursing education also has the potential to diminish stigma and marginalization through the process of nursing professional

identity development, and values alignment (Rojo et al., 2023). Nursing professional values center the delivery of care in a person-centered manner that is provided to all people regardless of their identities or circumstances (American Association of Colleges of Nursing, 2021; Willis et al., 2008). However, nursing education struggles to address stigma and marginalization of many non-normed groups of people, and spends very little time specifically teaching LGBTQIA+ health (Burton et al., 2021; Hodges et al., 2021; Lim et al., 2015; Moore et al., 2023; Murray, 2021). National nursing organizations all broadly embrace social justice and health equity as crucial to providing person centered care to all people (American Nursing Association, 2018; National League of Nursing, 2016; American Association of Colleges of Nursing, 2021). However, there is little guidance on how to incorporate concepts of social justice and health equity (Roy et al., 2022; Tengelin & Dahlborg-Lyckhage, 2017). Due to this multifaceted context nursing education struggles with the ability to train nurses that are prepared to prepared to deliver affirming, competent, and compassionate care to LGBTQIA+ people of all races and other intersecting identities (Burton et al., 2021; Hughes et al., 2022; Sherman et al., 2023).

Considering the potential impact of skillful inclusion of LGBTQIA+ health by nursing education on health inequities, the lack of attention to these topics is of significant concern. Additionally, the challenges of inclusion of LGBTQIA+ health are complex and varied. Despite this complexity, nursing education research has rarely touched on how nursing educators understand these challenges in their own words. Additionally, we know that many nursing educators feel uncomfortable, and lack the knowledge and skills needed to competently include LGBTQIA+ health (Lim et al., 2015; Marsh et al., 2022; Moore et al., 2023). According to a systematic review of US nursing faculty's knowledge, awareness, inclusion, and perceived

importance of teaching LGBTQIA+ health, there are only four studies that have addressed nursing faculty's understanding and needs in this area (Moore et al., 2023). The most recent study was conducted in 2017, and all four studies used quantitative methods (Moore et al., 2023). The paucity of research and having only one method of inquiry leaves a significant gap in this literature. One of the most intriguing findings from Moore et al., (2023) is that there were no reports that investigated facilitators or supports to the inclusion of LGBTQIA+ health. This lack of focus on what supports the inclusion of LGBTQIA+ health mimics a concern often noted in discussions of broad framing regarding this population. Research and scholarship often frames the health of LGBTQIA+ populations only from a negative perspective, focusing on health inequities, stigma, and marginalization, but rarely using a positive framework focused on support and thriving (Gahagan & Colpitts, 2017; Nye et al., 2024).

The overall lack of recent research on nursing faculty regarding inclusion of LGBTQIA+ health, as well as c of what supports inclusion, creates an opportunity to re-examine what we know and to gather that knowledge directly in the words of nursing faculty. This study will address some of these gaps in knowledge by utilizing a descriptive qualitative approach that asks nursing faculty that include LGBTQIA+ health about the challenges and supports during that experience. This study will address both challenges and supports from structural, institutional, interpersonal, and personal lenses, adding important context to the overarching experience nursing faculty have while including LGBTQIA+ health. Additionally, this study will seek to understand how the experience of this inclusion impacts nursing faculty. This knowledge can help advance the science of inclusion of LGBTQIA+ health by nursing faculty by providing a more current and comprehensive understanding of that experience. That knowledge will help

address the significant gaps seen in comfortable and competent inclusion of LGBTQIA+ health by nursing faculty.

Chapter 2: Review of the Literature

Stigma and Marginalization in Healthcare

Stigma is created when dominant social groups marginalize people who do not fit within the norms that define the dominant group (Link & Phelan, 2001). The Social Ecological Model of Health offers one way to examine stigma and marginalization at multiple levels of creation and impact (Bronfenbrenner, 1976). The Social Ecological Model of Health (SEM) elucidates the effect of levels of culture, policies, communities, organizations, and institutions, interpersonal interactions, and individual impacts on health. I will discuss how these levels impact LGBTQIA+ people's health using social norms, as well as how nursing education contributes to this process of stigma and marginalization in healthcare.

At the cultural level, stigma and marginalization of LGBTQIA+ people are created and reinforced through norms that center binary sex, gender, and sexuality. These cultural norms were created from the influence of settler colonization which reifies Western, Christian, and capitalist beliefs and values in the US. Those beliefs and values focus on White, Chrisitan, heterosexual, land owning men as the "normal" human that all other people are measured against (Duncan, 2002; Miller, 2022; Ray & Parkhill, 2021). The process of settler colonization forced compliance with rigid binary sex, gender, and sexuality norms on Indigenous people (Jacobs et al., 1997). That process also reinforced for all other populations that exiting outside the boundaries of western, Christian, and capitalist norms could be punished by physical, mental, emotional, and cultural means (Glenn, 2015; Mink et al., 2014). Through use and maintenance of cultural norms, there are continued threats of violence, stigma, and marginalization which oppress LGBTQIA+ people of many intersectional identities in the US (Kolysh, 2021; Rostosky et al., 2022).

Norms denote culturally accepted concepts of what is considered “typical” as it relates to identity, as well as body shape and function, creating expectations of individuals’ bodies and behavior. Expectations that can negatively impact LGBTQIA+ people vary from expecting that individuals who appear feminine in dress or behavior will have “female” genitals and reproductive organs to expecting adults are only ever sexually active with people who are perceived to be of the “opposite” sex.

Nursing education is also deeply influenced by these binary sex, gender, and sexuality norms (Eickhoff, 2021). The current model of nursing education uses a biomedical and biologically essentialist model in education (Priddle et al., 2023; Ray King et al., 2021). These lenses utilize binary sex, gender, and sexuality norms to teach about “normal” bodies, “disordered” bodies, and “cultural competence,” rather than teaching that focuses on the true diversity of the human experience (Nye et al., 2023; Nye & Dillard-Wright, 2023; Priddle et al., 2023). This biomedical and biologically essential model also erases the experiences and healthcare needs of LGBTQIA+ people, creating a system of education that reproduces stigma and marginalization (Nye et al., 2023; Priddle et al., 2023).

The next level after culture in the SEM pertains to policies, which are described as the rules and regulations that create uniform operations at business, community, state, national, and international levels (Mink et al., 2014). At the policy level, stigma and marginalization of LGBTQIA+ people are created through policies that determine who can access which public bathrooms, what type of healthcare people can access with their health insurance, or even allow healthcare providers to legally be able to refuse to provide care (Fry-Bowers, 2020; Murib, 2020). Policies of this nature are used to reinforce cultural norms of binary sex, gender, and sexuality through the use of power. At this level of the SEM, states and nations can create

policies that are used across levels of power to rigidly reinforce norms. An example is the national, state, and medical treatment of individual's born with indeterminate sex traits. Historically, and currently for many of these infants born today, after medical and genetic examination they are assigned a binary sex, which is reinforced through the state giving a sex marker attached to their identification (Rosenstadt, 2022). Once a person is identified as a binary sex that information is kept in official records and used throughout that individual's life, unless they actively seek to change their sex designation. In several US states, laws have been passed that prevent an individual from changing their sex marker, making an individual's binary birth sex the only legal sex allowed, despite 1.6% of the population being born with intersex traits, and 1.1% of the population identifying as transgender (Fausto-Sterling, 2015; Movement Advancement Project, 2024; USA Facts, 2024). After sex assignment, and depending on the degree of genital difference from expectations, through medical policy, parents are offered the ability to surgically alter their infants' genitalia to match the binary sex assigned (Lee et al., 2006). With these combined powers, the nation and state can control what genitals an individual has, what bathroom they use, what sports team they play on, or even what legal protections they are afforded. These sets of policies and laws derive from the processes of settler colonization, where sex and gender have been defined as binary only, assigned at birth, and reinforced through policing of bodies throughout US history (Bohrer, 2021; Davis & Evans, 2018; Nadal, 2020).

In nursing education, these policies and the impact they have are often ignored (Murray, 2021). Nursing education broadly accepts that nursing curricula contain very little LGBTQIA+ health content (Burton et al., 2021; Lim et al., 2015; Marsh et al., 2022). Nursing textbooks are framed to center the experiences of people who match social norms of binary sex, gender, and

sexuality, while erasing the experiences of sex and gender diverse people (Klepper et al., 2023; Ray King et al., 2021). Additionally, schools of nursing have an overrepresentation of White women faculty, despite many years of effort to diversify faculty ranks (American Association of Colleges of Nursing, 2023b). Only in the last several years have schools of nursing had racial and ethnic student representation that is similar to the US population of students of color (American Association of Colleges of Nursing, 2023b). There are no definitive data on the number of LGBTQIA+ identified nursing students or faculty, as most schools of nursing do not gather sexual orientation on students or faculty, making measurement of LGBQA populations impossible. Additionally, many schools of nursing only measure binary gender, as seen in the continued focus on men in nursing (American Association of Colleges of Nursing, 2023a). This continued focus on binary gender erases the experiences of transgender, non-binary, and gender diverse nursing student. When textbooks and lecture material exclude or barely include LGBTQIA+ people, students who have those identities continue to be erased and marginalized within education institutions (Priddle et al., 2023; Ray King et al., 2021). Those types of policies, and many more, stigmatize and marginalize LGBTQIA+ people by providing policy support to people who are in the norm, and intentionally creating policies that exclude or deny access to people outside of the norm.

Community, organizations, and institutions constitute the next level of the SEM. Stigma and marginalization that occurs at this level has also been described as structural stigma, where the resources of institutions prioritize people who fit the norm, and deny or exclude from resources everyone else (Crear-Perry et al., 2021; Flentje et al., 2022; Metzl & Hansen, 2014; Mink et al., 2014). One example of stigma and marginalization of LGBTQIA+ people at the institutional level is how the Electronic Health Record (EHR) is organized around binary

categorizations of sex, and assumptions of matching cisgender identity. The EHR's functionality is tied to binary sex assignments, so that recommendations for preventive care are only provided based on a binary sex designation that may not match an individual's experience (Lau et al., 2020). For example, a person with a female sex designation in the EHR will trigger a need for a pap smear. Even if this individual has a woman gender identity and has a neovagina, she does not have a cervix that needs a pap smear. Additionally, binary sex designations play a significant role in lab value ranges. An individual who is a transgender man and has a male sex designation in the EHR would have lab value ranges given exclusively for a male, which may not be appropriate for the individual. The EHR also uses binary sex designations to determine what order sets are available, so a transgender man would have an issue getting a vaginal swab tested, as there is no place in the EHR for that order. A person who has a nonbinary gender identification and has a mix of secondary sex traits presents an even more confounding picture for this binary sex and gender system. In waiting rooms of OB-GYN offices, the walls are full of images of women and babies, with no diversity of sex or gender presentation, or with heterosexual families, and no diversity of family structures represented.

We see these uses of power in nursing education as well. In nursing education, students are given didactic and theoretical education, but then are sent to clinicals and to practice in the healthcare settings with these limited EHR's and facilities. Additionally, simulation mannequins are either male or female and have distinct masculine and feminine face and body types, making them less adaptable to use for simulations of diverse people. Erasure and lack of representation is also seen in the lack of diverse skin tones in educational materials, where White skinned people are overrepresented in foundational nursing materials (Pusey-Reid et al., 2023). Each of these examples points to how an institution, like a healthcare system, or a nursing school, provides

resources and support to people in the norm, and excludes, erases, or ignores the needs of anyone outside of the norm.

At the interpersonal level, stigma and marginalization occurs by the direct or enacted forms of stigma, such as verbal harassment or physical assault based on one's social identity (Link & Phelan, 2001). Stigma can occur when healthcare providers accidentally or intentionally use the wrong pronouns for patients, or assume patients are heterosexual when asking about sexual activity. These actions can also be described as microaggressions, which are everyday verbal, nonverbal, and environmental insults, whether intentional or unintentional, that communicate derogatory or negative messages toward non-normed groups (Sue, 2010). Microaggressions are cumulative, hard to identify, and thus more difficult to combat than overt discrimination. Oftentimes, microaggressions are committed by people despite good intentions (Sue, 2010). These microaggressions also lead to specific healthcare avoidance behaviors by LGBTQIA+ people (Kcomt et al., 2020; Mink et al., 2014). Often, when a provider does not specifically use affirming language, LGBTQIA+ people will not disclose important and relevant health information due to a lack of trust. The need for trust in accessing needed healthcare extends to race and ethnicity, where issues of racism in healthcare leads to people of color delaying healthcare (Hamed et al., 2022; Rhee et al., 2019; Yearby et al., 2022).

In nursing education, nursing faculty often do not feel prepared to teach nursing students about the healthcare needs of populations that are very different from themselves (Davis & O’Brien, 2020; Hantke et al., 2022; Lim et al., 2015; Murray, 2021). They may struggle to teach about LGBTQIA+ health using affirming and direct language (Lim et al., 2015; McDowell & Bower, 2016). Many nurse faculty hesitate to directly discuss sexual health or feel uncomfortable discussing the effects of gender affirming surgeries for transgender patients (Lim et al., 2015;

McDowell & Bower, 2016). Nursing faculty who struggle to comfortably teach about human sexuality, or the experiences of racism in our society reinforces the discomfort that nursing students might already feel about these topics, making it even more difficult to overcome their discomfort to be able to provide affirming and compassionate care to all people (Bell, 2024; Lim et al., 2015; Nye et al., 2024).

At the individual level, the SEM focuses on how all these levels come together with each individual's embodied experience, including how they cope with the stress of the stigma and discrimination they have experienced (Krumholz et al., 2022; Mink et al., 2014; Shannon et al., 2022; Solomon et al., 2022). Additionally, each person has an internal understanding of their stigmatized status, and sometimes LGBTQIA+ people internalize ideas of stigma from cultural norms (Frost & Meyer, 2023). Specifically, this can lead people to experience self-hate or discomfort towards their identity, attempt to conceal their identity, and to carry the expectation of being rejected (Frost & Meyer, 2023). This process of internalizing stigma occurs across stigmatized and marginalized populations, with impacts on accessing care that range from race, ethnicity, ability to work, and housing status (Guenzel et al., 2020; Ju et al., 2023; Shannon et al., 2022; Solomon et al., 2022). The individual level of the SEM captures both how each of the other layers of the model impact people, as well as how each individual responds to the stigma and marginalization of the other levels.

