Homophobia in Registered Nurses: Impact on LGB Youth

Christopher W. Blackwell
Ermalynn M. Kiehl

ABSTRACT. This study examined registered nurses' overall attitudes and homophobia towards gays and lesbians in the workplace. Homophobia scores, represented by the Attitudes Toward Lesbians and Gay Men (ATLG) Scale, was the dependent variable. Overall homophobia scores were assessed among a randomized stratified sample of registered nurses licensed in the State of Florida who were educated at the diploma, associate, bachelors, masters, and doctorate levels. Statistical analyses were conducted using structural equation modeling and one-way analysis of variance.

KEYWORDS. Attitudes, discrimination, education, day, homophobia, homosexual, LGB youth, lesbian, nursing, registered nurse, workplace

There have been numerous critical inquires assessing differences between registered nurses educated at various educational levels. However, there is a great lack of study assessing differences between educational levels of registered nurses and attitudes towards societal issues, dilemmas, and controversies. Research suggests there are significant differences in several characteristics of nurses educated at the diploma, associate,

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clinical practice (Robinson & Miller, 199

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LITERATURE R

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bachelors, masters, and doctoral levels. Nurses educated at the baccalaureate and diploma levels, for instance, tend to be more conscious of cost-containment issues compared to associate degree nurses during clinical practice (Robinson & Miller, 1995).

Research also finds differences in educational levels and self-perceptions of professionalism among nurses (Williams, 1995). Differences in critical thinking, field dependent-independent thinking, adaptive style flexibility, and self-esteem have also been correlated with educational levels of nurses (Saint Clair, 1994). Stirring much controversy within the nursing profession, one study (Aiken, Clarke, Cheung, Sloane, & Silber, 2003) demonstrated a correlation with increased educational preparation of nurses and decreased patient mortality.

This study examines registered nurses' overall attitudes and homophobia toward gays and lesbians in the workplace. We posit an analogy between our results and registered nurses working with youth in schools and in the community. Homophobia has been defined as the fear or dislike of gay persons (Smith, 2007). Using the Attitudes Toward Lesbians and Gay Men (ATLG) Scale, overall homophobia scores were assessed among nurses educated at the diploma, associate, bachelors, masters, and doctorate levels. Statistical analyses were conducted using structural equation modeling and one-way analysis of variance.

LITERATURE REVIEW

This literature review concentrated on critical inquires assessing homophobia in healthcare and nursing; correlations between homophobia and education; the role of school nurses in helping to decrease violence, harassment, and abuse of lesbian, gay, bisexual, and transgender (LGBT) students; and the Attitudes Toward Lesbians and Gay Men (ATLG) Scale. There are very little data examining the amount of homophobia and prevalence of discrimination in the healthcare setting and when examining such discrimination, there is a lack of research studying the responsiveness to deal with homophobia within the workplace (Saunders, 2001).

Although some studies examine physician attitudes and discriminatory belief patterns (Lock, 1998; Muller & White, 1997; O'Hanlan, Cabaj, Schatz, Lock, & Nemrow, 1997; Olsen & Mann, 1997; Tellez, Ramos, Umland, Palley, & Skipper, 1999), none of these pertain to the homophobia of registered nurses. Burke and White (2001) conducted research examining the well-being of lesbian, gay, and bisexual medical doctors, discussing

correlations between well-being and workplace-related discrimination issues; nurses were not included in their sample.

While the work of Douglas, Kalman, and Kalman (1985) investigated some homophobia in nursing and medicine, more specifically, the researchers made correlations between homophobia and the treatment of AIDS patients. Only one article (Stephany, 1992), a qualitative study, examined the author's personal work experiences as a lesbian nurse.

