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**College of Health and Human Service Faculty's
Confidence and Inclusion of LGBTQ+ Health Content in Curriculum**

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Honors Thesis

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Abstract

In the health care system, those who identify as lesbian, gay, bisexual, transgender, queer, (LGBTQ+) face discrimination and health disparities. Students who are better prepared in higher education to provide care for this population have higher levels of confidence in LGBTQ+ health content than those who have less exposure. Therefore, faculty who teach curriculum related to health and wellness have an opportunity to prepare students to provide high quality, patient centered care by teaching culturally competent care that is inclusive of LGBTQ+ populations. The aim of the study is to determine whether the degree of confidence in teaching LGBTQ+ health content is related to the implementation of LGBTQ+ health content into health care faculty curriculum. Faculty from the University of New Hampshire College of Health and Human Services and Department of Psychology were surveyed to address the proposed research aim. The results were descriptive and correlational analyses. We found that there is statistically significant positive correlation between faculty's confidence of LGBTQ+ health content and their inclusion of this material in the curriculum ($r = .56$ & $r = .72$, $p < 0.05$). Our findings indicate that increasing confidence among faculty may increase their inclusion of the content in the curriculum.

Introduction

The lesbian, gay, bisexual, transgender, and queer (LGBTQ+) adult population face high rates of discrimination and inequities within the health care system (Casey et al., 2019). Previous surveys report that 16% of LGBQ respondents and 33% of transgender respondents reported discrimination when seeking clinical care (Casey et al., 2019; James et al., 2016). This is important because 18% of LGBQ participants and 22% of transgender participants reported avoiding health care due to anticipated discrimination by providers (Casey et al., 2019; James et al., 2016). In a national survey, over 55% of transgender respondents reported being denied insurance coverage for transition-related surgery (James et al., 2016). Historically, it was not until 1987 that homosexuality was no longer pathologized within the Diagnostic and Statistical Manual of Mental Disorders (DSM; Drescher, 2015); it was not until 2013 that efforts were made to destigmatize transgender people in the DSM by replacing “gender identity disorder” with “gender dysphoria” (Drescher, 2014). However, these stigmas toward LGBTQ+ and inequalities persist in health care settings (Casey et al., 2019; James et al., 2016). Therefore, it is important for students to understand the role of stigmatization towards the LGBTQ+ population and how it may impact the population’s experience within the health care system and their willingness to seek health care services.

The ongoing discrimination towards the LGBTQ+ community and subsequent avoidance of care due to the health care stigma contribute to health disparities within this population (Kcomt et al., 2020; Zeeman et al., 2019). Health disparities unique to the LGBTQ+ adult population include higher rates of substance use disorders, mental health disorders, and physical health problems than heterosexual and cisgender adults (Zeeman et al., 2019; Ruppert et al., 2020; Ruppert et al., 2021). The minority stress model suggests that the LGBTQ+ population

faces unique stressors such as discrimination, social stress, and internalized homophobia and transphobia that negatively impact this population's health outcomes (Meyer, 2003; Testa et al., 2015). Minority stress among the LGBTQ+ population is linked to negative impacts on physical health such as immune function, cardiovascular issues, and the development of cancer, diabetes, or chronic illnesses (Downing & Przedworski, 2018; Flentje et al., 2019). Minority stress is also associated with mental health outcomes and has been found to explain many of the disparities when compared to the general population (Rood et al., 2016; Puckett et al., 2016). Addressing minority stress to reduce health disparities is critical, as 40% of transgender respondents in a large national survey had attempted suicide in their lifetime, which is significantly higher than the 4.6% reported rate of the U.S. general population (James et al., 2016). A systematic review estimates that 11% of LGB adults have attempted suicide as reported in general population surveys (Hottes et al., 2016). The discrimination experienced by LGBTQ+ individuals in health care systems is an example of minority stress and should be addressed by health care professionals (Casey et al., 2019; James et al., 2016).

It is important to identify the confidence among students in health-related fields in treating members of the LGBTQ+ population. Among a study of dental, medical, and nursing students at a university, fewer than 50% of respondents felt their education had provided the tools they needed to feel comfortable when caring for LGBTQ+ patients in practice (Greene et al., 2018). To address this gap, a quality improvement project provided educational modules and panel discussions of LGBTQ+ health for health care providers (Felsenstein, 2018). After the intervention, participants reported greater feelings of preparedness to care for the LGBTQ+ population. Another study found that medical students who had experience caring for LGBTQ+ patients in clinical settings were more likely to ask screening questions and conduct assessments

about social and sexual history and were more knowledgeable of LGBTQ+ health matters than students with little to no exposure (Sanchez et al., 2006). Students in social work master's program did not feel confident or equipped to provide care to a LGBTQ+ client (Logie et al., 2015). It is important to better understand of health care faculty's ability to prepare students for caring for people who identify as LGBTQ+.