In nursing education, the individual level directly impacts the health of LGBTQIA+ students. Some students may not be out at school, some students may be noticeably different than their peers, so they are outed by their embodied experience, and some students may be proudly out about their LGBTQIA+ identity. All of these situations occur regularly at schools of

nursing across the country. While there are no specific studies that examine the experiences of LGBTQIA+ nursing students in particular, studies of college students in other professional training programs report consistent use of microaggressions, direct and indirect stigmatizing statements, and erasure of LGBTQIA+ people in their education and training (Bradbury-Jones et al., 2020). Additionally, nursing education has not prepared nurses to address how internalized stigma impacts LGBTQIA+ patients healthcare behaviors, or ways to effectively address additional needs those patients might experience related to internalized stigma (Chidiac & Connolly, 2016).

Each level of the SEM contributes a specific type of stigma, but they are also always combining with each other to reinforce and uphold the status quo of binary sex, gender, and sexuality norms (Mink et al., 2014). Each of the levels also contribute to a feedback loop, where the norm is centered and upheld on every level, and the combination of all of the levels creates an unbearable burden of "otherness" for LGBTQIA+ people (DeWilde et al., 2019; Jacob et al., 2021). When an individual is outside of these binary sex, gender, and sexuality norms, they are constantly reminded of their lack of belonging. That otherness is the significant driver of minority stress that leads to mental, emotional, and physical health inequities (Flentje et al., 2022; Frost & Meyer, 2023; Hatzenbuehler & Pachankis, 2016; Mink et al., 2014). This experience of otherness also exists for people of color, people with disabilities, and other people whose lives and experiences make them noticeably different than norms that center White, heterosexual, able bodied people.

Additionally, the enduring power of binary sex, gender, and sexuality norms are reinforced through multiple pathways. Currently, in the US, there is significant political pressure being applied to transgender people and their right to access gender affirming healthcare (Tanne,

2023). These conversations about affirming healthcare, especially regarding children's healthcare, are rife with biological essentialism that is often deeply tied to religious beliefs (Contreras, 2023). These political and policy conversations are also damaging to the mental health of transgender, non-binary, and cisgender LGBQ people who are constantly exposed to rhetoric that their very existence is a threat to others (Horne et al., 2022). In nursing education, providers are taught anatomy framed around what is considered "normal," which often resembles exclusively binary sex, cisgender identities, and heterosexual activities. People's bodies and behaviors that fall outside of these binary categories are taught as rare exceptions to the rule, are medicalized, and are often only discussed as "cultural competence", as opposed to these identities being integrated into how we discuss healthcare for all human beings, or ways in which these represent natural variation (Priddle et al., 2023; Sherman et al., 2023). As a result, nursing education produces providers who are unable to conceptualize bodies or behaviors that deviate from binary sex, gender, and sexuality norms in a non-stigmatizing or pathologizing manner, limiting their ability to provide affirming care to LGBTQIA+ people.

State of Nursing Education regarding LGBTQIA+ Health

Despite its shortcomings, nursing education has the potential to be a critical avenue by which healthcare for LGBTQIA+ people can be improved (Burton et al., 2021; Hughes et al., 2022; Rojo et al., 2023). Nurses and other health care providers could be influenced to provide better care to LGBTQIA+ individuals through the process of education and professionalization (Rojo et al., 2023; Van Schalkwyk et al., 2019). Nurses and nurse educators are members of broader social networks and cultures and are also constantly exposed to and absorb messages about cultural norms. Nursing education presents an opportunity to disrupt beliefs instilled through cultural norms as part of the process of nurse professional identity development (Waite

and Brooks, 201; Mezirow, 1978; Nye et al., 2022). National nursing organizations all broadly embrace social justice and health equity as crucial to providing person centered care to all people (American Association of Colleges of Nursing, 2021; Stokes, 2018). However, there is little guidance on how to incorporate concepts of social justice and health equity, or ways to address students' preconceived notions about non-normed groups of people during education (Roy et al., 2022; Tengelin & Dahlborg-Lyckhage, 2017). It is an established goal, but little is known about how to get there. Despite this fact, little attention is paid to LGBTQIA+ health in nursing education, and there have been few reports of attempts to broadly integrate LGBTQIA+ across the curriculum (Hodges et al., 2021; Lim et al., 2015; Sherman et al., 2021).

Additionally, nursing education praxis is a complex web of interrelated educational processes that draw on didactic and theoretical methods to address care concepts; skills learned and reinforced through clinical education; and professional standards that are woven throughout settings (Lyckhage & Pennbrant, 2014; Pitcher & Browne, 2023). The complexity of how nurses learn to be nurses introduces additional challenges to address when thinking about how to change approaches in nursing education. While nurse educators have some level of control over their in-classroom teaching related to didactic and theoretical learning of concepts, the curriculum is typically overseen by the larger School or College of Nursing, and the University it sits within. Also, nursing education standards for accreditation are set by the American Association of Colleges of Nursing (AACN), which publishes the core competencies that need to be addressed in nursing education (American Association of Colleges of Nursing, 2021). Under *The Essentials: Core Competencies for Professional Nursing Education*, Schools of Nursing are guided to map out their curriculum to show how all of the core competencies are addressed, in which courses, and how they will measure student learning (American Association of Colleges

of Nursing, 2021). This standardization leads to a narrowed set of topics to be addressed in individual courses but may also present an opportunity to integrate LGBTQIA+ health across the curriculum, as this review creates an opportunity to make certain all populations are being addressed. Also, in many larger schools, undergraduate courses are co-taught by teams of instructors, which further contributes to standardizing course syllabi and assignments and limiting the ability of individual instructors to integrate additional content (Hellier & Davidson, 2018). Despite this downside, team teaching has the potential to introduce mentorship and guidance when changes in content or approach are being implemented (Hellier & Davidson, 2018; Lock et al., 2016).

One key facet of nursing education is simulation learning. Simulation is a replication of real world scenarios that allow nursing students to actively learn nursing care in a lower stakes setting (Lavoie & Clarke, 2017). Simulation can be low fidelity, where the simulation is less like reality, for example, a case study used in a health history course (Lavoie & Clarke, 2017). Simulations can also be high fidelity, with environments, instruments, and high tech mannequins that mimic hospital and home settings (Lavoie & Clarke, 2017). Simulations also allow for more diversity of patient identities and experiences that may not be easily found in local clinical settings (Englund et al., 2019). Several studies have used simulation to teach cultural competence, affirming practice with transgender patients, sexual health history taking for LGBTQ patients, and more (Englund et al., 2019; Hickerson et al., 2018; Maruca et al., 2018; McCave et al., 2019; Ozkara San, 2020; Pittiglio & Lidtke, 2021). Simulations offer a less stressful setting to practice new skills, incorporate new concepts, and learn from mistakes. The ability to learn from mistakes without causing harm is a crucial component of simulations being a lower risk setting (Aebersold, 2018). These same premises are true for nursing faculty, and

simulations of nursing education settings could be an opportunity to practice new ways of teaching LGBTQIA+ health.

Despite calls to improve nursing education by focusing on social justice and health equity, the current framing and approach to LGBTQIA+ health faces significant challenges. While it is apparent that binary sex, gender, and sexuality norms are the primary drivers of stigma and marginalization of LGBTQIA+ people, and that stigma results in significant health inequities, there has been little discussion of this understanding within nursing education (Day et al., 2023). The continued recreation of stigma and marginalization by using binary sex, gender, and sexuality norms is seen in nursing curriculum and textbooks (Day et al., 2023; Klepper et al., 2023; Ray King et al., 2021). In the most commonly used nursing education textbooks in the US, there was either no mention of people with intersex traits, or those traits were discussed as exceptions to the male/female binary sex rule, with sexes defined based solely on the presence or absence of a Y chromosome (Ray King et al., 2021). Hormones and sex traits were also categorized as belonging to a sex, for example, male reproductive anatomy, or female hormones (Ray King et al., 2021). In addition, there was a consistent conflation of sex and gender terms, where a sex term is used to describe gender, for example, asking someone what is your gender identity, and giving only male and female options (Klepper et al., 2023).

What is known about LGBTQIA+ content inclusion in nursing education primarily focuses on how educational interventions impact students' Knowledge, Skills, and Attitudes (KSA's) (Eickhoff, 2021; Sherman et al., 2023; Yu et al., 2022). Knowledge, skills, and attitudes are often used as measurement of learning in nursing education (Billings & Halstead, 2019). Those terms are defined and described in Chapter 1.

An additional concept that is often used in nursing education, and sometimes applied to care of LGBTQIA+ people is competence. Competence is rarely used as a concept on its own regarding teaching nursing students about LGBTQIA+ health (Hall, 2021). Most often competence is framed as cultural competence, where the care of LGBTQIA+ people is framed through the lens of difference and the need to adequately accommodate for difference (Hickerson et al., 2018; Kim, 2023; Strong & Folse, 2015; Yu, 2024). A recent publication discusses a concept analysis of cultural competence in LGBTQIA+ health which describes four attributes (Kim, 2023). Those four attributes are cultural experience and cultural acceptance, cultural knowledge, cultural attitudes and perceptions, and cultural skills, so even this broader concept of cultural competence involves knowledge, skills, and attitudes, but also folds in concepts of experience. Last, the concept of being able to comfortably provide care to LGBTQIA+ people is sometimes used (Carabez et al., 2015; Reed, 2022).

When students are provided education on topics specific to the health needs of LGBTQIA+ populations, or cultural competence with these communities, their knowledge and skills improve (McCann & Brown, 2018; Priddle et al., 2023; Sherman et al., 2023; Yu et al., 2022). The data available on changes in attitude also shows improvement, with several studies reporting very high baseline attitudes, even before intervention (Sherman et al., 2021, 2023; Strong & Folse, 2015; Yu et al., 2022). A 2015 study also asked students what they felt most influenced their attitudes towards LGBT people, with 90% of students reporting the attitudes of families and friends were the most influential (Strong & Folse, 2015). This finding reinforces that social networks and cultural norms are deeply influential over attitudes and represents a significant challenge in improving nursing education that results in nurses with less stigmatizing attitudes.

The challenges of teaching LGBTQIA+ health extends to a lack of information on nursing faculties' knowledge, skills, and attitudes. While there have been very few investigations of nurse faculty KSA's, there is a clear consensus that a significant number of nursing faculty feel uncomfortable teaching LGBTQIA+ health, including knowing what to teach, where to include topics, or having the right resources to increase comfort and skills (Hodges et al., 2021; Lim et al., 2015; Moore et al., 2023). This lack of comfort and skills comes through in the fact that there is very little time spent on teaching any LGBTQIA+ topics. A 2015 survey of nursing faculty found the average time spent on LGBTQIA+ health across the entire curriculum was just 2.12 hours (Lim et al., 2015). By 2021, using the same survey instrument, that number had barely increased to 2.78 hours of teaching LGBTQIA+ topics across the curriculum (Hodges et al., 2021).

We know that nursing education could be a catalyst toward creating nurses that are critically aware, invested in social justice, and capable of addressing multiple levels of the Social Ecological Model of Health in healthcare (Nye & Dillard-Wright, 2023; Rojo et al., 2023). However, the ability to educate nurses in this revolutionary way requires nurse educators who are capable of addressing stigma and marginalization directly, with the ability to clearly name that health inequities directly result from cultural norms that are used to other people through the power of institutions (Nye & Dillard-Wright, 2023). This shift will also require nurse educators to embrace a more complex, nuanced, and realistic model of sex, gender, and sexuality that teaches the natural variation that is already the true diversity of humanity (Ainsworth, 2015; DuBois & Shattuck-Heidorn, 2021; Saewyc, 2017; Sharpe et al., 2023).

Not enough is known about what nurse faculty view as the challenges to teaching LGBTQIA+ health, which represents a significant barrier to moving the field of nursing

education towards those desired goals. In order for nursing education praxis to truly address the structural and social determinants of health that could create LGBTQIA+ health equity, we need to know much more about how nursing educators view these challenges, as well as what they see as supports and barriers to change. We need to know more about how they currently conceive of what to teach, including how and where they decide to incorporate topics. We also need to understand more about what processes help nursing educators include LGBTQIA+ health.

Present Study

This study will begin to address the challenges of inclusion of LGBTQIA+ health in nursing education. Nursing education research has not examined the impact of cultural binary norms on nursing faculty from their unique perspectives. There is a need to address how those norms impact nursing faculty's conceptions of what is included in LGBTQIA+ health, as well as how nursing faculty feel about their inclusion of this content. There are no examinations of how cultural binary norms impact nursing faculty's attitudes regarding LGBTQIA+ people, and how that might impact their inclusion. This study aims to address these gaps by using qualitative methods to identify what strategies nurse faculty use to include LGBTQIA+ health, challenges and/or barriers to that inclusion, and facilitators or supports to that inclusion.

Chapter 3: Methods

Purpose and Aims

The challenges of including LGBTQIA+ health in nursing education are complex and multifaceted. These challenges include similar challenges to teaching about any stigmatized and marginalized group of people, where cultural norms underlie stigmatizing beliefs that are likely unexamined (Davis & O'Brien, 2020). They also include the complexity of how nursing education is currently structured, with faculty having limited control over what they teach, or how much time they can dedicate to their interests within previously structured courses. Additionally, nursing faculty report feeling uncomfortable and unprepared to teach LGBTQIA+ health, which contributes to very little amount of time and attention paid to topics (Lim et al., 2015). Last, there is very little known about how nursing faculty think about the inclusion of LGBTQIA+ health, or their view on any of these challenges, ones not yet understood or addressed, or what supports they find useful.