Despite the dearth of data on homophobia in nurses, social science researchers that have extensively studied the relationship between education level and homophobia (Battle & Lemelle, 2002; Berkman & Zinberg, 1997; Herek, 2000, 2002; Herek & Capitanio, 1995; Hoffmann & Bakken, 2001; Lewis, 2003). These researchers reported a negative correlation between these two variables; thus, the more education heterosexuals obtain, the less homophobic they are (Battle & Lemelle, 2002; Berkman & Zinberg, 1997; Ellis, Kitzinger, & Wilkinson, 2002; Herek, 2000, 2002; Herek & Capitanio, 1995; Hoffmann & Bakken, 2001; Lewis, 2003). However, the exact role education plays in affecting a heterosexual's homophobia is unclear.

Lower degrees of education have been claimed as an etiologic source for increased homophobia among the African American community (Lewis, 2003). African Americans are two-thirds less likely than Caucasians to be college graduates. Education appears to positively correlate to a greater acceptance of differences in others, more liberal sexual outlooks, and an increase in the amount of interactions people have with gay men and lesbians. Therefore, it is speculated that African Americans should tend to be less accepting of homosexuals (Lewis). Scores on the ATLG Scale decrease as respondent educational level increases; thus, education is negatively correlated with homophobia (Herek, 2002).

Attempting to define at exactly what level of education differences in homophobia begins, college education appears to serve as a division point as research indicates that heterosexuals with a college degree hold significantly more favorable attitudes and less prejudice about homosexuals than do those with less education (Herek & Capitanio, 1995). Perhaps education itself isn't significant without educational experiences rich in sexual orientation issues, which has been correlated with lower degrees of homophobia (Hoffmann & Bakken, 2001). However, research on social workers hasn't been able to support this correlation (Berkman & Zinberg, 1997). Very little scholarly inquiry has been conducted assessing the role of school nurses in helping to decrease violence, harassment, and abuse of LGB youth. Data suggest gay and lesbian students, for example,

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School nurses believe they do not possess
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METHODOLO

Instrument

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face the denial of their existence by school professionals, adult biases against homosexuality, and institutionalized heterosexism (Rankin, 2003; Treadway & Yoakam, 1992). Discriminatory climates on university and college campuses for LGBT students also exist. A 2003 comprehensive assessment of campus climate for these students by Rankin (2003) found more than one-third (36%) of all LGBT undergraduate students have experienced harassment within the past year; 20% also expressed a fear of physical violence directed toward them; and half (51%) concealed their sexual orientation or gender identity to avoid intimidation by others. Perhaps of even greater significance, 41% of study participants stated their college/university was not addressing issues related to sexual orientation and gender identity.

Importance of actions of school professionals in preventing homonegativity in school settings is found in the work of Ramfedi (1993), finding that educators who received additional training on HIV/AIDS prevention and adolescent homosexuality were more likely to use more strategies to teach students about homosexuality and to improve the school environment for homosexual students. This additional training also translated to more referrals of gay and lesbian students to community resources.

School nurses believe they do not possess the necessary skills to competently assess and to treat gay youth (Bakker & Cavender, 2003). Scholars recommend school nurses increase their competency in providing services to LGB students by augmenting their knowledge, sensitivity, and awareness of this youth subculture, acquiring communication skills to relate to them and increasing cultural competence (Bakker & Cavender). Benton (2003) suggests that school nurses should act as advocates for lesbian, gay, bisexual, and questioning students during the process of "coming out"; school nurses can also play a unique role in agency and community referral and ensuring a student's confidentiality.

METHODOLOGY

Instrument

This study employed the Attitudes Toward Lesbian and Gay Men (ATLG) Scale (Herek, 1984, 1987a, 1987b, 1988, 1994).[1] The scale gauges heterosexuals' affective responses to homosexuality, gay men, and lesbians (Davis et al., 1998). Consisting of two subscales (one assessing affective response to statements concerning lesbians and the other to gay men), this

20-question survey instrument is designed as either a 4-point or 5-point Likert scale using labels from strongly disagree to strongly agree (Davis et al.). Scoring is evaluated by summing numerical values (1 = *strongly disagree*, 5 = *strongly agree*) across items for each subscale. Reverse scoring is used for some items; reverse scoring is corrected in the statistical analyses. The possible range of scores varies depending on the response of study participants. With the 5-point response scale used in this inquiry, total scale scores could range from 20 (extremely positive attitudes) to 100 (extremely negative attitudes).