A systematic review identified a significant gap in LGBTQ+ education among health professionals in undergraduate programs (McCann & Brown, 2018). On average, only 2.12 hours of LGBTQ+ teaching is spent in an entire bachelor's nursing program of four years (Lim et al., 2015). In their most recent position statement on LGBTQ+ health, the American Nurses Association recommends that nursing program accreditors should begin to require LGBTQ+ health content in the curriculum (Stokes, 2019). The American Association of Colleges of Nurses outlines initiatives to teach students about the diverse populations' needs without specifying the LGBTQ+ population (Giddens et al., 2022). The Council on Social Work Education released a qualitative study to identify preparedness among students for caring for the LGBTQ+ population as part of their efforts to improve guidance for the social work field (Martin et al., 2009). However, to integrate curriculum on LGBTQ+ population health and health care needs, health care faculty should feel comfortable teaching LGBTQ+ health content in the curriculum (Sirota, 2013). Building upon the knowledge and attitudes of future health care professionals is an important step in beginning to minimize the health disparities among the LGBTQ+ population (Bonvicini, 2017). Currently, there is limited research evaluating what factors are associated with inclusion of LGBTQ+ health content among health care faculty who teach curriculum related to health and wellness.

Therefore, the aim of this study is to identify whether the degree of confidence in teaching LGBTQ+ health content is related to the implementation of this material into health care faculty's curriculum. We hypothesize that the greater faculty's confidence teaching LGBTQ+ health content will be associated with greater inclusion of LGBTQ+ health content in their curriculum.

Methods

A Qualtrics survey was developed to assess LGBTQ+ Curriculum in the College of Health and Human Services (CHHS) and psychology department at the University of New Hampshire (UNH). The survey took approximately 20 minutes to complete. Participants were provided with the following definition for LGBTQ+ terms used in the survey: "For the following questions, 'LGB' refers to people whose sexual orientation is other than heterosexual (including lesbian, gay, bisexual, pansexual, asexual, demisexual). The term 'transgender' refers to transgender women, transgender men, nonbinary, and genderqueer people. This study was approved (IRB #FY2022-243) after ethics review by the Institutional Review Board of UNH.

Recruitment and Procedures

Emails were sent out to faculty members in the CHHS and psychology department at UNH inviting them to participate in the study. Flyers were placed in campus buildings with a QR code and web address that directed participants to the survey. The consent form included the purpose of the study, inclusion criteria, description of the survey, risks of taking the survey, and confidentiality with participants indicating a yes or no response to voluntarily participate. If participants did not meet the inclusion criteria, they were excluded from continuing the survey (n=11). If participants indicated that they consented to the study, they were directed to the inclusion criteria screening questions. Inclusion criteria included: over 18 years old, a faculty

member in the CHHS or psychology departments and have taught a course related to health and wellbeing in the 2020-2021 and/or 2021-2022 academic year to continue with the survey.

Recruitment took place from March 4th to April 13th of 2022. Upon completion of the survey, there is a link to a webform for the respondent to enter their name and email to win a \$50 gift card. Identifying information was collected in the gift card entry, but not linked to participants' survey responses.

Measures

Demographics

Demographics included 20 questions that measured respondents' age, gender identity, race, ethnicity, and sexual orientation. Age was measured by ranges: <20, 20-29, 30-39, 40-49, and 50+ years old. Gender identity was measured using select all that apply options with the following choices: genderqueer/nonbinary, man, transgender man, transgender woman, woman, and an option to fill in a gender identity not listed. Race was measured using select all that apply options with the following choices: Asian or Asian American, Black or African American, Native American or Alaskan Native, White, and an option to fill in a race not listed. Sexual orientation was measured using select all that apply options with the following choices: bisexual/pansexual, lesbian/gay, heterosexual/straight, queer, and an option to fill in sexual orientation not listed. Ethnicity was measured for by asking, "do you identify as Latino or Hispanic," with a yes or no option. On each demographic question with multiple choice or select all that apply response there was the option to "prefer not to answer".

Faculty's Confidence of LGBTQ+ Health Content

The survey includes 10 questions related to confidence that were measured using a Likert-type scale. These items were adapted from Christensen et al. (2019), Parameshwaran et al.