This study proposes to address these gaps by utilizing a qualitative descriptive study design that can answer exploratory research questions in an environment where there is partial or insufficient knowledge about this phenomenon (Kyngäs, 2020). Additionally, qualitative methods allow for gathering complex and in-depth data that is difficult to achieve with a quantitative method like a survey. Last, qualitative methods allow for participants to offer new information or points of view that have not been discussed in the literature (Kyngäs, 2020). Therefore, the purpose of this study is to understand the challenges nurse educators face in improving education related to LGBTQIA+ health. This qualitative descriptive study will answer the following research questions:

1. What are the broad challenges nursing faculty perceive when teaching LGBTQIA+ health?
2. What are the barriers and supports to teaching nursing faculty experience when integrating content relevant to LGBTQIA+ health?

Research Design

This study used a qualitative descriptive study design to explore the experiences of nurse educators in integrating LGBTQIA+ concepts into their teaching. Data were collected using semi-structured interviews. Due to the exploratory nature of this research and the need to better understand the current landscape of knowledge and perceptions, I used Reflexive Thematic Analysis (RTA) to explore nursing faculty's experiences of including LGBTQIA+ topics in nursing education (Braun & Clarke, 2006, 2019; Clarke & Braun, 2021). RTA is a flexible approach that allows for a critical realist ontology and epistemology, in which the world is acknowledged as real and existing beyond human perception, but also that knowledge is positioned both according to scientists' social positions, and the production of knowledge itself as it relates to power and inequality (Albert et al., 2020; Richardson, 2023). RTA also allows for the research process to examine nuanced and complex experiences, processes, and concepts that have opportunities for new and divergent perspectives to emerge from participants (Braun & Clarke, 2019). Another important element of RTA requires the researcher to engage in critical reflexive practice, where their own social positions are acknowledged for how they influence all aspects of knowledge production (Braun & Clarke, 2019).

Sample

Inclusion criteria were nurse faculty who teach any amount of LGBTQIA+ health to pre-licensure students at schools of nursing in the US Midwest states in the Midwest Nursing

Research Society service area (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Oklahoma and Wisconsin). These similarities allowed for in-depth analysis of the unique cultural milieu of the Midwest states. Participants taught at schools or colleges of nursing in Illinois, Iowa, Kansas, Michigan, Nebraska, South Dakota, and Wisconsin, with all participants teaching at schools in urban areas. Exclusion criteria were nursing faulty who did not teach pre-licensure students, who teach at schools outside of the states of inclusion, and who do not teach LGBTQIA+ health.

Specifically recruiting a sample who taught any amount of LGBTQIA+ health allowed me to find participants that had experience with the phenomenon and were able to speak in depth about their experiences with teaching. I defined any amount in recruitment emails and flyers as "Including content can be teaching specifically about LGBTQIA+ health topics, or using case studies that include LGBTQIA+ people, or using inclusive language when describing populations in your teaching.". I left the type and amount of inclusion intentionally broad, as there are very few nursing schools that have an entire course dedicated to LGBTQIA+ health, and I wanted to talk to participants with a broad range of experience.

Participants were asked to self-identify their race, ethnicity, sex assigned at birth, current gender identity, and current sexuality identity, with open text responses. The sample consisted of fourteen participants. Regarding race, all participants wrote in responses of either White or Caucasian. Regarding ethnicity, participants gave a wider range of identities, including White, northern European, Scandinavian, Not Hispanic, settler of Irish/European ancestry, German and Czech, and similar responses. Regarding current gender identity, eleven participants identified their gender as female, with one participant each identifying as a nonbinary woman, female but…, male, and nonbinary. Regarding sex assigned at birth, thirteen of the fourteen participants

wrote in their sex as female, and one participant as male. Regarding current sexuality identity, ten participants identified as heterosexual, two participants identified as bisexual, and another two as queer. In addition, there were two unusual entries, including "cysgender", and the type of specialty nursing the participant practiced. Experience teaching ranged from 6 to 35 years (Table 1). Participants ranged from having an MSN to PhD degrees, with all participants but one having a doctoral degree or being in a PhD program.

Study Procedures

The University of Wisconsin Institutional Review Board determined this study was exempt. Recruitment occurred by purposive sampling of nursing faculty through emails to the member list of the MNRS, and specifically to the Nursing Education Research Interest and Implementation Group, as well as to the National League for Nursing (NLN) email listserv. The recruitment emails contained a recruitment flyer (Figure 2), a description of the aims, and a link to a demographic questionnaire (Table 2), as well as my email for participants to ask questions and give consent to be contacted. I also continued to recruit nurse faculty through snowball sampling from participants who shared information about the study with other faculty they teach with. I recruited participants until I achieved a sample that resulted in sufficiently rich, varied, and contextual data to determine meaning (Clarke & Braun, 2021).

After recruitment emails were sent out, interested faculty participants were directed to a secure Qualtrics link where they consented to collect demographic data, and to receive communications from me at their preferred contact method, along with the best times to contact (Table 3). The demographic data was used to determine eligibility based on study inclusion criteria. If participants were eligible, I contacted them to schedule a virtual video interview.

Data Collection

Semi-structured interviews were an average length of 62 minutes. All interviews were conducted over a secure Zoom. The interview guide contained six questions (Appendix 3). Interviews began with me asking participants about their time as faculty and experiences with LGBTQIA+ content or curriculum to establish general background knowledge and create rapport. Initial questions addressed how participants included LGBTQIA+ health content, what course they teach that content in, and what pedagogical strategies they use to incorporate content. These questions set the stage for a more in-depth discussion of their experiences by helping understand what the current landscape of LGBTQIA+ health teaching is like for these participants. I then shifted to questions that examine what they believe to be the challenges regarding LGBTQIA+ content inclusion. These questions started with asking what it is like for them to teach LGBTQIA+ health, to provide an open forum to discuss their teaching broadly. During this portion of the interview some participants spontaneously discussed what challenges they face, but if they did not, the next question asked participants to specifically address the challenges they see. Participants were also asked about more direct supports and barriers they experienced teaching LGBTQIA+ health content. Finally, participants were asked what advice they would give to new faculty who teach LGBTQIA+ health. This allowed them the opportunity to think back to where they were when they started this journey, and what it was like to be on that journey (Table 4). Participants were offered a $50 honorarium for their time and expertise.

Analysis

Reflexive thematic analysis (RTA) with inductive coding was completed by the study team (Braun & Clarke, 2019). The study team was comprised of myself and two graduate students who have assisted with previous research. The analysis process was deeply informed by the study team's reflexive process. When we met as a team we noted what decisions we were

making regarding analysis, as well as what assumptions, ideas, lived experiences, and theoretical knowledge we were bringing to the process. We analyzed the data using the six steps of the RTA framework.

The first step of RTA is becoming familiar with the data (Clarke & Braun, 2021). To accomplish this, I rewatched the audio-visual recording alongside the auto-generated transcript provided by Zoom to verify transcription accuracy, deidentify the transcripts, and noted important nonverbal actions where they occurred (long pauses, facial movements, gestures used, etc). As I conducted the interviews, then created the transcripts, I became deeply familiar with the data, and was able to carry a lasting impression of the overarching arc of individual interviews, as well as the interviews as a whole.

Step two of RTA is generating initial codes (Clarke & Braun, 2021). To accomplish this step, I imported deidentified transcript data into the Dedoose software application, which facilitated collaborative analysis of the data for codes and themes. I examined the first two interviews line by line for both preliminary manifest codes on how and where content is taught, as well as emerging latent codes related to the experiences, thoughts, beliefs, and attitudes of nursing faculty regarding LGBTQIA+ content inclusion. After the initial codes were developed, we met as a study team to discuss how the codes were applied to the data in those transcripts. This allowed the team to start to develop a shared sense of what meaning we were trying to draw from the data. After the first two interviews, each interview was coded by two study team members, to ensure analysis occurred from more than one perspective (Braun & Clarke, 2019). As we each analyzed a transcript, we would add new and unique codes to the data that were informed by our experiences and perspectives. To deepen our analysis, we met as a whole team to discuss the tagged excerpt each person had generated a code for and what each of us thought

the code added to the analysis. We continued this process as new interviews were conducted and transcripts were imported into Dedoose.

In step three of RTA, the study team applied our analysis to the codes and determined underlying meaning that could be organized into themes. After the first eight interview were coded, we met as a team for a theme development session. We grouped over 200 codes into 20 broader concepts, and then mapped the broader stories we were seeing in the data. Those stories focused on the emotional impact of teaching and the connection to purpose participants described. There were several themes focused on the experiences of supports and challenges at several levels. Throughout this process, we engaged in reflexive practice, where we questioned our assumptions and how our knowledge informed our analysis. At one point we were able to recognize as a team when our latent analysis was moving too far away from the data so we refocused on the nuances in the data to be sure we were capturing the complexity of the narratives we were seeing.

As more interviews were completed and analyzed, the study team reviewed codes and themes for completeness and to assure they accurately reflected the interview data, which comprises step four of RTA (Clarke & Braun, 2021). For this step, the study team reviewed all previously coded interviews to ensure that the themes captured all of the variance in the interview data, verified that the developing themes were comprehensive, and that they adequately captured the meaning in the data. This step occurred alongside continuing recruitment of nursing faculty until we achieved theme saturation. Theme saturation was achieved with the fourteenth participant, as no new themes were identified during analysis (Clarke & Braun, 2021).

Step five of RTA, naming and concisely defining the themes and how they allow for meaning making from the data, occurred in stages over the final weeks of analysis, in

consultation with my advisor and dissertation committee team members (Clarke & Braun, 2021). We initially identified 15 themes that were then grouped together and consolidated into five larger themes. This process was recursive and reflexive, with multiple iterations of refining the story that the themes were revealing. During this iterative process and ongoing analysis we identified important relationships between the themes that were most accurately captured as a conceptual model. This model helped support the ongoing and interdependent nature of the processes of the themes.

The sixth and final step of RTA is writing the research report, where the themes and conceptual model are described in detail, including variability across interviews. In this report I will provide exemplar quotes that capture the essence of the themes, as well as the conceptual model (Clarke & Braun, 2021). In addition, there was a presentation and oral defense of the dissertation.

Trustworthiness

To promote trustworthiness and rigor, I employed a framework building from Lincoln and Guba's 1985 criteria, developed specifically for reflexive thematic analysis (Nowell et al., 2017). Lincoln and Guba described four ways to assess for rigor and trustworthiness of qualitative research (Lincoln & Guba, 1985). Credibility is described as the fit between the interview data and the researcher's interpretation of it (Lincoln & Guba, 1985). To establish credibility the coding team spent significant time analyzing the interview data, including rewatching the videos for embodied reactions and expressions, and the team brought multiple perspectives to understanding the interview data (Nowell et al., 2017). Transferability is described as the ability to transfer the knowledge to other situations, which are unknowable to the original researchers (Lincoln & Guba, 1985). To demonstrate transferability, I provided thick

and rich descriptions of the themes and conceptual model that emerged. They were supported by appropriate quotes that capture the variance and meaning in the data (Nowell et al., 2017). Dependability is described as the ability to trace the research process with clearly documented decisions and reflexive journaling (Lincoln & Guba, 1985). To promote dependability I created an audit trail of decisions made throughout the analysis process, including the study team reflexive journal that captured ideation and emotion around emerging codes and themes (Nowell et al., 2017). Confirmability is described as the ability to document that the researcher's interpretations accurately reflect meaning in the data (Lincoln & Guba, 1985). Confirmability is shown through the other three attributes (Lincoln & Guba, 1985). By promoting credibility, transferability, and dependability, the research is more confirmable (Nowell et al., 2017).

Reflexivity

Reflexivity, the researchers' insight into, and articulation of, their generative role in research, is key to good quality analysis. Researchers must strive to "own their perspectives." The study team all carried some of the identities under the LGBTQIA+ umbrella. DL, the primary author and lead of the study team is a White, queer, nonbinary registered nurse and PhD candidate. DD, a study team member, is a White, queer, trans and nonbinary counselor in training and graduate student. QH, a study team member, is a White, queer, trans man in training for mental health social work. We are all proudly trans and/or non-binary, and queer, and those identities by their very nature were influential on the process of analysis. Being trans and/or non-binary and queer people who are all trained in some form of a helping profession, we recognized that our positions and our knowledge influenced the process of analysis. We questioned our assumptions and why we made the decisions we made. We strove to recognize how our lived experiences as people outside of binary sex, gender, and sexuality norms impacted us, and how

those impacts became a part of the analysis. In RTA, the goal is not to become objective, but to own the perspectives you bring, and be clear about the impact they have on the generation of your analysis (Braun & Clarke, 2019).

During the initial coding phase, the study team captured reflexive journaling thoughts while coding in the Dedoose software, so initial codes and reflexive journaling were captured at the same time. These reflexive notes captured both ideas related to the data, as well as emotions regarding the data. This allowed for a more nuanced analysis which revealed meaning beyond what participants directly stated. During study team meetings, the team continued to use reflexive journaling notations related to how and why we assigned meaning to codes and themes, as well as what emotions were recognized during the process. During the theme generation meeting the study team continued to use reflexive journaling regarding meaning making processes, especially noting the emotions of participants, as this was a particularly noteworthy finding in the data. As the themes were being organized into a story that became the conceptual model, it was particularly important to capture reflexive thoughts regarding how we arrived at the themes and what meaning was assigned to them. During the final step of analysis, we continued to capture reflexive journaling notes related to every part of the research study process, from how we framed the research questions, to how we viewed and analyzed the data, to how we made meaning out of the analyzed data while writing a report of the study, including choosing excerpts from the data to exemplify the themes and meaning. Discussion? As the study team are all trans and/or non-binary, we experienced significant frustration, depression, and sometimes anger at being erased and stigmatized again. The process of coding was sometimes painful for each of us. To address these emotions, we often leaned on recognizing we were able to address some of the issues by offering our analysis back to the world. Taking action, even in this small way, helped keep us from absorbing the stigma and marginalization that we experienced during analysis.