The ATLG has been shown reliable with alpha levels $\geq .80$ (Herek, 1987a, 1987b, 1988, 1994; Herek & Glunt, 1991, 1993). Shorter forms of the ATLG have also shown reliable with alpha scores of .70 (Herek, 1994; Herek & Capitanio, 1996). To examine validity, higher scores were correlated with high religiosity, lack of personal contact with gay men and lesbians, an adherence to traditional sex-role attitudes, belief in a traditional family ideology, and high levels of dogmatism (Greene & Herek, 1994; Herek, 1994; Herek & Capitanio, 1995, 1996; Herek & Glunt, 1993).

These higher scores were also correlated with AIDS-related stigma (Herek & Glunt, 1991). Discriminate validity was supported through two studies completed by Herek in 1988 and 1994. Affiliates with a gay and lesbian organization and supporters of a local gay rights initiative scored significantly lower (at the extreme positive end) on the ATLG while community residents opposing the initiative scored much at the extreme negative end.

In addition to the ATLG, a demographic data collection sheet to gather information about the participants' age, gender, race/ethnicity, education level, belief in the "free choice" model of homosexuality, exposure to homosexuals through friends and/or family associations, and attitudes towards workplace nondiscrimination policies protective of gays and lesbians was used.

Data Collection

Research proposals were submitted for approval to the Institutional Review Board at one metropolitan university. To collect data in a random fashion, a mathematical approach was used to obtain the sample. Using the electronic database of registered nurses through the State of Florida Department of Health Board of Nursing, potential participants were selected by selecting every third name in the database under each letter of the alphabet until 20 names were selected per letter yielding a total of 520 potential

subjects. Only individuals with mailing ad
were included. If an individual living ou
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The study packet included directions f
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The respondents' identities were kept a
used during the data collection or analyse
withdraw from the study at any time witho
data were read only by the researcher. Cor
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Treatment of the Data

Data were analyzed through the use of
comparative statistics. Descriptive statistics
of aggregate sample data; measures of cen
report trends in the data while frequency d
persion of responses. To determine relation
variable of education and dependent varia
analysis of variance (ANOVA) and structu
were used. Confirmatory factor analysis wa
consistency of the ATLG Scale.

RESULTS

Demographics

Table 1 illustrates the demographic distril
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subjects. Only individuals with mailing addresses within the United States were included. If an individual living outside the United States was selected, the next name was selected; every third name was then selected using the newly selected individual as a starting point. In alphabet letters where the sample of 20 couldn't be arrived at by selecting every third registered nurse, the deficient amount was made-up by sampling every third name from the end of the alphabet forward. Forty were returned as undeliverable and 165 of the remaining 480 (34%) were included in the study.

The study packet included directions for completing the study, a two-page questionnaire (including the demographic data collection sheet and the ATLG Scale), and a postage-paid envelope for return of the survey. As explained in the directions included in the study packet, completion and return of the survey indicated informed consent for participation. Although disclosure of a homosexual or bisexual orientation was exclusionary for the study, data analysis indicated this was a nonsignificant variable and eventually removed from the structural equation model used for this study.

The respondents' identities were kept anonymous; no identifiers were used during the data collection or analyses. Participants could choose to withdraw from the study at any time without consequence. Individual raw data were read only by the researcher. Confidentiality was maintained by locking the questionnaires in a research office.

Treatment of the Data

Data were analyzed through the use of descriptive, correlational, and comparative statistics. Descriptive statistics were used for an examination of aggregate sample data; measures of central tendency were utilized to report trends in the data while frequency distributions indicated the dispersion of responses. To determine relationships among the independent variable of education and dependent variable of homophobia, one-way analysis of variance (ANOVA) and structural equation modeling (SEM) were used. Confirmatory factor analysis was used to support the internal consistency of the ATLG Scale.