(2017) and Shetty et al. (2016) so that each question involved inclusive, descriptive language. The items were duplicated to ask about faculty's confidence in LGB content and transgender content separately. Five of the questions asked about confidence regarding LGB health content and five of the questions asked about confidence regarding transgender health content. Examples of these questions can be found in Table 1. One of the LGB confidence questions, "I would be unsure what to do or say if I met someone who is openly LGB," was reverse coded to match the consistency of the range in which a score of 5 indicates lowest possible confidence and the score of 25 indicates highest possible confidence. One of the transgender confidence questions, "I would be unsure what to do or say if I met someone who is openly transgender," was reverse coded to match the consistency of the range consistency of the range in which a score of 5 indicates lowest possible confidence and the score of 25 indicates highest possible confidence. The results of this section were distributed into two separate variables used in our analyses (range: 5-25 for each variable).

Table 1. LGBTQ+ Confidence Survey Item Examples and Response Options

LGBTQ+ Confidence Question Examples	Response Options
I feel comfortable with the idea of teaching topics related to LGB people	For the following question, rate yourself on a scale of 1-5, 1 being strongly disagree, 2 as disagree, 3 as don't know, 4 as agree and 5 being strongly agree
How confident do you feel clarifying unfamiliar sexual orientation terms used by LGB clients	For the following question, rate yourself on a scale of 1-5, 1 being very unconfident, 2 as unconfident, 3 as neither unconfident or confident, 4 as confident, and 5 being very confident
I feel comfortable with the idea of teaching topics related to transgender people	For the following question, rate yourself on a scale of 1-5, 1 being strongly disagree, 2 as disagree, 3 as don't know, 4 as agree and 5 being strongly agree
How confident do you feel clarifying unfamiliar gender identity terms used by transgender clients	For the following question, rate yourself on a scale of 1-5, 1 being very unconfident, 2 as unconfident, 3 as neither unconfident or confident, 4 as confident, and 5 being very confident

Inclusion of LGBTQ+ Content in the Curriculum

The survey includes 22 questions related to inclusion of LGBTQ+ health content in the curriculum. These items were adapted from Lim et al. (2015) and separated into two categories with 11 related to the LGB population and 11 related to the transgender population. Refer to Table 2 for examples of the survey items and the Likert-type response options. These results were distributed into two separate variables used in our analyses (range: 11-55 for each variable). The score of 11 indicates the lowest possible inclusion with the score of 55 as the highest possible inclusion.

Table 2. LGBTQ+ Inclusion Survey Item Examples and Response Options

LGBTQ+ Inclusion Question Examples	Response Options
Access to early detection programs among LGB persons (e.g., HIV, cancer screening)	Frequency of LGB health-related topics taught in the last two years: 1= never, 2= seldom, 3= regularly, 4 = often, and 5= frequently
Access to early detection programs among transgender persons (e.g., HIV, cancer screening)	Frequency of transgender health-related topics taught in the last two years: 1= never, 2= seldom, 3= regularly, 4 = often, and 5= frequently

Analysis

Analysis of the data was completed using Stata software version 16.1 (Stata Corp, 2019). Descriptive statistics were used to summarize demographic characteristics and variables related to LGB confidence, transgender confidence, LGB inclusion, and transgender inclusion. The difference between 1) faculty's inclusion of LGB content versus transgender content and 2) faculty's confidence in LGB content versus transgender content was conducted using paired t-tests. The relationship between faculty's reported confidence of LGBTQ+ health content and inclusion of LGBTQ+ health content in the curriculum was analyzed using a Pearson correlation. Data is deemed statistically significant when $p < 0.05$.

Results

Demographics

A total of 24 participants were included in this study (Table 3). Within the sample, 29.2% identified as a sexual minority (LGB) person ($n = 7$). Most participants identified as women ($n = 19$). In terms of age, 41.7% of participants were 39 years old and under with 54.2% over 40 years old. White participants made up 100% of the sample, with 12.5% ($n = 3$) of this population identifying as white of Hispanic and/or Latino ethnicity. A total of 40.9% of participants were from the nursing department.