For discussion section? We took extensive reflexive notes around data that focused on values. One way our experiences and knowledge came up in this portion of the analysis related

to the overarching story we saw at the first theme development meeting relating to American White women and cultural norms and values that grew out of Victorian era ideas regarding White, Christian, upper-class womanhood, innocence, and discomfort with any aspect of sexuality or sexual expression. While there were likely some of those values underlying the discomfort that some participants expressed, there was no direct discussion of White womanhood, the desire for innocence, or even direct discussion around discomfort with sexuality. We noted that instead participants hesitated, used vague terms, or trailed off rather than directly discuss a topic about sexuality, even in answering questions during their interview.

Additional reflexive notes focused on aspects of power, and how power is used to maintain norms and other LGBTQIA+ people. While very few participants directly discussed uses of power, one participant discussed challenges to including LGBTQIA+ health that were the result of blatant uses of power being used to try and exclude people from discussions in Universities regarding people outside of White citizens and people who match binary sex, gender, and sexuality norms. Most participants noted that structural resources like textbooks and nursing education focused materials lack LGBTQIA+ inclusive content, which is another reflection of the use of power to exclude.

Chapter 4: Results

The results of this study have both manifest analysis on what, where, and how content is taught, as well as latent analysis on the meaning in the data. The manifest analysis shows that teaching LGBTQIA+ health is often done in content areas that directly relate to sexuality or reproduction. Several participants taught content related to LGBTQIA+ health in a mental health course, and often was framed regarding inequities in mental health outcomes. A few participants taught concepts related to LGBTQIA+ health in courses related to professional nursing development, with a few other content areas across the nursing curriculum represented. Participants used all manner of educational tactics to include LGBTQIA+ health, including didactic lecture, simulation, case studies, and guest lectures. Several participants relayed that storytelling, through media or guest lectures, seemed to be a particularly helpful method of inclusion.

Through this analysis we identified a conceptual model that describes the processes nursing educators used on their journey towards comfort and competence in teaching LGBTQIA+ health. The conceptual model includes an overarching central conceptual model, *Queering Teaching* and three surrounding and supporting themes, *Doing the Internal Work by Addressing Your Biases, Integrating Professional and Personal Values to Create a New Values Way* and *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes to Improve Teaching*. The themes and the central concept are all surrounded by supports and challenges at several levels (Figure 2). Each of the three themes describes a process that individuals report as essential to their ability to teach LGBTQIA+ health. To protect the privacy of participants I have used pseudonyms along with a few demographic details throughout the results section that help contextualize the quote used.

What, Where, and How Content is Taught

The first question of the interview protocol asked participants about what, how, or where they taught LGBTQIA+ health, with courses taught in captured in a table (Table 4). Several participants talked about how their teaching of LGBTQIA+ health focuses more on disrupting patterns of "heteronormativity" as described by Poppy, a cisgender heterosexual participant who teaches content on nursing practice fundamentals for new nursing students. Lupin, a non-binary queer participant who teaches content on population health discussed ways of "regularizing" non-binary sex, gender, and sexuality identities. All participants discussed the importance of using correct language when teaching LGBTQIA+ health. This was most often discussed as not making assumptions about patients' gender, pronouns, or relationships, with one participant using the concept of therapeutic communication to convey the importance of correct and compassionate use of language.

Participants used didactic lecture content, case studies, videos and movies, and guest panels to incorporate LGBTQIA+ health content into their courses. Several participants described the value of using storytelling in teaching LGBTQIA+ health, with Iris, a cisgender bisexual woman who teaches mental health content saying "I find that videos are especially helpful because students will watch videos much more easily than they'll read things." Several participants described how engaging students through stories allowed a more in-depth conversation than would otherwise occur through didactic teaching alone. Participants used storytelling through examinations of their time in clinical practice, and videos or panels that highlight both experiences of stigma, as well as more joyful experiences of LGBTQIA+ people's lives. Participants who used stories noted that storytelling kept students engaged and allowed them to think more critically about their nursing practice.

Participants described teaching that focused more on some populations under the LGBTQIA+ umbrella than others. Many participants include lesbian and gay people when teaching concepts about sexuality and reproduction. Some participants include transgender people, sometimes through specific content, and sometimes through more generalized discussions about transgender people and assumptions of binariness. One participant who is bisexual-identified specifically included bisexual people in their teaching. Only two participants included people with intersex traits in their teaching. No participants specifically spoke about the healthcare needs of asexual people.

The variability in attention to LGBTQIA+ identities highlights another concept that emerged in several participants' interviews, how being LGBTQIA+ identified conferred a lived experience expertise that seemed to imply to fellow educators that they are able to teach on any LGBTQIA+ health topic. The LGBTQIA+ participants described being asked to assist with teaching in other classes, with the request often being relayed as you have one hour, please teach LGBTQIA+ health. When participants asked for more specifics on what the requesting instructor wanted them to teach, the requesting instructor was often confused by the question. Participants interpreted this response as indicating the requesting instructor's lack of knowledge and understanding of LGBTQIA+ health and being unable to understand what is important for their class. In addition to overly broad requests for guest lectures on LGBTQIA+ health content, participants also noted how having such limited time kept them from going into any depth. LGBTQIA+ health needs are variable by experiences and intersecting identities that confer variable access to power, resources, and support. Trying to teach nursing students about the healthcare needs of all LGBTQIA+ people in one hour is impossible. Having no guidance on what is important for the course the lecture is being requested in conveys that LGBTQIA+ health

is a single concept that does not need variation depending on context, intersectional identities, or types of healthcare needed. This dynamic of limited time and vague requests was described by one participant as disheartening, given that LGBTQIA+ people utilize healthcare in every setting and experience all of the same health problems as cisgender heterosexual individuals. Additionally, Rose, a cisgender heterosexual woman who teaches pediatric health; (add name for 10 when you find it!) and Lupin, both noted that the provision of LGBTQIA+ content in only certain contexts contributed to further stigma of LGBTQIA+ people, and that the focus on sexual and reproductive health contexts highlighted only the ways LGBTQIA+ people are different, and ignored the realities of affirming healthcare needs in all settings. Finally, a few participants described concerns about LGBTQIA+ health being framed as cultural competence, diversity, equity, and inclusion defined broadly, or separated out as a special population. However, Tulip described her school's approach to LGBTQIA+ health as focusing on a "vulnerable population", which captures more of the nuance and complexity of stigma and marginalization and could help address some issues with the cultural competence terminology currently found in use in nursing education.

Themes

Three major themes emerged from the data, *Doing the Internal Work by Addressing Your Biases, Integrating Personal and Professional Values to Create a New Values Way,* and *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes to Improve Teaching.* These themes describe the individual and interrelated ongoing processes that participants found they had taken in order to teach LGBTQIA+ health in an effective and compassionate manner. The themes support and build on each other. They are also interdependent, whereby as one process occurs, the others occur as well, in a continuous motion. These themes describe how

participants moved through these three processes, which in turn deeply impacted how participants perceived and responded to their teaching, as well as informed what and how they taught LGBTQIA+ health.

Doing the Internal Work by Addressing Your Biases

This first theme was often the foundational step participants described to becoming an effective educator of LGBTQIA+ health. Most participants described needing to understand their own viewpoints on LGBTQIA+ people, and all participants used the language of "looking at" or "addressing" bias. Every participant described needing to recognize and address their own biases as crucial to successfully teaching LGBTQIA+ health. This was often described as an ongoing and lifelong process that each participant undertook. Iris outlined the questions she thought every nursing educator needed to think about when starting to teach LGBTQIA+ health, stating,

> "…first of all become self-aware. Where are you about this topic, or on this subject? And what are your emotions about it? Where do you have anxiety and to explore those areas with, in mind, the goal of resolving the anxiety around it."

Participants described a range of experiences that prompted them to address their biases. The most common motivation participants described was driven by having close friends or family members who identified as LGBTQIA+; the second most common motivation for addressing bias related to participants themselves being LGBTQIA+ identified. In these cases, participants described directly witnessing bias in themselves or others that led them to start addressing their biases earlier in their life. Finally, participants also described feeling motivated to educate on LGBTQIA+ health topics because they had personally witnessed discriminatory and harmful care directed toward LGBTQIA+ people. For some, witnessing discriminatory or harmful care helped participants understand the impact of bias. For example, Rose, a cisgender

heterosexual woman who now teaches content on pediatric health, described working with a trans patient admitted for complications post gender-affirming surgery. At the time, Rose was a new nurse, and the incident she described occurred in the very early days of gender affirmation surgery, before a broader cultural shift towards acceptance of LGBTQIA+ people had occurred. Rose described how she witnessed the patient receiving harmful and discriminatory care, she had not been taught the details of the surgery the patient received and did not understand the care the patient needed, or why other nurses would not directly discuss the patients' needs. This experience stayed with Rose, and when she became an educator, she started using that story in her teaching to highlight the negative impact of bias on patients and nurses.

To describe how she started the process of addressing her own bias, Calla, a cisgender heterosexual woman who teaches content on human sexuality relayed her experience of learning a friend was gay in high school

> "…she like put her hand on my knee, and was like, uhm, I'm gay, and I was like (makes confused face) what? and she was like, I'm gay. Because this challenged my whole idea of what being gay was right, I was in high school. And I was all "Oh that's fine! That's ok!" and she just started laughing. And I think I just leaned into, like I went home that night, and I really analyzed like, what does that mean? Does she think I like her, I mean all of the things that we tell people not to do, was going through my head like if I spend time with her will I be gay, right? …So, I think that's what helps."

This experience set off a lifelong journey of understanding where her biases originated, which in turn led her to purposefully seek out more diversity in her life through friendships. Calla

described how these diverse experiences and people in her life were crucial to her skill and comfort with teaching LGBTQIA+ health.

Daisy, a cisgender queer woman who teaches content on gender affirming care in multiple classes across her school's curriculum relayed that she had started to do her internal work when she realized she was LGBTQIA+ identified in her young adult years. The process of coming out helped her recognize the cultural and religious beliefs that influenced her thoughts and feelings previously, and she worked to overcome her internalized stigma toward LGBTQIA+ people by embracing her queerness. Overcoming her internalized stigma then carried over into her professional life, where she described a career specifically focused on gender affirming healthcare that prepared her to teach LGBTQIA+ health in neutral language and a judgement-free manner.

Several participants circled back to addressing bias in response to a question about what advice you would give nursing faculty who are new to teaching LGBTQIA+ health. Those participants emphasized the importance of addressing bias in their response, and often discussed their own work of addressing their biases throughout the interview as well. These aspects emphasize how foundational addressing bias was to comfortably teach LGBTQIA+ health for these participants.

Iris also discussed using the nursing process of assessment, devising a plan, implementing the plan, and then assessing again, alongside the Harvard Implicit Association Tests (IAT; Project Implicit, 2011) to support her lifelong journey of addressing her biases. She described taking a version of the IAT every few months and developing a nursing care plan for the biases she showed on the test. For example, she would take an IAT test on transgender people and if her test results showed a bias, she would devise a plan to include more images and

stories of transgender people in her life, and then she would reassess in several months. Iris highlighted how using the familiar nursing care plan process helped her to feel more comfortable with what felt like an otherwise inscrutable process. She also described liking the structure she set up for herself as it created both a sense of internal accountability to address her biases, and also utilized a data and research-oriented approach.

This internal work occurs most often outside of participants' typical nursing education preparation. For most participants, this work had occurred earlier in their lives, and had been prompted by outside experiences that they then integrated into their teaching. However, for Tulip, doing the internal work was prompted after being asked to include a young transgender patient in her course. The need to be able to skillfully and comfortably include content on transgender youth prompted a deeper dive into her beliefs specific to this population and was crucial to her eventual comfort with her teaching.

The fact that the work of identifying and addressing your biases is internal also creates a potential pitfall. As this process is internal, it often does not include outside checks on progress toward addressing biases. Some participants described themselves as very comfortable with teaching LGBTQIA+ health and identified that it was important to them to be an ally. However, these same participants described LGBTQIA+ people and concerns in a manner that underscored differences, rather than similarities, between themselves and LGBTQIA+ individuals. Some participants also exhibited hesitancy in their discussion of LGBTQIA+ health, using euphemisms rather than direct language (e.g., "gender issues"), trailing off, or moving on when directly discussing aspects of LGBTQIA+ health with which they seemed uncomfortable. A few participants struggled to use pronouns correctly when describing transgender individuals. It seemed that several participants were more comfortable with discussing diversity in sexuality,

(e.g., lesbian and gay people), but they struggled with discussing diversity in gender (e.g., transgender people).

Our analysis included a focus on how stigma and marginalization were discussed by participants. Some participants were direct in discussions of stigma and marginalization, but a few participants were more indirect, and only discussed concepts about bias but did not draw connections to how bias shapes stigma. Two participants used language and concepts around vulnerable populations, which included an awareness of stigma and the processes of marginalization.

Most participants did not discuss the impact of race, or Whiteness and White Supremacy on their teaching, or their processes of addressing their biases. However, Lupin and Sorrel, a cisgender heterosexual man teach at the same school and they both utilized a presentation that was given by an LGBTQIA+ person of color, who is also Lupin's wife. Lupin and Sorrel discussed the importance of utilizing intersectional perspectives, as their internalized White supremacy and lack of lived experience made them hesitant to discuss LGBTQIA+ health without the perspective of a person of color. Calla described the impact of addressing her internal White supremacy starting in high school and continuing into college and her adult life. She described purposefully seeking out diverse experiences and connections with diverse people as one way to address her otherwise very limited experiences and White perspective that was too often reflected in her culture. Calla described the diversity of her friendships as one of the reasons she was so comfortable teaching about LGBTQIA+ health.