RESULTS

Demographics

Table 1 illustrates the demographic distribution of the sample. The typical respondent was a Caucasian heterosexual female, between the ages of

TABLE 1. Frequencies of demographic responses*

	Variable	Sample Composite
Gender		
$n = 163$	Male	11 (7%)
	Female	152 (92%)
Age		
$n = 162$	20–29	13 (8%)
	30–39	28 (17%)
	40–49	55 (33%)
	50–59	40 (24%)
	>60	26 (16%)
Race		
$n = 163$	Caucasian	131 (79%)
	African American	8 (4.8%)
	Hispanic	5 (3%)
	Asian	16 (10%)
	Other	3 (2%)
Education		
$n = 162$	Diploma	17 (10%)
	Associate	64 (39%)
	BSN	57 (35%)
	MSN	21(13%)
	Doctorate	3 (2%)

*Due to missing data, variable categories do not sum to total sample size ($N = 165$).

40 and 49 years, with an Associate Degree in Nursing. With regard to religiosity, the majority were moderate Christian, attending church weekly. Seventy-three percent of participants have at least one friend or family member who is a gay man or lesbian and 62% indicated they would support a nondiscrimination policy in their workplace that protects gay men and lesbians.

Validation of the ATLG Scale

The ATLG scores of this study's sample ranged from 20 to 100. Seventy-eight percent of respondents had an overall ATLG score of 60 (midrange) or less while the remainder (22%) had scores greater than 60 (higher level of homophobia).

Validation of the research instrument used in this study was completed with the use of confirmatory factor analysis. Specifically, the standardized regression weights of each of the 20 ATLG items were correlated with the

overall construct of homophobia. Analysi
indicated that 16 of the 20 items were sta
of the indices had a factor loading value ≥

Thus, the regression values indicate th
on the construct is relevant. The only ATL
≤ .71 were item numbers 1, 2, 4, 13, and
regression weights, each item's critical r
support validity. According to Garson (20
with standard normal distributions, estima
1.96 are significant at the .05 level. Each it
in the overall model, with critical ratio
alpha for the ATLG Scale was .77; validit
with a Cronbach's alpha score ≥ .7 (Ga
ATLG for this study was also supported b

Age Ethnicity, and Nursing Educatio with Homophobia

Significance was found with age and et
way ANOVA indicated a statistically sign
5.3, $p \leq .05$, between mean ATLG scores
of the sample. Tukey's post hoc analysis i
($p \leq .05$) differences between the age grou
and 40–49. Statistically significant differer
were also found in the mean ATLG scor
nicities. Of individuals identifying their ra
lowest on the ATLG at 42; African America
Asians had a mean ATLG score of 52 and
individuals who indicated their race/ethnici
of 26. Tukey's post hoc analysis indicated t
mean ATLG scores between the ethnicities
($p \geq .05$).

Differences in mean ATLG scores betw
ucation in the sample were not statistically
$p \geq .05$. Nurses who indicated an educati
mean ATLG score of 46 compared to 42 for
Nurses who indicated the highest level of ed
ence in Nursing (BSN) had a mean ATLG
Science in Nursing had a mean ATLG of 3
at the doctoral level had the highest mean A

es of demographic responses*

le	Sample Composite
	11 (7%)
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overall construct of homophobia. Analysis of the regression of the indices indicated that 16 of the 20 items were statistically significant. All but five of the indices had a factor loading value $\geq .71$ at $p = .05$.

Thus, the regression values indicate that the influence of these indices on the construct is relevant. The only ATLG items with a regression weight $\leq .71$ were item numbers 1, 2, 4, 13, and 17. In addition to analysis of the regression weights, each item's critical ratio value was also analyzed to support validity. According to Garson (2005), in random sample variables with standard normal distributions, estimates with critical ratios more than 1.96 are significant at the .05 level. Each item on the ATLG was significant in the overall model, with critical ratio values > 1.96. The Cronbach's alpha for the ATLG Scale was .77; validity for an instrument is supported with a Cronbach's alpha score $\geq .7$ (Garson). Thus, the validity of the ATLG for this study was also supported by the Cronbach's alpha value.