Table 3

Demographics (N= 24)	n (%)
<i>Age</i>	
20-29	3 (12.5)
30-39	7 (29.2)
40-49	8 (33.3)
50+	5 (20.8)
Prefer not to answer	1 (0.04)
<i>Gender Identity</i>	
Genderqueer/non-binary	1 (0.04)
Man	4 (16.7)
Woman	19 (79.2)
<i>Identify as member of sexual minority</i>	
Yes	7 (29.2)
No	17 (70.8)
<i>Race</i>	
White	24 (100)
<i>Latino/Hispanic</i>	
Yes	3 (12.5)
No	21 (87.5)

LGB and Transgender Confidence and Inclusion

Analysis using a paired t-test, revealed no statistically significant difference between LGB and transgender content confidence ($t(20) = -1.81, p > 0.05$). Similarly, there was no

statistically significant difference between LGB and transgender content inclusion ($t(20) = -0.73, p > 0.05$).

Relationship Between Confidence and Inclusion

The relationship between faculty's confidence and inclusion of LGB health content was positively correlated and moderately strong, ($r = .56, p < 0.05$, Table 4). The relationship between faculty's confidence and inclusion of transgender health content was positive and strong ($r = .72, p < 0.05$, Table 5). This indicates that as faculty's confidence of LGBTQ+ health content increases, faculty's inclusion of these topics tends to increase in the curriculum. Tables four and five describe the Pearson pairwise correlation analyses between the variables studied.

Table 4
Confidence and Inclusion Correlation of LGB Health Content

<i>Inclusion</i>	1.0000	
<i>Confidence</i>	0.5592	1.0000
<i>P value</i>	0.0084	
<i>Sample size</i>	21	

Table 5
Confidence and Inclusion Correlation of Transgender Health Content

<i>Inclusion</i>	1.0000	
<i>Confidence</i>	0.7194	1.0000
<i>P value</i>	0.0002	
<i>Sample size</i>	21	

Discussion

The LGBTQ+ population faces unique challenges and needs within the health care system (Ayhan et al., 2020). Unique needs of the LGBTQ+ population include access to early detection programs for illnesses and LGBTQ+ inclusive social support services including housing and transportation programs (Zajac & Godshall, 2020; Furness et al., 2020). Health care faculty who teach curriculum related to health and wellness have the responsibility to prepare students to provide affirming care in their profession. The purpose of this study was to identify whether the degree of confidence in teaching LGBTQ+ health content is related to the implementation of this material into health care faculty's curriculum. We found that as confidence of LGBTQ+ health content increases, inclusion of LGBTQ+ health content in the curriculum likely increases as well, for faculty in both the UNH CHHS and psychology departments. This indicates that increasing faculty's confidence surrounding this population may increase their inclusion of this content in the curriculum.

Existing research surrounding this topic has primarily focused on nursing departments rather than including multiple disciplines, as we have examined in this study (Eickhoff, 2021; Lim et al., 2015). A previous study found a positive correlation between the faculty's perceived importance of inclusion of this content and their readiness and comfort to teach it (Lim et al., 2021). This is important to keep in mind when considering factors that influence confidence. Most previous studies focus on the feeling of preparedness of students to care for LGBTQ+ individuals rather than the faculty's confidence in educating students about LGBTQ+ health content (Carabez et al., 2015; Christensen et al., 2019; Greene et al., 2018; Logie et al., 2015). It is important to study the faculty's confidence in educating students about LGBTQ+ health content and their inclusion of the material to see if changes need to be made to improve the curriculum to best prepare students.

Diversity within the faculty may contribute to the expansion of LGBTQ+ health content in the curriculum. For example, one study found that compared to their heterosexual faculty members, LGBTQ+ faculty reported higher rates of readiness and comfortability (*i.e.*, confidence) to teach and discuss LGBTQ+ health (Lim et al., 2015). This is important to note as almost one third of the respondents in our study identified as LGB and indicates that our sample likely has a skewed level of confidence and likelihood to include relevant content as opposed to what we would likely observe in a more representative sample of faculty. However, our sample lacks representation of transgender faculty, who experience higher rates of discrimination than the LGB population and could contribute to changes in the strength of our analyses (Casey et al., 2019; James et al., 2016).

Implications in Education

There are resources departments can use to improve confidence among faculty regarding LGBTQ+ health content and support its integration into the curriculum. For example, Lim et al. (2015) suggested that universities could incorporate seminar workshops led by LGBT health experts and advocates for improving faculty's understanding of the material. For example, a training program with the goal of changing the curriculum at a university has been shown to improve faculty's confidence in teaching about diversity (Booker & Campbell-Whatley, 2016). Barriers to inclusion of LGBTQ+ health content in the curriculum includes limited time, lack of guidance, and the content not being required for accreditation (Eickhoff, 2021; Lim et al., 2015). The recommendations from these studies provide greater support for national standards to be set by professional organizations to require and guide departments in making changes to the curriculum.