In summary, *Doing the Internal Work by Addressing Your Biases* was described by participants as foundational to the ability to comfortably teach LGBTQIA+ health. All participants discussed addressing bias as the most influential step in their process. This process

was described as ongoing, and even lifelong, as well as continuous. Participants recognized that the US culture has biased attitudes toward LGBTQIA+ people that impacted their own ideas, concepts, and values regarding these populations. All participants named addressing their own bias as important, and most also suggested addressing bias in advice they would give to nursing educators who are new to teaching LGBTQIA+ health.

Integrating Professional and Personal Values to Create a New Values Way

This theme describes the process participants undertook to navigate tensions between personal, cultural, religious, and professional values. Participants describe needing to undertake a process of integrating their professional values with their personal values that were informed by cultural and sometimes their religion's, values. *Integrating Professional and Personal Values to Create a New Values Way* occured when participants centered their professional values of promoting human dignity while providing compassionate healthcare that patients need. Participants described integration of their values when they realized that by *Doing the Internal Work by Addressing Your Biases*, they no longer held values that felt in tension with valuing the rights of LGBTQIA+ people to dignified and compassionate healthcare. Sometimes this resolution of tension occurred because participants no longer saw LGBTQIA+ people as "different" than themselves, thereby disrupting the gears of norms, othering, and power inside themselves. Sometimes the religious values of participants held significant sway, so that resolution occurred when participants recognized that their religious, personal, and professional values aligned on compassion and dignity, which they centered in their teaching. Rose described it this way

> "I usually introduce the content by telling the students my experience and about why I'm motivated to include this because I don't want them to experience the

same thing, and I want them to be prepared to care for whatever patient crosses their path, in as therapeutic a manner as possible. I don't use my classroom as a bully pulpit for my faith, but I am very hopeful that by how I conduct myself on campus and in the school, and in individual interactions with students, that they do realize that I am a person of faith. And I guess my biggest hope is that, because I do identify as a Christian, my background is coming from a cradle Catholic background to finding Christ in high school and being born again, and then, you know, developing my faith and the ups and downs of a walk with Christ throughout my life, that I guess my biggest hope is that I'm a role model about you can have strong faith, but that doesn't need to get in the way of you providing just and therapeutic care, right? Because you are meeting that individual wherever they are, with whatever their beliefs are, and you don't have to agree with them to give them therapeutic care. And I hope that comes across."

Tulip had a similar, but more recent struggle with the tensions surrounding teaching LGBTQIA+ health that occurred when she was assigned to teach a related concept on a transgender youth during a curriculum wide revision process. Tulip decided she would include the transgender youth in the content related to the concept of advocacy. When she was first decided to teach about advocacy using a transgender youth as the focus, she realized she had to address her religion's values regarding binary sex and cisgender identity, which led to her religiously inspired beliefs that gender affirming care for transgender youth was immoral. Tulip described the process relating to navigating her religious and professional values around the topic like this

"I will also be honest, I am a conservative Christian person. And so some of these topics were uncomfortable for me from a what am I advocating for space and I

> had to reckon with myself…. I had to get to, and what I realized I needed to clarify for my students, especially those that had some issues, and maybe this isn't the best thing but advocating for a specific lifestyle, or whatever that might be, is different than advocating for the health of the people that we're caring for and I don't necessarily have to, I know that I don't have to necessarily agree with an aspect of anybody, whatever that might be, to be able to provide them with the optimal health. And that's never been it, I mean, I certainly would provide the best care to everyone so, and I knew that was true for me. But I needed, with some pushback from the students that I got earlier on in teaching it, from the well, you're, you know, you're forcing us to change our values and our beliefs and believe that this is okay. This is not about how you feel about a certain population. This is about making sure that we are providing equitable care to all people, and that comes with that. So, I would say that was something I had to work through and navigate for myself."

This description highlights how she wrestled with teaching about advocating for a medical process she did not believe was moral, and through this process recognizing that her religious, personal, and professional values aligned around providing the dignified healthcare that each person needs.

Integrating Professional and Personal Values to Create a New Values Way touches on aother area of tension: navigating the fear of saying the wrong thing, which might cause harm to a patient. Nursing professional values include being a positive source of support for patients, and our values as educators extend that support to students. Some participants described recognizing they may not know the right thing to say, are not familiar with using non-binary pronouns, or

how to describe the care of a transgender patient without utilizing binary concepts. Even after having addressed their biases, participants described the practical application to language that needed practice to improve comfort. Aster teaches reprodutive health content and also has a practice in a perinatal clinic described,

> "It takes effort to change language and to do that work. And I think for me, it's not the same sex couples, that has been something that I've experienced throughout my entire career. It's more the pronouns and the transgender population. It's more of that, that seems to be a little bit more, again, it's not new, but it's newer, you know. I, so to me, it's like that's the thing that's been a little bit trickier."

She did not directly reflect on why content and teaching regarding transgender health was harder for her, but she did mention that she was used to working with clients to achieve pregnancy and had learned to remove sex/gender when thinking about how to create and grow a baby during her clinical practice. It's likely she had learned to replace binary sex concepts with ideas of sperm and egg but she hadn't addressed the underlying constructs of binariness that she was using in her practice. This is likely what made a more nuanced conversation about sex and gender without binary constructs harder.

In summary, *Integrating Professional and Personal Values to Create a New Values Way* was described by participants as the purposeful integration of personal, cultural, and religious values with professional values that brought them to the point where their values were not in conflict. This new way is created through the process of values integration, and it results in participants understanding their values with more complexity and nuance. For most participants, this resulted in feeling more comfortable teaching LGBTQIA+ health, and likely represents a crucial aspect to competence.

Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes to Improve Teaching

Participants described the next point of action this tension provokes as *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes to Improve Teaching.* With this process participants discussed how *Doing the Internal Work* and *Creating a New Values Way* led them to an awareness of gaps regarding LGBTQIA+ health in their teaching, and for some participants, in the entire curriculum of their institution. Several participants described recognizing the need to change how they taught on these topics, with many of them describing how they changed framing of topics, and what language they use. Those participants discussed teaching with a nonheteronormative lens, emphasizing that gender and sexuality are on a spectrum, not only binary. Two participants discussed including people with intersex traits, by acknowledging that some people do not have binary sex traits. Most participants taught something related to transgender health, which also includes the need to work with patients that may not have binary sex traits in ways that students may assume.

Several participants talked about the importance of challenging sterotypes or stigma through the way they frame or discuss topics. Participant 3, a cisgender heterosexual woman who teaches in a simulation lab said,

> "…you wanna be very careful that you're representing that all people have health issues but don't want to inadvertently reinforce a stereotype, and it's really hard to navigate that space. When I teach about more of those like social determinants or the background factors, and things of race or sex or gender come up, I usually tell my students that's a trend. We tend to see this more in this population. I've worked very hard to switch my languaging away from being X is a risk factor, cause I'm

> like, that's not really how this works. It's way more complex than that. …I'm trying to help them understand that typically, that's because of some other shared experiences, or some other shared factors, …it's those barriers to care or stigma or insurability or employment status... I do want them to have that exposure to be like, this person can have breast cancer, and so I think that that's my biggest challenge is trying to navigate in a way that is sensitive and respectful towards representation, not shying away from the representation but finding a way to do so that is challenging a stereotype rather than reinforcing a stereotype."

Participants 2 and 10 had experiences assisting other faculty on how to include LGBTQIA+ health in their courses. Participant 2, a nonbinary woman who is bisexual, and is frequently asked to guest lecture on LGBTQIA+ health in many content areas described a painful process she undertook with her fellow faculty,

> "…there was at least one meeting that I've been a part of that was just to teach the educators about how to teach LGBTQIA+, as if I was an expert on the subject, which is not what I'm studying, but I did my best. It went well. The day of everyone was very excited. They had good questions. They were wondering, you know, how does this apply to the course that I'm teaching? And when should I discuss what? And so, they had good questions, and it seems like everyone really wanted to follow through. But then no one did."

This participant further expressed her surprise and disappointment that none of her peers followed through, which she attributed to lack of time and overwhelm being experienced by her fellow faculty. Their peers did continue to ask them to come back and do guest

lectures on LGBTQIA+ health, even if they did not do the process of integrating content into their own courses.

Particpant 10 described how she approached conversations during curriculum meetings when courses are discussed.

> “I've tried to help with the curriculum development to be like, “hey, this is where you should put sexual gonadal development in your growth and development classes but talk about intersex people. And this is where, in the cultural diversity class, this is where we can talk about societal stuff and discrimination, and how gender is not binary, has not been binary in multiple cultures for multiple periods of time”, so they have sort of this foundation.”

Those gaps created the need to find resources for teaching, which took a significant amount of time and effort. Most participants described needing to extensively search for, and often ended up creating, high quality resources that were nursing-specific. The time and effort that process takes was described as a challenge by most participants. Participant 11 described as a significnat challenge to teaching on LGBTQIA+ health, “Finding the information, the up-to-date information, all the variety of sites, where I’ve got some great resources, but also, you just always have to be looking for it, versus other areas of health.”

It should be noted that many of these participants asserted that this time and effort did not construe a barrier, that they were willing to spend the time necessary, both because this teaching mattered to them in some way, and also because they wanted to be very intentional and thoughtful about their approach to including LGBTQIA+ health. Participant 3 described her approach to including LGBTQIA+ health,

> "I think there's always some trepidation with (including LGBTQIA+ health), and so that's why, like I said, I feel like I have to have that moment of, you know, is this meeting their learning outcomes, you know? It's kind of like, almost like a beneficence kind of thing. This is in their best interest. I'm doing this because it's in their best interest. It matches their learning outcomes. That's going to help them be a better nurse."

The concept of competence regarding LGBTQIA+ health in both nursing education and nursing practice emerged in a few interviews. Competence has been used in nursing education literature on how to include LGBTQIA+ health, or how to evaluate student learning, but the concept and how to apply it is rarely described in detail. A similar description of basic competence was seen in a few interviews, but Participant 10 also described the differences between basic and expert competence. Basic competence for nurses was described as having enough background knowledge of LGBTQIA+ people's lives, bodies, and behaviors to communicate and assess healthcare needs in a compassionate and affirming way. Expert competence depends on the setting of care and could range from understanding gender affirming care needs to understanding the management of fertility in a person with intersex traits. Pre licensure nursing education is a generalist degree that is not intended to prepare students for practice in every setting, so most nurses only need a basic level of competence. Participants described competence in terms of what nurses need to know, and those concepts extend to what nurse educators need to know. Most nurse faculty will need a basic level of competence, which should include an in-depth enough understanding of LGBTQIA+ people's lives, bodies, and behaviors to teach students in their specific content areas.

However, *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes to Improve Teaching* provokes another area of tension that highlights the continual nature of these interdependent processes. This area of tension circles back to values, where nursing professional and education values require nurse educators to not impose personal values on students. Participant 10 described

> "I have my own personal passion because it's about me and my life and the people I love, personally, which then, because it's a marginalized experience, becomes political, which also gives me more passion to fight for justice. And then I bring that into my work, cause that's just who I am, and that's how I do it. And so, I think part of the grappling is like, I can't force that on other people."

Most participants described their teaching as focused on helping students understand that their professional values were to provide dignfied and compassionate healthcare that LGBTQIA+ people need. This translate into nursing educators focusing on how professional values trump any personal, cultural, or religious values students might hold. Participant 3 described,

> "…nursing, the care that we give being very much different than people's personal beliefs or politics, or whatever...if people exist, we have to care, we're caring for them like we care for all people, so we can't not teach about certain groups of people, that's unethical… we talk to them about also how in our nursing role, you have to kind of, for some of you, you might have to sort yourself into boxes at times, and you can have that political opinion, and that is fine, but right now, your job is to provide good healthcare."

While participants in this study emphasized the importance of not imposing their own values on students, it is worthwhile to remember that student attitudes are deeply influenced by the

attitudes of families and friends (Strong & Folse, 2015). While the participants recognized the need to address their own biases in order to skillfully teach LGBTQIA+ health, most participants were more hesitant to directly discuss the process of addressing bias. Some of this is tied to a lack of time or the right circumstances to facilitate longer and more complext conversations that are needed to address students bias. However, Participants 3 and 11 described that post simulation or clinical conferences provided a rare opportunity to address helping students understand how to navigate values in ways that highlight the need to address their biases, and create a new values way. These conversations were described as influential on students when they had the opportunity to have them, but they did not occur when teaching every course.

By *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes to Improve Teaching*, participants hoped that skillfully teaching LGTBQIA+ health gave their students the practical skills needed to provide dignified and compassionate care, and they hoped that care rippled out beyond their students. Participant 9 described the work she does in nursing education as similar to the butterfly effect, where the movement of the butterfly's wings make ripples of change, she was making change in each cohort of nursing students.

In summary, *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes in Teaching* describes the process of taking the changes that occur through *Doing the Internal Work by Addressing Your Biases,* and *Integrating Professional and Personal Values to Create a New Values Way* and employ them in their teaching. This process often occurred because the processes of having addressed their biases and navigated their personal and professional values highlighted gaps in how and what they were teaching. Participants described adjusting how they framed topics in order to reduce stigma and bias, often by being sure to use the correct language. Participants also described framing LGBTQIA+ health as "nonheteronormative", and

"regularizing" LGBTQIA+ people and their healthcare needs. This framing shows how these participants wove the concepts related to LGBTQIA+ health throughout everything they teach by reducing the use of norms and othering in their teaching. Most participants described feeling that including LGBTQIA+ health fulfills a purpose for them, brings them joy, and they hope how and what they teach will ripple out beyond them and their students.

Reflexive notes regarding this theme focused on the emotional impact of teaching that participants discussed and how that seemed to be a reflection of their commitment to advancing health equity for LGBTQI+ people. This commtiment to action and evidence of follow through was seen by study team members as one of the shining lights of positivity in the data. Another shining light that was noted by study team members was how some cisgender heterosexual faculty use some of their privilege to support LGTQIA+ people.