Age Ethnicity, and Nursing Education as Correlates with Homophobia

Significance was found with age and ethnicity but not education. One-way ANOVA indicated a statistically significant difference, $F\ (5, 157) = 5.3$, $p \leq .05$, between mean ATLG scores between the various age groups of the sample. Tukey's post hoc analysis indicated statistically significant ($p \leq .05$) differences between the age groups 20–29 and 30–39 and 30–39, and 40–49. Statistically significant differences, $F\ (5, 158) = 3.4$, $p \leq .05$, were also found in the mean ATLG score of the sample's various ethnicities. Of individuals identifying their race/ethnicity, Caucasians scored lowest on the ATLG at 42; African Americans highest at 61. Hispanics and Asians had a mean ATLG score of 52 and 54, respectively. Finally, those individuals who indicated their race/ethnicity as "other" had a mean ATLG of 26. Tukey's post hoc analysis indicated that individual differences in the mean ATLG scores between the ethnicities were not statistically significant ($p \geq .05$).

Differences in mean ATLG scores between the different levels of education in the sample were not statistically significant, $F(6, 156) = 1.7$, $p \geq .05$. Nurses who indicated an education at the diploma level had a mean ATLG score of 46 compared to 42 for those with an associate degree. Nurses who indicated the highest level of education as the Bachelor of Science in Nursing (BSN) had a mean ATLG of 48. Nurses with a Master of Science in Nursing had a mean ATLG of 37 while the 3 nurses educated at the doctoral level had the highest mean ATLG score of 60.

TABLE 2. Comparison: Goodness of fit of original and reconfigured SEM

Measurement	Original Model	Reconfigured Model
Chi-Square	1162	635
Probability	0.000	0.000
Comparative Fit Index	.80	.88
Tucker-Lewis Index	.77	.86
RMSEA	0.91	.89
CMIN/(Degrees of Freedom)	2.35	2.30
Squared Multiple Correlations	.52	.55

While the differences between the levels of homophobia among the various educational levels of the nurses were insignificant, overall, levels of education were not positive correlates to the overall homophobia scores of the sample. Using structural equation modeling (SEM), the endogenous variable of education was postulated as a predictor of the exogenous variable of homophobia. With a critical ratio value of .41 (< 1.96), education was a nonsignificant endogenous variable. In addition to the critical ratio value, goodness of fit criteria are also assessed in conducting SEM. Variables deemed insignificant statistically are removed from the model, thus strengthening fitness criteria (including chi-square, probability, comparative fit index, Tucker-Lewis index, root mean square error of approximation [RMSEA], computed minimum sample descrepancy (CMIN)/ degrees of freedom, and squared multiple correlations). Removal of the insignificant endogenous variables of this study, including education, greatly improved the goodness of fit of the SEM (Table 2).

The overall chi-square for the model significantly decreased from 1162 to 635, indicating a strengthening of the goodness of fit. The comparative fit index increased significantly from .80 to .88 while the Tucker-Lewis Index significantly increased from .77 to .86, both indicating an increase in the goodness of fit with the reconfigured model. The root mean squared error of approximation dropped .2 from .91 to .89. CMIN/ (degrees of freedom) decreased from 2.35 to 2.30, indicating an overall better goodness of fit of the reconfigured model compared to the original model. The squared multiple correlations value also increased slightly from .52 to .55, indicating a strengthening of the model's measurement of the construct.

In summary, the goodness of fit measurements significantly improved after reconfiguration of the structural equation model to include only those variables that were statistically significant predictors of homophobia. Other

variables predictive of homophobia in thi
race/ethnicity, personal belief regarding c
interpersonal contact with gay and lesbian
crimination policy.

Support Workplace Nondiscriminatio with Homophobia

The hypothesis for this study predicted
correlation between support for a nondiscr
and lesbians in the workplace and homo
structural equation modeling (SEM) was u
of the study (support or nonsupport of a non
of gay men and lesbians in the workplace)
the model and were correlated with the l
which was then correlated with the 20-iter

Next, using a critical ratio (CR) signific
pendent variable was assessed for statisti
ratio value of −4.01, support for a nondis
gays and lesbians was a significant negati
With a critical ratio value of 3.23, nonsuppo
protective of gays and lesbians was a signi
among the nurses.