Universities should work with local and national LGBTQ+ organizations to develop resources for faculty to use in the curriculum. In a promising example, the Johns Hopkins School of Nursing developed an initiative comprised of subcommittees with the goal to train faculty and staff in LGBTQ+ health content, implement this content into the curriculum, and evaluate for effectiveness of the initiative (Sherman et al., 2021). Within this study, the university worked with LGBTQ+ community members and those who serve the LGBTQ+ population to build representative subcommittees to implement the aims (Sherman et al., 2021). This is important for uplifting the voices of LGBTQ+ community members who have unique perspectives, experiences, and knowledge of the health care system. There are online resources such as Lavender Health LGBTQ+ Resource Center and the Gay and Lesbian Medical Association which provide educational resources regarding LGBTQ+ health care (*Resources*, 2014; *Health Profession Education*, 2022). Faculty can be encouraged to use these tools and engage in educating themselves on the material prior to including it in the curriculum. During training sessions for faculty, their confidence of LGBTQ+ health content should be assessed prior to and after completing trainings to identify the significance of these sessions.

There are recommendations from previous research to guide health care faculty in bringing LGBTQ+ health content into the classroom. For example, Grosz et al. (2017) evaluated a student led informational session in which fourth year medical students educated first year students regarding this material using presentations, patient led panels, and small group case study discussion. This was found to significantly improve the confidence and knowledge of caring for the LGBTQ+ population. At UNH, Safe Zones is a club that holds panel discussion training led by members of the LGBTQ+ community to inform students on the experiences and challenges faced by this population (*UNH Safe Zones*, 2016). Professors can request training

sessions by Safe Zones with the focus being on health care to stimulate insightful conversations in the classroom. Simulations and mock interviews allow students to apply their understanding of material into practice, which has shown to improve health care students' confidence regarding LGBTQ+ health content (McCave et al., 2019; Englund et al., 2019).

Limitations

There are several limitations to this study. The data was collected using voluntary response sample which can contribute to biased results. Participants who have interest in or feel strongly about the topic may be more likely to take the survey, contributing to the skewedness of the responses. Non-response bias is also a consideration because this study surrounds a timely social issue and the description of the survey during recruitment may prevent people who are not interested in this issue, or who have strongly negative attitudes toward LGBTQ+ people or their relevance to curriculum, from responding. Possible solutions to this limitation include developing additional recruitment techniques and focusing the survey description on curriculum improvement rather than highlighting LGBTQ+ health care specifically. Additional strategies could include speaking at department meetings and delivering individualized invitations to the survey to faculty offices.

It is also important to note that the sample size of 21 respondents is small and could impact the results. This sample size increases the sampling error which could lead to the possibility of coming to a false conclusion (Faber & Fonseca, 2014). In terms of demographics, this sample lacks diversity in race, gender identity, ethnicity, and distribution of departments. If there was more diversity within this sample, we could begin to look at how faculty's background impacts their confidence and inclusion of this material. It is important to keep in mind that 40.9% of participants were from the nursing department when generalizing the results to health care

faculty in different departments. The departments in CHHS/psychology could have had different training and resources than one another that address LGBTQ+ health content which may contribute to the results.

Future Directions

Future directions in this area of study involve researching curriculum changes as LGBTQ+ content is incorporated into university curriculum. It is important that while implementing this material, health care faculty do not pathologize sexual and gender minorities. Therefore, future research is needed on inclusive LGBTQ+ health content resources to incorporate into the material. Once the curriculum is updated, student's confidence and knowledge of this content and preparedness to work with LGBTQ+ patients should be evaluated to identify the effectiveness of the curriculum. Students' confidence and skills to care for LGBTQ+ people could be evaluated for in a similar study design. This way health care faculty can address gaps in their curriculum going forward. Future research should evaluate the quality of education incorporated into the curriculum in the departments.

Conclusions

The findings of the analysis suggest that by increasing faculty's confidence regarding LGBTQ+ content, their inclusion of LGBTQ+ content in the curriculum may increase. This can be done through departmental training sessions, seminars led by experts, working with local advocacy groups, and using online educational resources. It is important to include diverse voices when developing curriculum changes. When incorporating this information into the classroom, faculty can use panel discussions, simulations, case-based learning, and lectures. This study is significant because health care workers and clinicians have a duty to provide equitable, patient centered care by recognizing the unique physical and mental health

needs among the LGBTQ+ population. The study will contribute to identifying the need for improving confidence of faculty in teaching about the LGBTQ+ population and their inclusion of this content in the curriculum.

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