Conceptual Model

Through these interviews, participants described a teaching process outside of the norm for nursing education. Participants described needing to address their own biases and how they understood the emotional impact on themselves of teaching LGBTQIA+ health. With approaches to teaching that took on a different form and process than typical nursing education, what participants described can best be understood as *Queering Teaching*. Black, Queer, and Feminist scholar bell hooks elucidates that queerness is not only about an individual's sex, gender identity, or sexuality, but as a way of being that is at odds with everything around you, which leaves people with the need to create and invent a space to exist and thrive in (bell hooks, 2014). Queer theory also illuminates the experience of areas of tension with the world around queer people, where beingness is outside of social norms. In this way, *Queering Teaching* can be seen as a way of being that is at odds with the typical experience of nursing education.

Several participants declared that this experience is different from any other type of teaching they have done. Specifically, most participants described how teaching LGBTQIA+ health affected them emotionally: ranging from joy and fulfilling a sense of purpose, to fear and feelings of imposter syndrome. Participant 5's face lit up when she described what it's like for her to teach LGBTQIA+ health,

> "I love it. I look forward to it. Every semester I feel excited to share those thoughts with the class. I always hope that it matters…I'm excited to do it, I wish I got to do it more."

Participant 7 described the impact and motivation for teaching,

> "I was in the hospital setting, and somebody would come in with a same sex partner, or somebody would come in identifying differently, and we all know that what nurses talk about in the nurses station is not very friendly to patients, and hearing that would just like rub me the wrong way and be like we have to make sure the new generation of nurses is not continuing this…"

Another way that this teaching is queer relates to the way that inclusion is driven by personal connections that drew participants to this teaching. Most participants decided to teach LGBTQIA+ health due to being, or closely knowing someone, who is LGBTQIA+ identified. Most often this started to occur as participants recognized the impact of biased thinking on themselves, through their own process of coming out, or through witnessing the experiences of LGBTQIA+ family or friends. Having a personal connection was the most common reason participants chose to include LGBTQIA+ health in their teaching, including taking on the extra work and effort required to do that. While nurse educators often focus on areas of passion in their teaching, it is rare for a content area to be so dependent on personal, familial, or friendship

identities. Participants that were LGBTQIA+ identified themselves described experiencing discrimination and bias from healthcare providers which fueled their desire to competently include LGBTQIA+ health in their own teaching. Participant 13 stated, “Having had to walk the walk. Having experienced stigma when trying to navigate care for myself or my loved ones.”

An additional layer of how queer teaching LGBTQIA+ health relates to the impact of teaching for LGBTQIA+ identified participants. Three of the four LGBTQIA+ identified participants described feeling the harmful emotional impact of negative experiences during teaching. A non-binary participant described the three to four comments they get every semester that are homophobic or transphobic. They described both the personal cost of those comments, as well as the institutional cost, noting their concern related to lower quantitative ratings on end-of-semester teaching evaluations based on students’ discriminatory attitudes. Each semester, this participant noted having to navigate the decision of keeping or deleting those comments, which was only possible after a laborious process. If they deleted the comments, they would lose important context to situate lower quantitative scores on their teaching evaluations. This participant additionally described how they were assigned a co-teacher in a course they were more than prepared to teach alone due to student pushback to their visible queerness.

The themes are interdependent and represent various pathways into and on the journey toward comfort and competence in teaching LGBTQIA+ health. Most participants described the process of addressing their biases having started in the past, at various provocations of experiencing or witnessing bias by others impacting them or people they love. Addressing bias is also described as on ongoing and lifelong process that fed back into integrating participant values, which resulted in changes to their teaching. It is possible for participants to start the process at integrating values, as highlighted by Participant 14. She found she needed to start the

process of addressing her bias after recognizing a conflict between her personal and religious values and her professional values that was provoked by the content she was assigned to teach. While her entering pathway was different, the result was the same. She needed to address her biases to find a pathway toward integrating her values, which she then applied to her teaching. The relationships of the three themes are visualized operating in a counterclockwise manner, which is a queering of the typical visual representation of conceptual models. This represents another way the energy of this process as different than typical processes discussed in nursing education literature.

In this way, *Queering Teaching* represents the outcome of the interdependent and continuous processes of *Doing the Internal Work by Addressing One's Bias, Integrating Professional and Personal Values to Create a New Values Way,* and *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes in Teaching.* Figure 1 depicts these three thematic processes surrounding the central process of *Queering Teaching.* Each of the three thematic processes are interdependent on each other, and also in continuous relationship with each other. Additionally, these processes are in a continuous relationship with *Queering Teaching*, where all three processes inform the central process, and the central process informs the outer three, both individually, and on a collective level. Additionally, supports and challenges are represented as forces that limit or are helpful to the ability to teach LGBTQIA+ health.

Multi-Level Supports and Challenges for Teaching LGBTQIA+ Health Supports for Teaching LGBTQIA+ Health

Participants described supports to this process of Queering Teaching. These supports occurred at structural, institutional, interpersonal, and personal levels, but the structural level had a significant impact on this study. Participants described important structural supports occurring

through nursing professional values that highlight the need to provide dignified and compassionate care for all people, which was crucial to *Integrating Professional and Personal Values to Create a New Values Way*. Most also described the importance of the newest AACN Essentials as being crucial to teaching LGBTQIA+ health (American Association of Colleges of Nursing, 2021). Participants described that knowing the expectations for nursing education included concepts like diversity, equity, and inclusion (DEI), health equity, and social determinants of health was an important source of support. Participant 14 put it like this

> “when you're looking at the new essentials…DEI is one of the eight concepts, as are social determinants of health. I mean, those are two that they are calling out that should be embedded all the way throughout.”

Another participant leaned on the support of their school’s Dean of Diversity, Equity, and Inclusion, highlighting how important it is for people to have structural support focused on diverse identities and experiences.

Participant 14’s experience highlights the importance of structural and institutional support for including LGBTQIA+ health in nursing education. As described elsewhere, she was assigned to include a transgender youth in her course through a curriculum wide revision that was driven by the AACN Essentials. She additionally described how there is very little pushback from the students to using pronouns and asking who was in the room during a birth simulation, as the hospital associated with their academic center had very consistent guidelines for all staff, including nursing students in clinicals. Those guidelines included that all staff and students would consistently use their own pronouns, would ask about patients’ pronouns, and ask who is in the room with the patient, without making assumptions. These two scenarios highlight how radically institutional expectations can alter teaching and practice. An additional description of

institutional support was described by Participant 12, who explained their school is attempting to integrate LGBTQIA+ health topics across the curriculum by teaching content where it applies which diversifies how the content is taught and who is included in those modules. He described a small team of faculty members at his school using the Tool for Assessing LGBTQIA+ Health Teaching (TALHT) to revise their curriculum and then surveying students for changes in knowledge and attitudes (Sherman et al., 2022).

Participants described interpersonal support mostly through relationships. Participants described those relationships as occurring with fellow faculty, with faculty from other parts of their colleges, and with friends or family members that were LGBTQIA+ identified. Interpersonal support was described as having people to support you during the difficulties associated with teaching LGBTQIA+ health. Participant 14 described partnering with a co-teacher from her University's LGBTQ center to support her teaching, as she knew she was not an expert. The LGBTQIA+ identified participants almost all described support from relationships as a crucial component of their ability to effectively teach. Participant 13, who described themselves as visibly queer, discussed needing to have a co-teacher for a class that included LGBTQIA+ health content in order to disrupt stigma or discrimination from students.

Participants described personal support most often in terms of their commitment to including LGBTQIA+ health, their personal identities, and their ways of viewing the world. This level of support was described as important to their improved comfort and competence when teaching LGBTQIA+ health. Most often this personal support was tied back to the process of addressing their biases.

Challenges to Teaching LGBTQIA+ Health

Participants were asked about broad challenges to including LGBTQIA+ health, as well

as more specific barriers. Some participants used challenge and barrier interchangeably in their responses. However, Participant 14 had an insightful way of viewing challenges and barriers, stating that barriers stop you from doing something, and the issues she presented were challenges to be overcome, but not barriers. Challenges to this process of *Queering Teaching* were described at all levels, but again, the structural level had a significant impact for these participants. The most common structural challenge cited was lack of nursing-specific resources. Participants described spending a significant amount of time on finding appropriate resources, sometimes resorting to creating their own out of necessity. An additional structural barrier that almost every participant mentioned was time. Nursing education is known to be a content heavy curriculum. There is a lot of content-based knowledge that students need to learn before they can apply it to practice. Additionally, the resources needed for inclusion are not readily available, so individuals are left to figure it out on their own, recreating the same wheel over and over. Also, competence in this field, for practicing nurses as well as for nurse educators, is not well defined. As reviewed in Chapter 2, the literature on inclusion of LGBTQIA+ health in nursing education is inconsistent, and competence is rarely directly defined, if it is used at all. In the literature, what is measured most often relates to attitudes and knowledge, with very little focus on skills, and most assessments of skill occur through self-report versus a verifiable and objective measurement.

Participant 10 outlined competence very specifically as knowing enough background information on LGBTQIA+ identified people's bodies, experiences, and behaviors to know how to ask the right questions at the right time. She also described the importance of knowing your own biases, as she stated here

> “I think for nurse educators it starts with the implicit bias stuff, I mean, you know, cause most people are not going to be prescribing hormones or you know, consenting someone for a vaginoplasty or like whatever they're gonna be taking care of a trans person who just had an appendectomy, or someone who is coming in as a parent, you know, a lesbian couple with a kid who needs vaccine or something. Like, that's where 90% of 95% of people are going to be practicing and so competence means understanding implicit bias, understanding the basics about language, understanding the basics about, I think the impact for trans people, the impact that the gender affirming procedures have on people's bodies. And where does that actually influence everything else in healthcare? And where does it not… And then also, before all of that is the cultural safety and the language and identities. How do you use people's pronouns correctly. What's important to ask people in that context versus not like it isn't really important for a nurse in an emergency setting to like, understand the intricacies of someone's identity.”

In the current model of teaching LGBTQIA+ health inclusion relies on personal connection or passion and what is included is scattershot and inconsistent across curriculum and schools, which is an institutional level challenge. An additional issue arose for one participant that taught in a highly politicized state. That participant described a constant fear of losing their job by including LGBTQIA+ health. Their approach to inclusion was unique, as they had to keep a constant eye on their intentionality and needing to assess the applicability for including LGBTQIA+ health in each instance. Even that participant did not describe this level of external pressure as a barrier, but rather as a part of the process to including LGBTQIA+ health, which

they viewed as crucial to better preparing nurses to practice in today's world. An additional institutional challenge were focused on the lack of time due to many competing priorities at the University or College level. These priorities include research and service obligations that almost all faculty had to include time for, which put pressure on the time needed to find or create resources for including LGBTQIA+ health.

Interpersonal challenges focused on the interactions participants had with faculty peers. This level of impact was felt by LGBTQIA+ identified participants. One participant who identifies as non-binary stated that most fellow faculty do not use their pronouns consistently. Another participant who identifies as bisexual noted that she was often asked to guest lecture on LGBTQIA+ health, even though this is not her area of expertise, it is her lived experience that brought her to this teaching. This participant also noted that they often felt imposter syndrome when teaching LGBTQIA+ health. Feeling that sense of imposter syndrome may be related to the general lack of visibility or acceptance of bisexual people in the LGBTQIA+ community more broadly (Velasco et al., 2024). In the realm of personal level challenges, some participants noted that fear of saying the wrong thing, or inadvertently hurting a patient or student.

In summary, supports and challenges to including LGBTQIA+ health occurred at multiple levels, including structural, institutional, interpersonal, and personal. However, for both supports and challenges, the structural level had the most impact on the process for participants. Participants described challenges throughout the process, but these challenges were never construed as a reason to not teach LGBTQIA+ health. Participants universally reported that teaching this content comfortably and competently was important enough to them that the challenges are just part of the process. Many participants expressed the need for structural

support in the form of well-designed and updated materials that are specific to nursing education and care.

Chapter 5: Discussion

Introduction

Queering Teaching describes a process that nurse educators have taken in order to feel comfortable and competent when teaching LGBTQIA+ health. *Queering Teaching* is informed by three additional interconnected processes, *Doing the Internal Work by Addressing Your Biases, Integrating Professional and Personal Values to Create a New Values Way, and Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes in Teaching*. These processes describe what occurs on the journey towards comfort and competence, and center on the central process of *Queering Teaching.*

Another key facet of *Queering Teaching* was participants' recognition of their biases regarding LGBTQIA+ people through the process of *Doing the Internal Work by Addressing Your Biases*. These biases are created and reinforced through the use of social norms that categorize LGBTIQ+ people as "other." In turn, powerful institutions make decisions about access to resources based on who is inside the norm. Every participant described addressing their biases as a key component of comfort and competence in LGBTQIA+ teaching. Participants recognized that there are cultural and religious beliefs that impact personal beliefs about LGBTQIA+ people. These beliefs are often the basis of feelings and attitudes, which are deeply impactful in nursing care for any marginalized group. As described in the section on stigma and marginalization of LGBTQIA+ people, all levels of the Social Ecological Model of Health impact these populations through the use of binary sex, gender, and sexuality norms. Those binary norms are applied through levels of the SEM, and directly impact LGBTQIA+ people's health, leading to a multitude of health inequities. Participants were very clear that they needed to understand their own attitudes and feelings toward LGBTQIA+ people, and then work to

adjust those attitudes that are stigmatizing. The process of *Doing the Internal Work by Addressing Your Bias* describes a lifelong and ongoing process that participants felt was the key to adjusting stigmatizing attitudes.