DISCUSSIO

Homophobia exists in nursing (Blackw
Röndahl, Innala, & Carlsson, 2004).While
highlight the significance of the relationsh
ables and dependent variables, perhaps it
findings in research that largely conflict wit
dictors. It is also useful to examine the role t
people can play, given the proper values, kn

Homophobia and Level of Education:

As noted earlier, published data largely su
tween homophobia and education level. In
of this sample were not statistically signific

ess of fit of original and reconfigured SEM

Original Model	Reconfigured Model
1162	635
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.80	.88
.77	.86
0.91	.89
2.35	2.30
.52	.55

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significant predictors of homophobia. Other

variables predictive of homophobia in this sample of nurses included age, race/ethnicity, personal belief regarding controllability of homosexuality, interpersonal contact with gay and lesbian persons, and support of a nondiscrimination policy.

Support Workplace Nondiscrimination Policies as a Correlate with Homophobia

The hypothesis for this study predicted that there would be a negative correlation between support for a nondiscrimination policy protecting gays and lesbians in the workplace and homophobia. To test this hypothesis, structural equation modeling (SEM) was used. The independent variables of the study (support or nonsupport of a nondiscrimination policy protective of gay men and lesbians in the workplace) were placed on the left side of the model and were correlated with the latent construct of homophobia, which was then correlated with the 20-item ATLG scale.

Next, using a critical ratio (CR) significance level of >1.96, each independent variable was assessed for statistical significance. With a critical ratio value of −4.01, support for a nondiscrimination policy protective of gays and lesbians was a significant negative correlate with homophobia. With a critical ratio value of 3.23, nonsupport of a nondiscrimination policy protective of gays and lesbians was a significant predictor of homophobia among the nurses.

DISCUSSION

Homophobia exists in nursing (Blackwell, 2005; Christensen, 2005; Röndahl, Innala, & Carlsson, 2004).While most notable research tends to highlight the significance of the relationships between independent variables and dependent variables, perhaps it is also significant to highlight findings in research that largely conflict with established and expected predictors. It is also useful to examine the role that nurses working with young people can play, given the proper values, knowledge, and resources.

Homophobia and Level of Education: Alternative Explanations

As noted earlier, published data largely support a negative correlation between homophobia and education level. In contrast, the educational levels of this sample were not statistically significant predictors of homophobia

among registered nurses. There could be a multiplicity of reasons explaining the lack of correlation. Salient to this discussion is the survey instrument, which is a limitation of this study.

There is a great deal of difference and debate regarding path to entry-level nursing practice and the education of nurses (Kenny, Carter, Martin, & Williams, 2004). It is possible that participants were unable to strongly identify with one of the options (Diploma, Associate, BSN, MSN, Doctoral) presented in the survey instrument. For example, a nurse who has been educated with an associate degree education might pursue a Bachelors or Masters degree outside of nursing. This presents ambiguity among the survey options; although the nurse was educated at the associate level, he or she went on to earn a baccalaureate degree outside of nursing, which was not an option on the survey instrument.

Similarly, a nurse educated at the diploma level, who eventually went to graduate school and received a Masters degree in health administration or public health, would have had difficulty in the survey choices provided. Participants may have been forced-into an answer option that didn't represent their highest level of education. Thus, the finding of nonsignificant differences between homophobia scores and education may have been a Type 2 error.

However, beyond the limitations of the study instruments there may be important differences between which variables predict homophobia in the general heterosexual population and nurses in general. It is widely supported that interpersonal contact with gays and lesbians is a strong negative correlate with homophobia (Berkman & Zinberg, 1997; Douglas et al., 1985; Finlay & Walther, 2003; Herek, 1988, 2000, 2002; Herek & Capitanio, 1995; Hoffmann & Bakken, 2001; LaMar & Kite, 1998; Landen & Innala, 2002; Lewis, 2003; Plugge-Foust & Strickland, 2001). Perhaps nurses' homophobia is influenced more significantly by their interactions with gay men and lesbians compared to educational experience.

Although not a statistically significant predictor of homophobia in this study, gender composition of nurses is of significance to this discussion. Only 11 male nurses were included in this study, with all of them returning surveys. There is a societal misperception that nursing is a feminine career choice or that nursing is a profession that is gender specific (Clifford, 2005). One might hypothesize that male nurses overstate their homophobia due to societal stigma of being a male nurse working in a female-dominated industry. Or, this stigma may lead to irrational thought process among male nurses. Perhaps knowing the existence of a social stigma placed on male nurses alters their rationality of male gender

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roles. Male nurses may irrationally believe that because society may associate nursing as feminine, effeminate behaviors often associated with homosexuality further perpetuate the social stigma. Irrational thought process has been positively correlated with male gender and homophobia (Plugge-Foust & Strickland, 2001).

Nurses practice in a variety of settings, treating clients from many diverse backgrounds (Coffman, 2004). Because interpersonal contact with gays and lesbians has been negatively correlated with homophobia, perhaps the increased exposure to and greater amount of interaction with diverse clients, including gay and lesbian clients, tends to be more of a predictor of homophobia than education. In addition, although extraneous to the scope of this discussion, in this study, interpersonal contact with gays and lesbians was a strong predictor of homophobia with a critical ratio of 3.61.

Heterosexuals who are more tolerant of culturally diverse individuals tend to be more open to interaction with homosexuals and also tend to be more supportive of human rights initiatives (Ellis, Kitzinger, & Wilkinson, 2002). Like the correlation between interaction with homosexuals and homophobia, increased personal interactions with minority groups, in general, tend to lessen discriminatory beliefs and attitudes of majority cultures on minority cultures (Mahoney, 2005). Given the diversity of the nursing student population, the quantity of interactions between majority and minority individuals throughout the education process may have lessened the impact that more education had on reducing homophobia.

Another explanation or contributor to the lack of significant relationship found in this study between homophobia and education levels is that the inclusion of topics in nursing curriculum pertaining to sexual orientation. For example, Abrums and Leppa (2001) authored an approach to infusing cultural diversity in nursing education that was inclusive of issues regarding sexual orientation. Perhaps an across-the-board increased concentration on the provision of culturally competent care to homosexual clients in nursing curricula has resulted in nonsignificant differences in homophobia derived from educational background. Campinha-Bacote (2006) noted the belief that nursing education is on a "progressive course" (p. 244) towards increasing the cultural competence of nurses through paradigm shifts in curricula.

Role of the Nursing Profession in Working with LGBT Youth

To the degree to which interpersonal contact with homosexual persons, intercultural interactions, and/or curriculum inclusion have impacted homophobia among school nurses in this sample is not known. However,

clearly nurses can play an important role in addressing issues faced by LGBT questioning (Q) youth, in part, because of their traditional role as a trusted caregiver. While such adolescents tackle many of the same growth and development issues as other adolescents and have the similar health education needs and safety and health concerns, they also confront homophobia as they incorporate identities that are generally invisible, stigmatized, or marginalized (Adams, 1997; Bakker & Cavender, 2003). Four out of five LGBTQ students, for instance, report being verbally harassed because of their sexual orientation—while 83% of LGBT students note that faculty and staff never or only rarely intervene when they are present and homophobic remarks are made; they are 40% more likely to skip school out of fear for their safety (gay, lesbian, straight education network (GLSEN), 2003). In their *2004 State of the States* report by (GLSEN) (2004), 42 states received failing grades. The vast majority of students did not have legal protections against anti-LGBTQ bullying and harassment.

Given the additional problems facing LGBTQ youth such as increased drug and alcohol use, sexually transmitted infections and pregnancy risks, depression, and suicide, school nurses can play a unique role in the lives of these students (Benton, 2003; Russell & Joyner, 2001). School nurses are in a particularly good position to provide support for these youth since they often work individually with a young person in the confidentiality of their office or a hospital room. If these nurses have both low levels of homophobia and are knowledgeable about issues facing these young people, they can provide much needed services even within institutions or locations where no protections exist.