In *Integrating Professional and Personal Values to Create a New Values Way,* participants described the process of navigating the differences in their cultural, personal, and sometimes religious values and their professional values. Nursing professional values dictate that nurses provide dignified and compassionate healthcare that is needed for all people, regardless of who they are. This value is a cornerstone of nursing care and is often communicated as “Nurses take care of everyone equally”(van der Cingel & Brouwer, 2021). Participants in this study discussed their process of finding ways to integrate their values so they were not in conflict. Most participants found that their cultural, personal, and often religious values did not conflict with providing and even advocating for the dignified, compassionate, and needed healthcare of LGBTQIA+ people. Thus, their integration of values focused on the values themselves, to recognize how they support and are in alignment with each other. For a few participants, addressing their biases led them to the point that they no longer saw LGBTQIA+ people as different than themselves. This is a critical point of Queering Teaching, as the ongoing processes of *Doing the Internal Work by Addressing Your Biases* and *Integrating Professional and Personal Values to Create a New Values Way* can produce a force great enough to disrupt the gears of norms, othering, and power in nursing faculty. There is also significant potential to disrupt those gears for nursing students if nursing educators find a way to encourage students to address their bias and integrate their values through the process of professional nursing identity development.

In *Applying it All to Teaching by Using New Knowledge, Skills, and Attitudes in Teaching*, participants described how those processes of D*oing the internal Work by Addressing Your Biases* and *Integrating Professional and Personal Values to Create a New Values Way* led them to recognize gaps in their own teaching of LGBTQIA+ health. Participants described that through this process they realized their teaching needed adjustment. For most participants this focused on using the correct language when discussing LGBTQIA+ health. A few participants also discussed the elements of basic competence for nurses to provide compassionate and affirming care. One participant laid out the differences between basic and expert competence. Basic competence was seen as having enough background knowledge of LGBTQIA+ people's lives, bodies, and behaviors to communicate and assess healthcare needs in an affirming manner. Some participants continued this process and applied their improved teaching to other courses through guest lectures. A few participants extended their awareness of gaps in teaching LGBTQIA+ health to the entire curriculum of their school.

Connections to Previous Literature

The results of this study are consistent with previous research that has documented significant challenges to teaching LGBTQIA+ health. Similar to what participants described in the present study, a nationwide study of nursing faculty by Marsh et al., (2022) found that the most influential negative factors on the decision to include LGBTQIA+ health were feeling a lack of competence, and not having sufficient knowledge of LGBTQIA+ health topics. Participants in the present study reported how it would be helpful to have resources, a finding echoed by participants in Marsh, et al., (2022) who reported being more likely to teach if they had a course on how to include topics, if there were readily available resources to use, and if there was more time in the curriculum (Marsh et al., 2022). This lack of resources and

preparation was also found in Hodges et al., (2021), where faculty from US Southeastern states reported not feeling adequately prepared or competent to include LGBTQIA+ health. That study consistently found that 30-40% of faculty did not have the necessary understanding, knowledge, or training to comfortably and competently include LGBTQIA+ health, and only two participants had ever received formal training on how to include LGBTQIA+ health (Hodges et al., 2021). In a systematic review of nurse faculty preparedness to include LGBTQIA+ health, the authors found that there were only four reports of research on nurse faculty with a search conducted between 2000 and mid-2020, but the most recent article was from 2017 (Moore et al., 2023). That study also reported similar findings from the present study that there is little formal training on LGBTQIA+ health, or training on how to incorporate content into their teaching. Also echoing results in this study, this review found that barriers focused on feeling discomfort with the subject, not having appropriate teaching materials, time constraints, thinking LGBTQIA+ health is less important than other topics, and that there are no questions on the NCLEX regarding LGBTQIA+ people.

The influence of religious beliefs in this study is undeniable. Previous literature has shown the impact of religion, and particularly conservative religious beliefs on LGBTQIA+ people. As described by Mink et al., (Mink et al., 2014) spiritual health is an crucial component of holistic health. This paper also notes that many mainstream Western religions, especially those with a more conservative orientation continue to be intolerant of and condemn LGBTQIA+ people (Mink et al., 2014). In the past several years this condemnation of LGBTQIA+ people, and particularly transgender people, has been a cornerstone of Christian Nationalism (Bjork-James, 2019). The emergence of such strong opposition, even to the point of vitriolic hate, toward LGBTQIA+ people adds significant stigma in some parts of our culture. Having such a

prominent public conversation on the details of gender affirming care adds complexity to the existing need to introduce content on LGBTQIA+ health in a skillful manner that emphasizes nursing's professional values. An international review of the literature on the impact of religion on healthcare and social service providers and students found that many students and professionals with religious beliefs have negative attitudes about LGBTQIA+ people (Westwood, 2022). This effect was magnified by the degree of religiosity, with people who are highly identified with their religion being more likely to have negative attitudes. The one study in the review focused on nurse faculty also found that Muslim and evangelical Christian nurse faculty held more negative attitudes about LGBTQIA+ people, and that effect was compounded by religiosity (Sirota, 2013).

This ties to the findings of this study, particularly the process of *Integrating Professional and Personal Values to Create a New Values Way.* For one participant in this study who identified as a conservative Christian, the importance of navigating her religiously informed personal values regarding healthcare for transgender people was crucial to her success in comfortably and competently teaching LGBTQIA+ health. She highlighted the need to be very clear that her personal and professional values aligned on providing compassionate and dignified care to transgender people; even if her religious values generally held that LGBTQIA+ people are sinners if they practice their sexuality or seek healthcare to create a body that matches their gender identity. However, spotlighting that religious beliefs are variable, even within Christianity, another participant described how she wrestled with her Christian beliefs for much of her life, and now discusses the importance of providing "just and therapeutic care" as important to both her religious and professional values.

Linking to previous literature on teaching the care of transgender individuals, a few participants struggled to use pronouns correctly when describing transgender individuals (McDowell & Bower, 2016). It seemed that several participants were more comfortable with discussing diversity in sexuality, (e.g., lesbian and gay people), but they struggled with discussing diversity in gender (e.g., transgender people). This might relate to the experience of social change in the US over the last 20 years, where there is now broad social acceptance of diversity of sexuality, but a push toward acceptance of gender diversity has received significant political pushback (Burke, 2023; Lavietes & Ramos, 2022). That political pushback is a clear example of the use of power by states and nations to maintain cultural norms and other LGBTQIA+ people. Another participant in this study taught in a state that was actively pursuing anti DEI and LGBTQIA+ legislation that extended into scrutiny of teaching at the University level. She described needing to justify her inclusion of LGBTQIA+ health to her Dean and needing to insert language in her syllabus that warned students that they may address "sensitive topics" in this course. While this level of politicization of topics was rare in this sample, it is likely that nursing faculty at Universities in many US Midwest and US Southern states may have to contend with this degree of politicization of teaching in the future, showcasing the importance of addressing this particular challenge.

This study adds important new knowledge to the field in several ways. The conceptual model that resulted from this study's findings, *Queering Teaching,* outlines the processes that nursing faculty took to feel more comfortable and competent to teach content on LGBTQIA+ health. Participants did not directly state that the biases they needed to address were created by institutions and structures utilizing norms to create othering by using their power to restrict access to resources and support. However, it was a part of the background of all the data, as if it

were so much a part of the process that it did not need to be said. This level of normalization of bias, and lack of attention to how bias is created and maintained is a significant issue in nursing education.

Additionally, in a systematic review conducted by Moore et al., (2023) the authors found that no reports of research included information on facilitators or support to including LGBTQIA+ health. The results of this study highlight important supports to including LGBTQIA+ health at structural, institutional, interpersonal, and personal levels. This study also adds important context to what makes it challenging to include LGBTQIA+ health in teaching. The three interconnected themes described in this study, representing a central process of *Queering Teaching*, make clear that developing comfort and competence in teaching LGBTQIA+ health is a journey that requires different processes than are typically needed in developing comfort and competence in other topics. This process takes time as well as significant and intentional attention and effort to address nurse faculty biases (Pitcher & Browne, 2023). This also requires nurse faculty to navigate perceived differences in their personal and professional values in a manner that is rarely seen in nurse education (Kaya & Boz, 2019). Additionally, this process requires a significant amount of time and effort to change the way faculty teach (Rojo et al., 2023). All participants highlighted the need to use correct language, as well as an affirming and compassionate approach to teaching LGBTQIA+ health. Rarely does nurse education require such careful attention to language and approach, but this study highlights that that level of attention should be applied when teaching about any marginalized population (Truong et al., 2022).

The results of this study also highlight a lack of structural support that would make inclusion of LGBTQIA+ health easier if it were readily available. Support could include

guidelines on what nursing schools should include in their curriculum regarding the health of LGBTQIA+ people, training on how to include relevant topics as well as affirming framing of topics, and a repository of up-to-date resources that are relevant to nursing practice and education. Having enough time to add additional content is an ongoing concern for nursing faculty, as the amount of content that must be included continues to expand alongside the complexity of nursing practice. The amount of content and the impact that it has on time in the curriculum is not a modifiable issue in and of itself. However, having access to training and resources to support faculty as they become more comfortable and competent in LGBTQIA+ health teaching would reduce the strain of the time it currently takes to find or create resources.

Additionally, the results of this study help shine a light on why nursing students' attitudes show little change after including LGBTQIA+ content. Attitudes are tightly connected to values, and this study highlighted the importance of the process of navigating values for participants. The process of *Integrating Professional and Personal Values to Create a New Values Way* requires significant time and resources to do well. Nursing education has the potential to start the process of changing attitudes, but attitude change will likely occur over the course of nurses' lives and may not show change on a short-term basis, particularly if the focus in nursing education is on improved knowledge or skills rather than on directly addressing bias. This ties into the most important addition of this study, a conceptual model that shows a process that has the potential to disrupt the gears of norms, othering, and power in nurse faculty, and how that disruption might spread to other faculty as well as the students they teach. This leads back to the guiding theory of this study, The Norm Critical Theory of Nursing Education (Figure 1), where the grinding of the gears of norms, othering, and power create a massive force that requires significant counter action (Nye et al., 2022). The process of *Doing the Internal Work by*

Addressing Your Biases allowed some participants to understand that they were utilizing binary cultural norms that then created a bias in themselves. To counteract norms, nursing education needs to emphasize the true diversity of human bodies, lives, and behaviors rather than utilizing concepts of a typical person or situation in any setting. This also requires nursing education to truly integrate this human diversity throughout the curriculum, rather than adding LGBTQIA+ health content as separate concept that in addition to traditional content or focusing on concepts of cultural competence. The process of *Integrating Professional and Personal Values to Create a New Values Way* unfolded for participants in a manner that had the potential to disrupt othering by emphasizing nursing's professional values related to providing dignified and compassionate care to all people. To counteract power, nursing education needs to directly address the impact of structural exclusion on marginalized people. Nursing education can do this by clearly identifying where exclusion from resources and support occurs, naming the impact on marginalized people, and highlighting avenues to disrupt this structural exclusion through advocacy and activism by nurses.

Implications

VERY STRONGLY saying Queering Teaching advocates for not just different material, or more time spent on content, but requires reshaping how we conceptualize teaching in nursing. Attitude change only occurs when we are explicit about and provide resources and support for bias work. Attitude change only occurs when we are explicit about and provide resources and support for values integration work.

The results of this study offer important insight into applications in research, education practice, and policy. The future of LGBTQIA+ health inclusion in nursing education needs to continue to address the needs of nursing faculty in becoming competent and comfortable. This

study offered the perspectives of US Midwest nurse faculty, but LGBTQIA+ people live everywhere on the planet, and all nurses need to be educated on their unique care needs. More research that examines the challenges and supports that nursing faculty face is needed from other areas of the US and the world. More research is needed to examine the processes nurse faculty use to become competent and comfortable in teaching LGBTQIA+ health. This should include the development of quantitative tools that can measure these concepts across nursing educators in many settings. More research is needed on the experience of faculty in addressing biases toward non normed groups in general, and LGBTQIA+ people in particular. This research should include more direct discussions of bias, and the impact of cultural norms. More research is needed on how The Norm Critical Theory of Nurse Education might be applied to teaching about marginalized populations, including LGBTQIA+ people. This research should include direct discussions of how norms are utilized in nursing education, as well as how power is used inside of nursing education to reinforce those norms through the process of othering.

In nursing education practice, there is an overwhelming need to create standards for training in LGBTQIA+ health for both nursing students and nursing faculty. These standards should utilize concepts of competence that are specific to LGBTQIA+ people, perhaps even using the overarching ideas of basic and expert competence presented in these results. These standards should be included in the AACN Essentials or some other governing document that makes it clear that all nursing schools should include teaching about LBBTQIA+ health.

Additionally, there is a need to diversify where and how LGBTQIA+ health is taught. LGBTQIA+ health looks different in reproductive care than it does in geriatrics, or oncology care. LGBTQIA+ people have the same care needs as other people, but are often only addressed in teaching about sexuality, reproduction, or mental health. A few participants in this study

focused on ways to infuse LGBTQIA+ health across the curriculum. A consistent and standard approach to including LGBTQIA+ health across the entire curriculum should be developed. This approach should include information on where and what content to include on LGBTQIA+ health, ways to address both student and faculty bias, and outcome measures of the impact of that inclusion. The Tool for Assessing LGBTQI+ Health Training (TALHT) in pre-licensure nursing curricula is an excellent tool to assess the incorporation of LGBTQIA+ health across the curriculum (Sherman et al., 2021, 2022).

Further, there are specific recommendations for policy. There are several national nursing education organizations, including the American Association of Colleges of Nursing, and the National League of Nursing. These national organizations are best situated to create training for nursing faculty on why, how, and where to incorporate LGBTQIA+ health content. These trainings should be freely available and should include access to both didactic content on LGBTQIA+ health content concepts, as well as opportunities for practice of teaching new content with the opportunity for feedback. There is also a need for an updated repository of resources for teaching LGBTQIA+ health. A lack of nursing specific education content on LGBTQIA+ health is a significant challenge for skillful inclusion. National nursing education organizations are best situated to create resources for inclusion across all nursing topics, as well as keep those resources up to date. Those resources should include both the impacts of stigma and marginalization on LGBTQIA+ people's health, and also stories of thriving and resilience that can counter the overwhelming negative messaging that is typically seen. Last, similar to the need for training on how to include LGBTQIA+ health content, these organizations should create training that provides both didactic content and opportunities to practice incorporating structural competence concepts into nursing education across all topic areas.