Although it has been the role of school nurses to identify at-risk students, it should also be expected that they be prepared to provide health care for the subculture of LGBT youth. The National Association of School Nurses adopted a position statement on Sexual Orientation and Gender Identity/Expression in 1994, which was revised in 2003. The policy states:

> [A]ll students, regardless of sexual orientation, gender expression, and gender identity are entitled to equal opportunities in the educational system. The school nurse needs to be aware of students who are lesbian, gay, bisexual, transgender and questioning; sensitive to their needs; knowledgeable about the health needs of this group of students; and effective in interventions to reduce risk factors. The school nurse should be actively involved in fostering a safe environment, demonstrating an understanding of the issues and modeling respect for diversity (p. 2).

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However, nurses report that they do not have the knowledge or skills needed to identify and to address the needs of this group (Bakker & Cavender, 2003). School nurses need to be aware of, sensitive to, and knowledgeable about the subculture and possess communication skills required to relate appropriately to this group of young people. Yet, a review of the *Journal of School Nursing* from 2000–2006 revealed that in the 39 issues and 390+ articles, only 3 articles addressed issues related to LGBTQ youth. Clearly, there needs to be a greater focus on nursing research, program development, and implementation.

It is suggested (GLSEN, 2002) that every school should have at least one clearly identifiable person who understands the needs of LGBT youth. Benton (2003) found that school nurses' perceived a professional responsibility toward these youth. Thus, it would seem logical that a nonhomophobic school nurse would be the ideal person to fill this role. Nurses who have low degrees of homophobia, have knowledge about LGBT issues and assume a proactive role can also play an important role outside of the school. In hospitals, for example, pediatric nurses can employ their assessment skills to identify clients who might be at risk for psychosocial disturbances or other health issues related to their sexual orientation or gender identity. Recognition of high risk clients can lead to faster intervention and can also enhance the opportunity for the nurse to provide wellness education among adolescents encountering unique developmental experiences.

Although the level of education does not appear to correlate with homophobia among nurses, it is imperative that nursing curricula embrace culturally diverse students and continue to ensure that issues regarding sexual orientation remain an essential part of the training of nurses in providing culturally competent care.

NOTE

1. The ATLG Scale was developed in 1988 and can be obtained from the *Handbook of Sexually-Related Measures* (Davis, Yarber, Davis, Bauserman, Scheer, & Davis, 1998). Herek (1984, 1987a, 1988, 1994) has completed factor analyses, item analyses, and construct validity studies.

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APPENDIX

PROFESSIONAL DEVELOPMENT WITH LGBT Y

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TRAINING MA

1. *Ending Anti-Gay Bias in Schools:* training-of-t vides educators and activists with a resource duct antibias workshops in their local commun for conducting your own two-day session and tions, handouts, and surveys. The training is des Lunchbox but offers a variety of strategies an any training program. Phone: 1-800-247-6553; bin/iowa/all/library/record/580.html . . . Adult
2. *"Not Round Here: Affirming Diversity, Chall vice Providers Training Manual:* This rich, w ton Penley Miller & Mahamati of Outlink, a Equal Opportunity Commission (Australia), http://www.hreoc.gov.au/pdf/human_rights/Not_r Rights and Equal Opportunity Commission 200 quote from the kit without any obligation to seek knowledge the Commission, as long as the source format)
3. *"The GLSEN Lunchbox: A Comprehensive Tra Bias in Schools":* A comprehensive training p menu of exercises and activities aimed at provi knowledge, skills, and tools necessary to bui to develop more inclusive school environments. http://www.atlasbooks.com/glsen/ordercur.htm .
4. *"Guide to Leading Introductory Workshops on H* from the Campaign to End Homophobia. Includes and activities so that someone with little experie lead introductory workshops on homophobia. T as a form of oppression. P. O. Box 382401, Ca bszoloth@aol.com; Web site: http://www.endhom