Limitations

This study has several limitations. First, this study was designed to capture the particular cultural milieu of the US Midwest. The US Midwest shares some common cultural backgrounds through patterns of migration and colonization in a similar timeframe that included waves of settler colonists from similar Upper Western European countries like Germany, Norway, and Ireland. These European countries share similarities in terms of race, ethnicity, and cultural values that are often deeply rooted in Christianity. This cultural milieu is significantly different from both the US Coastal regions, as well as the US South that it was important to capture the particular challenges that nursing educators face in the US Midwest. However, the implications of study findings are limited in their application to other US regions and other countries. Additionally, the study is limited by the type of knowledge generated. Last, this study is limited by the racial and ethnic similarities in identification of all participants. While this is a large portion of nurse faculty across the US, the lack of perspective from nursing faculty of color represents a limitation of the research.

Conclusion

This dissertation research study fills a significant gap in the literature on inclusion of LGBTQIA+ health in nursing education. This research illuminates a journey that nurse faculty have taken to be comfortable and competent with teaching LGBTQIA+ health. The conceptual model of *Queering Teaching* clarifies the interdependent and continuous processes needed to address bias, integrate values, and apply new knowledge, skills, and attitudes to teaching these topics.

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Figure 1: The Norm Critical Theory of Nursing Education

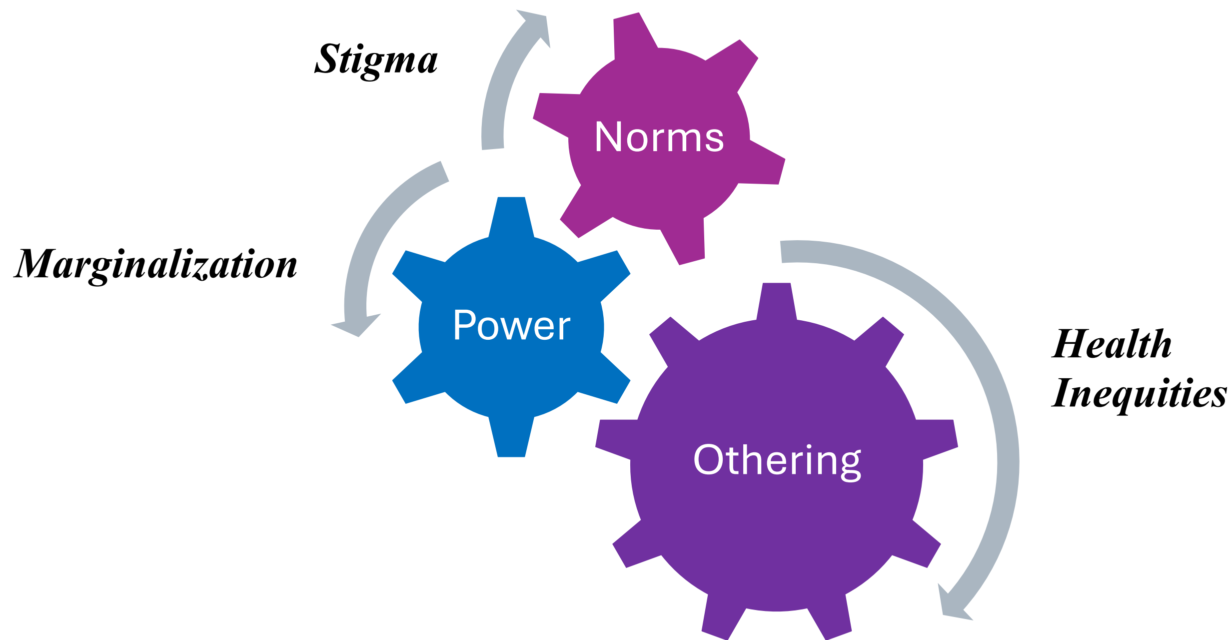


Table 1: Participant Demographics

Participant Demographics

Race	
White	12
Caucasian	1
Prefer not to answer	1

Sex	
Female	12
Male	1
Prefer not to answer	1

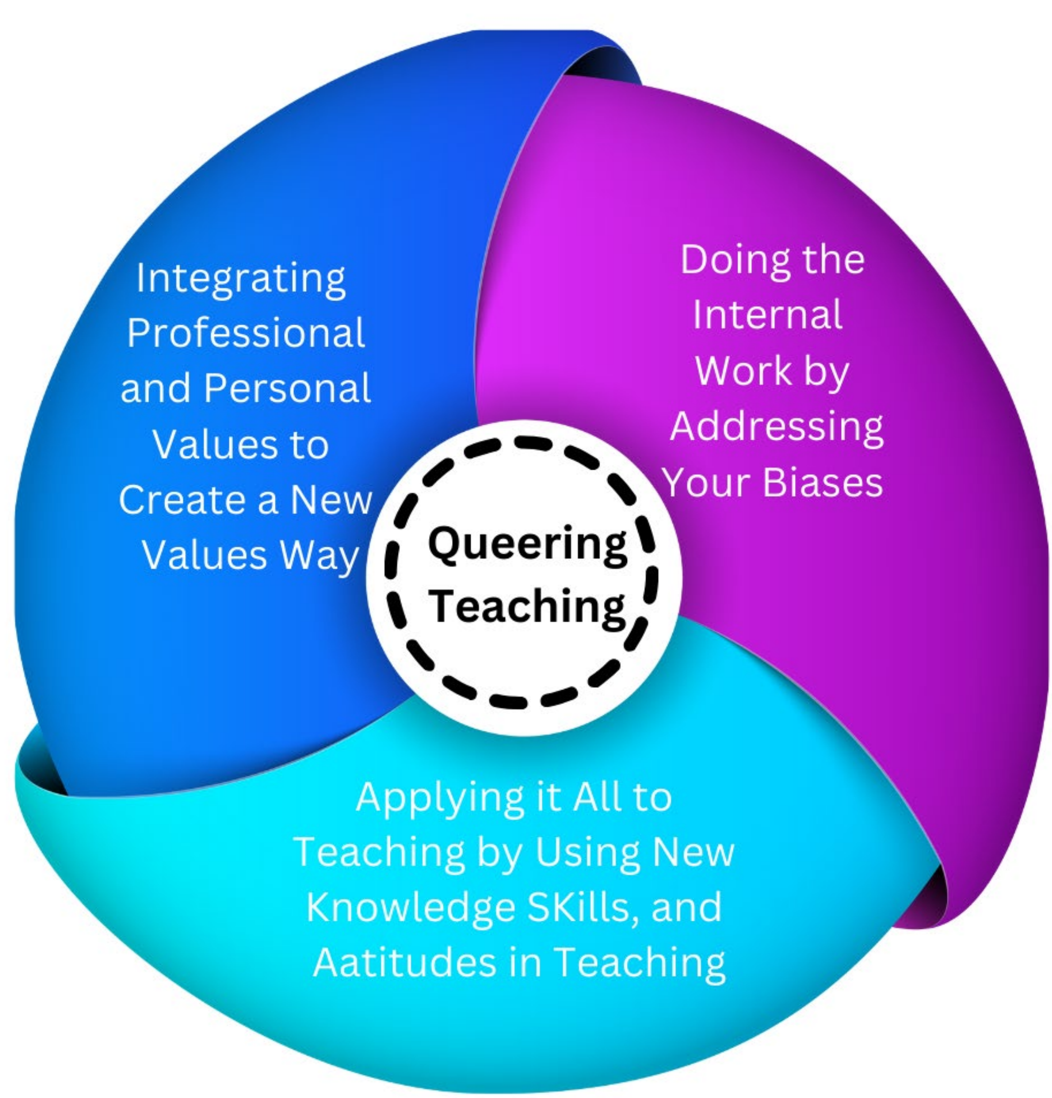
Ethnicity	
Not Hispanic	5
White	2
European	2
German/Scandinavian	1
White, Northern European	1
Northern European	1
Non-Hispanic, German, Czech	1
White settler of Irish/European ancestry	1
It's a mixed bag	1
Prefer not to answer	1
None	1

Sexuality	
Heterosexual	8
Bisexual	2
Queer	2
"Cysgender"	1
Area of Nursing Specialty	1

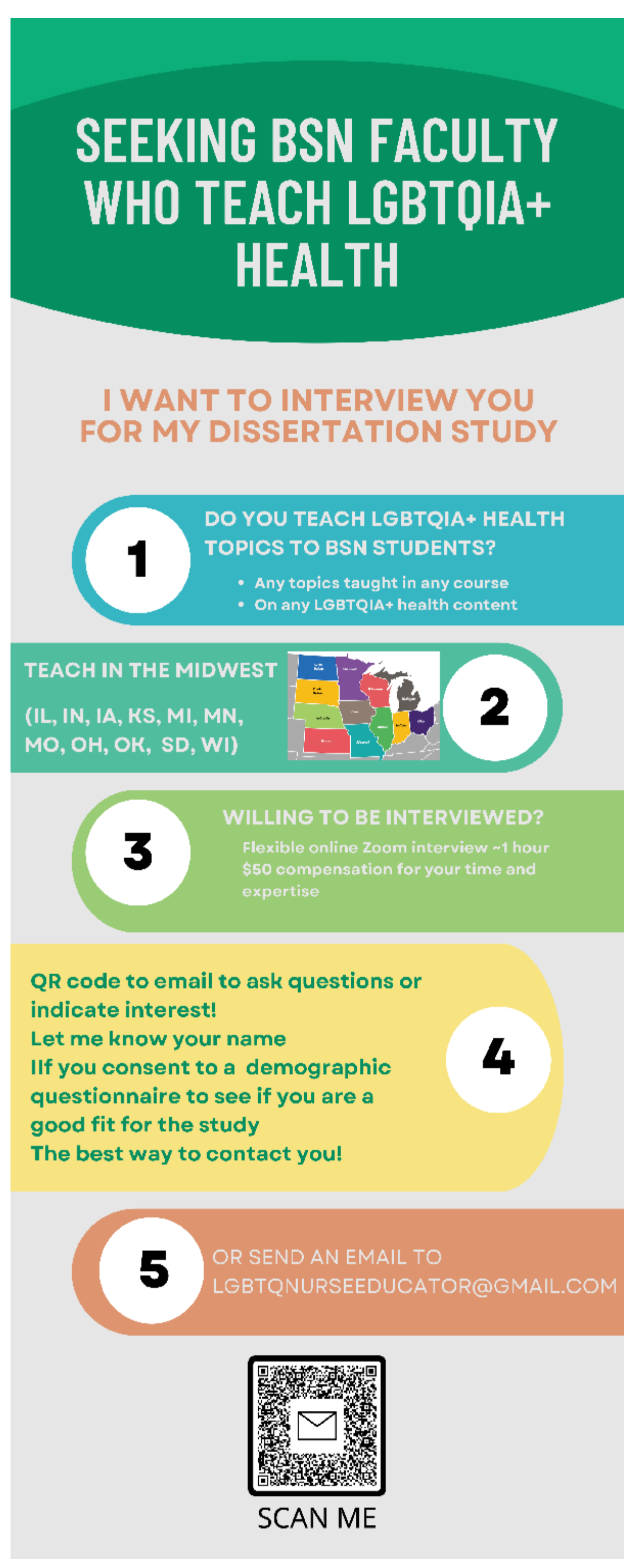
Table 2: Where content is taught

Course taught in	Number of Participants	Course taught in	Number of Participants
Introduction to Nursing Fundamentals	1	Obstetric care	1
Public Health/Population Health	3	Maternity	2
Health Promotion	1	Nursing and Society	1
Mental Health	4	Medical Surgical Nursing	1
Health Assessment	1	Human Sexuality	1
Cultural Diversity in Health Care	1	Professional Development	1

Figure 2: Queering Teaching Model



Appendix 1: Recruitment Flyer



Appendix 2: Demographic Questionnaire

We'd like to ask you for some basic demographic information that will help us determine if you are a good fit for the study. We ask about what state and school you teach nursing, your background and experience with nursing education, your race and ethnicity, and questions about your sex, gender, and sexuality, in order to ensure a variety of perspectives. If you consent to answer these questions to be considered for this study, please press the YES button below. Answering NO will take you to the end of the survey with no information gathered from you, but there is an opportunity to ask any questions regarding the survey. Thank you for your time!

1) What state do you teach nursing in? (Drop down menu of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin). No selection takes them to the last page to ask questions.
2) How long have you been a nurse educator?
3) What is the highest degree you have earned?
4) What is your race? (Fill in option to offer the language people use about their race)
5) What is your ethnicity? (Fill in option to offer the language people use about their ethnicity)
6) What is your sex assigned at birth? (Fill in option to offer the language people use about their sex)
7) What is your gender identity? (Fill in option to offer the language people use about their gender)
8) What is your sexuality? (Fill in option to offer the language people use about their sexuality)

What is the best way for us to contact you? If you prefer email, we suggest you use a personal email address that is not associated with your employer, in order for us to best protect your confidentiality. You can also give us a phone number to call or text, with the best days and times to reach you.

Appendix 3: Interview Protocol

The main questions you will be asked (along with follow-up questions not listed here):

1. Tell me about what LGBTQIA+ health topics you teach.
    - Where do you include topics?
    - What strategies do you use to include topics?
    - Have you met any resistance when including topics?
        - From students? Peers? Leadership in School or University?
2. What is it like for you to teach LGBTQIA+ health topics?
3. What do you see as the challenges to teaching LGBTQIA+ health?
    - Any issues with deciding what, how and why to teach for your courses?
    - Are there issues across the curriculum?
4. What do you think supports or facilitates your ability to include LGBTQIA+ health in your teaching?
    - Where do you find resources and support when needed?
    - What has worked well with students?
    - What has not worked as well with students?
5. What do you think are barriers or issues that make LGBTQIA+ health inclusion more difficult?
6. This is our last question for today. Do you have any tips or advice you would offer to other faculty who teach similar topics?